Aegis | Bone Health Research and Education

NovaSpine Pain Institute
Your Minimally Invasive Spine, Pain & Arthritis Care Experts™

Bone Health Intake Forms

Patient name _____ **DOB** _____

Email _____

Height _____ **Weight**_____

Name of Referring Physician: _____

Name of Primary Care Physician: _____

☐ **Male** ☐ **Female**

Ethnic Origin: _____

Race:
☐ Asian ☐ African American ☐ Native American/Alaskan Native ☐ Native Hawaiian
☐ Pacific Islander ☐ White/Caucasian ☐ Hispanic ☐ Multiracial ☐ Other

Females Only
Any history of frequently missed periods (>3/year, excluding pregnancy)? ☐ Yes ☐ No
Did you have a hysterectomy with bilateral oophorectomy (removal of both ovaries)? ☐ No

If yes, at what age? _____

Have you ever taken Hormone Replacement Therapy (HRT)? ☐ Yes ☐ No

What age did you start? _____

How long did you take it? _____

Males Only
Have you ever been told you have low testosterone? ☐ Yes ☐ No ☐ N/A

HEALTH HISTORY

☐ Diabetes – recent A1c_____
☐ High Blood Pressure
☐ Heart Disease
☐ Blood Clot(s)
☐ Kidney Disease
☐ Liver Disease
☐ Arthritis
☐ Smoker (tobacco, marijuana, etc.)
☐ GI Disorder
☐ Autoimmune Disorder
☐ Cancer: _____ (type)
☐ Psychiatric Disorder: _____(type)
☐ Other: _____
_____

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DENTAL HEALTH

How often do you visit the dentist for a routine check-up?

- ☐ Every 6 months
- ☐ Once a year
- ☐ Every 2-3 years
- ☐ Only when I have a problem
- ☐ Other: _____

Date of your last dental check-up: _____

Have you ever had a dental implant? ☐ No ☐ Yes

Year and location (if known)_____

Have you ever had a tooth extraction? ☐ No ☐ Yes, _____

Are you currently planning or considering any of the following procedures? ☐ None

☐ Tooth Extraction ☐ Bone Graft ☐ Dental Implant

Other: _____ Please explain timeline: _____

EXERCISE HABITS

Do you currently exercise? ☐ Yes ☐ No, explain: _____

What type(s) of exercise do you participate in? _____

On average, how many days per week do you exercise? ☐ 1 day ☐ 2-3 days

☐ 4-5 days ☐ 6-7 days ☐ Rarely

Average duration of each exercise session: ☐ Less than 20 minutes ☐ 20-30 minutes

☐ 30-45 minutes ☐ 45-60 minutes ☐ More than 60 minutes

Please describe your typical exercise routine (optional):

_____

_____

_____

_____

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MEDICATION & SUPPLEMENT LIST	
MEDICATION NAME	**DOSING/FREQUENCY**

Fracture History

☐ No Previous Bone Fractures

Year	Description/Location of Fracture

DXA Scan History (include dates and location, if known)

☐ No Previous DXA Scans

Date	Location

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Allergies to Medications (please list and condition associated) ☐ N.K.D.A (no known drug allergies)

List Allergy	Condition/Reaction Associated

FAMILY MEDICAL HISTORY

	Father	Mother	Sibling
Diabetes	☐	☐	☐
High blood pressure	☐	☐	☐
Heart disease	☐	☐	☐
Blood clot(s)	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Arthritis	☐	☐	☐
Psychiatric Disorder	☐	☐	☐
Smoker	☐	☐	☐
Reaction to Anesthesia	☐	☐	☐
Cancer, type: _____	☐	☐	☐
Other: _____	☐	☐	☐

Patient Signature: _____

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Bone Health Intake Forms

REVIEW OF SYSTEMS (check all that apply)

