REGENERATIVE
SPINE AND PAIN INSTITUTE
STOP YOUR PAIN. START YOUR LIFE.

666 Plainsboro Road Suite #100D
Plainsboro, NJ 08536
Phone: (609) 269-4451
Fax: (609) 853-0495
Email: info@njpaindoc.com

PATIENT REGISTRATION FORM

Today's Date: 01/31/2023 Referred by: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: M □ F □ Social Security #: _____

Address: _____
Street City State/Zip

Home Phone:_____Cell Phone:_____ Email: _____

Employer: _____

Emergency Contact: _____ Telephone: _____

Pharmacy Name _____ Phone: _____

Primary care physician information:

Dr. _____

Address: _____
Street City State/Zip

Office Phone: _____ Fax: _____

Do you give us permission to send or fax a report to your primary care physician: □ YES □ NO

Insurance Information (Present Insurance Card(s) to Receptionist)

Primary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Primary Insurance: _____

Subscriber Information (IF DIFFERENT than above):

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____Zip: _____

Secondary insurance: _____ **Group/Plan#** _____

Advance Directives

Do you have a health care proxy/living will? □ Yes □ No Do you want to discuss this with your physician? □ Yes □ No

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Disclosure to Designated Family/Friends/Caregivers

I allow REGENERATIVE SPINE AND PAIN INSTITUTE to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

Print Name	Date of Birth	Relationship	Phone Number
Print Name	Date of Birth	Relationship	Phone Number

Authorization to Access Electronic Prescription Records

I authorize Regenerative Spine and Pain Institute and its affiliated providers to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Regenerative Spine and Pain Institute medical record.

Health Information Exchange (HIE)

REGENERATIVE SPINE AND PAIN INSTITUTE also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize REGENERATIVE SPINE AND PAIN INSTITUTE and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs, and instructions on how to do that can be found in the REGENERATIVE SPINE AND PAIN INSTITUTE Notice of Privacy Practices, the HIE brochure which is available from participating REGENERATIVE SPINE AND PAIN INSTITUTE offices or may be requested from REGENERATIVE SPINE AND PAIN INSTITUTE's Privacy Officer.

Authorization for Photographs and Release for use in Medical Records

I hereby authorize and consent to the taking of photographs and moving pictures of me by REGENERATIVE SPINE AND PAIN INSTITUTE, its agents or employees. I hereby authorize and consent to the use and storage of such photographs and moving pictures for identification purposes and as part of my medical record.

I hereby release REGENERATIVE SPINE AND PAIN INSTITUTE, its medical staff, agents and employees from all liability related to the making, storage, and use of such photographs and moving pictures for identification purposes and as part of my medical record.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in REGENERATIVE SPINE AND PAIN INSTITUTE for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, copayments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize REGENERATIVE SPINE AND PAIN INSTITUTE or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

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Consent to Treat

I, the undersigned, voluntarily consent to and authorize REGENERATIVE SPINE AND PAIN INSTITUTE through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my REGENERATIVE SPINE AND PAIN INSTITUTE physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

Acknowledgments and Agreement

I acknowledge that I have been advised of my right to an Advance Directive.

- I acknowledge receipt of the REGENERATIVE SPINE AND PAIN INSTITUTE Financial Policy and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices.
- I agree to allow access to my electronic prescription records as described above.
- I agree to the release and assignment of benefits as described above.
- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

_____ _____

Patient/Representative's Signature Date

_____ _____

If signed by Authorized Representative, print name of Signatory Relationship to Patient/Authority to Sign for Patient

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FINANCIAL POLICY

We are dedicated to providing our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our **FINANCIAL POLICY.**

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company.

AND

Your doctor's bill for services provided is an agreement between you and your doctor.

All co-payments or payments for non-covered services are the patient's responsibility and will be collected by our staff at time of service.

SPECIALIST OFFICES & REFERRALS: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment for services provided if you fail to supply all required referral forms.

