RELIEVE
Pain Center

Please review and complete this Medical Questionnaire, Patient Financial Responsibility Policy and HIPAA Compliance Requirement Form/Notice of Relieve Pain Center Privacy Practices. This information is confidential.

Today's Date:	Legal Name:		
Social Security Number:	Date of Birth:	□ Male □ Female □ Other	□ Single □ Widowed □ Married □ Legally Separated □ Divorced
Home Address:			
Preferred Phone Number:	Email:		Preferred Language: □ English □ Spanish □ Other
Race: □ American Indian or Alaska Native □ Black or African American □ Asian □ White □ Native Hawaiian or Pacific Islander □ Hispanic □ Other Race □ Refuse to Report			Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino □ Decline to Specify
Emergency Contact Name:	Relationship to Patient:		Emergency Contact Phone:
Preferred Pharmacy Name:	Pharmacy Phone Number:		

Name of Insurance: _____

Subscriber's Name:	Subscriber's Social Security Number:	Subscriber's Date of Birth:
Patient Relationship to Subscriber: □ Self □ Spouse □ Guardian □ Other		
Employer's Phone Number:	Employer's Address:	

All information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Relieve Pain Center. I also authorize Relieve Pain Center or Insurance Company to release any information required to process my claims.

Signature: _____ Date: _____

3969 4th Ave. Suite 208
San Diego CA 92103
619-849-5777
www.relievepaincenter.com

Patient Financial Responsibility Policy:

- Always bring your insurance card and ID to your appointment. If your coverage cannot be verified, you will be responsible for any payments at the time of service.
- It is your responsibility to notify us if there are any changes to your insurance, address, phone number, or family status at check-in or sooner.
- It is your responsibility to pay for your co-pay, co-insurance, and/or deductible at the time of service.
- If uninsured, it is your responsibility to pay your bill in full at the time of service.
- If your insurance does not cover any office visit, diagnostic testing, and/or treatment, you understand that you are responsible for payment of service and will make immediate, satisfactory arrangements to settle your account.
- Collection Fees: In the event that your account is referred to a third-party collection agency, you agree that you will be responsible for any and all collection fees
- Litigation Fees and Costs: In the event that your account is referred to a third-party collection agency and/or collection attorney, you agree that you will be responsible for any and all collection/attorney fees and interest. If costs are expended in order to collect your account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.
- Telephone Consumer Protection Act Consent Disclosure: In order for us to service your account or to collect any amounts you may owe us, you authorize us and our affiliated physicians, as well as their affiliates which include debt collectors, to contact you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact include but are not limited to the use of pre-recorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders, and facsimile as applicable.

If you have:	You are Responsible for:	Our staff will:
Commercial Insurance also known as indemnity, “regular insurance or 80%/20% coverage”	Payment of the patient responsibility for all office visits, procedures, and other charges at the time of the office visit	Check your insurance coverage to determine deductibles, co-insurance, and co-pays. File your insurance claim.
Medicare HMO	All applicable co-pays and deductibles at the time of the office visit	File the claim on your behalf
Worker’s Compensation	If we have verified the claim with your carrier, no payment is necessary at the time of the visit. If we are not able to verify your claim payment in full is requested at the time of the visit.	
Workers' Compensation “out of state”	Payment in full at the time of the visit.	
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please speak to our staff if you need assistance.

Abusive Patient Policy:

- For the safety of our patients and staff, Relieve Pain Center has a ZERO TOLERANCE POLICY for any threatening or abusive behavior, verbal or physical, against anyone in this facility or in the adjacent building. Such behavior will result in the immediate termination of the Provider-Patient relationship.

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Cancellation Policy:

- We request that you give our office at least 24 hours advance notice if you need to reschedule or cancel your appointment. In the event you fail to give at least 24 hours advance notice to reschedule or cancel your appointment, you will be charged (i) a $25 fee for any office visit or (ii) $50 for any new patient consultation or (ii) a $75 fee for an in-office or outpatient procedure. This fee will not be billed to the insurance company. To cancel/reschedule your appointment call us directly at (619)849-5777 or email us at info@relievepaincenter.com. If it is after hours please leave us a message with your name, date of birth, and date and time of your appointment.
- If a patient is late to his/her appointment it may result in a cancelled appointment and, as determined by Relieve Pain Center, you may be responsible for the cancellation fee.

