

PATIENT INFORMATION SHEET

Solas Health, PLLC

Welcome to Solas Health! Your time is valuable and we feel that your being aware of the information found below will help your interactions with our office to be as efficient as possible.

Please arrive 30 minutes early for your first appointment with our office with completed necessary paperwork. New patient paperwork is also available on our website at www.painmanagementofnc.com. Please bring your insurance cards to every visit. Due to federal regulations, all patients will be required to present a photo I.D. upon request. **Payment of co-pays is expected at time of service. Please understand that this appointment is for evaluation purposes only. You are not guaranteed medications or injections at this appointment.**

OUR OFFICE IS LOCATED AT:

- 285 Olmsted Blvd, Suite 1
Pinehurst, NC 28374
Phone: (910) 295.7246
Fax: (910) 222.3168
- 204 Ashville Ave, Suite 60
Cary, NC 27518
Phone: (919) 460.7246
Fax: (919)324-1766
- 2911 Breezewood Ave, Suite 101
Fayetteville, NC 28303
Phone: (910) 295.7246
Fax: (910) 222.3168

EMERGENCY SITUATIONS / PHONE CALLS

If you are calling about an emergency, **please inform the operator immediately** so that your call will be handled appropriately.

Other phone calls will be returned during the course of the day as the schedule allows. Please remember that the physicians and nurses are seeing scheduled patients throughout the day and it may take some time before a return call can be made. **The office functions with a timely and efficient message system, so it is not necessary to make repeat phone calls to the office during the course of a day.**

OFFICE HOURS

- Our office staff is available Monday-Thursday 8:00am to 5:00pm, and Friday 8:00am to 2:30 pm, and may be reached at (910) 295.7246.

APPOINTMENTS

- Solas Health is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments well in advance of follow up due dates, as we book up quickly. When calling for an appointment, please provide your name, date of birth, phone number, reason for visit, and updated insurance information.
- If you are unable to make a scheduled appointment, we ask that you call to cancel your appointment at least 24 hours in advance. This will allow us to offer that time to another patient in need of care.
- While we strive to schedule appointments appropriately, emergencies can occur in specialty medicine, and our physicians will give their patients the time they require. For this reason, we kindly request your patience & understanding should a delay or rescheduling be necessary on your appointment date.

PRESCRIPTIONS

- Refills of opioids and other narcotics can only be made at your scheduled office visit. **Controlled substances will not be refilled after regular office hours, on weekends, or on holidays.**
- For all other medication refills, please contact your pharmacy and have them fax the request to (910) 222.3168. Requests received after 3:00pm will be processed the following business day.

PROCEDURES

- If you are scheduled for a procedure, you will be required to have driver take you home after your visit. Should you come to your appointment without a driver, your procedure will be rescheduled.
- If you are currently taking Plavix, you will be required to stop taking your medication 7 days prior to your procedure. If you are currently taking Coumadin, you will be required to stop taking your medication 5 days prior to your procedure. On the 6th day you will need to have a PT/INR lab test done at least 45 minutes before your procedure.

REFERRALS

- Some insurance carriers require that a patient obtain a referral from their primary care physician in order for the insurance to pay for care by a specialist physician. Most insurance carriers do not require a referral, but if yours does it is your responsibility to ensure that the referral is in effect prior to visiting our office. Some referrals are good for 6 months to 1 year, others require referrals per visit. If your insurance company authorizes a referral yearly, it is your responsibility to update that referral.

AUTHORIZATIONS

- Certain insurance companies mandate authorization for some services. These can include procedures, radiology and laboratory services, and even medications. When an authorization is needed, our office submits this request to the patient's insurance company. Once they receive this request we must wait for their approval or denial. Traditionally this takes between one and 14 business days.

MEDICAL RECORDS

- Please allow **7-10 business days** to complete requests for medical records. If you do not have a signed release on file, you will be asked to sign one when picking up your records. If you need records sent from another medical facility to this office, you will need to send a signed medical release to that office in order for the records to be released to Solas Health, PLLC. There may be a charge associated with copying records. Please contact our Medical Records Department for more information at (910) 295.7246.

BILLING

- We ask that you always bring your current health insurance card with you to every appointment. Please notify us at time of check-in if any changes in insurance, address, telephone, or family status. Please remember that we must receive your billing information at the time of each visit in order to meet claim submission guidelines set by your insurance plan.
- **Co-pay/Coinsurance:** We are required by our insurance contracts to collect all co-pays and other patient responsible amounts, at the time of service.

- **Deductibles:** If you have not met your deductible – we will estimate the expected insurance payment for your visit and request that amount at check-in. Please note this is only an estimate and you may receive a statement with remaining balance after your visit.
- **Returned Checks:** There is a \$25.00 fee for any checks returned by the bank.
- **Statements:** If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payment or credits applied to your account during the month.
- **Payments:** Unless other arrangements are approved by the billing department in writing, the balance on your statement is due and payable once the statement is issued and is past due after 30 days.
- If you have any questions regarding your account balance, please call (910) 295.7246, for assistance.