YOUR RESPONSIBILITY: Our Physicians participate with only Medicare. It is *your* responsibility to call your insurance company to verify that the doctor you are seeing is participating. Please be advised that when using you out of network benefits, your insurance company may be mailing payments for our services directly to you (the patient). It is THE PATIENT'S RESPONSIBILTIY to make sure our office receives those payments by promptly endorsing the back of the received check(s) and either mailing or hand delivering the endorsed check(s), along with the explanation of benefits (EOB) to Regenerative Spine and Pain Institute. For your protection, please make copies of all checks for your files before sending them to our office. I understand that I am utilizing my OUT OF NETWORK BENEFITS. Failure to complete the above in a timely matter is considered noncompliant and no future appointments will be scheduled.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self-pay" and ask for full payment.

Patient Initials: _____

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PAYMENT FOR SERVICES PERFORMED:

1. Our office accepts Visa, MasterCard, Discover and American Express, as well as Cash, Debit Cards, Money Orders and Personal Checks for payment of services.
2. Any copay required by an insurance company must be paid at the time of service. This is an insurance requirement; we cannot bill you for these.
3. Any coinsurance or deductible that is the patient's responsibility must be paid in full within 30 days of receipt of bill.
4. All payments are expected at the time of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

RETURNED CHECK FEE: $30

CHARGES TO ACCOUNT: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment or fail to reschedule or cancel with less than 24 hours' notice will be charged a $25.00 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

FORMS FEE: Any forms to be filled out by a provider for the use of the patient will be charged a $20.00 fee-this excludes temporary disability forms.

MISSED TEST FEE: Patients who do not show up on time for a scheduled office-based test or fail to reschedule or cancel with less than 24 hours' notice will be charged a $150.00 fee. This charge will not be reimbursed by your insurance.

MISSED PROCEDURE FEE: Patients who do not show up on time for a scheduled procedure or fail to reschedule or cancel with less than 48 hours' notice will be charged a $100.00 fee. This charge will not be reimbursed by your insurance.

RELEASE OF RECORDS: If you require a copy of your records for personal use, you must submit a request and pay a copying fee of $1.00 per page up to a maximum of $100.00.

Copies of records, including payment history, will be provided at no charge to other healthcare providers pursuant to a valid HIPAA authorization*.

RIGHT TO AMEND: You understand and agree that Regenerative Spine and Pain Institute may amend the terms of this Financial Policy at any time without prior notification to the patient.

Patient Initials: _____

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Assignment of Benefits

I, _____, irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights and benefits under the **Employee Retirement Income Security Act** ("ERISA") applicable to the medical services at issue. I irrevocably authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights and benefits under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and regarding my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

If you, my medical provider, initiates a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of my medical provider's attorneys' fees and court fees in connection with that proceeding.

Patient Name_____ Date_____

Signature_____

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NOTICE OF PRIVACY PRACTICES
Effective December 1, 2018

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

I. We are required by law to protect the privacy of your health information often referred to as protected health information or "PHI" which may include individually identifiable information that relates to your past/present/future physical or mental health condition and provision of health care and/or past/present/future payment for health care.

We are required to provide you with a copy of this notice describing the privacy practices and legal duties and to explain how, when, and why Regenerative Spine and Pain Institute (REGENERATIVE SPINE AND PAIN INSTITUTE) may use or disclose your protected health information.

REGENERATIVE SPINE AND PAIN INSTITUTE recognizes and respects your right to confidentiality, and we maintain numerous safeguards to protect your privacy. We are required by law to abide by the terms of this notice currently in effect. We reserve the right to change this notice from time to time and to make the Notice effective for all PHI we maintain. You can always obtain a copy of our most current notice by contacting the Privacy Officer.

