



# EAST TENNESSEE BRAIN & SPINE CENTER

**PLEASE PRINT THE INFORMATION BELOW**

Please print your name as it appears on your insurance card or license

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_ Home Phone #: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Primary Language:  English  Other \_\_\_\_\_ Ethnicity (Hispanic/Non Hispanic) \_\_\_\_\_

Education: Last Grade Completed \_\_\_\_\_ Email Address \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status:  Divorced  Married  Separated  Single  Widowed

Spouse Name (if married) \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Insurance Company Name \_\_\_\_\_

Name of Cardholder (if not the patient) \_\_\_\_\_ SS# of cardholder \_\_\_\_\_

Date of Birth of cardholder \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Group/ID Number: \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_

Name of Cardholder \_\_\_\_\_ SS# of Cardholder \_\_\_\_\_

Date of Birth of Cardholder \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Group/ID Number \_\_\_\_\_

EMERGENCY CONTACT (person not living with you): \_\_\_\_\_ Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

REASON FOR VISIT? \_\_\_\_\_

Date symptoms began? \_\_\_\_\_

Described what caused the symptoms: \_\_\_\_\_

### **SOCIAL HISTORY:**

Currently working? \_\_\_\_\_ Disabled- list reason & date \_\_\_\_\_ Date last worked \_\_\_\_\_

Do you live alone? \_\_\_\_\_ If not, with whom do you live? \_\_\_\_\_

Do you smoke or use chew tobacco? \_\_\_\_\_ If so, amount per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you consume alcohol products? \_\_\_\_\_ If so, how much and how often? \_\_\_\_\_

Has anyone told you to cut down on your drinking? \_\_\_\_\_

Are you Claustrophobic? \_\_\_\_\_ Right or left handed? \_\_\_\_\_  
 Do you drink caffeinated beverages? \_\_\_\_\_ Cups/Glasses/Cans per day: \_\_\_\_\_  
 Do you use drugs for reasons that are not medical? \_\_\_\_\_ If yes, please list: \_\_\_\_\_  
 Do you exercise regularly? \_\_\_\_\_ If yes, what type and how many times per week \_\_\_\_\_  
 Do you get enough sleep at night? \_\_\_\_\_ Do you wake up feeling rested? \_\_\_\_\_

**Pharmacy name and phone number that you are currently using:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Family History:**

Is your Father living?  Yes Health: \_\_\_\_\_  No Age of Death: \_\_\_\_\_; Cause: \_\_\_\_\_  
 Is your Mother living?  Yes Health: \_\_\_\_\_  No Age of Death: \_\_\_\_\_; Cause: \_\_\_\_\_  
 Number of Siblings: \_\_\_\_\_ Number living: \_\_\_\_\_ Number deceased: \_\_\_\_\_  
 Number of Children: \_\_\_\_\_ Number living: \_\_\_\_\_ Number deceased: \_\_\_\_\_ Please list their ages: \_\_\_\_\_  
 Health of Children: \_\_\_\_\_

**Family History (Indicate relationship to you – mother, father, sibling, etc.)**

___ Alcoholism	___ Diabetes	___ Leukemia
___ Asthma	___ Epilepsy	___ Psoriasis
___ Back pain/ruptured disc	___ Goiter	___ Rheumatic Fever
___ Bleeding	___ Headaches	___ Stroke
___ Cancer	___ Heart Disease	___ Tuberculosis
___ Colitis	___ High Blood Pressure	___ Other Inherited Diseases

