WOOSTER PAIN AND ANESTHESIA CENTER, LLC
Maher Jeffrey Zackary, MD, MB, BCh
Lisa Prebish, NP
WE TREAT YOU LIKE FAMILY
3373 Commerce Parkway, Suite 3
Wooster, Ohio 44691
Phone: (330) 439-4656 Fax: (888) 833-4132, (330)601-0081
Website: woosterpaincenter.com Email: wpac@woosterpaincenter.com

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations less than 24 hours notice, we are unable to offer that slot to a waiting person.

Effective Date: November 9, 2016

Office Visits

Office appointments which are canceled with less than 24 hours notice, may be subject to a $15.00 cancellation fee.
Patients who do not show up for their appointment without calling, will be considered a **NO SHOW**. Patients may be subject to a $25.00 fee for an office appointment No Show. Patient's who No Show three (3) or more times within a twelve (12) month period, may be dismissed from the practice.

Procedures

Procedure cancellation require 5-7 business day advance notice, without such notification, you may be subject to a $50.00 cancellation fee.
Patients who do not show for their procedure without calling, will be considered a **NO SHOW**. Patients may be subject to a $75.00 fee for a procedure No Show. Patients who No shows or cancel a procedure three (3) times, will not be permitted to schedule another procedure at the Wooster Ambulatory Surgery Center.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next scheduled appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with management approval.

Please sign that you have read, understand and agree to this cancellation and No Show Policy.

Patient Name (Print): _____

Patient/Guardian Signature: _____ Date: _____

REVISED 12/3/18

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Authorization to Release Medical Records

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **PLEASE REVIEW CAREFULLY.**

I authorize the office of WOOSTER PAIN AND ANESTHESIA CENTER, LLC to: Send or Obtain my medical records to/from the following physicians or facilities below:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

The Medical records and data pertaining to:

_____ _____
Patient Name Social Security

_____ _____
Street Address Date of Birth

_____ _____
City, State, Zip Code Phone Number

Please specify what records should be released:

☐ Initial Consultation and Last 2 Clinic Notes
☐ MRI, CT, and X-rays ☐ Labs, Toxicology (e.g. UDS)
☐ Discharge letter ☐ Other:

Fax Records to (888) 833- 4132 or (330) 601-0081 **REVISED 12/3/18**

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Do we have your permission to:

Send appointment reminders to your home?	Y or N
Send test results to your home?	Y or N

Do we have permission to leave the following on your home answering/voice mail:

Appointment information	Y or N
Billing information	Y or N
Medical information (ie: Lab/MRI/X-rays results)	Y or N

I give permission to share appointment, billing and medical information with the person(s) named below:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

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Revocation: I understand that I may revoke this authorization at any time by sending a written notice WOOSTER PAIN AND ANESTHESIA CENTER, LLC
However. the revocation will not have any effect on any uses or disclosures WOOSTER PAIN AND ANESTHESIA CENTER, LLC may have made
before the revocation was received.
Expiration: I understand that unless I revoke this authorization earlier, this authorization will expire 12 months automatically after the date this authorization is signed. I understand that if I choose to add anyone else to this list I must sign another release form and that your office will not add any additional persons
Re-disclosure: I understand that the information used or disclosed in accordance with this authorization may no longer protected by federal law, and could be disclosed by the receiving party.
Refusal to sign: I understand that I may ref use to sign this authorization and that WOOSTER PAIN AND ANESTHESIA CENTER, LLC will not condition treatment on whether I sign this authorization.

Patient Name (Print): _____

Patient/Guardian Signature: _____ **Date**:_____

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Notice of Privacy Practices

Respecting the privacy of medical information is important to us. We understand that it is personal and we are committed to protecting it. Patient records are kept in order to provide quality care and to comply with legal requirements. Please review the following carefully. It explains how we may use and disclose patient information as well as inform you of the rights of the patient/guardian.

Law Requires Us To:

1. Give you this notice.
2. Follow the terms of this notice now in effect.
3. Keep your medical information private and only disclose patient information based on federal regulations.

We Have The Right To:

1. Change our privacy practice and terms of this notice and any policy or practice at any time based on the regulations.
2. These changes, when made, will be effective for all medical information we keep, including information we created before the change.

Notice of Changes to Privacy Practice:

When making a change in our privacy practices. We will document the change in this privacy notice. The new notice will be posted and a copy will be available upon request.