General ☐ Loss of appetite ☐ Fatigue ☐ Night sweats ☐ Fevers/Chills ☐ Recurrent Infections	**Skin/Hair/Nails** ☐ Hair loss ☐ Rashes ☐ Skin ulcers	**Eyes** ☐ Blurred vision ☐ Double vision ☐ Vision Loss ☐ Difficulty Seeing at night	**ENT** ☐ Impaired hearing ☐ Ringing ☐ Difficulty Swallowing
Respiratory ☐ Shortness of breath ☐ Chronic cough	**Cardiovascular** ☐ Chest pain ☐ Palpitations	**Gastrointestinal** ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Heartburn ☐ Diarrhea	**Urinary** ☐ Frequent pain ☐ Painful urination
Neurologic ☐ Headaches ☐ Dizziness ☐ Seizures	**Endocrine** ☐ Heat intolerance ☐ Cold intolerance ☐ Weight Gain ☐ Weight Loss ☐ Excessive hunger/thirst	**Heme/Lymph** ☐ Easy bruising ☐ Easy bleeding	**Psychiatric** ☐ Depression ☐ Anxiety ☐ Other: _____

Age of onset of menses _____ ☐ N/A

Age of menopause _____ ☐ N/A

Do you wear any corrective lenses? ☐ Yes ☐ No

Have you ever had vision correction surgery? ☐ Yes ☐ No

Any current current concerns with your vision? ☐ Yes ☐ No

Frequency of vision exams: _____

SOCIAL HISTORY

Alcohol Use: ☐ No ☐ Yes – Frequency _____

Caffeine Use: ☐ No ☐ Yes – Frequency _____

Tobacco Use

Cigarette ☐ No ☐ Yes – Frequency _____

Cigar ☐ No ☐ Yes – Frequency _____

Chew ☐ No ☐ Yes – Frequency _____

☐ No ☐ Yes – Type _____ Frequency _____

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Bone Health Intake Forms

BONE HEALTH RISK FACTORS (check all that apply)

- ☐ Over the age of 50
- ☐ Prior fragility fracture- fall from a standing height (includes: spine, hip, pelvis, shoulder, or wrist)
- ☐ Family history of osteoporosis or fragility fracture in first degree relative
- ☐ History of Inflammatory Disease: COPD, Rheumatoid Arthritis, Lupus, Psoriatic arthritis
- ☐ History of Autoimmune Disease: Multiple Sclerosis, Sjogren's syndrome
- ☐ Endocrine/ Hormonal diseases: Diabetes, Hyperthyroidism, Hyperparathyroidism, Adrenal gland disorders
- ☐ Cancer: Multiple Myeloma, Lymphoma, Leukemia, Cancer along the GI tract
- ☐ GI Disease: Inflammatory Bowel Disease, Celiac Disease
- ☐ Other disease states: Chronic kidney disease, Chronic liver disease
- ☐ Current or historical use of chronic steroids (e.g. taking 5mg of prednisone for longer than 3 months, or a daily steroid inhaler)
- ☐ Medications that can cause bone loss:
    - anti-seizure medications (Tegretol, Dilantin Phenobarbital), certain cancer treatments (aromatase inhibitors, anti-androgens, chemotherapy), long-term use of some anti-coagulants (warfarin, heparin, or Plavix), proton pump inhibitors (pantoprazole, omeprazole, esomeprazole), SSRIs (Prozac, Paxil, or Zoloft), Loop diuretics (Lasix), and Depo-Provera
- ☐ Thin body frame or low body weight
- ☐ History of fall(s)
- ☐ Current or history of osteopenia or osteoporosis
- ☐ Current smoker or history of smoking

- [ ] Drinks > 1 serving of alcohol per day
- [ ] Drinks > 200mg of caffeine per day (1 cup of coffee= 100mg, 1 cup of tea= 35mg, 1 soda= 40mg)
- [ ] Perceived height loss of greater than 1.5 inches
- [ ] Low calcium intake/do not take supplemental calcium
- [ ] Low Vitamin D intake/do not take supplemental Vitamin D
- [ ] Current or history of an eating disorder (Bulimia or Anorexia)
- [ ] Scheduled/ plans for spine surgery
- [ ] Scheduled/plans for a total joint replacement (hip, knee, shoulder, or ankle)
- [ ] History of a compression fracture
- [ ] Menopause before the age of 45
- [ ] Removal of both ovaries
- [ ] Low testosterone (men)
- [ ] Delayed puberty- for women: no breast development by 13 years of age or no menarche 3 years after breast development; for men: no testicular enlargement by 14 years of age
- [ ] Inactive lifestyle or decreased physical activity
- [ ] Immobilization for an extended period in a cast or non-weight bearing
- [ ] Patients that have a surgical implant (joint replacement)
- [ ] Poor nutrition consisting of less than 2 meals per day
- [ ] Previous gastric surgery for weight loss
- [ ] Impaired balance
- [ ] Reduced vision