If you have questions or want additional information regarding subjects covered in the notice, contact the Privacy Officer, REGENERATIVE SPINE AND PAIN INSTITUTE, 666 Plainsboro Road, Suite 100D, Plainsboro, NJ 08536, (609) 269-8629 or info@njpaindoc.com.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we may use or disclose medical information about you. For each category, we have provided some examples:

- **Treatment** means the provision, coordination, or management of your health care, including consultations between doctors, nurses, and other providers, regarding your care and referrals for care from one provider to another. For example, your primary care doctor may disclose your protected health information to a cardiologist if he is concerned that you have a heart problem. We also may, for example, allow one specialist within our practice who treats you to see the electronic medical reports from other specialists within REGENERATIVE SPINE AND PAIN INSTITUTE who have treated you, or we may, for example, allow all the physicians in REGENERATIVE SPINE AND PAIN INSTITUTE who examine you to see certain entries in your electronic medical records such as vital signs, allergies, and medications, so that REGENERATIVE SPINE AND PAIN INSTITUTE may provide more coordinated care to you, and avoid adverse treatment interactions.
- **Payment** means the activities we carry out to bill and collect for the treatment and services provided to you. For example, we may provide information to your insurance company about your medical condition to determine your current eligibility and benefits. We may also provide PHI to outside billing companies and others that process health care claims.
- **Health Care Operations** means the support functions that help operate REGENERATIVE SPINE AND PAIN INSTITUTE such as quality improvement studies, case management, responding to patient concerns, and other important activities. For example, we may use your PHI to evaluate the performance of the staff that cared for you or to determine if additional services are needed.

III. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your protected health information for treatment, payment, and health care operations, we may also use your information in the following ways:

- **Appointment Reminders and Health-Related Benefits or Services.** We may use PHI to contact you for a medical appointment or to provide information about treatment alternatives or other health care services that may benefit you.
- **Disclosures to Family, Friends, and Others.** We may disclose your PHI to family, friends, and others identified by you as involved in your care or the payment of your care. We may use or disclose PHI about you to notify others of your general

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- condition. We may also allow friends and family to act or you and pick-up prescriptions, x-rays, etc. when we determine it is in your best interest to do so. If you are available, we will give you the opportunity to object to these disclosures.
- **To Avoid Harm.** As permitted by law and ethical conduct, we may use or disclose protected health information if we, in good faith, believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.
- **Fundraising & Marketing Activities.** We may contact you as part of our fundraising and marketing activities as permitted by law. You have the right to opt out of receiving such fundraising communications.
- **Research Purposes.** In certain circumstances, we may use and disclose PHI to conduct medical research. Certain research projects require an authorization which will be made available to you prior to using your PHI.
- **Lawsuits & Disputes.** If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other process by others involved in the dispute. We will only disclose information with assurance that efforts were made to inform you about the request or to obtain an order protecting the information requested.
- **Required by Law Enforcement.** We may release health information about you if asked to do so by law enforcement in response to a court order, subpoena, warrant, summons, or similar process. We also may disclose information to identify or locate a suspect, fugitive, material witness, or missing person. In addition, we may disclose information about a crime victim or about a death we believe may be the result of criminal conduct. In emergency situations, we may disclose PHI to report a crime, to help locate the victims of the crime, or the identity/description/location of the person who committed the crime.
- **Disaster Relief.** When permitted by law, we may coordinate our uses and disclosures of protected health information with other organizations authorized by law or charter to assist in disaster relief efforts. For example, a disclosure to the Red Cross or a similar organization.
- **To Employers.** In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer, or the Hospital as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

IV. SPECIAL SITUATIONS

- **Organ and tissue donation.** If you are an organ donor, we may disclose PHI to an organ procurement organization.
- **Military personnel.** If you are a member of the armed forces, we may release PHI about you as required by military authorities. We may also release PHI about foreign military personnel to appropriate foreign military authorities.
- **Worker's compensation.** We may disclose PHI about your work-related illness or injury to comply with worker's compensation laws.
- **Public health activities.** We routinely disclose information about you for public health activities to:
  - Prevent or control disease, injury or disability.
  - Report births and deaths.
  - Report child abuse or neglect.
  - Persons under the jurisdiction of the Food & Drug Administration for activities related to product safety and quality and to report reactions to medications or products.
  - Notify people who may have been exposed to a disease or are at risk of contracting or spreading a disease; o Notify government agencies if we believe an adult has been the victim of abuse, neglect, or domestic violence, if the adult patient agrees or when required by law.