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Use and Disclosure of Patient Medical Information

We will not release or disclose your information for any purpose that is not listed below unless we receive written authorization from the patient/guardian. You may revoke (in writing) any authorization at any time: please refer to the Required Authorizations section below. Also, please refer to Restrictions and Limitations, Amendments, and Confidential Communications included under the Individual Patient Rights section below:

1. **Treatment**
   We may use and disclose medical information about the patient in order to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, referral staff, or other people who are involved in taking care of you or providing service to you. This includes all other healthcare providers involved in your care.

   Example: Your primary care physician is Dr. Kelly, but Dr. Smith is on call. Dr. Smith and his staff need access to your information to treat you.

   Example: You have an injured shoulder. Dr. Smith sends you to the Urgent Care facility. The Urgent Care referral staff needs your information to complete the referral; the Urgent Care physician and staff require your initial assessment by Dr. Smith in order to properly treat you and the Urgent Care pharmacy needs to know about allergies if providing any medications.

2. **For Payment**
   We may use and disclose medical information about the patient for payment purposes.

   Example: Your insurance company denies payment on a claim. We may send the chart notes to support the charge. The insurance company reviews the information and documentation and payment is made.

3. **For Healthcare Operations**
   We may disclose medical information about the patient to other health-care-related operations such as: Internal and External audits, training staff, evaluating employees and physicians, and measuring quality of our services.

   Example: We wish to measure the quality of care you received from the staff. To do this, we must access your chart and review the documentation and appropriateness of treatment.

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Additional Uses and Disclosures

□ **Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care in the office or in regard to a referral outside the office. Appointment information can be left on the answering machines, voice mail, or with another person as appropriate.
□ **Test Results:** We may use and disclose medical information to contact you regarding the availability of test results.
□ **Referring to Names:** We may use patient names in the waiting area, as well as throughout the office when required to identify a patient.
□ **Government Functions:** Due to some government requirements. we may disclose your medical information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
□ **Court Orders and Judicial Proceedings:** We may disclose your medical information in response to a court administrative order, subpoena, discovery request, or other lawful process, under most circumstances. Under limited circumstances such as a court order, warrant, or grand jury subpoena, we may be required to share your medical information with a law enforcement official in a situation involving a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution.
□ **Public Health:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration (FDA) for purposes or reporting adverse events associated with product defects or problems. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

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□ **Health Oversight:** We may disclose your medical information to an agency providing health oversight for audits: civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions or other authorized activities.
□ **Victims of Abuse, Neglect, or Domestic Violence:** We may disclose your medical information to appropriate authorities if we reasonably believe that patient is a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the heath or safety of others.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Required Authorizations
Your authorization is required in the following examples:
1. General request for the patient's medical information.
2. Request for medical information to be transferred out of our office. (Example, moving).
3. Life Insurance claim.
4. Workman's Compensation claim.
5. Any other circumstance where you are requesting disclosure of your medical information.

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To give authorization: You or your parent/guardian must submit your request in writing through personal letter, requesting, completing and submitting a form obtained from our office. The request must include patient name, date of birth, primary care physician, where records are to be sent, place where the requester can be contacted, and your or your parent/guardian 's signature and date.

Payment: We have the right to request payment for copies of medical information needing to filled out by the doctor. The amount is $25.00 per page.

Availability of Medical Records: We are allowed 30 days to retrieve and provide copies of medical records that are still available within the office.

For questions about this Notice or concerns that your rights might have been violated, please contact: A formal complaint, however, must be in writing and sent to: Privacy Officer, Wooster Pain and Anesthesia Center. LLC. You may also file complaints with the Dept. of Health & Human Services, Atlanta Federal Center, Suite 3870, 61 Forsythe St., SW, Atlanta, GA 30303-8909 (Phone: 404-562- 7886).

HIPPA PRIVACY PRACTICE ACKNOWLEDGEMENT OF RECEIPT
By signing this form, you acknowledge receipt of the Notice of Privacy Practices for the Office of Wooster Pain and Anesthesia Center, LLC. Our Notice of Privacy Practices provides information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (330) 439-4656.

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Individual Patient Rights

You have the right to:

1. Inspect and receive a copy of medical information that is used to make decisions about your care.
2. Request an account disclosure. This is a listing of disclosures that we have made of your medical information. This request must be made in writing or by calling our office and requesting a form to be completed and submitted. Your request must specify a time period, which may not be longer than six (6) years.
3. Request restrictions or limitations on the medical information we use and disclose about you. We are not required to agree to any restriction or limitation, but if we do, we will abide by that agreement. All requests for restrictions or limitations must be made in writing or by calling our office and requesting a form for completion and submission.
4. Request an amendment to your medical information. If you believe information is incorrect or incomplete you may ask to amend the information. No information can ever be removed or deleted from medical information. All requests must be made in writing or by calling our office and requesting a form for completion and submission. We are not required to agree to any amendment, but if we do, we will abide by that agreement and make reasonable efforts to tell others involved in your medical care of the change and include the change in any future sharing of information. If we deny your request, we will provide a written explanation.
5. Request confidential communications. You may ask that we communicate with you about certain information in certain ways or at a certain location (ex. Request that we never call work). We will accommodate all reasonable requests. The request must be made in writing or by calling our office and requesting a form for completion and submission.
6. Request a paper copy of this Notice of Privacy practices at any time. Please call our office to obtain a copy.

