NON-SURGICAL ORTHOPAEDICS, P.C.
Specializing in Spine Care & Pain Management

Arnold J. Weil, M.D.
Anthony R. Grasso, M.D.

Dear Patient,

The doctors at Non-Surgical Orthopaedics, P.C. will be performing your upcoming spinal injection procedure. Your procedure will be performed in an ambulatory surgical center (ASC), The Center for Spine Procedures, P.C. which is a separate entity from Non-Surgical Orthopaedics, P.C.

The Center for Spine Procedures, P.C. meets the Federal definition of a "physician-owned facility." A list of physician owners is available upon request.

Non-Surgical Orthopaedics, P.C. will be billing your insurance company for the professional component of your procedure. The doctors' fee for performing your procedure will be submitted to your insurance company separate from any facility charges. You will need to pay your co-insurance and/or deductible specific to your insurance policy at the time of service.

The Center for Spine Procedures, P.C. will have a separate facility charge for the procedure performed in their center. The facility charges will be submitted to your insurance company **separate** from the doctors' fees. You will also need to pay any facility co-insurance and/or deductible amounts at the time of service.

By signing below, you acknowledge that the doctor's office and the ASC explained above are two separate entities.

_____
Patient Name

_____ _____
Patient Signature Date

335 Roselane Street • Marietta, GA 30060 • (o) 770.421.1420 • (f) 770.421.8055
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AUTHORIZATION & INFORMED CONSENT FOR OUTPATIENT PROCEDURE

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

NAME: _____ DATE: _____ AGE: _____ SEX: ○ Male ○ Female

PHYSICIAN: ○ Arnold J. Weil, M.D. ○ Anthony R. Grasso, M.D.

PROCEDURE:

- ○ Cervical ESI
- ○ Thoracic ESI
- ○ Lumbar ESI & SNRB
- ○ Caudal ESI
- ○ Facet Injection (Cervical / Lumbar)
- ○ SI Injection / Prolotherapy
- ○ Sympathetic Nerve Injection
- ○ RFL (Cervical / Lumbar)
- ○ Discogram
- ○ Disc Decompression
- ○ IDET
- ○ Spinal Cord Stim Implant

PATIENT HISTORY:

Yes	No		Yes	No	
☐	☐	Heart Attack/Irregular Heartbeat/MVP	☐	☐	Diabetes/Thyroid Disease
☐	☐	High Blood Pressure/Stroke	☐	☐	Current Infection or Fevers
☐	☐	Previous Heart Surgery: (year) _____	☐	☐	Seizures
☐	☐	Paralysis/Muscular Weakness	☐	☐	Phlebitis/Lung Blood Clots
☐	☐	Circulation Problems: _____	☐	☐	Bleeding/Clotting Problems
☐	☐	Allergies: _____	☐	☐	Are you Pregnant?
☐	☐	Other Problems: _____			
☐	☐	Are you required to take antibiotics prior to dental treatments?			
☐	☐	**Are you on Aspirin or other blood thinners?**			
☐	☐	**Are you on Glucophage / Metformin?**			

I acknowledge and understand that the following procedure or treatment has been explained to me (sometimes referred to as the patient) in layman's terms and I understand that it is to be performed as an outpatient procedure.

1) The patient's diagnosis is:

- ○ Cervical Herniated Disc
- ○ Sympathetic Medicated Pain
- ○ SI Joint Arthropathy
- ○ Lumbar Herniated Disc
- ○ Facet Arthropathy
- ○ Neuropathic Pain

2) The procedure is an injection or treatment to the affected or injured area of the body.

3) The purpose of the procedure is to decrease pain, repair the injury, and promote healing.

4) MATERIAL RISKS OF THIS PROCEDURE OR TREATMENT. The material risks associated with this procedure or treatment include but are not limited to the following: **soreness, allergic reaction, infection, numbness, tingling, paralysis or partial paralysis, loss of partial loss of function of any limb or organ, severe loss of blood, pneumothorax, disfiguring scar and/or depigmentation, cardiac arrest, brain damage, mental status changes, disorientation, sensory disturbance, insomnia, mood swings, euphoria, depression, facial warmth or flushing, fluid retention, hypertension, hypotension, hyperglycemia, headaches, gastritis, menstrual irregularities, nausea, rash, fever, dizziness, dural puncture resulting in headaches, cerebral spinal fluid leak, fistula, abscess or hematoma formation, steroid induced bone damage (avascular necrosis), skin necrosis, unknown developmental/birth**

defects for pregnant females, seizure, paraplegia or quadriplegia; temporary worsening of pain; change in pain, nerve damage; and even death.

