Pinnacle Pain Management
Nazareth Medical Office Building
2701 Holme Avenue
Suite 205
Philadelphia, PA 19152
P: (215) 338-1811
F: (215) 338- 3606

Dear Patient,

Thank you for making an appointment with Pain Management Physicians. Hopefully we can help you with your matter. To better assist us with you appointment we need any **MRI's, X-Ray** or **EMG** (typed report). For the doctor to be able to give you a full complete consult you deserve he would need those reports. Also if your insurance requires a referral or co-pay must be on hand at appointment time. Also fill out the highlighted areas on several pages of the packet. Looking forward to seeing you.

Sincerely
Pain Management Physicians

Appointment Time:
Date:

Pain Management Physicians

Eric R. Ratner, M.D.
Scott E. Rosenthal, D.O.

To New Patients of Pain Management Physicians:

We would like to take this opportunity to thank you for scheduling an appointment with Pain Management Physicians. In order to better serve you complete the required paperwork before your visit with our physicians. If you did not have enough time to fill out the paper work please arrive 15 minutes before your scheduled time. If your insurance requires **Referrals or Co-Pay bring it with you to your appointment. You will not see the doctor if you are not prepared.**

- **New Patient Evaluation:** Your new patient evaluation will last approximately 30 minutes. It will consist of a history and evaluation.
- **Physicians:** All staff physicians are board certified under the auspices of the American Board of medical Specialties.
- **Parking:** Available
- **Fee:** Our office will charge for any forms to be filled out. Must give 72 hour notice
- **Cancellation:** If you are unable to make your appointment, please call 24 hours before to cancel.

Note: Please ensure that all necessary records pertaining to your conditions are either mailed or **faxed 215-338-3606** prior to your visit or bring them with you the day of your new patient evaluation.

Once again, thank you for scheduling an appointment with Pain Management Physicians. If you have further questions concerning your visit, please do not hesitate to call us at **215-338-1811** *Monday – Friday from 8 A.M. to 4 P.M. We look foreword to serving you.*

OUTPATIENT INFORMATION WORKSHEET
DR. RATNER

PATIENT DATA

DEMOGRAPHIC INFORMATION

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____

WORK PHONE: _____

OTHER: _____

SEX: M F AGE: _____

MARITAL STATUS: _____

SOCIAL SECURITY#

PATIENT: _____

SPOUSE: _____

DATE OF BIRTH

PATIENT: _____

SPOUSE: _____

DIAGNOSIS: _____

INSURANCE INFORMATION

COMPANY: _____

ID# _____

GROUP# _____

PHONE# _____

2ND

COMPANY: _____

ID# _____

GROUP# _____

PHONE# _____

COPAY: _____

PRECERT/AUTH# _____

WC/AUTO DOI: _____

COMPANY: _____

CLAIM# _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

ADJUSTER: _____

EMPLOYER: _____

VERIFIED: _____/_____

OFFICE VISIT	DATE

PROCEDURE	DATE

Pain Management Physician

Is this a work related injury? YES NO

Name of Employer: _____
Employer Address: _____
Employer Phone#: _____
Name of Supervisor: _____
Workers Compensation Carrier _____
Date of Injury _____
Claim# _____
Adjustor's Name: _____
Adjustor's Phone# _____

Is your injury due to a motor vehicle accident? YES NO

Motor Vehicle Insurance Carrier _____
Date of Injury _____
Claim # _____
Adjustor's Name _____
Adjustor's Phone # _____
Policy # _____
Policy Holders Name _____
Policy Holders Address _____
Relationship to Policy Holder _____

Do you have an attorney? YES NO

Name of attorney: _____
Attorneys Phone# _____

Patient Signature _____ Date _____

Pain Management Physicians

The following is for the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Pain Management Physicians.

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Pain Management Physicians.

Signature _____ Date: _____

For patients with medicare only (In addition to the above)

I request payment of authorized Medicare benefits be made to Pain Management Physicians for any services furnished to me by the provider. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date: _____

For Patients with Medicare and Supplemental Insurance (In addition to the above)

I hereby give Pain Management Physicians permission to ask for Medicare Supplemental Insurance payments for my medical care.
I understand that my Supplemental Insurance Carrier needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to my Supplemental Insurance Carrier. I request that the Supplemental Insurance Carrier make the payment of authorized Medicare Supplemental benefits to Pain Management Physicians for any and all services rendered to me. I authorize any holder of medical information regarding me, to release to my Supplemental Insurance Carrier any information to determine and pay these benefits.

Beneficiary Signature _____ Date : _____

Pain Management Physicians

Eric R. Ratner, M.D.
215-338-1811

Patient's Name: _____ Date: _____

If you would like the following physicians to receive reports, this form must be completed with their correct mailing address.

