PAIN MANAGEMENT ASSOCIATES, LLC.

7500 Greenway Center Dr. Suite #940
Greenbelt, MD 20770
Tel: 301-220-2333 Fax: 301-220-2339
WWW.METROPAIN.ORG

PATIENT INFORMATION: (Please fill in all information completely)

Last Name: _____ First Name: _____ MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone #:Home: _____ Work: _____ Cell: _____
Date of Birth: _____ SS#: _____ Marital Status: S M D W
Emergency Contact: _____ Relationship: _____ Phone: _____
Email Address: _____
Primary Care Physician (First and Last Name) _____
Referring Physician (First and Last Name: _____ Phone:_____
How did you first learn about Dr. Hagos at Pan Management Associates LLC?
_____ Doctor Referral _____ Insurance Wed-Site _____Internet Search _____ Friend/Family
_____ Advertisement _____ Hospital Referral _____ Seminar _____ Other

Did you sustain an injury at work? Y N **Are you covered under an employer or union policy? Y N**
Are your injuries accident related? Y N **Are you under Workers Compensation? Y N**

INSURANCE INFORMATION: (Please fill in all information completely)

Primary Insurance Company Name: _____ Co-Pay $_____
Address: _____
ID#: _____ Group#: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder's DOB: _____ Policy Holder's SS#: _____
Policy Holder's Employer: _____

Secondary Insurance Company Name: _____ Co-Pay $: _____
Address: _____
ID#: _____ Group: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder's DOB: _____ Policy Holder's SS#: _____
Policy Holder's Employer: _____

PATIENT'S AUTHORIZATIONS:

I authorize the Hanover Surgery Center (HPSC) (Dr. Hagos) to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regards to my insurance coverage to be true and correct and further authorize the release of any necessary information (to include medical information) for any related claims. I further understand that is my insurance plan requires me to obtain a referral and if I do not have the necessary referral with me at the time of service, or if my referring physician will not issue a referral, I am responsible for paying all fees for services owed to HPSC. I understand that if I do not have out-of-network benefits under my insurance plan and if HPSC of attending physician of HPSC is not a participating provider under my insurance, I am responsible for all fees for services rendered by the physicians of HPSC. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked be me in writing. I Understand that nothing herein relieves me of the insurance carrier made tome for services provided by any member of HPSC will be surrendered to HPSC. This includes office visits, surgery or other procedures.

_____ _____
Signature Date
I have received a copy of the Hanover Parkway Surgery Center's Financial Policy & Notice of Privacy Practices _____ (Initials)

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New Patient Survey

Patient Name: _____

Date: _____

How did you hear about us?

- o Managed Care Health Directory
- o Insurance Website
- o Friend/Relative: If currently our patient please list their name so that we will be able to tell them Thank You.
  ☆ _____
- o Pain Management Associates Website (www.metropain.org)
- o Other – Please Specify _____

_____

_____

Thank You for your Support!

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PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1966 (HIPPA)

- ○ I have received a copy of the Notice of Privacy Practices
- ○ I understand that if changes are made to this Notice Privacy Practices, a revised copy of the notice will be posted in the office
- ○ I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regards to this Notice of Privacy Practices, I may contact:
    - ○ Dr. Haddis T. Hagos
      Medical Director
      Tel: 301-220-2333
      Fax: 301-220-2339

To ensure your privacy, please indicate below how would you like us to contact you regarding your healthcare.
Please check off and initial each one that applies.

( ) Home Number: _____ ( ) Work Number: _____

( ) Cell Number: _____

( ) You may leave information regarding my health with:

- O Spouse(name): _____
- O Other: _____
- O Message on answering machine/voice mail/TEXT MESSAGE

This authorization is good for 5 years unless noted: _____

Patient/Guardian signature: _____ Witness: _____

Print Name: _____ Date: _____

FOR PRACTICE USE ONLY:
Date acknowledge denied by patient: _____
Reason Denied by patient: _____
Name of Person reviewing: _____
Date;_____

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PATIENT MEDICATION LIST

Instructions:

1. INFORM US WHEN WAS THE LAST TIME YOU TOOK THE MEDICATION
2. THE DOCTOR WILL REVIEW THIS INFORMATION WITH YOU DURING THE ADMISSION PROCESS

Allergies (list of all allergies, including food, latex and medications. Please include reactions o items you list as allergies, i.e. rash, fever, nausea/vomiting, etc.)