Patient Name (Print): _____

Patient/Guardian Signature: _____ **Date:** _____

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FINANCIAL POLICY

Your health is our care. Thank you for selecting the WOOSTER PAIN AND ANESTHESIA CENTER, LLC as your health care provider. We know you have many choices when it comes to your healthcare and we appreciate the opportunity to care for you. We are committed to delivering outstanding healthcare. Please take some time to read this policy and contact our Billing Office with any questions. **The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.**

We **cannot** waive co-payment, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with the various health plans. Payment of co-payments and co-insurances are due at the time of the office visit. Please be ready to make payment on the day you visit the office.

We require you to make your payment at the time of service so that we do not have to send you a bill. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible.

If you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. If your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you are asked to assist us in contacting your insurance carrier.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service, while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates, which may bear no relationship to the current standard, and cost of care in this area.

You are responsible for obtaining the necessary referral, if required by your insurance company and bringing the completed form to your appointment. In the event that you are seen without the proper referral/authorization as required by your insurance carrier and our office, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us.

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We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Statements will be mailed monthly and are due for payment within 30 days. Monthly statements will follow until the account is paid in full. If you have not paid your bill, or have not set up a payment plan within 90 days, we will ask for the assistance of a collection agency.

Returned checks and balances referred to outside collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Our staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, your employer or group plans administrator best addresses. coverage issues. Your insurance policy is a contract between you and your insurance carrier. The WOOSTER PAIN AND ANESTHESIA CENTER, LLC is not a party to that contract and cannot act as a mediator with the carrier or your employer.

Methods of Payment
Cash, personal check, Visa, MasterCard or Discover are accepted methods of payment by WOOSTER PAIN AND ANESTHESIA CENTER, LLC.

Past Due Accounts All patient responsible balances that remain delinquent after 120 days, with no response to our requests for payment, may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will have to settle the debt with the agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from WOOSTER PAIN AND ANESTHESIA CENTER. LLC. If this is to occur, you will be notified by regular and mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis. It is your responsibility to inform us of any changes in your insurance, telephone numbers. and address. Please have your insurance card available at all office visits.

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COMMERCIAL INSURANCE PATIENTS:

Patients will be informed when they make their appointment of the fee range, when possible, for their office consultation. Patients are responsible at the time of service for any co-pay that they may have per their contract with the insurance company. The office will file their commercial insurance claim for them. Any approved amount not paid (i.e. deductible, co-pay, out of pocket) will become the immediate responsibility of the patient.

REFERRALS-HMO AND PPO PLANS:

You are responsible for obtaining an authorization for examinations and treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests. and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Without this the insurance company will not pay for your visit.

SELF PAY PATIENTS:

The full cost of the office visit will be due at the time of service.

MEDICARE PATIENTS WITHOUT SUPPLEMENTAL COVERAGE:

Patients will be informed at the time they make their appointment of the policy regarding Medicare and if possible, the fee range, plus any additional anticipated charges. Any unpaid deductible, plus the 20% co-pay amount is due at the time of service. The office will file a claim to Medicare for the balance.

MEDICARE PATIENTS WITH SUPPLEMENTAL COVERAGE:

Patients will be informed at the time they make their appointment of the policy regarding Medicare and if possible, the fee range, plus any additional anticipated charges. The office will file a claim to both to Medicare and the supplemental carrier for all charges. Any approved amount not paid will become the immediate responsibility of the patient.

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SURGERY CENTER CHARGES:

If your physician recommends surgery, you will meet either in-person or by telephone with a Surgery Center Counselor who can answer specific questions about the surgery scheduling process, discuss paperwork and tests involved, and complete all per-certification/authorization if your insurance company requires it. It is important to note that the Surgery Center is a **separate** entity and will bill you separately from the physician practice. You may be asked to make payment of any co-insurance and deductibles prior to your surgical encounter. The Surgery Counselor will explain the cost estimate and your financial responsibility based on your coverage levels and benefits of your plan.