REFUNDS

- While Solas Health makes all reasonable efforts to estimate the patient's out of pocket or co-payment due at the time of service, occasionally overpayments may occur. Refunds are issued within 60 days of receipt of payment at Solas Health, PLLC. If you are aware of an account credit, please allow thirty days before contacting your account representative (910) 295-7246

PATIENT REGISTRATION (please print)

Solas Health, PLLC

1. Patient's Full Name _____ Sex: M F
Last First Middle
2. Race: (Please Circle) American Indian, African American, Caucasian, Native Hawaiian or Pacific Islander, Other _____
3. Ethnicity: (Please Circle) Non-Hispanic, Hispanic
4. Patient's Social Security # _____ 6. Date of Birth _____ 7. Age _____
8. Patients Home Address _____
9. Patient's Email Address _____
10. Primary Care Doctor _____ 11. Referring Provider _____
12. Patient's Marital Status: Single Married Divorced Widowed Separated
13. Person we may contact in case of an emergency:
 Name _____ Phone # _____
14. Patient's Home Number (_____)_____-_____ Patient's Cell Number (_____)_____-_____

Insurance Information - We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

15. Insurance Company _____ Address _____
16. Subscriber's Name _____ 17. Subscriber's Sex: M F
18. Subscriber's Date of Birth _____ 19. Subscriber's Social Security # _____
19. Patient's Relationship to Subscriber: Self Spouse Child Other
20. Subscriber's ID # _____ Group # _____

SECONDARY INSURANCE COVERAGE

21. Insurance Company _____ Address _____
22. Subscriber's Name _____ 24. Subscriber's Sex: M F
23. Subscriber's Date of Birth _____ 25. Subscriber's Social Security # _____
26. Patient's Relationship to Subscriber: Self Spouse Child Other
27. Subscriber's ID # _____ Group # _____

OTHER INSURANCE Yes No

FINANCIAL AGREEMENTS AND AUTHORIZATION OF TREATMENT: I hereby authorize Solas Health, PLLC and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above such medical care, examination, and treatment as may be ordered by a Solas Health physician in his/her medical judgment and such medical care, examination, or treatment as is reasonable to incident thereto. I hereby authorize direct payment to Solas Health of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the patient is entitled in consideration of services to be rendered by Solas Health to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be financially responsible to Solas Health for charges not covered by this agreement, and I hereby guarantee payment to Solas Health on demand for all such charges.

Signature _____ Date _____

Please check one: Patient Authorized Representative Parent or Guardian of Minor

CURRENT MEDICAL PROBLEMS (Include Why You are Here Today)

DATE OF ONSET

PAST MEDICAL PROBLEMS / HOSPITALIZATIONS / SURGERIES

DATES

IMAGING (Date of last):

X-Ray: _____ Reason: _____ Location: _____

MRI: _____ Reason: _____ Location: _____

CT: _____ Reason: _____ Location: _____

OTHER SPECIALIST THAT YOU SEE ON A REGUALR BASIS (name and specialty):

FAMILY MEDICAL HISTORY: Please list all family members/relatives diagnosed with any of the following conditions including their age at onset (please note if deceased).

Heart Disease: _____

Diabetes: _____

High Cholesterol: _____

Hypertension: _____

Colon Cancer: _____

Breast Cancer: _____

Ovarian Cancer: _____

Thyroid: _____

Other: _____

Additional Information: _____

HIPAA AUTHORIZATION FORM

Patient Name _____ Date _____

I give my permission for the providers of Solas Health to release ANY information about my medical condition, prescriptions, and financial account to:

Name: _____

Name: _____

At this time, I do not authorize any persons to any of the above actions

Below, I give my permission for the providers Solas Health, PLLC to release prescriptions, samples, forms, and medical records to:

Name: _____

Name: _____

At this time, I do not authorize any persons to any of the above actions

The above-mentioned person(s) will be required to provide photo ID when picking up requested items.

**Patient Name: _____ Date of Birth: _____

**Patient Signature: _____

By signing on the line below, I acknowledge that I was provided access to the Notice of Privacy Practices of Solas Health, PLLC.

**Print Name: _____ Date of Birth: _____

**Patient Signature: _____

For Personal Representation of the Patient (if applicable)

Print Name of Personal Representative: _____

Representative's Relationship (i.e. parent/guardian/other, etc.) _____

Signature of Personal Representative: _____

Signature of Practice Employee

Date

Solas Health, PLLC
Notice of Privacy Practices

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 Officer.

Effective Date: April 14, 2003

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: painmanagementofnc.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- **If required by law:** The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- **Public health activities:** The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- **Health oversight agencies:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Legal proceedings:** To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- **Police or other law enforcement purposes:** The release of PHI will meet all applicable legal requirements for release.
- **Coroners, funeral directors:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- **Medical research:** We may disclose your protected health 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 protected health information.
- **Special government purposes:** Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- **Correctional institutions:** Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request, we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12-month period, you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights, or you have a complaint about our privacy practices you can contact:

[Insert name of responsible person responsible and contact information]

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003.