- ☐ Sarcopenia (muscle weakness, such as difficulty opening jars)
- ☐ Dementia
- ☐ Orthostatic hypotension (dizziness with changes in position)
- ☐ Spinal cord injury
- ☐ Current use of a GLP-1 medication (semaglutide, tirzepetide, Dulaglutide, etc.)

Patient Name: _____

Patient Signature: _____ **Date:** _____

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Bone Health Intake Forms

Environmental - Pillar IV- Pre-Home Evaluation Assessment

This questionnaire is to be completed while you are in the clinic. Please reflect on your home environment and answer the questions as honestly as you can.
Please choose the best response to each of the following questions:

1. **As I move from room to room in my house, I have areas in my house with clutter, exposed cords, or other items that may make me fall or trip**
   - ○ Everywhere
   - ○ Most places
   - ○ Not at all
2. **As I move from room to room, my floor coverings are in good condition**
   - ○ Everywhere
   - ○ Most places
   - ○ Not at all
3. **My floor surfaces are non-slip**
   - ○ Everywhere
   - ○ Most places

Not at all ○

4. **My rugs and mats are securely fixed to the floor**
   - ○ Everywhere
   - ○ Most places
   - ○ Not at all
5. **The stairs in and around my home are secure and the handrails are stable and in good condition**
   - ○ Everywhere
   - ○ Most places
   - ○ Not at all
6. **I can get in and out of every chair in my house easily**
   - ○ Always
   - ○ Almost always
   - ○ Sometimes
7. **I can get in and out of my bed easily**
   - ○ Always
   - ○ Almost always
   - ○ Sometimes
8. **I can reach the light by my bed easily to turn it on or off when desired**
   - ○ Always
   - ○ Almost always
   - ○ Sometimes

9. **I can get on and off the toilet easily**
   - ○ Never
   - ○ Rarely
   - ○ Sometimes
   - ○ Often
10. **I have difficulty getting in and out of the bath or shower**
   - ○ Never
   - ○ Rarely
   - ○ Sometimes
   - ○ Often
11. **I can get in and out of my shower without having to step over a ledge**
   - ○ Always
   - ○ Almost always
   - ○ Sometimes
   - ○ I don't have a shower
12. **My bath or shower has non-slip surfaces**
   - ○ Yes
   - ○ No
13. **I have a seat in my shower to sit if I desire**
   - ○ Yes
   - ○ No
14. **My shower or bath has soap containers at the appropriate height**
   - ○ Yes
   - ○ No
15. **The lights in my house illuminate all areas clearly**
   - ○ Yes
   - ○ No
16. **All the walkways, steps, and stairs in my home are well lit at night**
   - ○ Yes
   - ○ No
17. **The area from my bedroom to the bathroom is well lit**
   - ○ Yes
   - ○ No
18. **In my kitchen, I can reach everything I need without the use of step ladder**
   - ○ Always
   - ○ Almost always
   - ○ Sometimes
   - ○ Never
19. **I stand on my toes to get things out of reach in my kitchen or closets**
   - ○ Never
   - ○ Rarely
   - ○ Sometimes
   - ○ Often

20. I can walk in and out of every door at my home safely and easily

- ○ Always
- ○ Almost always
- ○ Sometimes

21. All the outside paths, steps, stairs, and entrances to my home are well lit at night

- ○ Yes
- ○ No

22. In the place I walk outside, there are uneven surfaces, cracked sidewalks, slippery steps, or other issues that make me trip or stumble