Without this information, your physician will not receive copies.

REFERRING PHYSICIAN: (Physician who referred you to Pain Management Physicians)

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____

PRIMARY PHYSICIAN: _____

SPECIALTY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____

OTHER PHYSICIAN: _____

SPECIALTY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____

OTHER PHYSICIAN: _____

SPECIALTY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____

Pain Management Physicians

Comprehensive Intake Form

Patient's Name: _____

Date: _____ Referring Physician: _____

Age: _____ Sex: _____ Reason for Consult: _____

1st Complaint: _____ Date of onset: _____

2nd Complaint: _____ Date of onset: _____

History of Present Illness: _____

Precipitating Event: _____

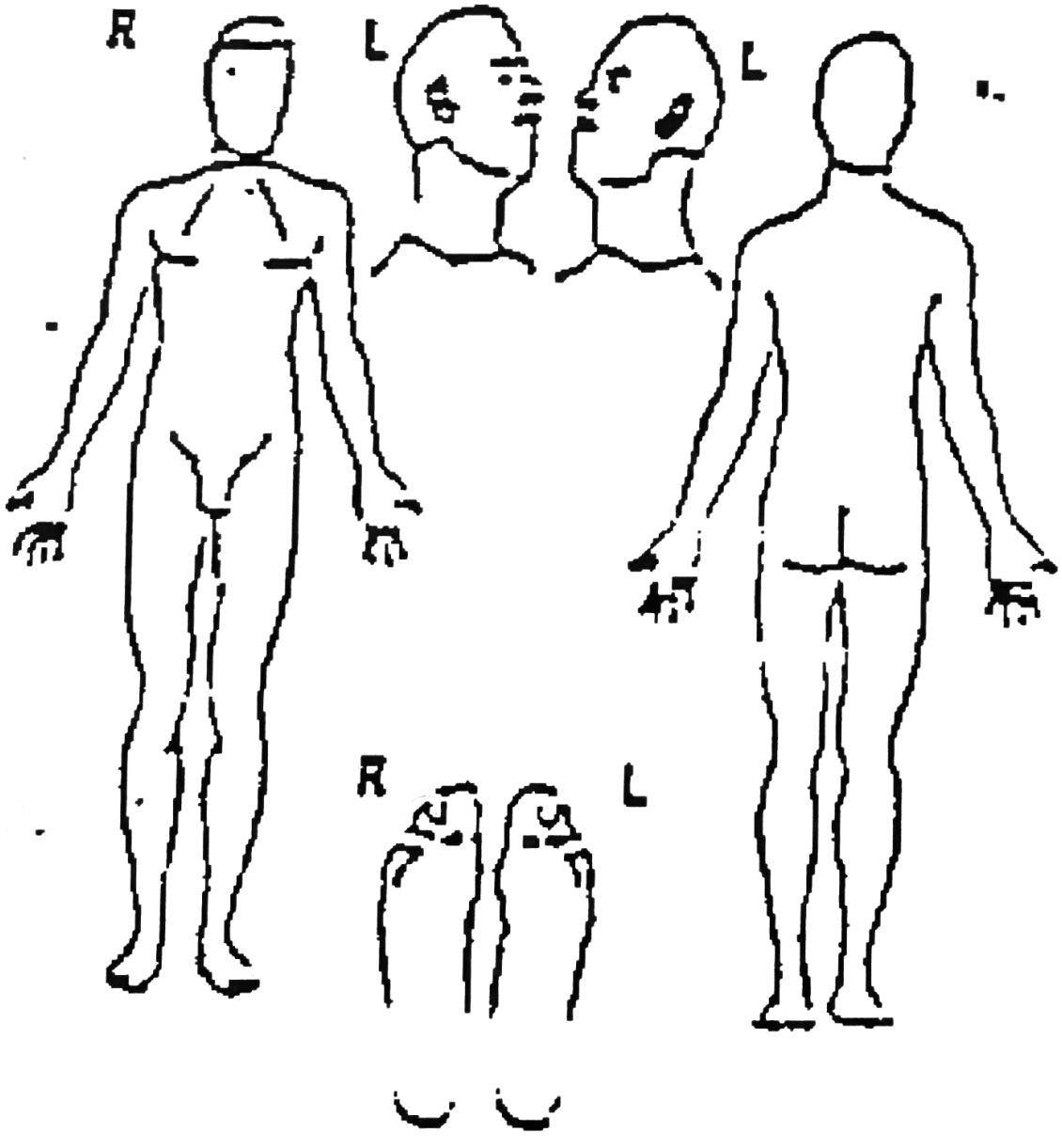
Clinicians, Diagnosis, Studies/Treatments, Outcome, Action Taken: _____