MEDICATIONS	REACTION	OTHER ALLERGIES	REACTIONS

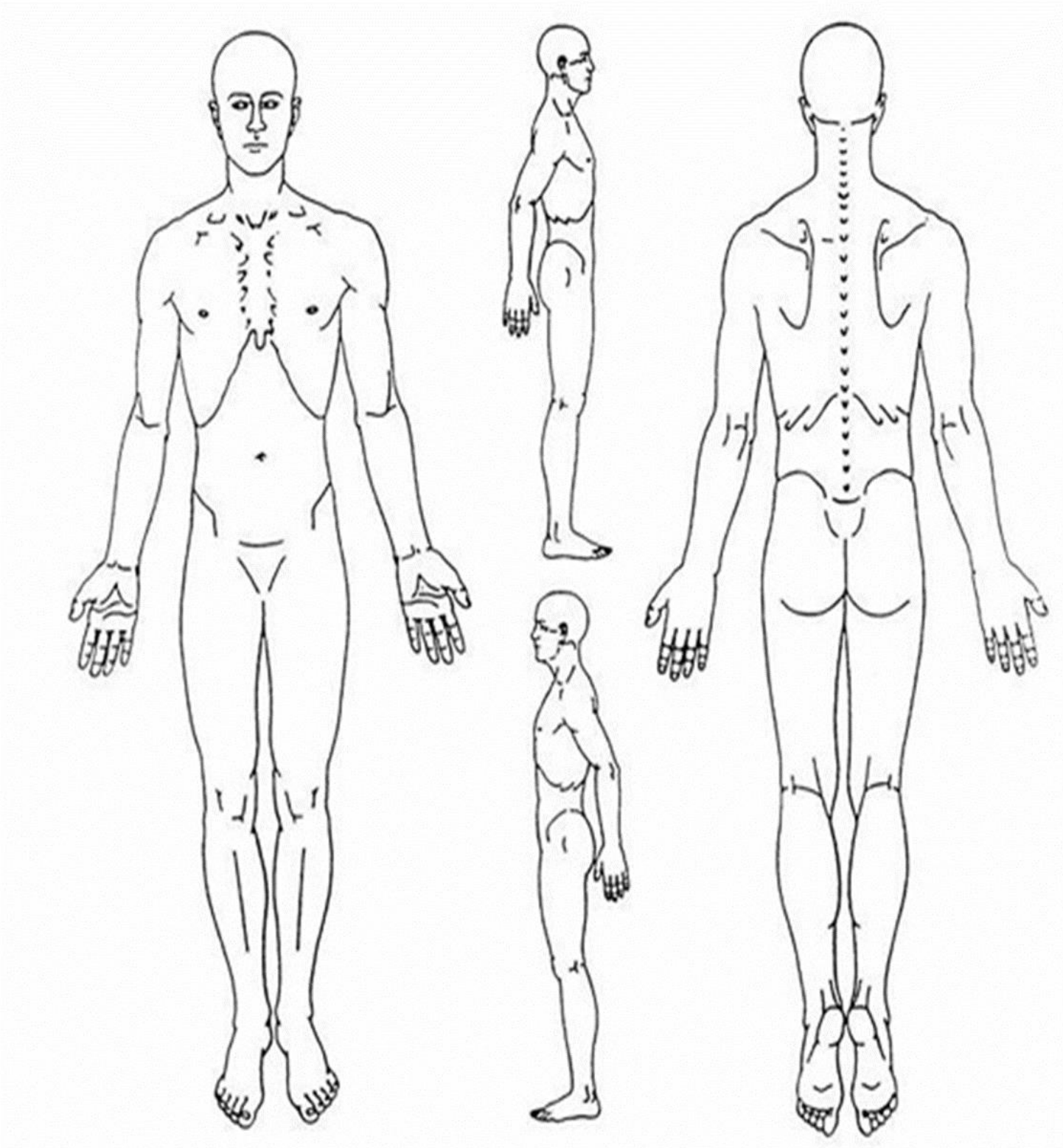
Please complete this form, list all medications you currently take, including vitamins, herbal supplements, antacids, or other OTC (over-the-counter) medications.