I have filled out the above information to the best of my knowledge and verify the information to be accurate and true. I have read and understand the Patient Financial Responsibility Policy. I agree to be bound by the terms thereof, including without limitation the Cancellation Policy. I also understand that Relieve Pain Center may amend such terms from time-to-time.

_____ _____

Printed Name of Patient | Your Name and Relationship to Patient

_____ _____

Signature | Date

HIPAA Compliance Requirement Form
Notice of Relieve Pain Center Privacy Practices

THIS DOCUMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO SUCH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to ask each of our patients to acknowledge receipt of our Notice of Privacy Practices. Relieve Pain Center must take steps to protect the privacy of your Protected Health Information ("PHI") in accordance with HIPAA. PHI includes information that we have created or received regarding your health care, including payment and billing for your health care. In addition to your medical records, PHI includes personal information such as your name, social security number, address, and phone number.

This Notice of Relieve Pain Center's Privacy Practices is also available at www.relievepaincenter.com. If you need a copy thereof, please ask for a copy to be provided to you.

Under federal law, we are required to: (i) protect the privacy of your PHI (Relieve Pain Center therefor requires our employees to maintain the confidentiality of PHI); (ii) provide you with this Notice of Relieve Pain Center's Privacy Practices explaining our duties and practices regarding your PHI; and (iii) follow the practices and procedures set forth in this Notice of Relieve Pain Center Privacy Practices.

I,_____, understand that as a part of my healthcare, Relieve Pain Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information serves as follows:

A basis for planning my care and treatment;
A means of communication among health professionals who contribute to my care;
A source of information for applying my diagnosis and treatment to my bill;
A means by which a third-party payer can verify services billed were provided;
A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as a part of Relieve Pain Center's treatment, payment and/or healthcare operations, it may become necessary to disclose my PHI to another entity and I consent to such disclosure for these permitted uses including disclosures via fax and sharing of electronic medical records. Additionally, PHI may be released without my authorization for (i) legal and/or governmental purposes and for (ii) certain miscellaneous circumstances, such as to a person accompanying you for treatment or to an authorized public party for disaster relief purposes, all as allowed under HIPAA.

Except for the situations listed above, we will use and disclose your PHI only with your written authorization. We will not disclose your PHI in the following cases, unless you give us written permission: (i) marketing purposes; (ii) sale of your information; and (iii) most sharing of psychotherapy

notes. Federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose such PHI. In these situations, we will contact you for the necessary authorization. In some situations, you may revoke your authorization. If you have questions about these laws, please contact the Privacy Officer at (619)849-5777.

Email: You are advised that email is not a secure method of communication. If you email us you agree to our communication by use of email and you agree to the risks. If you prefer to not exchange health information by email, please let us know by sending an email to info@relievepaincenter.com.

Without limitation, you have the right to request: (i) restrictions on the disclosure of your PHI; (ii) ask for a specific means of communication; (iii) request an electronic or paper copy of your PHI; (iv) an amendment to your PHI; (v) seek an accounting of the disclosures made of your PHI; (vi) a paper copy of this Notice; and (vii) a written notification of any breach of the confidentiality of your PHI. All requests must be in writing and in certain circumstances a request may be denied or require the payment of a fee. In any such circumstances we will explain our response. You may file a complaint if you believe your privacy rights have been violated. You can file a written complaint with us and/or with the U.S. Department of Health and Human Services Office for Civil Rights. Their address is 200 Independence Avenue, S.W., Washington, D.C. 20201. You may also contact them by calling 1-877 696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

On occasion, Relieve Pain Center may have PHI about you, such as laboratory results, which we may wish to share with you by telephone. Please indicate below how you would like us to handle this:

Call: _____ to leave all health-related information.
Detailed confidential message may____ may not_____ be left at this number if answered by a machine.

My PHI may be discussed with the following people:

1._____ 2. _____

3._____ 4. _____

I hereby agree to the above and consent for Relieve Pain Center to obtain my past, present and future medication and medical information as well as all other PHI:

_____ _____
Patient's Signature Date