Dr. Craig Nairn, M.D.
8080 Academy Rd. Suite A, Albuquerque, NM 87111 (505) 247-9700 (505) 247-4333

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No

Name of primary insurance	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Sp. Co-pay:

		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable)	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims. Pain Solutions, LLC may use my health care information and may disclose such information to the above insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits available for related services.

Patient/Guardian signature *Date*

PAIN SOLUTIONS 2016+ FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. This is our new policy. ***You must initial where indicated to let us know that you have read and understood our policies.***

Payment

► ______Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept all major credit cards.

► ______If you have an outstanding balance, the entire balance must be paid prior to your next appointment or you cannot be seen.

Billing & Insurance

► ______If we are contracted with your insurance, we will bill your insurance. We also bill all Medicare plans. ***WE DO NOT BILL SECONDARY POLICIES OR MEDIGAP PLANS.*** We will be happy to provide you with a receipt of payment for that purpose; we will not provide HICFA forms or UB15 forms.

► ______***We do not accept Medicaid or ANY Medicaid programs.***

► ______***We are non-participating providers for Medicare. This means you pay in advance and we submit your claim for you. Medicare will reimburse you. Because we do not participate, your coinsurance will be approximately 10% higher than it would otherwise.***

► ______Keep in mind that your insurance policy is basically a contract between you and your insurance company. If we are contracted with your insurance, as a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company directly pay the doctor**. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment.** If we later receive a check from your insurer, we will refund any overpayment to you.

► ______If your insurance information changes, you must notify us in advance of the change and give us a copy of your new insurance card. If you do not do so, you will be responsible for all unpaid medical bills.

► ______If you are insured by a plan that we do not have a prior arrangement with, you must submit your own claims. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

► ______Not all insurance plans cover all services. In fact, even if we acquire a prior authorization, your insurance company can decide not to pay. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

► ______We will bill your insurance company for all services provided in the hospital by Dr. Nairn. The hospital will bill its charges separately. You are responsible for any balance due.

Fines & Penalties

► ______There is a $40.00 fee on all returned checks**. [$40 + tax Returned Check Fee**]

► ______**If you need to cancel a scheduled appointment, you must do so twenty-four hours in advance. We assess a *$45* fee for failure to give us advance notice of cancellation. If you are assessed this fee, it must be paid prior to your next appointment. Furthermore, failure to cancel your appointment in advance may mean that you will no longer be able to see one of our providers. *[$45 + tax No Show Fee]***

► ______Any balance that has not been paid off within thirty days is considered overdue. All overdue balances will be assessed a **1% FINANCING CHARGE PER MONTH, 12.68% COMPOUNDED ANNUALLY.**

► ______ If you fail to pay your medical bills on a timely basis, and we are compelled to submit your bills to a collection agency or a lawyer, a **thirty-five percent (35%) collection** fee in addition to the New Mexico state **sales tax of seven percent (7.1%)** will be added to your bill. (Example: You owe $100. If we submit to a collection agency or a lawyer you will owe $100 x 7.1% = $107.10 x 35% = $144.56 will be the new sum due.)

I have read and understand the practice's financial policy, including the $40+ tax returned check fee, the $45+ tax no show fee, and the collection fee, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or responsible party, if minor) Date

Printed Name of Patient :____

Authorization for leaving messages

1. I, (name printed), _________________ give permission to Pain Solutions and its medical staff to leave a message at (phone number) _______________ on my answering machine/voice mail at home regarding my medical care:

Please circle one:

Home: Yes No

Please circle one:

Work: Yes No

If yes, please write work number _________________________________

2. I, (name printed), ________________ give permission to Pain Solutions and its medical staff to leave a message regarding medical care with the listed contact at the current home phone number:

Contact Name: ____

Contact Number: ____

Signature: ____

Date: ___

Release of Health Care Information by Pain Solutions to Below Authorized Person

Name of Individual to whom Health Care information may be released

1. ____(herein "Authorized Person(s)")
2. This authorization specifically applies to all health care records currently and in the future present at Pain Solutions and allows Pain Solutions to disclose protected health information to Authorized Person.
3. The purpose of the use and disclosure by Pain Solutions to Authorized Persons shall include assistance by my Authorized Person(s) in monitoring and sharing my health care status with family and friends for my benefit.
4. I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, as well as the exceptions to my right to revoke will be performed in accordance with applicable federal law and any applicable policy of my health care provider.
5. I understand that, I may refuse to sign this Authorization. I also understand that my healthcare provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.
6. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure.
7. The authority given to said Authorized Person(s) shall supercede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

I have read and understand the information in this authorization form.

Signature: ____________________ Date: ________________________

Print Name: _____________________

Witness: _____________________ Witness: _____________________

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.

If you have any questions about this notice , please contact the Privacy Official for
Pain Solutions
Craig Nairn
(505)247-9700

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At Pain Solutions, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit Pain Solutions, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Pain Solutions, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Pain Solutions is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Pain Solutions, reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.
Examples of How Pain Solutions, May Use or Disclose Your Health Information

For Treatment: Pain Solutions, may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: Pain Solutions, may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointments: Pain Solutions, may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification, or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Pain Solutions, may use and disclose information about you as required by law. For example, Pain Solutions, may disclose information for the following purposes:

for judicial and administrative proceedings pursuant to legal authority;
to report information related to victims of abuse, neglect or domestic violence; and
to assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice's Privacy Official, [Practice:Privacy Official].

Pain Solutions
715 Martin Luther King NE #201

Albuquerque, NM 87102
Phone: (505)247-9700
FAX: (505)247-4333

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Acknowledgment of Receipt of this Notice

Pain Solutions is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Pain Solutions

Name of Patient (PRINT)____

____ ____________________
Signature of Patient or Authorized Representative Date