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- **Health Oversight Activities.** We may disclose information to government agencies that oversee our activities. These activities are necessary to monitor the health care system and benefit programs, and to comply with regulations and the law.
- **National Security.** We may disclose PHI to authorized officials for national security purposes such as protecting the President of the United States or other persons or conducting intelligence operations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of law enforcement, we may release PHI about you to the correction facility or law enforcement officials. This would be necessary for the institution to provide you with health care; to protect your health and safety and the health and safety of others; or for the safety and security of the correctional institution.
- **Health Information Exchanges (HIEs).** We and other health care providers participate with regional health information exchanges (HIEs). These exchanges allow patient information to be shared electronically with among health care providers, through a secured connected network. HIEs give your health care providers who participate in the same exchanges electronic access to some of your pertinent medical information for treatment and continuity of your care. If you do not opt-out of the HIEs, we may release your health information through the HIEs to your participating providers, and we may also access information about you that has been made available through the HIEs. If you do opt-out of the exchanges, following the opt-out instructions near the end of this notice, your PHI will

  not be made accessible to other providers through the HIEs, and your information may not be as quickly accessible by your other health care providers.
- **Other Uses of Your Health Information.** Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under federal privacy laws and rules. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

V. YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Request Limits on Uses and Disclosures of your PHI. You have the right to request restrictions to how we use and disclose your PHI. Your request must be in writing and sent to the Privacy Officer. We will review your request, but we are not required to agree to your request. We are, however, required to comply with your request if it relates to a disclosure to your health plan regarding health care items or services for which you have paid the bill in full. If we agree to your request, we will document the restrictions and abide by them, except in emergency situations, as necessary. You may not limit the uses and disclosures that we are legally required or allowed to make.

Right to Request Confidential Communications. You have the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. For example, sending information to your work address rather than to your home address, or asking that we contact you by mail rather than telephone. To request confidential communications, you must specify your instructions in writing on a form provided on request. You must specify where and how you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Obtain Copies of your Protected Health Information. In most cases, you have the right to inspect and obtain copies of protected health information used to make decisions about your care, subject to applicable law. To inspect or copy your medical record, you must make a request in writing to the Privacy Officer. If you request copies of your health information, we may charge a fee for copying, postage, and other supplies associated with your request.

Right to Amend your Protected Health Information. If you believe that the protected health information we have about you is incorrect or incomplete, you may request that we amend the information. To request an amendment, you must make your request in writing to the Privacy Officer and specify a reason that supports you request. We may deny your request for an amendment subject to applicable law.

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Right to Obtain a List of Disclosures We Have Made. You have the right to request an "accounting of disclosures" of your protected health information. Your request must be made in writing and include a time period no longer than six years prior to the date of the request. There are several exceptions to the disclosures we must account for. Examples include disclosures for treatment, payment, and health care operations; those made to you; those made as a result of an authorization by you; and those made for national security or intelligence purposes. Requests for an accounting of disclosures must be made in writing to the Privacy Officer. The first accounting you request within a 12-month period is free. For additional accountings, we may charge you for the cost of providing it. We will notify you of the cost before processing your request so you may withdraw or modify your request before costs are incurred.

Right to Be Notified of Breaches. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Federal privacy laws and rules.

Right to Opt-Out of Health Information Exchanges. With regard to health information exchanges (HIEs) only, if you do not wish to allow other health care providers involved in your care to electronically share your PHI with each other through HIEs, you have the right to opt-out of the HIE, by contacting the Privacy Officer in writing, or you can complete, sign and submit the HIE "opt-out" form(s) available during registration, and mail the form(s) as instructed on the form(s), and your information will not be accessible through the HIEs. If you do opt out of the HIEs, your information will not be accessible from the exchange networks; however, all other typical uses and releases of your information will continue in accordance with this notice and applicable law.