**PAST MEDICAL HISTORY: (Mark what you have or had)**

**MEDICAL:**

___ Abnormal Bleeding	___ Easy bruising	___ Low back pain	___ Sexually transmitted disease
___ Abnormal blood clotting	___ Esophagitis	___ Low blood pressure	___ Sickle Cell anemia/trait
___ Angina	___ Gastritis	___ Multiple Sclerosis	___ Sleep apnea
___ Anxiety	___ Gout	___ Neck problems	___ Snores
___ Asbestosis	___ Headaches	___ Pacemaker	___ Stroke
___ Asthma	___ Heart failure	___ Pancreatitis	___ Swallowing difficulties
___ Bipolar	___ Heart murmur	___ Pneumonia	___ Swelling in extremities
___ Bronchitis	___ Heart valve prolapsed	___ Polio	___ Syncope (fainting)
___ Cancer _____	___ Hepatitis A B C	___ Prostate problems	___ Thyroid disease
___ COPD	___ High blood pressure	___ Pulmonary embolism	___ Tuberculosis
___ Coronary artery disease	___ High cholesterol	___ Reflux	___ Ulcers
___ Crohn's disease/colitis	___ HIV positive	___ Rheumatic heart disease	___ Other: _____
___ Depression	___ Irregular heart rate	___ Sarcoidosis	
___ Diabetes	___ Kidney disease	___ Seizures	

**SURGICAL (Please list dates):**

No surgical history

_____ Appendectomy	_____ Heart surgery	_____ Tonsillectomy/Adenoidectomy
_____ Back surgery	_____ Hernia surgery	_____ Vascular surgery
_____ Brain surgery	_____ Hysterectomy	_____ Other: _____
_____ Gall Bladder surgery	_____ Neck surgery	

**SPINE TREATMENT HISTORY:**

No spine treatments tried

___ Acupuncture	___ Physical Therapy	___ Spinal Injections	___ Therapeutic Massage
___ Chiropractic	___ Spinal Cord Stimulators	___ TENS	___ Other _____



**CURRENT SYSTEM REVIEW:** Please read through the following and mark any problems you **CURRENTLY** have.

**CARDIOVASCULAR**

- Abnormal blood pressure
- Chest pain
- Difficulty breathing on exertion
- Fainting
- Heart Murmur
- Hypertension
- Irregular heart beat
- Night Cramps
- Palpitations
- Shortness of breath
- Sudden changes in heart beat
- Swelling of extremities

**ENDOCRINE**

- Excessive thirst

**GASTROINTESTINAL**

- Abdominal pain
- Black tarry stools
- Blood in stool
- Constipation
- Difficulty swallowing
- Heartburn
- Jaundice
- Nausea
- Persistent diarrhea
- Stomach pain relieved by food/milk
- Vomiting blood

**General**

- Chills
- Fatigue
- Fever
- Lethargy
- Night sweats
- Persistent Infections
- Weight gain
- Weight loss

**GENITOURINARY**

- Blood in urine
- Cloudy "smoky" urine
- Getting up at night to urinate X \_\_\_\_
- Painful intercourse
- Painful urination
- Pus in urine
- Rash/Ulcers
- Sexual difficulties
- Urinary difficulties

**MEN ONLY**

- Discharge from penis
- Prostate problems

**WOMEN ONLY**

- Bleeding after menopause
- Discharge from vagina
- Menstrual irregularities
- Vaginal dryness

**HEAD-EARS-EYES-MOUTH-NOSE-THROAT**

- Bleeding gums
- Double vision
- Dry eyes
- Dry mouth
- Dryness in nose
- Excessive tearing
- Eye pain
- Eye redness
- Glasses/contact lenses
- Headache
- Hearing loss
- Hoarseness
- Itchy eyes
- Loss of smell
- Loss of taste
- Nasal discharge
- Nosebleeds
- Oral ulcers
- Ringing in ears
- Sore throat
- Sore tongue
- Swollen glands

**HEMATOLOGICAL/LYMPHATIC**

- Anemia
- Easy bruising
- Excessive bleeding
- Tender glands
- Transfusions- When: \_\_\_\_\_

**MUSCULOSKELETAL**

- Calf pain
- Decreased range of motion
- Fibromyalgia
- Joint pain
- Joint swelling
- Low back pain
- Middle back pain
- Muscle cramps
- Muscle tenderness
- Muscle weakness
- Neck mass
- Neck pain
- Neck stiffness

**NEUROLOGICAL**

- Auras
- Change in bladder frequency
- Decrease memory
- Difficulty speaking
- Dizziness
- Generalized muscle spasms
- Hypersensitivity of hands/feet
- In coordination
- Loss of bowel control
- Loss of consciousness
- Loss of urinary control
- Muscle twitching
- Numbness/tingling
- Seizures
- Tremors
- Trouble walking
- Unsteadiness
- Visual changes