MRI: _____

CT Scan: _____

EMG: _____

* Shade in painful areas in the diagram below. (Please circle the one most painful area)



FOR PHYSICIAN'S USE ONLY - DO NOT WRITE BELOW THIS LINE

PAIN: _____

ASSOCIATIONS: _____

WORSE: _____

BETTER: _____

SLEEP: _____

BOWEL / BLADDER: _____

***CHECK APPROPRIATE BOXES THAT DESCRIBE YOUR PAIN (Check only one box within each category)**

	None	Mild	Moderate	Severe
Throbbing	☐	☐	☐	☐
Shooting	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐
Sharp	☐	☐	☐	☐
Cramping	☐	☐	☐	☐
Gnawing	☐	☐	☐	☐
Hot-burning	☐	☐	☐	☐
Aching	☐	☐	☐	☐
Heavy	☐	☐	☐	☐
Tender	☐	☐	☐	☐
Splitting	☐	☐	☐	☐
Tiring-exhausting	☐	☐	☐	☐
Sickening	☐	☐	☐	☐
Fearful	☐	☐	☐	☐
Punishing-cruel	☐	☐	☐	☐

Please circle the level of your present pain intensity:

0 - No pain.
1 - Mild.
2 - Discomforting
3 - Distressing
4 - Horrible
5 - Excruciating

***PREVIOUS MEDICATIONS** (Check (3) appropriate boxes below if you have used these types of Medications for your current pain problem)

☐ **Narcotics** (i.e., Demerol, Morphine, Dilaudid, MS Contin, Methadone, Darvon, Percocet, Percodan, Talwin, Vicodin, Codeine, Tylenol 3, Tylox, Fentanyl Patch.
☐ **NSAIDS** (i.e., Aspirin, Motrin, Ibuprofen, Dolobid, Toradol, Advil, Naprosyn, Relafen, Orudis.
☐ **Sedatives/Relaxants** (i.e., Ativan, Xanax, Valium, Librium, Flexeril, Parafon Forte)
☐ **Sleep Medications** (i.e., Halcion, Ambien, Restoril, Benadryl)
☐ **Antidepressants** (i.e., Elavil, Pamelor, Desipramine, Effexor, Desyrel, Prozac, Zoloft, Paxil)
☐ **Anticonvulsants** (i.e., Neurontin, Klonopin, Tegretol, Dilantin)
☐ **Neuropathic Pain Mediations** (i.e., Baclofen, Mexitil, Hytrin, Phenoybenzamin)

***PREVIOUS TREATMENTS** (Please check (3) all pain therapies you have used or are currently using)

☐ Acupuncture ☐ Traction ☐ TENS Unit ☐ Psychiatrist

☐ Chiropractor ☐ Warm Heat ☐ Physical Therapy ☐ Other (Specify)_____

☐ Biofeedback ☐ Massage ☐ Psychologist _____

***PAST SURGICAL HISTORY** (Please indicate date, type of surgery and physician's name)

DATE	SURGERY	SURGEON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***ROS:** Please check (3) box if you are currently experiencing any of the following:

☐ Fever, weight loss, sweats ☐ Swelling, rash ☐ Chest pain, palpitations

☐ Cough, sputum production Shortness of breath, wheeze ☐ Abdominal pain, change of bowel habits, nausea ☐ History of easy bruising or using blood thinners ☐ Change in bladder habit (frequency, pain on urination)

☐ Weakness or paralysis of arms Or legs ☐ Lightheadedness, dizziness, headache or vision changes ☐ Pregnancy

☐ Headache

☐ Other (Specify) _____

***PMH:** Please check (3) box if you have a history of:

☐ High blood pressure ☐ Angina ☐ Heart attack

☐ Heart failure ☐ Emphysema or asthma ☐ Chest pains

☐ Stroke ☐ Liver disease ☐ Thyroid disease

☐ Rheumatologic disease ☐ Cancer ☐ Depression or anxiety

☐ Problems with anesthesia ☐ Kidney disease ☐ gastrointestinal illness

☐ Other (Specify) _____

☐ No other relevant PMH (For physician use only)

FOR PHYSICIAN'S USE ONLY - DO NOT WRITE BELOW THIS LINE.

