CalSpine MD
Minimally Invasive Spine Care

PATIENT DEMOGRAPHICS DATE________________

Patient Name: (First)________________________(MI)____(Last)________________________________

Date of Birth:_____/_____/_____Age:______Address: ____

City:____ Home State:___________Zip Code: ________________

Phone: (___________)_________-____________ Cell Phone: (_______)_________-______________

E-mail address:____

Social security number________________________________**Sex:** ☐ **M** ☐ **F**

- -

Who can we thank for referring you to Dr. Ball? ______________________

Emergency Contact/ Relationship:____________________/___________Phone: ___________________

Work Status: ☐ Retired ☐ Not Employed ☐ Employed FT ☐ Employed PT ☐ Student FT ☐ Student PT

Employer:____________________________________Occupation: ________________________________

Address:____City: ______________________________

State:_____Zip Code: __________ Work Phone:_________________Ok to Call Work? ☐ YES ☐ NO

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other_________________________

- -

Referring Doctor:__________________________**Medical Group:**____________________________

Address:____

City:____________________________________State:_____________Zip Code: ____________________

Phone: (_____)_______-________Fax: (_____)________-________Specialty: _____________________

- -

Primary Doctor:___________________________**Medical Group**:____________________________

Address:____

City: ___________________________________State: _____________Zip Code: ____________________

Phone: (_____)_______-________Fax: (_____)________-________Specialty: _____________________

Consulting Doctor (e.g. Cardiologist, Oncologist):____________________________________

Address:____

City:____________________________________State:_____________Zip Code: ____________________

Phone: (_____)_______-________Fax: (_____)________-________Specialty: _____________________

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Primary Insurance Carrier: ____

Subscriber/ Relationship:____/__________________

Subscriber's date of birth: _____/______/_____________

Insurance ID#:____Group#:_________________________

Secondary Insurance Carrier: ____

Subscriber/ Relationship:____/__________________

Subscriber's date of birth:______/______/_____________

Insurance ID#:____Group#:_________________________

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Medication List

Please provide us with a list of any medication allergies and list all medications (prescribed or over the counter) that you are presently taking including vitamins and herbal supplements. Please be sure to include the dosage and frequency. Example: Ibuprofen 200mg 2 times a day. * List of current medications are required for any pre-operative appointments. *

Allergies	**Reactions**

Medication Name	**Dosage**	**Frequency**

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MEDICATION REFILL POLICIES

For all patients needing refills of their medication(s), please note the following practice policies for Hieu T. Ball, MD, California Comprehensive Spine Institute, NovaGenMD:

All refill requests must be faxed by your pharmacy to our office-our fax number is (925) 838- 8836.

Requests should be made during regular business hours, 9am-5pm Monday-Friday, which will then be messaged to Dr. Ball on that business day by office staff.

Please allow three (3) business days for Dr. Ball respond to your refill request. For example, a call on Friday may not be filled by Dr. Ball by Wednesday of the following week. Do NOT wait until you have little to no medication left.

Medication requests will not be put through by the Answering Service after 5pm and on weekends.

Preoperative appointments are the best time to request medications for the postoperative period. Please remind Dr. Ball and/or the office staff to prescribe postoperative medications at the time of your preoperative appointment.

If you are currently seeing, or being referred to a pain management specialist doctor, please have ALL medication(s), refill requests, and new prescriptions filled through that specialists' office only, with the exception of the immediate postsurgical period of time, during which Dr. Ball will prescribe pain medications, muscle relaxants, and other medications.

______________________________ ______________

Patient Name **Date of Birth**

______________________________ ______________

Patient Signature **Date of Signature**

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COMPLIANCE & TEAMWORK

PATIENT NAME________________________DATE OF BIRTH__________

We want you to receive excellent care. The best way to meet this goal is to work together. The patient- doctor relationship relies on open communication and teamwork. Predictable outcomes depend on both parties understanding and working towards the same goals.

Patient (Your) Responsibilities:

- Ask questions, share your feelings, and actively be part of your care
- Be honest about your history, symptoms, and other important information about your health
- Tell your doctor about any changes in your health and well-being
- Schedule accordingly based on the recommended care plan and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Be respectful to office staff and healthcare providers, and understand that we are on the same team with the goal of taking optimal care of you and your family
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and
- future plans.
- Comply with post-procedural instructions regarding activity, bracing, medication weaning protocols, physical therapy and rehabilitation instructions

Healthcare Provider (Dr. Ball's) Responsibilities:

- Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way
- Listen to your questions and help you make decisions about the direction of your care
- Keep treatments, discussions, and records private
- Provide instructions on how to meet your health care needs when the office is not open
- Determine when a breakdown of the doctor-patient relationship is justification for terminating care Determine when referral to another provider or specialist is appropriate
- End every visit with clear instructions about expectations, treatment goals, and future plans
- Share patient information with other providers involved in your health care, as appropriate