**PSYCHIATRIC**

- Agitation
- Anxiety
- Depression
- Difficulty falling asleep
- Difficulty staying asleep
- Easily loses temper
- Excessive worries
- Hallucinations
- Mood Changes
- Weakness

**RESPIRATORY**

- Bloody sputum
- Cough
- Difficulty breathing
- Difficulty breathing at night
- Wheezing

**SKIN AND/OR BREAST**

- Bruising
- Hair loss
- Hives
- Itching
- Nodules/bumps
- Rash
- Redness
- Skin color changes
- Sun sensitive
- Tightness

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Circle or write in answers.**

1. What is your pain level today?

0 1 2 3 4 5 6 7 8 9 10

2. In the last month, what was your lowest pain level?

0 1 2 3 4 5 6 7 8 9 10

3. In the last month, what was your highest pain level?

0 1 2 3 4 5 6 7 8 9 10

4. Draw X's where your pain is at, to the right.

5. What type of pain is it?

(sharp) (burning) (dull) other \_\_\_\_\_

6. How long have you had this pain?

\_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

7. How frequent is pain?

(constant) (comes and goes) other \_\_\_\_\_

8. Where does the pain travel to?

(hand) (arm) (leg) (foot) other \_\_\_\_\_

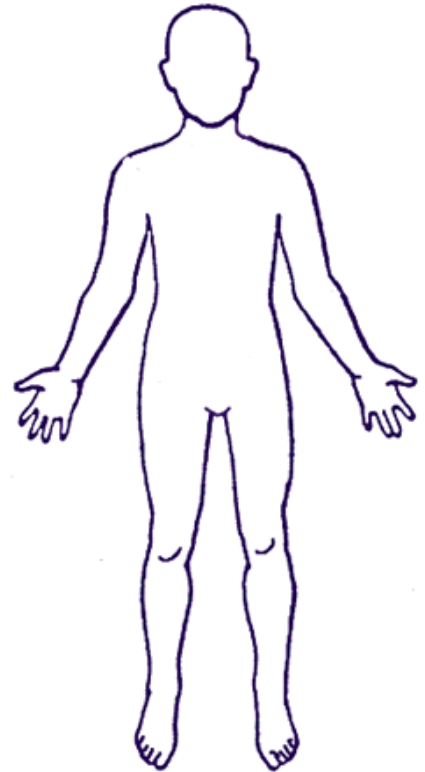
9. Does anything help for the pain?

(ice) (heat) (medication) other \_\_\_\_\_

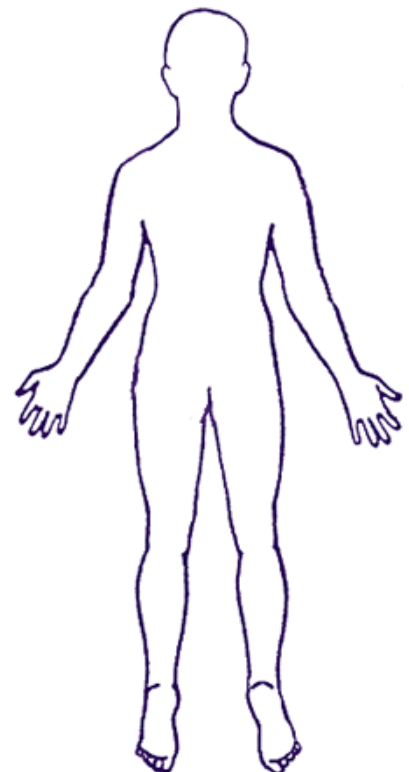
10. What makes the pain worse?

(sitting) (standing) (bending) (lifting) other \_\_\_\_\_

Front



Back



# HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information** Your protected health information will 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. In addition, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as Required by Law, Communicable Diseases ; Health Oversight; Abuse or Neglect; Food or Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; and Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**Research Related Material** If you are chosen to participate in part of a study for ongoing research, you will be notified in writing that your information will be released in exchange for nominal compensation on the part of the physician.

**Telephone Consumer Protection Act (TCPA) of 1991** You agree, in order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via e-mail or text message using any e-mail address you provide. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing device.

