ADVANCED PAIN MANAGEMENT & REHABILITATION
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Diplomat of the American Board of Pain Medicine

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TAX ID 86-1149392. NPI 1902826589

PATIENT INFORMATION SHEET

Last Name ______________________________ First Name ______________________________ Sex: M F

If patient is a minor, name of parent or guardian accompanying Patient ____________________________

Relationship to Patient ________________________________ Phone Number ______________________

Address _________________________ City _____________ State ___________ Zip Code _____________

Home Phone # __________________ Cell Phone# __________________ Email ______________________

Date of Birth ________________ SSI# ___________________ Married___Single___Divorced Widowed___

Referred By ___________________________ Phone# ________________ Location ____________________

Primary Care Physician ________________________________ Phone# _____________________________

Pharmacy Name _______________________ Location ______________________ Zip Code _____________

INSURANCE

Primary Medical Insurance __________________________ ID# _______________ Group # ____________

Address ____ Phone# _______________________________

Subscriber _______________________________ DOB _________________ SSI# ____________________

Secondary Medical Insurance __________________________ ID# ____________ Group# ____________

Address ____ Phone# _______________________________

Subscriber _________________________________ DOB _________________ SSI# ___________________

Date of Accident (If Applicable) _______________________ **Type of Accident** _____________________
Please briefly describe the accident; you may use the back page to continue if needed. Please also note whether you were the accident occurred while working (Worker's Comp) and time and date: ___________
____

Attorney Name _________________________ Phone# _________________ Fax# ____________________

Employer Name _________________________ Phone# _________________ Fax# ____________________

Are we authorized to release medical information to the emergency contact listed above Yes____ No____

Signature ____ **Date** ___________________________

ADVANCED PAIN MANAGEMENT & REHABILITATION
PAIN MANAGEMENT AGREEMENT

I____________________________________, understand that I have pain that has not been adequately controlled with other Medications, and that my function is limited by my pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the pain.

I will take the medication only as prescribed. I will not take any sedatives, alcohol or other pain medications without the prior approval of my doctor. I understand that the medication will be prescribed only by **Dr. BHAVINI CHANDARANA**. upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone. I will not seek or accept any medications for pain other than those prescribed by my doctor. "Medication for pain" includes prescriptions from other doctors, medications borrowed or accepted from family or friends and any illicit or street drugs. Medication refills will be provided as written prescriptions only. No refills will be given prior to the next scheduled appointment date. ONLY DURING

BUSINESS HOURS NO EVENINGS OR WEEKENDS. If I do not keep my appointment; I will not receive a refill. Two (2) appointment cancellations with less than one working Days' notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement. Understand that my doctor is under no obligation to provide these medications to me, and that he or she reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.

(Females only)
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 term while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not a mother is on medications.

(Males only)
I am aware that chronic opioid use has been associated with low testosterone levels. 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. Diversion agree not to sell, give, trade, or otherwise transfer any controlled substance to any other individual as this activity constitutes a sale of drugs, and is a felony. I further understand that if someone were to die as the result of such a

transaction, I could be charged with manslaughter or even murder, as well as drug dealing. Pill Counts I agree to unannounced counts of my medication. Drug Screening I agree to random drug screening. I authorize this clinic to test my blood, urine or hair, for the presence of illicit substances and non-prescribed medications, without prior notice, and agree to submit to psychiatric or drug abuse evaluation should the clinic staff request it. Addiction I am aware that opioids have some potential to be addictive and am willing to take that risk, as long as the benefits of treatment in my situation outweigh the risks. I understand that if i do become addicted, this is a treatable condition, and I have the right to request and be referred for treatment. I am aware that addiction if defined as the continuing use of a drug or activity in spite of harm, cravings, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I agree to tell my doctor my completed and honest personal drug history and that of my family to the best of my knowledge. I agree to immediately report any psychological cravings I may experience for the substances with which I am being treated, as well as to report any adverse consequences or side effects of their use. I agree to report to Dr. Chandarana, any use or desire to use controlled substances thyroid function, suppression of menstrual cycle, suppression of male hormone, itching, and allergic reactions. High dose methadone is suspected of causing irregular heartbeats, which can be life threatening. Dangers/Driving I understand that the medications used to treat pain may impair alertness and coordination, primary during the days following the introduction of a new medication, or when a dose has been recently increased. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or I am not thinking clearly. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, walking at unprotected heights, or Being responsible for another individual who is unable to care for himself or herself. It is illegal to operate a motor vehicle while the ability to drive is impaired by medication, and I agree to comply with such prohibition. I understand that lost or stolen medications will not be re-filled under any circumstances. It is my responsibility to protect and secure any medications. That includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen narcotics or narcotic prescriptions. I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and a copy of this agreement when a referral is made. In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication from a source other than my doctor.
2. 1 give, sell or in any way distribute prescribed medications to any other person(s).
3. I in any way attempt to forge or alter a prescription.
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well -being or safety
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I agree to fill my prescriptions only at the pharmacy I list below. If I change pharmacies, I will contact my doctor's office and Provide them with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain Medications from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office will Provide my chosen pharmacy with a copy of this agreement. If for some reason the Pharmacy chosen cannot provide the medication I will contact the Doctors office and let them know so that we may choose another Pharmacy.