5) Available alternatives to this procedure or treatment include: physical therapy, conservative care, or surgery.

6) The likelihood of success of the above procedure is:
   ● **good** ○ fair ○ poor

7) If I choose not to have the procedure, I have been informed that my prognosis (my future medical condition) is:
   ○ good ● **fair** ○ poor

8) I understand that the physician, medical personnel and other assistants will rely on statements by the patient, the patient's medical history, symptoms, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure or treatment which has been explained.

9) I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure or treatment.

10) I understand that during the course of the procedure or treatment described above it may be necessary or appropriate to perform additional procedures or treatments that are unforeseen or not known to be needed at the time this consent was given. It may also be necessary or appropriate to have diagnostic studies, tests, anesthesia, x-ray examinations and other procedures performed in the course of my treatment. I consent to and authorize the persons described herein to perform such additional procedures and treatments, as they deem necessary or appropriate.

11) Depending on the patient's diagnosis and the procedure or treatment to be performed, it may be necessary or appropriate for tissues and specimens to be removed from the patient's body. I consent to the removal, testing, retention for scientific or teaching purpose, and disposal of such tissues and specimens within the discretion of the physician, facility or other healthcare provider.

12) I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education.

13) **By signing this form, I acknowledge that I have read or had this form read and/or explained to me and that I fully understand its contents. Additionally, I have read the office injection procedure manual. I also have been given ample opportunity to ask questions and that the questions have been answered to my satisfaction. All blank areas or statements that I did not approve were stricken before I signed this form.**

14) I understand that if I "no show" for the procedure without calling the office by 5:00 pm on the evening before the procedure, I will be assessed a fee of One Hundred ($100) Dollars. This fee will be assessed unless a specific message informing us of your intention to cancel or reschedule the procedure is left on our scheduler's voice mail at 770-420-4654.

Your signature below represents your understanding and agreement that this fee will be considered your personal responsibility, and will not be submitted to your insurance company.

15) For women only: I represent to my physician that I am not pregnant nor am I breast feeding at this time, and understand that there are risks of sedation or of the procedure to an unborn child.

I hereby voluntary request and consent to the performance of the procedure(s) or treatment(s) described or referred to herein by Dr. Weil or Dr. Grasso or any other physicians or other medical personnel who may be involved in the course of my treatment.

_____
Patient's Printed Name

_____ _____ _____
Signature of Person Giving Consent Date Time
(and relationship to the patient if person giving consent is not the patient)

If the person giving consent is not the patient, state the reason why the patient is unable to consent:

_____
Nurse's Printed Name

_____ _____ _____
Nurse's Signature Date Time

*Consent valid for 30 days from date of signature.

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GUIDE FOR PATIENT PROCEDURES

You have been scheduled for a non-surgical injection procedure. Your physician has informed you of the type of procedure you are scheduled to have.

INSTRUCTIONS PRIOR TO APPOINTMENT

- The entire process, from check-in to discharge, takes approximately 1 ½ hours. Please be at the surgical center 45-60 minutes hour prior to the scheduled procedure time (as instructed).
- A light snack can be taken up to two (2) hours before the scheduled procedure time.
- **Medications, including pain pills, and especially heart/blood pressure/diabetic medications should be taken the morning of the procedure.**
- **DO NOT take any ASPIRIN, blood thinners or NSAIDS (including prescription anti-inflammatories) for three (3) days prior to the procedure. Examples: Motrin, Ibuprofen, Aleve, Naproxen, Lodine, Mobic and Indocin Do NOT Take Any of These three (3) days prior to procedure.**
- **If you are taking Coumadin, Warfarin, Heparin or Plavix, check with your prescribing physician five (5) days prior to procedure. If your prescribing physician orders an INR, bring the report to procedure appointment.**
- If having Valium prior to procedure, it will be necessary to have another adult driver present at the procedure appointment to drive you home.
- If you have Mitral Valve Prolapse or normally take antibiotics prior to procedures, please notify your physician.

THE PROCEDURE ITSELF:

The performance of this procedure causes very little significant discomfort to patients. An I.V. will be started prior to the procedure. The area to be injected is cleansed with antiseptic solution and draped in a sterile fashion. Anesthesia is obtained by injecting a small amount of local anesthetic into the skin and underlying tissues. There should be minimal discomfort felt by the patient during the injection. Should any pain be felt, more local anesthetic could be administered. After the injection, patients will be monitored for 15 to 30 minutes, and then allowed to go home. Occasionally, patients may experience some numbness after the procedure. This is short-lived and should be gone by the end of the day.

