Procedure Contact Information

Name: _____

Provider: _____ Acct #:_____

DOB: _____ / _____ / _____ Age: _____ Date of Service: _____ / _____ / _____

Are you an Organ Donor? ☐ Yes ☐ No

Please provide most current phone number: _____

Email Address: _____

PRIMARY EMERGENCY CONTACT:

Name: _____ Phone: _____

Relationship: _____

SECONDARY EMERGENCY CONTACT:

Name: _____ Phone: _____

Relationship: _____

DRIVER INFORMATION:

Name: _____ Phone: _____

Patient's Signature: _____ Date: _____

PLEASE INFORM THE PATIENT CARE REPRESENTATIVE ABOUT ANY CHANGES IN YOUR INSURANCE COVERAGE OR NEW INSURANCE CARDS YOU HAVE RECEIVED.

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Patient Rights And Responsibilities

THE PATIENT HAS THE RIGHT TO:

Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.

Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of service.

Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.

Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care and related fees for services rendered.

Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.

Make informed decisions regarding his or her care.

Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or the facility.

Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.

Be informed of any human experimentation or other research/ educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.

Express grievances/complaints and suggestions at any time.

Be given assistance in changing primary care or specialty physicians if other qualified physicians are available.

Provide patient access to and/or copies of his/her medical records.

Be informed as to the facility's policy regarding advance directives/living wills.

Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.

Express those spiritual beliefs and cultural practices that do not harm or interfere with a planned course of medical therapy for the patient.

Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English. The facility presents information in a manner and form, such as TDD, large print materials and interpreters, that can be understood by hearing and sight impaired individuals.

Have an assessment and regular assessment of pain.

Education of patients and families, when appropriate, regarding their roles in managing pain, as well as potential limitations and side effects of pain treatment, if applicable.

Have their personal, cultural, spiritual and/or ethnic beliefs considered when communicating to them and their families about pain management and their overall care.

Exercise his or her rights without being subjected to discrimination or reprisal.

Voice grievances regarding treatment or care that is (or fails to be) furnished.

Personal privacy.

Receive care in a safe setting.

Be free from all forms of abuse or harassment.

To change providers if other qualified providers are available.

Have access to a copy of this form.

To know that physicians performing procedures at The Pain Management Group/Tennessee Pain Surgery Center, LLC may have a financial interest in the operation of the Center.

If is patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.

If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State laws may exercise the patient's rights to the extent allowed by the State law.

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Patient Rights And Responsibilities

PATIENT RESPONSIBILITIES:

Be considerate of other patients and personnel and for assisting In the control of noise, smoking and other distractions.

Respecting the property of others and the facility. Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.

Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.

Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.

Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right of care at the facility and is responsible for the outcome.

Promptly fulfilling his or her financial obligations to the facility.

Payment to facility for copies of the medical records the patient may request.

Identifying any patient safety concerns.

ADVANCE DIRECTIVE NOTIFICATION:

In the State of Tennessee, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Pain Management Group/Tennessee Pain Surgery Center, LLC respects and upholds these rights.

It is our policy to respect your wishes for a DNR order. If you have a Tennessee POST form completed and signed by your Primary Care Physician, we will honor your request. If you do NOT have a signed POST form, but only an Advance Directive form, it is our policy that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation.

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE:

To report a complaint or grievance you can contact the facility Administrator by phone at 615.941.8501 or by mail at:

Tennessee Pain Surgery Center, LLC
5811 Crossings Boulevard
Antioch, TN 37013

Complaint and grievances may also be filed through the State of Tennessee Division of Health Care Facilities at:

Tennessee Department of Health
Division of Health Care
Facilities Centralized Complaint
Intake Unit Heritage Place,
Metro Center 227
French Landing, Suite 501
Nashville, TN 37043
615.747.7221
1.877.827.0010 (Toll Free)

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage on the web at:
www.cms.hhs.gov/center/ombudsman.asp

Acknowledgement that I or my representative have received both verbal and a written notice prior to my scheduled procedure and understand my rights and responsibilities.