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often

23. All the edges of my stairs/steps are easily identified

- ○ Always
- ○ Almost Always
- ○ Sometimes
- ○ I do not have stairs

24. I can easily pick up my pet and care for them without being at risk of falling over

- ○ Always
- ○ Almost Always
- ○ Sometimes
- ○ I do not have a pet

25. I have one or more pets in my home that could make me trip and fall

- ○ Yes
- ○ No

26. I slip or have difficulty with steps in my house

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often

27. Please check all that apply

- ○ I feel safe moving around in my home
- ○ There are things in my home that make me fearful of falling
- ○ If something happens to me, I can easily call for help
- ○ I feel safe going up and down stairs
- ○ I sometimes do not go outside for fear of falling
- ○ I often trip on uneven surfaces or curbs

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

PATIENT INFORMATION

NOVASPINE PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts™

PATIENT INFORMATION

PATIENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS Street City State Zip		SEX ☐ Female ☐ Male
HOME PHONE NO.	CELL PHONE NO.	WORK PHONE NO.
E-MAIL	MARITAL STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed	
RACE ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Other: ☐Native American ☐Native Hawaiian ☐Pacific Islander		ETHNICITY ☐Hispanic ☐Non-Hispanic
2ND/SEASONAL ADDRESS Street City State Zip		
EMPLOYER	PATIENTS OCCUPATION	
EMPLOYER ADDRESS Street City State Zip		
PHARMACY NAME	PHARMACY PHONE NO.	

How did you hear about us? ☐Physician ☐Newspaper ☐Magazine ☐Online ☐Flier/Brochure ☐Lecture ☐Friend

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS	RELATIONSHIP TO PATIENT	
City State Zip	PRIMARY PHONE NO.	
EMPLOYER	EMPLOYER PHONE NO.	
EMPLOYER ADDRESS: City State Zip		

If this is a job related injury, is this the employer you were working for at the time of injury? ☐Yes ☐No If due to an injury, date of injury: _____/_____/_____

Will an attorney or Liability Carrier be involved in payment of charges? ☐Yes ☐No

Is injury related to: ☐Accident ☐Auto Accident ☐Job Related ☐Other: _____

If job related: Claim Number_____Case Manager: _____Phone No.: _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE
ADDRESS Street City State Zip		

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Name	Policy ID Number	Insurance Name	Policy ID Number
Policy Holder's Name	DOB	Policy Holder's Name	DOB
Social Security Number	Relationship to Patient	Social Security Number	Relationship to Patient

I hereby certify the above information is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Notice of Privacy Practices

NOVASPINE
PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts™

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Novaspine Pain Institute (Novaspine) is committed to protecting your medical information. Further, we are required by law to maintain the privacy of your protected health information (PHI) and to give you this notice, explaining our legal duties and privacy practices with regards to your protected health information. We are required to must abide by the terms set forth in this notice. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. Any revisions will be posted in a prominent location in our office and, upon request, a copy will be provided to you of the revised notice. .

Uses and Disclosures of Your Protected Health Information:

1) **Treatment:** Your PHI may be used provide, coordinate, or manage your health care and any related services. We may also disclose your PHI to other health care providers who may be treating you or involved in your health care to ensure they have the necessary information to diagnose, treat or provide a service.
2) **Payment:** Your PHI may be used and disclosed to obtain payment for health care services provided by us or to determine whether we may obtain payment for services recommended for you. Your PHI may be disclosed to obtain payment or for payment activities from you, a health plan, healthcare clearinghouse, or a third party). As an example, we may need to include information that identifies you, your diagnosis, procedures performed, with a bill to a third-party payer or your health plan to agree to payment for that treatment.
3) **Health Care Operations:** We may use and disclose your PHI to support the business activities of our office. The activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for education and learning purposes. As an example, we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.
4) **Appointment Reminders/Treatment Alternatives/ Health-Related Services:** We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.
5) **Facility Directory:** Unless you object, we may use and disclose in our facility directory your name, location in the facility, general condition and religious affiliation. All of this information, except for your religious affiliation, will be disclosed to persons who ask for you by name. Information in the facility directory may be shared with clergy.
6) **Persons Involved in Your Care:** We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.
7) **Notification:** We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.
8) **As required by Law:** We will disclose your PHI when required to do so by international, federal, state or local law. Examples include:
    - Public health activities including reporting of certain communicable diseases,
    - Workers' compensation or similar programs as required by law,
    - Authorities when we suspect abuse, neglect, or domestic violence,
    - Health oversight agencies, including the Food and Drug Administration and Department of Health and Human Services
    - For certain judicial and administrative proceedings pursuant to an administrative order,
    - Law enforcement purposes, legal proceedings
    - Medical examiner, coroner, or funeral director,
    - The facilitation of organ, eye, or tissue donation if you are an organ donor,
    - To avert a serious threat to your health and safety or that of others,
    - For governmental purposes such as military service or for national security; and
    - In the event of an emergency or for disaster relief
    - Inmates, during the course of providing care
9) **Business Associates:** We may share your PHI with other individuals or companies that perform various activities on behalf of, our office such as after-hours telephone answering, quality assurance, or clinic research. Our Business Associates agree to protect the privacy of your information.
10) **Marketing & any purposes which require the sale of your information**: These disclosures require your written authorization.
11) **Any other uses and Disclosures not recorded in this Notice** will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Notice of Privacy Practices