PMH: Mother: Living / Deceased Cause: _____

Father: Living / Deceased Cause: _____

Drug Allergies:

☐ NKDA ☐ YES (Describe) _____

Drug Intolerance: _____

***MEDICATIONS** (Please fill out all medications that you are using at this time)

DRUG NAME	DOSE	HOW MANY TIMES / DAY

***SOCIAL HISTORY** (Please complete information below)

Do you drink alcohol? ☐ No ☐ Yes (Specify quantity) _____

Do you smoke cigarettes? ☐ No ☐ Yes (Specify quantity) _____

Current employment status: ☐ Employed full-time ☐ Employed part-time ☐ Retired

☐ Self Employed ☐ Unemployed due to pain ☐ Unemployed due to other reasons

Present or most recent occupation: _____

Marital history: ☐ Single ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed

Litigation history: *Is there any litigation in progress in regard to your pain condition?* ☐ Yes ☐ No

With whom do you live with? ☐ Self ☐ Spouse ☐ Children ☐ Parents ☐ Friends ☐ Other: _____

FOR PHYSICIAN'S USE ONLY - DO NOT WRITE BELOW THIS LINE.

Illicit Drug Use: _____

PHYSICAL

BP Pulse Resp Ht. Wt. (lbs.)

General: _____

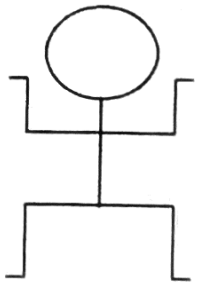
HEENT: ☐ NC / AT Neck: ☐ Supple Lungs: ☐ Clear Cor: ☐ RRR Abd: ☐ Soft, non-tender
☐ PERRLA/EOMI

GU: ☐ NL External Skin: ☐ Clear Extremities: ☐ WNL LE Pulses R PT DP L PT DP
☐ Deferred

Neurologic: Cr. Nerves II-XII

Sensory: UE: R L
LE: R L

Reflexes



C5	C6	C7	C8	T1
Elb Flex	Wrist Ext	Elb Ext	Finger Ext	Finger Abd

Motor: UE: R
L

L2	C3	L4	L5	S1
Hip Flex.	Knee Ext.	Foot Dorsiflex	Hallux Dorsiflex	Hallux Plantarflex

LE: R
L

Babinski: _____
Clonus: _____
Hoffman's _____

Gait: Non Antalgic/ Antalgic

FOCUSED EXAM

Cervical ROM: _____

Lumbar ROM: _____

Patrick's Test: Left: + / - Right: + / -

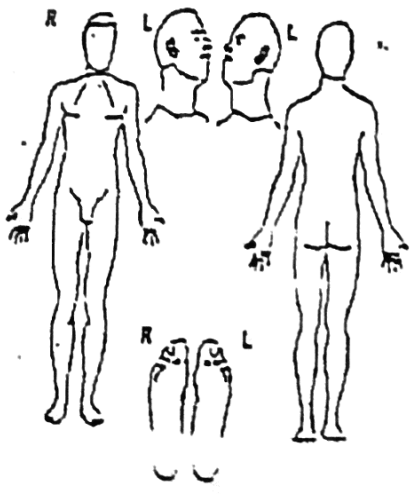
Straight Leg Raise: Left: + / - Right: + / -

Tenderness to palpation:

Facet - _____

SI Joint - _____

Muscle - _____



IMPRESSION:

1st Dx: _____

R/O (other dx's): _____

Comment:

PLAN:

Risk / Decision Making

☐ Minimal ☐ Low ☐ Moderate ☐ High

Counseling: Subject

_____

NOTICE OF PRIVACY PRACTICES

Pain Management Physicians 8019 Frankford Ave Suite A. Phila, PA 9136

Privacy Officer Tracey Everham (215)-338-1811

Effective Date: Dec 2008

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, casemanagement or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entitieswhich collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you.We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization.The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your

health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

18. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your

commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be

reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

Pain Management Physicians

Receipt of notice of privacy practices written acknowledgement form

I, _____, have received a copy of the Pain
Print Name
Management Physicians notice of privacy practices.

_____ _____

Signature of Patient Date

Delaware Valley Anesthesia Associates
Clinical Pain Management Associates
PO Box 606
Langhorne, PA 19047-0606
215.785.0145

Patient Name: **DVA/CPM account #:**

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for anesthesia for your pain procedure, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may **not** pay for the anesthesia below.

Service	Reason Medicare May Not Pay:	Estimated Cost:
Anesthesia for Pain Procedures • Transforaminal Epidural joint inj • Paravertebral Facet joint injection • Sacroiliac joint injection	**Medicare does not pay for anesthesia for this pain injection/procedure**	**$125.00 (per procedure)**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive anesthesia for the pain procedure listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the anesthesia listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the anesthesia listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the anesthesia listed above. I understand with this choice I am **not** responsible for for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**