FORMS:

Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits or maintaining employment or handicap permit for parking. Our fee for these services is ($25.00 per page) reflects the resources diverted to the effort.

RETURNED CHECKS:

There will be a $25.00 charge for all returned or canceled checks.

RELEASE OF MEDICAL RECORDS:

There will be a charge for any medical records you need for your records. It will be .10 cents per page or $25.00 for over 20 pages.

If you have any questions, please feel welcome to contact our billing department at your convenience. Your health is our care.

I have read the above Financial Policy and agree to its terms and conditions.

Patient Name (Print): _____

Patient/Guardian Signature: _____ Date: _____

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Authorization for Filing and Collecting Insurance Claims

I,_____, a patient of WOOSTER PAIN AND ANESTHESIA CENTER, LLC authorize the release of any medical or other information necessary to process any such claims related to my care under this institution. I also request payment of government benefits either to myself or to the party who accepts assignment for my medical care. In addition, I authorize payment of medical benefits to the caring physician at the WOOSTER PAIN AND ANESTHESIA CENTER, LLC for services rendered.

Responsible Party for Payment of Account (if other than patient):

First:_____ Middle:_____ Last: _____

Address: _____ City: _____, OH Zip: _____

Responsible Party's Date of Birth: ____/____/____

Responsible Party's Social Security Number: ____ /____/____

Relationship to Patient: _____

Patient Name (Print): _____

Patient/Guardian Signature: _____ **Date:** _____

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PAIN MANAGEMENT AGREEMENT FOR CONTROLLED SUBSTANCES

The purpose of the Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. while under our care. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. By signing this agreement, you indicate your intention to comply with the following:

• I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship, and that my doctor undertake my treatment based on this Agreement.

• I understand that if I break this Agreement, my doctor will stop prescribing my pain control medications. In this case, my doctor may, as necessary, taper me off my medicines over several days in order to avoid withdrawal symptoms. In addition. a drug-dependence treatment program may be recommended.

• I agree to use my medicine at a rate no greater than the prescribed rate. I understand that if I use my medicines at a greater rate than prescribed, I will be out of medicine for a period of time, which may result in withdrawal symptoms. I understand that if I run out of medicines, the doctor may not refill them early.

• I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is working to relieve my pain symptoms.

• I agree to participate fully in all aspects of my care, including all recommended treatments.

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• I will not use any illegal controlled substances, including marijuana, cocaine, methamphetamine, etc. Although alcohol is not illegal, it will interact with controlled substances and increase the risk of sedation and overdose and its use is discouraged.

• I will not share, sell or trade my medications with anyone or use medications not prescribed for me.

• I will not attempt to obtain any controlled medicines, including pain medicines, from any other doctor. I understand that the treatment of pain includes any and all pain that I might experience, and is not limited to just the pain that I have been referred for treatment.

• I will safeguard my medications from loss or theft and I understand that lost or stolen medications are **not replaced**.

• I understand that medication refills are made only at regularly scheduled office visits or during regular office hours. I understand that no refills will be made during the evenings or on weekends.

• I agree to submit to a urine test, if requested by my doctor, to determine my compliance with my program of pain control medicine.

• I understand that failure to show for a scheduled appointment, or no show, including cancellation within 24 hours of a scheduled appointment places an additional burden on the staff in coordinating patients to be seen. In addition. I understand that these appointment slots are not available to be filled by other patients in need of services. I understand, therefore, that **three no-shows or cancellations within 24 hours of scheduled appointments within a 12 month period is unacceptable behavior and will result in discharge from the practice.**

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• I agree to come in to the office, or other specified location, when requested, for a random pill count. I understand that I must comply with the requested pill count or a random urine drug screen within the time frame given by the office. I understand the time frame for these requests, is determined by the Physician or the Nurse Practitioner. If I fail to comply with this request, I understand that I may be discharged from the practice or I may no longer receive opioid medication.

• I agree to always use _____pharmacy, located at

_____, for filling my prescriptions for pain medications.

• I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency. including the state's Board of Pharmacy, in the investigation of any possible misuse, sales or other diversion of my pain medicines. I also authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

• FEMALES- I certify that I am **not pregnant** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them I am aware, that should I carry a baby to delivery while taking these medicines; the baby will become physically dependent upon opioids. I am aware that use of opioids is generally not associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

• MALES- I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

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• I agree I must have a current OHIO photo ID available for my office visits. I understand if I cannot provide a valid OHIO photo ID, my appointment may be canceled until I am able to provide one.

• I agree to follow these guidelines, as have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me upon my request.

Patient/Guardian Signature:_____ **Date:** _____

Witnessed by: _____ **Date:** _____