NOVASPINE
PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts™

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF NOVASPINE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU.

BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1) **Copy of this notice:** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
2) **Inspect and Copy:** You have the right to inspect and copy your PHI that we maintain about you for as long as we maintain that information. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or PHI that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer at the address listed below. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. Novaspine has up to 30 days to make your PHI available to you (fee may apply), or 60 days if stored off-site, but must inform you of this delay.
3) **Request an Electronic Copy:** You have the right to request that an electronic copy of your PHI be given to you or transmitted to your designated officer. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fee may apply).
4) **Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. You may ask us not to use or disclose any part of your PHI and by laws we must comply when the PHI pertains solely to health care items or services for which the health care provider involved has been paid out of pocket in full. Request must be made in writing to our Privacy Officer with instructions. If we agree to the restriction, we may only be in violation of the restriction for emergency treatment purposes. By law, you may not request we restrict the disclosure of your PHI for treatment purposes.
5) **Right to receive Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.
6) **Request Amendments:** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be in writing to the Privacy Officer as listed below. In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy.
7) **Request Accounting of Disclosures**: You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12- month period will be free. If you request an additional list within 12- months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.
8) **Request Restrictions:** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.
9) **Request a Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.
10) **File a Complaint**. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our Privacy Officer must be in writing. We will not retaliate against you for filing a complaint.
11) If you have questions about this notice or would like additional information, please contact our Privacy Officer at:
NovaSpine Pain Institute, Attn Privacy Officer, 13203 N 103rd Ave Ste H4 Sun City, AZ 85351 or 623.777.4747

By signing below, I acknowledge that I have received the Notice of Privacy Practices of this office, which outlines how patient confidential information will be used, disclosed, and protected. I understand that I may refuse to sign this Acknowledgement.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided Was Emergent

_____ Other: _____ Employee Initials: _____ Date: _____

FINANCIAL DISCLOSURE STATEMENT

NOVASPINE PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts™

NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/we) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services as follows:

Durable Medical Equipment - Orthosis/Bracing
Dynamic Managed Services AZ LLC
Genetic Technological Innovations-toxicology and phlebotomy
Insight Management Group LLC - toxicology and phlebotomy
Simple Ventures, LLC
Chiropractic and or Therapy services
Avon Surgery Centers, LLC

Further, as indicated below, goods or services (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

Sonora Quest Laboratories
LabCorp Laboratories
Practical Medical
Hanger Clinic Orthotics and Prosthetics
Summa
Rx Medics Equipment & Supplies
Foothills Physical Therapy
Van Metre Chiropractic
Heid Chiropractic
Aris Physical Therapy
Banner Physical Therapy

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file.

ACKNOWLEDGEMENT: I/We have read this "Notice to Patients" form and understand the disclosures that it contains.

_____ _____
Signature of Patient or Guardian Date

FINANCIAL POLICY

NOVASPINE
PAIN INSTITUTE

Thank you for choosing NovaSpine Pain Institute as your pain management specialist. Please review and sign the following financial policy to indicate your agreement to these terms. Our financial policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients.