TODAY'S DATE	NAME OF MEDICATION/VITAMINS HERBAL SUPPLEMENT AND DOSAGE	DOSAGE	WHEN DID YOU LAST TAKE THIS MEDICATION	COMMENTS

Date: _____

PAIN MANAGEMENT ASSOCIATES, LLC

Where Is Your Pain?



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Pain Management Associates LLC and is committed to excellent patient care.

The following guidelines will provide you with specific information regarding our financial policies. We believe. that your understanding of these policies is important to our professional relationship.

Co-Pays, Deductibles, and Fees: All co-payments, insurance deductibles, and fees for services not covered by your insurance policy is due at the time service is rendered. For your convenience, our office accepts cash, Visa and Master Card.

Office Appointment Cancellations: We charge $25.00 for missed appointments, unless canceled 24 hours in advanced. This fee is not billed to your insurance company and must be taken care of prior to your next appointment.

Release of Medical Records: You will be charged a fee of $.76 per page. We also must have a 24-hour notice Before the records can be processed. This charge must be paid before the records can be released. Your record Request will be processed in five to seven business days.

Disability Forms: The forms that are needed to be filled out will have to be brought, faxed or mailed to our office in advance and given about a week to 14 days to be filled out. If they are not complete with in that time an appointment will be made to further process the forms. A charge will occur for these forms.

Past Due Balances: Outstanding balances are due within 30 days, unless prior arrangements have been made with the billing department. Seriously past due accounts or those failing to honor the agreed-upon payment terms will be sent to a collection agency. If your account is sent to collections, a 33% fee will be added to the outstanding balance along with any other collection fees incurred. You must pay all past due amounts before subsequent appointments can be scheduled. In addition, payment in full will be expected at the time of service for any future services.

Insurance Coverage: Your health insurance is an agreement between you and your insurance company. They will provide you with an EOB (Explanation of Benefits) to explain the services they cover. Please inquire to the receptionist and/or billing department to ensure the provider participates with your plan. If the provider participates with your insurance company, all services performed in our office and at the hospital will be billed directly to the insurance company unless we have received prior notification of non-covered services. All co-pays and deductibles are your responsibility. Co-pays are due at the time of the visit. Deductibles will be billed to you. We will not be able to bill an insurance company that we do not participate in, nor can we accept payment for them as payment for services performed.

Inform the receptionist if you have had a change in insurance since your last visit so we can bill the appropriate parties. Any balance not covered by the insurance company becomes your responsibility. Payment for the office visits is due at the time of the visit. We will provide you with an itemized bill so that you may submit the charges to your insurance company.

Referrals: If your insurance requires a referral, it is your responsibility to obtain one prior to your appointment. If a referral is not presented at the time of service, you will not be able to be seen or you may have the option to pay in full for those services not covered.

Please contact our billing department at Pain Management Associates, LLC. if you have specific questions or concerns. When calling, please have your account number available so that we may serve you more effectively.

I have read and fully understood the financial policy set forth by Pain Management Associates, LLC. and I agree to the terms of the Financial Policy. I understand that the terms of the policy may be amended by Pain Management Associates, LLC at any time without prior notification.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date

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PRIVACY NOTICE

THE FOLLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within Hanover Parkway Surgery Center for the purpose of providing you with quality care.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Hanover Parkway Surgery Center receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may **NOT** be released for any other purpose then that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by Hanover Parkway Surgery Center to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by Hanover Parkway Surgery Center for the purposes of raising funds to support the organization's operations.
- You have the right to restrict the use of your confidential healthcare information. However, Hanover Parkway Surgery Center may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review the photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of the Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Hanover Parkway Surgery Center is required by law to protect the privacy of its patients. We will keep confidential, any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential health information.
- Hanover Parkway Surgery Center will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to Hanover Parkway Surgery Center if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

  ATTN: Haddis T. Hagos, M.D.
  Hanover Parkway Surgery Center
  7300 Hanover Dr. Suite 204
  Greenbelt, MD 20770

  - All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact: Haddis T. Hagos, M.D. at (301)-220-2333.
- This notice is effective as of Date of Effectiveness. This date must not be either then the date on which the notice is printed or published.