VI. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with us, please contact the **Privacy Officer, REGENERATIVE SPINE AND PAIN INSTITUTE, 666 Plainsboro Road, Suite 100D, Plainsboro, NJ 08536, (609) 269-8629 or** info@njpaindoc.com. We will not act against you for filing a complaint.

Patient Name_____ Date_____

Signature_____

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Pain Treatment with Opioid Medications: Patient Agreement

This Agreement is essential to the trust and confidence necessary in a prescriber/patient relationship. My prescriber has discussed my treatment plan with me. I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances for pain. I have been told about the side effects that I may experience. My prescriber is undertaking to treat me with controlled substances for pain because:

I, _____, understand and voluntarily agree to the following (initial each statement after reviewing):

____ I have told my prescriber about other medications I am taking and my medical history, including my prior experience with pain medications or other drugs. Throughout my treatment, I will communicate fully with my prescriber about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve pain.

____ I will take my medication as instructed and not change the way I take it without first talking to my prescriber or other members of the treatment team. I understand that my prescriber may change this medication during my course of treatment.

____ I will not attempt to obtain pain medications from any other prescribers and understand that my prescriptions will be issued only during scheduled office visits with the treatment team or during regular office hours. If I require surgery or emergency treatment, and I can communicate, I will tell the health care professional taking care of me about all the medications I am taking and, at or before my next refill, I will tell my prescriber about my use of medications in these circumstances.

_____ I agree not to use illegal drugs or alcohol while on these medications.

_____ I understand that I should not drive a motor vehicle or operate machinery if the medication causes dizziness, drowsiness, or sedation.

_____ I will use one pharmacy to get all my medications: _____

(Pharmacy Name/Phone Number)

_____I understand that I may be referred to other health care professionals for other modes of treatment, such as physical therapy, exercise, relaxation techniques or psychological counseling, or for certain diagnostic tests and that my prescriber may speak with other health care professionals about my treatment plan. Currently my treatment plan includes: _____.

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_____I will keep the medicine safe, secure, and out of reach of others, and will dispose of unused medications in a Project Medicine Drop Box, through a Take-back Program or in a drug disposal pouch.

_____ I will not sell this medicine or share it with others. If my medicine or prescription is lost or stolen, I understand that it may not be replaced.

_____ I understand that I may need to submit to random urine drug testing to ensure compliance to pain medication regimen and random pill counts if requested by my prescriber and that my prescriber will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site.

_____ I understand that if I do not follow all the terms of this Agreement, my prescriber may stop prescribing pain medications, and/or that I could be required to find another prescriber or health care professional for my future medical treatment.

_____ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team or during regular office hours.

_____ I will keep all my scheduled appointments including appointments for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ Patient Name / Date

_____ Patient Signature

_____ Prescriber Signature

_____Ronak D. Patel MD_____Prescriber Name Printed Date

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HIPAA Privacy Authorization & Medical Release Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**

I authorize Regenerative Spine and Pain Institute to use and disclose the protected health information described below to Regenerative Spine and Pain Institute (Individual seeking the information).

2. **Effective Period**

This authorization for release of information covers the period of healthcare from:
a. □ _____ to _____. OR
b. ☒ all past, present, and future periods.

3. **Extent of Authorization**

a. ☒ I authorize the release of my complete health record (Including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Communicable diseases (Including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (Please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

REGENERATIVE
SPINE AND PAIN INSTITUTE
STOP YOUR PAIN. START YOUR LIFE.

666 Plainsboro Road Suite #100D
Plainsboro, NJ 08536
Phone: (609) 269-4451
Fax: (609) 853-0495
Email: info@njpaindoc.com

5. This authorization shall be in force and effect until _____ (Date / Event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected byfed eral or state law.

Patient Name_____ Date_____

Signature_____