APPOINTMENTS

1) **No insurance card, referral, co-payment or outstanding balance.** Copayments and/or outstanding balances are due at the time of service. In addition, we may not be authorized to see you until referral authorization and insurance benefits have been obtained and/or verified. Your appointment may be rescheduled until such time that these document and/or payments are provided.
2) **Procedure Prepayment.** NovaSpine Pain Institute collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy (see below). We reserve the right to reschedule your procedure until prepayment has been made.
3) **Missed Appointments and Late Arrivals.** If you are more than 15 minutes late, we reserve the right to reschedule your appointment. If you are more than 60 minutes late, no show for an appoint, or do not give cancellation notice at least 24 hours in advance, you will be responsible for a missed appointment fee. The first 'missed appointment' occurrence will not be charged a fee. Any additional missed appointments will result in a missed appointment fee as follows:
    - Missed office visit appointments are subject to a $50 charge.
    - Missed procedure, or EMG appointments are subject to a $75 charge.

    These charges are your responsibility and will not be billed to any insurance carrier. It is at the provider's discretion to determine whether or not you will be dismissed from the practice due to missed appointments.

INSURANCE PAYMENTS

4) **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
5) **Coverage Changes and Timely Submissio**n. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Novaspine Pain Institute must submit a claim on your behalf to your insurer. If NovaSpine is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
6) **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by NovaSpine Pain Institute, then you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

7) **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.
8) **Prior Authorization and Non-Covered Services.** NovaSpine Pain Institute may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. As a courtesy to our patients, NovaSpine makes a good faith effort to determine if services are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
9) **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to NovaSpine, immediately.

ACCOUNT BALANCES AND PAYMENTS

10) **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

11) **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Novaspine reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay NovaSpine for any expenses incurred to collect your account, including reasonable attorneys' fees and collection costs.

12) **Returned Checks.** Returned checks will be subject to a $38 returned check fee.

13) **Refunds.** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed.
Requests may be sent to: NovaSpine Pain Institute, Attn: Billing Department, 13203 N 103rd Ave Ste H4, Sun City AZ 85351

14) **Forms and Records Requests.** I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

15) **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

I have read and understand the financial policy of NovaSpine Pain Institute, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to NovaSpine Pain Institute. I understand that I am financially responsible for all services I receive from NovaSpine Pain Institute. I understand that this financial policy is binding upon me, my estate, executors and/or administrators, if applicable.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY/AGREEMENT

NOVASPINE
PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts ™

_____
Patient Initials

PROVIDER FEES: Patient is aware that NovaSpine Pain Institute healthcare providers including Clifford Baker MD, John Paul Malayil, MD, Jae H. Park, MD, Kristin Oarde, MSN, FNP-C, Victoria Tweedy, FNP, NP-C, Terrie Pasch PA-C, Mynon Mitton, MSN, FNP-C, Samantha Gonzalez, PA-C, Michelle Hitchcock, PA-C, Alexandra Gral, MSN, FNP-C, Brittany Anderson, MSN, FNP-C, Peter D. Cummings, MD, Rachel Patel, FNP and Aaron Rodarte, PA-C are in network with majority of insurance carriers and when appropriate will accept assignment according to the terms of the contract. The patient understands they will be responsible for only the fees as determined by the plan. This will include any previously unmet portion of the in-network deductible and co-insurance based on their benefit

_____
Patient Initials

ANESTHESIA FEES: Because most pain injection procedures can be performed without the administration of anesthesia, in most cases it is the patient's decision whether-or-not to have conscious sedation administered. Patient is aware the sedation is administered by a certified registered nurse anesthetist (CRNA) or anesthesiologist and that provider may be out-of-network with his/her insurance. Patient understands their insurance will be billed for this service. In the event insurance does not pay for administration of the sedation, the patient will be billed a MAXIMUM of $150 per procedure. Patients are aware providers are in network with Medicare and BCBS.

_____
Patient Initials

PAYMENTS TO PATIENTS: In some instances, the insurance carrier will pay the patient directly for out-of-network services. The patient understands and agrees to relinquish payment to our office upon receipt.