Patient Signature: _____

Patient Name: _____

Witness Signature: _____

Date: _____

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Patient Financial Policy

This is an agreement between Tennessee Pain Surgery Center, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Tennessee Pain Surgery Center. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

- **10% of balance is due at time of service.**

We accept the following: Cash or Credit Card ***(Visa, MasterCard, Discover, American Express)***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

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WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on _____/ _____/ _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____/_____/_____

Attorney Name: _____ Phone: _____

BILLING INFORMATION

STATEMENTS: A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by email at Billing@OurAdvancedHEALTH.com or call 615.239.2018. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to Tennessee Pain Surgery Center and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS: You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **$20 flat rate** for 1-5 pages plus .50 per additional page and postage.

- If age 18 years and over, you should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members. A copy should be on file within the office.
- Please notify the office if you have a Living Will or Power of Attorney.

Procedure Discharge Instructions

FOLLOW THESE INSTRUCTIONS AFTER YOUR PROCEDURE

- No driving the day of the procedure.
- Resume your regular medications as prescribed by your provider. If you take a blood thinner you may resume taking it 12 hours after the procedure.
- Rest today and resume daily activities tomorrow. Do not engage in strenuous activity or heavy lifting for 48 hours.
- Remove your bandage(s) in 24 hours.
- If you had an injection with contrast, drink plenty of fluids to help flush contrast from your body.

COMMON SIDE EFFECTS

- Increased pain/discomfort at the procedure site for the first day or two.
- Increased pain: You can expect some discomfort for several days after your Radiofrequency Ablation. An ice pack to the injection site is helpful for the first 12 hours. Take your usual pain medications prescribed by your physician.

STEROID INJECTIONS ONLY

- Steroids most often begin to work in 3 to 4 days.
- Elevated blood sugar: Steroids may cause an increase in blood sugar in patients with pre-existing diabetes. If there is a rise in your blood sugar that is not controlled by your normal medications, contact your primary care physician.
- Elevated blood pressure: Steroids can cause an increase in blood pressure in patients with hypertension. If there is a rise in your blood pressure that is not controlled by medications, please call 615-941-8501.

CAll YOUR DOCTOR (615.941.8501) IF ANY OF THE FOLLOWING OCCUR:

- Fever greater than 101 degrees.
- Swelling, redness, or unusual drainage from the injection site.
- Increased SEVERE pain, inability to walk, profound weakness in your arms or legs, or loss of bladder or bowel control.

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SPINAL CORD STIMULATOR TRIALS

- You will be given a post-operative antibiotic, please take your antibiotic as directed for the entire course of treatment.
- **DO NOT SHOWER WITH THE STIMULATOR OR GET THE PROCEDURE SITE WET.** Sponge bathing is acceptable until the follow-up appointment and your stimulator is removed.
- Do not engage in strenuous activity or heavy lifting until your follow-up appointment. No extensive bending or twisting.
- Do not remove dressing or bandages.

STELLATE GANGLION NERVE BLOCKS ONLY

- You may resume your regular diet. You may resume your regular diet 3-4 hours **AFTER** your procedure. Small sips of water are OK.
- Eye/Face Drooping: Stellate Ganglion Blocks may make your eyelid droop on the side of the injection site. Your voice may also be hoarse. These will go away within a few hours once the anesthetic wears off.
- Difficulty breathing or swallowing.
- Prolonged hoarseness.

If you have an emergency dial 911 or go to the nearest Emergency Room.

You may be contacted by telephone within 48 hours after your injection for a follow up questionnaire. It is important to complete this questionnaire as it may delay any future injections that may be scheduled. If we are unable to contact you, your next injection may not be able to be completed. Your nurse will notify you if you are to be contacted. If this applies to you, please call if you have not heard from us within 5 days.

Patient Signature: _____

Witness Signature: _____

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