**You have the right to inspect and copy your protected health information.** Under federal law, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 423-232-8301.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**PLEASE LIST THE INDIVIDUALS THAT YOU AUTHORIZE THE PRACTICE TO RELEASE YOUR  
PROTECTED HEALTH INFORMATION TO:**

I, \_\_\_\_\_ (Date of Birth \_\_\_\_\_), authorize East Tennessee Brain and Spine Center, P.C. to give information regarding my health and treatment to:

Person \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Person \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

These people can be verified using the following password identified here \_\_\_\_\_

(Suggestions include the last 4 digits of your social security number, date of birth, or mother's maiden name)

This limited authorization will remain in effect for one year from the date of signature unless changed by me while I am a patient at East Tennessee Brain and Spine Center, PC.

If there are any problems and/or questions concerning this form they are to be referred to the East Tennessee Brain and Spine Center, PC Privacy Officer. Signature below is acknowledgement that you have received our Notice of Privacy Protection.

Patient Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

## PAIN MANAGEMENT AGREEMENT

I, \_\_\_\_\_, understand that I have entered into a treatment relationship with the physicians and staff of East Tennessee Brain and Spine Center. I further understand that part of that treatment may include the use of OPIATES and OTHER CONTROLLED SUBSTANCES. In order to use these medications safely, I understand that I will follow the following guidelines:

- I will take the medications at the dose and frequency prescribed
- I agree to bring ALL over the counter and prescribed medications with me to ALL of my appointments
- I understand that if opiates and controlled substances are prescribed I may be required to come to clinic MONTHLY for follow-up appointments
- I will not increase or change how I take my medications without the approval of this healthcare provider
- I will obtain refills ONLY at my clinic appointments and will not request refills over the phone.
- I will obtain refills only at the following pharmacy with the full consent for my provider and pharmacist to exchange information in writing or verbally. If this pharmacy does not have my medication, I will use another pharmacy WITH THE APPROVAL AND PRIOR NOTIFICATION OF MY PROVIDER

Name of Pharmacy: \_\_\_\_\_

- I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking
- I will inform my other healthcare providers that I am taking these medications and of the existence of this agreement. In case of emergency, I will provide this same information to emergency room providers
- I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions WILL NOT be replaced. Police reports for stolen prescriptions or medications WILL NOT be accepted unless the report documents property damage or injury
- I will keep medications only for my own use and will not share them with others. I will keep all medications away from children
- I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider
- I will actively participate in any program designed to improve function, including physical and occupational therapy, psychological and social training, and daily or work activities.
- I will not use illegal or street drugs or another person's prescription. If I have an addiction problems with drugs and/or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include:
  - 12-step program and securing a sponsor
  - Individual counseling

- Inpatient or outpatient treatment
- I will consent to random and directed drug screening to assure that I am only taking prescribed medications. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking
- I will keep all my scheduled appointments. If I need to cancel an appointment, I will do so a minimum of 24 hours before it is scheduled.
- I will keep this clinic informed of all primary and emergency contact addresses and telephone numbers
- I acknowledge that I have read and understand the Controlled Substance Informed Consent material provided by the clinic
- I understand that this provider may stop prescribing the medications listed if
  - I do not show any improvement in pain control or my activity is not improved
  - I develop rapid tolerance or loss of improvement from the treatment
  - I develop significant side effects to the treatment
  - My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from this clinic

I understand that the manufacturer of some drugs including narcotics/controlled substances, muscle relaxants, tranquilizers, recommends not operating heavy machinery, including motor vehicles. We recommend that you follow the manufacturer's recommendations. East Tennessee Brain and Spine Center, P.C. will assume NO liability should you choose not to do so. Please be aware that if you choose to drive, you can be charged with Driving Under the Influence.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## **FINANCIAL PAYMENT POLICY**

Thank you for choosing us as your health care provider. We are committed to your medical treatment being successful. Please understand that payment of your bill is mandatory. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

All patients must complete our information and insurance form before receiving treatment.