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PATIENTS RIGHTS

1. You have the right to personal privacy and care in a safe setting free for all forms of abuse, harassment, discrimination or reprisal.
2. You have the right to accurate and easily understand information about your health plan, treatment, health care professionals and health care facilities. If you speak another language, have a physical/mental disability or just do not understand something, help should be given so you can make informed health care decisions prior to your treatment or procedure.
3. You have the right to choose health care providers who can give you high-quality health care.
4. You have the right to know what patient support services are available, including access to an interpreter if language is a problem.
5. You have the right to know your treatment options and take part in decisions about your care. Parents, guardians, family members or surrogates that you select can represent you if you cannot make your own decisions according to state law. If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are to be exercised by the person appointed under state law to act on your behalf.
6. You have the right to considerate, respectful care from your doctors, health plan representatives, and other health care providers that does not discriminate against you.
7. You have the right to talk privately with health care providers and to have your health care information protected. You also have the right to read and copy your own medical record. You have the right to ask that your doctor change your record if it is not correct, relevant, or complete. Unless authorized by law, you have the right to approve or refuse record release.
8. You have the right to a fair, fast and objective review or any complaint you have against your health plan, doctors, hospitals or other health care professional without fear of reprisal. This includes complaints about waiting times, operating hours, the actions of health care personnel and the adequacy (or lack of) of treatment or care.
9. Contact information if you feel as if any Rights were violated is as follows:
   Office Care Quality Unit: Ambulatory Care Programs Spring Grove Hospital Center Bland Bryant Building, 55 Wade Avenue Catonsville, Maryland, 21228.
   Website: www.dhmh.state.md PH (800)-492-6005.
10. You have the right to submit a grievance either verbally or in writing to: Administrator of the Hanover Parkway Surgery Center, 7300 Hanover Dr. #204 Greenbelt, MD. PH (301)-477-3959. You will receive a written notice of decision within 30 calendar days describing the steps taken to investigate the results and the completion date

PATENTS RESPONSIBILITES

1. You have the responsibility to provide to the best of your knowledge, accurate and complete health information.
2. You are responsible for following the treatment plan recommended.
3. You are responsible to participate in your plan of care and provide an Advance Directive if you have one.
4. You are responsible for making known whether you clearly understand the medical treatment.
5. You must have a responsible adult to provide you transportation and assist with your care for the first 24 hours post op.

ADVANCE DIRECTIVE

Advance Directives will not be honored at our surgery center. We will do everything to stabilize you; the patient and the arrange for immediate transfer to a nearby hospital. If indeed a need did arrive, we will try any life saving measure to stabilize you for transport. If you do not have an Advance Directive and would be interested in completing one, we are happy to supply you with information. All patients are asked if they have an Advance Directive, which is placed in their medical record. Patients are also informed that Advance Directive will not be honored while a patient at Hanover Parkway Surgery Center.

FINANCIAL INTEREST/OWNERSHIP: Dr. Haddis Hagos (50%) ; Dr. Netsere Tesfayohannes (50%)

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PATIENT COMPLAINTS

Patients have the right to register a complaint in writing the Medical Director of Hanover Parkway Surgery Center. Please submit the complaint to:

ATTN: Haddis T. Hagos, M.D.
Hanover Parkway Surgery Center
7300 Hanover Drive, Suite 204
Greenbelt, MD 20770

If the complaint is not resolved to the patient's satisfaction, he/she has the right to file a grievance with the Office of Health Care Quality (unit for Ambulatory Care Programs Unit) for concerns against the surgery center, the Maryland Board of Physicians (intake unit) concerning the physician or the Maryland Board of Nursing (Complaints & Investigations Division) for concerns against any of the nursing staff. The patient should call any Of the complaint units, send a written copy or submit the claim online (if available).

The patient should provide the physician or surgery centers name, address and specific nature of the complaint.

COMPLAINTS AGAINTS THE SURGERY CENTER

1. Office of Health Care Quality
   Unit: Ambulatory Care Programs
   Spring Grove Hospital Center
   Bland Bryant Building
   55 Wade Avenue
   Catonsville, Maryland 21228
   PH: (800)-492-6005
   Online: http://www.dhmh.state.md.us/ohcq/regulated_programs/ac_file_a_complaint.htm?id=7

COMPLAINTS AGAINT THE PHYSISIAN

2. Maryland Board of Physicians
   INTAKE UNIT
   4201 Patterson Avenue
   Baltimore, Maryland 21215
   PH: (410)-764-2480
   PH: (800)-492-6836 ext. #2480
   Form: http://www.mbp.state.md.us/forms/complaint.pdf