By signing below, I accept the terms as outlined above. I acknowledge that I have read or had explained to me and fully understand all of the above information. I have had the opportunity to ask questions. I understand I have the right to cancel the procedure if I do not agree. I wish to proceed with the procedure with full understanding of the above information. Should questions arise prior to the procedure, I understand that I may speak to a financial representative at 623-777-4747.

_____
Patient Signature

_____ _____
Patient Name Date

NovaSpine Pain Institute PLC

TEL: 623.777.4747
FAX: 623.777.4748

Authorization for Use and Disclosure Of Protected Health Information

NOVASPINE PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts ™

By signing below, I authorize NovaSpine Pain Institute, its agents and employees ("**Provider**"), to use and/or disclose any and all of my protected health information ("**Records")** on my behalf, of any kind and description, to the following ("**Recipient**"):

Recipient Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

I also authorize Provider to release my protected health information to my insurance, primary care provider(s), referring provider(s), hospitals, diagnostic centers and/or laboratories that may require this information for continued care and authorize Provider to transmit this information through electronic means.

Authorization to Disclose Protected Health Information including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnoses or treatment for HIV, HIV-related diseases and communicable disease-related information. With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

I understand I have the right to refuse to sign this authorization, writing, at any time and that I do not have to sign this authorization to receive treatment at Novaspine Pain Institute. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is:

NovaSpine Pain Institute, Attn Privacy Officer, 13203 N 103rd Ave Ste H4 Sun City, AZ 85351

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This Authorization will remain effective until one-year following the date set forth below, or, if not date is set forth below, the date Novaspine Pain Institute receives this executed Authorization, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

MEDICAL RECORDS RELEASE
Authorization to Disclose Health Information

NovaSpine Pain Institute
Your Minimally Invasive Spine, Pain & Arthritis Care Experts ™

PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____

Patient Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

INFORMATION TO BE RELEASED: (check all items to be released)

- ☐ Entire Record
- ☐ History and Physical
- ☐ Office Visit / Progress Notes
- ☐ Other:
- ☐ Period From:_____
- ☐ Urine Toxicology Results
- ☐ Operative Reports
- ☐ Medication List
- ☐ Lab Reports
- ☐ EMG/NCS Results
- ☐ Imaging Reports (X-rays, CT, MRI)
- ☐ Radiology Images CD / DVD
- ☐ All ☐ _____

REQUESTING RECORDS FROM:_____ _____

Special Records: I understand that protected information related to my diagnosis or treatment for AIDS/HIV, psychiatric care treatment, treatment for drug and alcohol abuse may be released as part of my health information. **Please check appropriate boxes below.**

AIDS/HIV Information	Psychiatric Care/Treatment	Treatment for Drug or Alcohol use/abuse
☐ YES, Disclose	☐ YES, Disclose	☑ YES, Disclose
☐ NO, do not disclose	☐ NO, do not disclose	☐ NO, do not disclose

PURPOSE/USE OF REQUESTED INFORMATION:

☐ Personal ☐ Treatment ☐ Insurance ☐ Disability ☐ Legal ☐ Other: _____

RELEASE INFORMATION TO:

Name: NovaSpine Pain Institute

Address: 13203 N 103rd Ave Ste H5 Phone: 623.777.4747

City: Sun City State: AZ Zip: 85351 Fax: 623.777.4748

FORMAT:

☐ Paper Copy ☑ Electronic Copy (Fax) 623.777.4748

AUTHORIZATION:

- **FOR PERSONAL REQUESTS**: There will be a $0.25 per page fee for all requests on paper (plus the cost of postage and envelope) or there will be a $0.25 per page fee for all requests on CD (plus the cost of postage and envelope).
- **FOR DOCTOR TO DOCTOR REQUESTS**: There will be no fee. By default the past two (2) years of pertinent information will be sent. •
- I understand that I may revoke this authorization at any time, by notifying NovaSpine Pain Institute in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under the applicable law, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- My refusal to sign this authorization will not affect enrollment, eligibility for benefits, payment, or my ability to receive treatment.
- I understand that I may inspect or copy the information that is used or disclosed

Patient or Legal Representative Signature:_____ Date :_____

(If a personal representative executes this authorization, then the authorization must contain a description of the representatives authority to act for the individual, e.g., "parent" or "guardian ad litem")