### **PLEASE REPORT ANY CHANGES IN INSURANCE COVERAGE TO THE RECEPTIONIST.**

1. **REGARDING INSURANCE:** If you have a policy which requires pre-authorization or a referral it is your responsibility to make sure that authorization is obtained. Please contact either your primary care physician or your insurance company to complete that.

We will file your medical insurance for your treatment. We may accept assignment of insurance benefits from your health care plan, but your insurance policy is a contract between you and your insurance company. Any unpaid balance or denial is your responsibility. It is important to remember these services are provided directly to you and not your insurance company. Any delinquent payments will be the patient's responsibility to pay.

If we are a participating provider in your insurance plan, all deductibles, co-payments and co-insurance will be due prior to treatment, including Medicare and TennCare.

2. **METHODS OF PAYMENT:** We gladly accept cash, checks, Visa and Mastercard. This office understands special needs and we offer a pre-approved extended payment plan. Please note if you are paying by check there will be a \$25.00 service fee for any returned check.
3. **USUAL AND CUSTOMARY RATES:** Our practice is committed to the best treatment for our patients and we charge what is usual and customary for our area. Please be aware that some of the services provided may be non-covered services and not considered reasonable and customary under the Medicare Program and/or other medical insurance. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.
4. **PHYSICIAN ASSISTANT CHARGES:** Medicare recognizes the value of Physician Assistants and provides reimbursement at 80% of the physician fees. Some insurance companies do not cover medical services provided by non-physicians. You will be responsible for those fees not covered by your insurance company.
5. **SCHEDULED PROCEDURES:** If a procedure is scheduled, payment for your deductible, copay and co-insurance will be due prior to scheduling the procedure.
6. **MISSED APPOINTMENTS:** Unless cancelled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We are here to help.**

I have read this financial policy. I understand and agree to this financial policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

## **INSURANCE DISCLAIMER**

It is YOUR responsibility to know your insurance benefits. You are given an insurance membership handbook and ID card at the time you become a participating member of your insurance company. You need to look in your handbook for the following important information:

In-Network Provider; Co-pay Amount; Individual or Family Deductible Amounts; Benefits for Routine Examination; Pre-Existing Waiting Periods

You can also call the customer service telephone number on the back of your ID card and ask for the benefits department. Some insurance companies also have a web site and on-line capabilities to obtain information regarding your benefits. They will be able to tell you all the details of your policy benefits, such as your remaining deductible, pre-existing periods, and amounts they will pay for the office visits and/or procedures. Everyone's policy is individualized. Five people may have the same insurance, but each policy will contain different benefits, and will pay different amounts according to their benefit schedule.

Because of the 2003 HIPAA regulations, insurance companies now have disclaimers protecting individual information. The disclaimer also states that a reference number or authorization number for an office visit or procedure is not a confirmation of coverage or benefits. The coverage of benefits depends upon the individual contract terms, conditions, exclusions and eligibility at the time the services are rendered. Due to this healthcare privacy act, we are not able to get the details of your insurance benefits.

Insurance companies will only give benefit and contract term information to the individual patient. They will not tell us if the service will be paid, the amount if it will be paid, but they will tell you, the patient.

### **RIGHTS:**

1. You have the right to receive professional, courteous and considerate treatment from your physician and his staff with recognition of your dignity and need for privacy.
2. You have the right to participate in decision making regarding your healthcare. This includes the right to accept or refuse medical or surgical treatment.
3. You have the right to have access to a phone number which you can use to receive instruction from the physician 24 hours a day, 365 days a year.
4. You have the right to voice grievances concerning treatment by provider and/or his staff.

### **RESPONSIBILITIES:**

5. You are responsible for carrying your insurance card at all times..
6. You are responsible for providing to the extent possible, information needed by the provider in order to care for you, this includes medical conditions, medications, present complaints, past illnesses, hospitalizations, and all other matters relevant to care.
7. You are responsible for following instructions and guidelines given by the provider.
8. You are responsible for showing consideration and respect to providers and staff.
9. You are responsible for making required co-payments and co-insurance payments.
10. You are responsible for seeking assistance from your insurance company or health plan administrator concerning the specifics of your health plan benefits and specialty services.
11. You are responsible for reporting any illness that appropriate measures may be taken to protect the provider and staff from infection.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_