I understand that any alteration in my medication prescriptions will require a new written agreement. I fully understand
the agreement and all my questions have been answered, and I consent to the course of treatment laid out by Dr.
Chandarana. I will be provided with a copy of this signed document for my records.

Pharmacy Name ______________________________ **Location** ____________________________

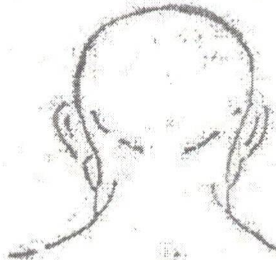
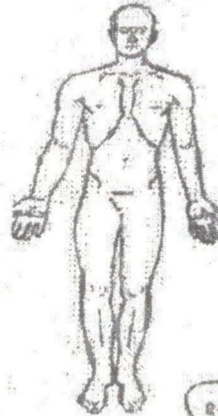
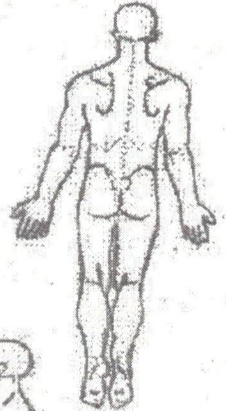
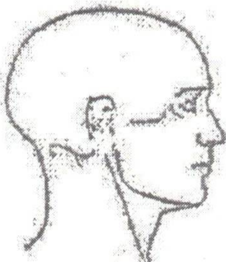
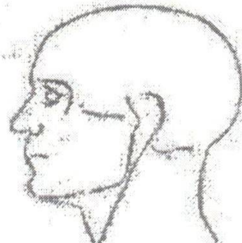
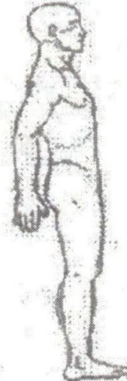
Phone Number _________________________________ **Fax** _______________________________

Signature ____ **Date** _______________________

Print Name ____ **Date** ________________________

Witnessed by ____ **Date** ________________________

Current Pain? Please circle areas of current pain

Circle Pain Level

☐ NECK: Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

☐ MIDBACK: Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

☐ LOWER BACK: Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

☐ HEADACHE: Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

☐ Other Location: ____________________ 0 1 2 3 4 5 6 7 8 9 10

☐ Other Location: ____________________ 0 1 2 3 4 5 6 7 8 9 10

☐ Location: ____

____

____

____

- Does the pain radiate anywhere? ("shooting down the left or right arm" or "shooting up to the head"):

____

____

- When did the pain start? ______________________________

- Describe your pain: ☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Numbness ☐ Burning

- How often is your pain present? ☐ Occasionally ☐ Frequently ☐ Constantly

- Worst time of the day? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All the time

- Any color change or temperature change? ______

- Numbness anywhere? ______

- "Pins and needles" or tingling sensation anywhere? ______

- Weakness? (Right leg, right arm, both legs…) ______

- Swelling? ______

- What makes symptoms worse/exacerbate? ______

☐ Walking ☐ Standing ☐ Lying Down ☐ Sitting ☐ Bending Forward ☐ Bending Backward ☐ Driving

☐ Coughing ☐ Bowel Movement ☐ Cold Weather ☐ Hot Weather ☐ Rainy Day ☐ Lifting Objects

- What makes symptoms better? ______

☐ Resting ☐ Massage ☐ Exercise ☐ Sitting ☐ Lying Down ☐ TENS Unit ☐ Physical Therapy ☐ Chiropractic

☐ Injections ☐ Sleeping ☐ Medications (Names): ______ ☐ Other: ______

- Sleeping: ☐ Well ☐ "OK" ☐ Terrible Sleeping How long? ☐ 2 hrs ☐ 4 hrs ☐ 6 hrs ☐ 8 hrs ☐ >10 hrs