AT HOME, AFTER THE INJECTION:

PAIN MEDICATION: For minor discomfort, non-prescription pain relievers may be used as directed on the product labels. Medication prescribed by your physician may be taken as directed for discomfort not relieved by non-prescription medication.

ACTIVITY/DIET: You may be up and around as tolerated by your level of comfort; however, plan to take it easy for the remainder of the day. Intermittent use of an ice pack is acceptable. **Do not use heat for 24 hours after the procedure**. You may eat and drink fluids as you desire and we suggest you increase your fluid intake after the procedure.

RARE POST-PROCEDURAL SYMPTOMS:

You should be alert to report any signs of infection including, but not limited to: redness and or/warmth at the needle puncture site, increased pain other than expected from the procedure, swelling, drainage, chills, night sweats, and fever above 101 degrees F. Should you develop a headache, stay quiet with your head and body flat, drink plenty of fluids and take a pain reliever. If your headache persists beyond 12 hours or is noticeably increased by standing upright, it may be an indication of a spinal fluid leak and our office should be notified even after normal business hours. Usually in this event, the symptoms are self-limiting and resolve in time without additional

_____ _____

Printed Patient Name Patient Signature

Date: _____

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THE CENTER FOR SPINE PROCEDURES, P.C.

NAME: _____ Date: _____

Medication allergies: _____

Latex / environmental allergies: _____

Are you allergic to Shellfish? ○ Yes ○ No

Current infection or communicable disease? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No Date of last menstrual period: _____

Current Medications	Strength	Times per Day	Date / Time of Last Dose

Patient Signature: _____

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The Doctors and Staff of Non-Surgical Orthopaedics P.C. and The Center for Spine Procedures P.C. Want You to Know How We Will Protect Your Private Health Information.

When you visit our Center it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our Center has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and others healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our Center provide all of our patients that we see after April 14, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for you records.

Thank you for your cooperation.

Acknowledgement of receipt of Non-Surgical Orthopaedic Pain Center, P.C.'s Notice of Privacy Practices

Patient Name:_____

(Please Print)

Signature of Patient or Personal Representative:

_____ **Date:** _____

THE CENTER FOR SPINE PROCEDURES, P.C.
PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

1) The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration, and dignity.
2) Patients shall receive assistance in a prompt, courteous, and responsible manner.
3) Patient medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval.
4) Patients have the right to know the identity and status of individuals providing services to them.
5) Patients have the right to change providers if they so choose.
6) Patients, or a legal authorized representative, have the right to thorough, current, and understandable information regarding their diagnosis, treatment options, and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.
7) Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with the provider.
8) Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
9) Patients have the right to express complaints about the care they have received and to submit their grievance to the appropriate regulatory (below) agency or to the Clinical Supervisor who will bring the issue to the attention of the Medical Director in a timely manner.
10) Patients have the right to be provided with information regarding emergency and after-hours care.
11) Patients have the right to obtain a second opinion (at their expense) regarding the recommended procedure.
12) Patients have the right to a safe and pleasant environment during their stay.
13) Patients have the right to have procedures performed in the most painless way possible.
14) Patients have the right to an interpreter if required.
15) Patients have the right to be provided with informed consent forms as required by Georgia law.
16) Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed. No visitors will be allowed in the recovery area.
17) Patients have the right to develop Advance Directives which will be respected by Center staff.

PATIENT RESPONSIBILITIES

1) Patients are expected to provide complete and accurate medical histories including providing information on all current medications, keep all scheduled pre- and post-procedure appointments, and comply with treatment plans to help ensure appropriate care.
2) Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
3) Patients are responsible for providing insurance information at the time of their visit and to notify the receptionist of any changes in information regarding their insurance or medical information.
4) Patients will be provided, upon request, all available information regarding available services, estimated fees and options for payment.
5) Patients are responsible for paying all charges for co-payments, co-insurance, deductibles on non-covered services at the time of the visit unless other arrangements have been made in advance with the Medical Practice.
6) Patients are responsible for treating Center Physicians and staff in a courteous and respectful manner.
7) Patients are responsible for asking questions about their medical care and to seek clarification from their physician of the services to be provided until they fully understand the care they are to receive.
8) Patients are responsible for following their provider's advice and to consider the alternatives and/or likely consequences if they refuse.
9) Patients are responsible for expressing their opinions, concerns, or complaints in a constructive manner to the Center personnel.
10) Patients are responsible for notifying their healthcare providers of patient's Advance Directives.