COMPLATINS AGAINST NURSING STAFF

3. ATTN: Patricia Noble, MSN, RN
   Executive Director
   Maryland Board of Nursing
   Complaints & Investigations Divisions
   4140 Patterson Avenue
   Baltimore, Maryland 21215-2254
   PH: (888)-202-9861
   PH: (410)-585-1925
   FAX: (410)-358-3530
   FORM: http://www.mbon.org/invest/complaintform.pdf

HANOVER PARKWAY SURGERY CENTER

7300 Hanover Drive, Suite 204

Greenbelt, MD 20770
Office: 301-477-3959/301-220-2333
Billing Depart: 240-297-9016

Due to our contractual arrangement with Aetna and United Healthcare, you may receive checks for services provided at Pain Management Associates or Hanover Parkway Surgery Center. Since we are an "out of network provider" for these insurance providers; checks will be mailed directly to you and in your name. This check is payment for the service(s) we have provided you; therefore, the check(s) belongs to **Hanover Parkway Surgery Center**.

As soon as you receive the check(s), below are steps to take to ensure your services are paid in full:

Sign the back of the check and forward the payment to Hanover Parkway Surgery Center:

Mail to or in person at 7300 Hanover Drive, Suite #204, Greenbelt, MD 20770.

1. **DO NOT CASH OR DEPOSIT CHECKS INTO YOUR ACCOUNT.**
2. FAILURE TO RETURN THE CHECKS TO HANOVER PARKWAY SURGERY CENTER WILL RESULT IN OUR PRACTICE TAKING APPROPRIATE LEGAL ACTIONS AND COLLECTION AGENCY ASSISTANCE TO ENSURE PAYMENT FROM YOU. YOU WILL IN ADDITION BE LIABLE TO A COLLECTION FEE OF 35% AND/OR ATTORNEY COST. FINALLY, YOUR OUT-STANDING BALANCE WILL BE REPORTED TO THE CREDIT BUREAUS.

If you have any questions or concerns regarding our practice or facility payment process for Aetna or United Healthcare; please contact us.

Thank you,
Management/Practice Providers

Please print and sign your name below as confirmation that you understand, and agree with these terms:

_____

Print Patient's Name

Patient's Signature Date

PAIN MANAGEMENT ASSOCIATES
Haddis T. Hagos, M.D., DABA, DABA PM
Medical Director
Pain Management
7500 Greenway Center Dr., Suite #940
Greenbelt MD, 20770
Tel: (301)220-2333
Fax: (301)220-2339

PLAN OF CARE AGREEMENT

Cash payment at the time of appointment guarantees a full evaluation by the doctor. The evaluation may include medication management, referral to spine intervention, physical therapy, or referral to detoxification.

Cash payment does not guarantee the continued prescription of medication prescribed by other healthcare providers.

There will be no refund given after payment.

Patients Name (PRINT): _____

Patient Signature: _____

Date: _____

Dr. Haddis T. Hagos
Dr. Brent Earls

Patient Contract

for
Using Opioid Pain Medication in Chronic Pain

This is an agreement between _____(the patient) and Health Care Provider _____concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.

3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.

4. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic painkillers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.

5. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

6. I understand it is my responsibility to inform the provider of any and all side effects I have from this medication.

7. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. *Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the provider to discontinue prescribing to me.*

8. I agree that the opioids will be prescribed by only Pain Management Associate Providers and I agree to fill my prescriptions at only <u>one</u> pharmacy to the best of my abilities. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with my pain management provider. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will <u>NOT</u> be replaced.

10. I agree not to sell, lend, or in any way give my medication to any other person or take any medication from family and/or friends.

Dr. Haddis T. Hagos
Dr. Brent Earls

11. I agree *not to drink alcohol*, or *use illegal substance such as cocaine, heroine, pcp, fentanyl or take other mood-altering drugs* while I am taking opioid analgesic medication. I agree to submit a urine specimen or oral specimen *at any time* that my doctor requests and give my permission for it to be tested for alcohol and drugs.

12. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities as needed recommended by my proider.

13. I understand that there is a risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

14. I will treat the staff at the office respectfully at all times. I understand that if I am disrepectful to staff or disrupt the care of other patients my treatment will be stopped.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the provider may discontinue prescribing narcotic pain-killers and I may be discharged from the practice.

Patient signature DATE

Health Care Provider signature DATE