I certify that I have read or had read to me the contents of this form. I understand the possible advantages that compliance with professional healthcare recommendations can provide as well as potential consequences of non-compliance. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

______________________________ __________
Patient's or Patient Representative's Signature Date

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CONSENT FOR TELEMEDICINE TREATMENT

Patient Name: ____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

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Consent for Telemedicine Treatment

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature:_____________________________ **Today's date:____________**

If under 18:

Parent/Guardian Signature:___________________________________

Relationship:____

Date:_____________

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CANCELLATION and NO-SHOW POLICY

We understand that you may need to cancel your appointment and/or your surgery due to unavoidable circumstances. As a courtesy to our healthcare professional and to other patients, please notify us of your cancellation as soon as possible to allow us to schedule other patients waiting to see Dr. Ball. *When you do not call to cancel and appointment or procedure in a timely fashion, you may be preventing another patient from receiving care.*

Cancellation/No-Show Policy for Appointments

Your appointment time is reserved especially for you. Should you find that you are unable to keep your appointment, please notify our office at least 48 business hours in advance. This will allow us to offer your appointment slot to another patient.

- If you fail to show for your appointment, a **$250.00** fee* will be charged to your account. The same applies to appointments canceled with less than 48 business hours' notice.

  **This penalty fee is not covered by insurance and must be paid in full prior to rescheduling the missed appointment or any future appointments.*
- We understand that extenuating circumstances such as illness may cause you to cancel at the last minute. Fees may be waived, subject to management approval.
- Patients who schedule and fail to keep three (3) appointments in the span of one year may be dismissed from the practice, and the Practice is exempt from any professional abandonment claims by the patient.

Cancellation/No-Show Policy for Surgery

Due to large block of time reserved for your procedure, last minute cancellation creates access -to-care problems for other patients, as well as, significant expenses for the Practice and surgery facility. If you need to cancel surgery, please notify at least 14 days, or two weeks in advance.

- Failure to show up for surgery, or if surgery is not cancelled at least 14 days in advance for reasons *other than failure to clear Internal Medicine or Cardiology pre-op consultation*, you will be charged a **$7,000.00** fee*. The cancellation fee for pain procedures is **$3,000.00**.

  **This fee is not covered by insurance and must be paid in full prior to rescheduling your procedure.*
- We understand the extenuating circumstances may cause you to cancel less than 14 days prior to your scheduled procedure. Fees may be waived, subject to management approval.
- Patient who cancel the same procedure <u>twice</u> may be dismissed from the practice for "treatment noncompliance" and the Practice is exempt from any professional abandonment claims by the patient.

Patient Name: ________________________ Date of Birth: ____________________
Patient Signature: ______________________ Date Signed: ____________________

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ASSIGNMENT OF BENEFITS

Financial Responsibility

I have requested and/or received professional healthcare services from healthcare provider(s) associated with Hieu T. Ball, MD, MPH, including California Comprehensive Spine Institute, Hieu T. Ball, MD, Inc., NovaGenMD, PC, including allied health professionals associated with or employed by Hieu T. Ball, MD, MPH (referred to as the Practice in this document). On behalf of myself or my dependents, and understand that by making this request, I am responsible for charges incurred during the course of said services. I understand that fees for services rendered are due and payable on the date of service and agree to pay such charges according to the arrangements that have been made.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to the Practice. I certify that the health insurance information that I have provide to provider and the Practice is accurate as of the date set forth below and that *I* am *responsible for updating all health insurance information.*

I hereby authorize Practice and any affiliates on behalf of me and my healthcare provider to submit claims on my, and/or my dependent's behalf to the benefit plan (or administrator) to pay directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Practice,

I hereby instruct and direct my benefit plan (or its administrator} to provide documentation stating such non- assignment to myself and my provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to my healthcare provider.

I am aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services are paid in full.

I understand that I am responsible to pay my deductible and co-insurance, including co-payment obligations.

Authorization to Release Information

I hereby authorize my health care provider to:
(1) release any information necessary to my health plan
(or its administrator) regarding my treatments;
(2) process insurance claims generated in the course of
examination or treatment; and
(3) allow a copy of my signature to be used to process insurance claims. This
order will remain in effect until revoked by me in writing.

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ERISA Authorization

I hereby designate, authorize, and convey to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative:
(1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have under such insurance policy and/or benefit; and

(2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right to including, but not limited to, pursuing available administrative appeals or filing suit and all other causes of action on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of services I received from my provider and Practice and, to the extent permissible by law, to claim on my behalf such benefits, claims, reimbursement, and any other applicable remedy, including fines.

A copy of this Assignment/Authorization shall be as effective and valid as the original.

Patient Name_________________________________DOB_____________

Name of Subscriber______________________________DOB_____________
(If different from patient)

Patient or Guardian Signature_____________________Date Signed_____________