PATIENT COMPLAINT OR GRIEVANCE

The Center for Spine Procedures will promptly review, investigate & resolve any patient grievances or complaints in a timely manner. If you feel you may have an issue, we provide you with the following contact information The Center for Spine Procedures, P.C. 335 Roselane Street Marietta, GA 30060 Attention: Administrator

Composite State Board Of Medical Examiners
2 Peachtree Street, NW, 10th Floor
Atlanta, GA 30303-3465
404-656-3913
http://medicalboard.georgia.gov

Office of Regulatory Services Department of Human Resources
2 Peachtree Street, Suite 33,250
Atlanta, GA 30303-3142
404-657-6487
http://ors.dhr.georgia.gov/portal/site/DHR-ORS/

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the "Ombudsman" webpage at: www.cms.hhs.gov/center/ombudsman.asp

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE I HAVE READ, UNDERSTAND AND AGREE TO ITS CONTENTS

Patient: _____ Date: _____

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The Center for Spine Procedures, P.C. Financial Payment Policy

Welcome to The Center for Spine Procedures, P.C. Our facility accepts most commercial insurance plans, i.e., PPO's, HMO's and other provider networks. Please appreciate the complexity of insurance coverage today. It is impossible to obtain payment for services without having the full cooperation of the patient. We are experts in Orthopaedic care, not insurance. **We will help you if we can with this process however, it is ultimately your responsibility to know your insurance policy coverage and in-network/out-of-network responsibilities.**

If you are on a managed care plan in which we participate, then **you are responsible for paying your co-payment, co-insurance, or portion of your medical deductible at the time of service.** As a courtesy, before a procedure is performed, we will give you an estimated amount for the facility fee and professional component.

If you are **not** on a managed care plan in which we participate, then **you are responsible for paying the difference between our charges and what your insurance company paid, in addition to paying your co-payment, percentage, or portion of your medical deductible at the time of service.**

Our fees are generally considered to fall within the acceptable range by most insurance companies and are therefore covered as maximum allowable, as determined by each carrier. Some insurance companies utilize an arbitrary schedule of what they consider to be "UCR" (usual, customary and reasonable). Please understand that we have an agreement with you and your insurance company. We routinely make an effort to appeal any charges not covered; however, **any charges not covered, denied, or deemed to be not medically necessary by your insurance company will be your responsibility.** This excludes our contracted fee arrangements with managed care companies, including HMO's, PPO's, Workers' Compensation, and Medicare.

- I hereby understand that I am responsible for giving "The Center for Spine Procedures, P.C." the correct insurance information.
- I understand that I am also responsible for obtaining the proper referral from another physician, if applicable.
- I agree to pay for services for which I failed to obtain a referral.
- I agree to pay for non-covered, denied, or other non-paid services under my insurance plan.

_____ _____

Print Patient Name Patient Signature

Date: _____

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CENTER FOR SPINE PROCEDURES, P.C.
ACKNOWLEDGEMENT FORM
ADVANCE DIRECTIVES

1. The Center, through the Medical Practice, shall provide all adult patients with written information concerning the individual's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
2. The patient (or surrogate decision-maker) shall sign an "Acknowledgment Form" indicating they have received such information. A signed copy of this form will be maintained in the patient's medical record.
3. The Center will maintain information about Advance Directives and copies of Georgia's "Durable Power of Attorney for Health Care" and "Living Will".
4. If, at admission, a patient's medical record does on contain any of the forms mentioned above, the admitting nurse will ask the patient or a family member, if necessary, whether the patient has executed an advance directive document. If patient has not done so, information will be provided to the patient and a notation will be made in the medical record. If the patient has an advance directive, this will be documented. A copy will be placed in the patient's medical record if possible.
5. In the event a patient is already incapable of making medical decisions or incapable of communication at the time of admission, appropriate decisions shall continue to be made in the best interests of the patient through the conjoint efforts of the attending physician, the patient's surrogate decision-maker or immediate family, and the care team.
6. It is understood that if an adult patient has not executed or issued a directive, this does not create a presumption that the patient does not want a treatment decision to be made to withhold or withdraw life-sustaining procedures.
7. Although information will be provided to patients concerning advance directives and health care decisions, it shall not be constructed as either medical or legal advice. Such consultation, if needed or desired, should be sought from a qualified physician or attorney.
8. Center staff who provide direct care or are involved directly with financial matters are not permitted to act as witnesses to advance directives completed by patients at the Center.
9. The Center will provide education for its staff members on issues relating to advance directives.
10. The content of an advance directive shall be transcribed as a physician's order and the chart appropriately flagged.
11. This policy is presented to every patient either at the time of scheduling or upon admission to the Center. A signed copy of this form acts as the "Acknowledgment Form".

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Print Form Clear Form Save Form Submit Form