- How often do you wake up due to pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >5 times

- Physical Therapy Location: ______ Date of Last Appt: ______ Duration: ______

- Chiropractic Treatment Location: ______ Date of Last Appt: ______ Duration: ______

- TENS Unit: ☐ Never Used ☐ I have a Unit ☐ Used at home daily ☐ Used at home as needed ☐ Used during PT

Previous "Injections" Treatments

	Date	Number of Injection(s)	Doctor's Name
☐ Epidural			
☐ Facet			
☐ Trigger Point			
☐ PENS			
☐ Acupuncture			
☐ Joints			
☐ Other ______			

Previous Injury/Accident History

Did you have an MVA or work-related injury prior to this accident? ☐ Yes ☐ No
If Yes,

- What kind of injury / accident? ______

- When? ______

- Symptoms? ______

Previous Injury/Accident History (Continued from Previous Page)

- Treatments? ______________________________

- Last Treatment (ex. 2 years prior to this accident) ______________________

Review of System

General: ☐ Weight loss ☐ Weight Gain ☐ Fever ☐ Fatigue ☐ Loss of Appetite ☐ Nausea ☐ Vomiting
Skin: ☐ Skin Problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
Neuro: ☐ Lightheaded/dizziness ☐ Fainting ☐ Weakness ☐ Stroke ☐ Tremor ☐ Seizure ☐ Memory Loss
Eyes: ☐ Vision Problem ☐ Glaucoma ☐ Blurred Vision ☐ Double Vision
ENT: ☐ Ear pain ☐ Hearing loss ☐ Ear noises ☐ Nose bleed ☐ Sore throat ☐ Hoarseness ☐ Dental Problems
Cardiovascular: ☐ Chest pain ☐ Chest Pressure ☐ Shortness of breath ☐ Irregular heart beat ☐ Murmurs
Respiratory: ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Coughing up blood
Gastrointestinal: ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Bloody stool ☐ Pain in stomach ☐ Ulcers ☐ Hepatitis
Genitourinary: ☐ Painful urination ☐ Frequent Urination ☐ Bloody Urine ☐ Kidney stone ☐ Incontinence ☐ Loss of libido ☐ Sexual difficulty ☐ Infection
Endocrine: ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
Hematology: ☐ Anemia ☐ Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
Immunologic: ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay Fever ☐ Frequent Sinus Problems ☐ Allergies
Musculoskeletal: ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Compression Fracture ☐ Head Injury ☐ Neck Injury ☐ Lower back injury ☐ Spina trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus ☐ Spina bifida ☐ Gout ☐ Osteoporosis ☐ Muscular Dystrophy ☐ Muscle pain ☐ Scoliosis
***Women Only:** ☐ Irregular periods ☐ Premenstrual depression ☐ Hot flashes ☐ Menstrual Cramps ☐ Vaginal discharge ☐ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram ________
***Men Only:** ☐ Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty starting urination
Psychiatric: ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts ☐ Suicidal ideation ☐ Homicidal ☐ Hallucination ☐ Psychosis ☐ Other: ______________

Past Medical History

Heart: ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐ Valvular disease ☐ Aneurysm ☐ High Cholesterol
Lungs: ☐ Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung Cancer ☐ Other: ________
Gastrointestinal: ☐ Ulcer ☐ Reflux ☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other: ________
Kidney: ☐ Failure ☐ Stones ☐ Dialysis (When): ______________ ☐ Other: ______________
Endocrine: ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other: ______________
Neuro: ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia ☐ Seizures ☐ Parkinson's ☐ Other: ______________
Psychiatric: ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐ Other: ______
Bone/Muscular: ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis
Cancer: ______________________________
Other: ______________________________

Past Surgery History

____
____
____
____
____
____

Allergies

Latex: ☐ Yes ☐ No Reaction: ______________ Contrast (Dye): ☐ Yes ☐ No Reaction: ______________

Allergies to any medication(s) ☐ Yes, please list below ☐ Not that I know of

____

____

Current Medications (Please list current medications)

____

____

____

____

____

Significant Family History (Cancer, hypertension, diabetes, depression, back pain…)

Father's side: ____

Mother's side: ____

Siblings: ____

Social History

Tobacco: ☐ Never ☐ Quit in __________ ☐ Currently _____ pack per day

Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ______________

Use of drugs: ☐ Never ☐ Occasionally ☐ Frequently, Type/frequency: ______________

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Family Status: Living with: ____

Occupation: ____

Disability: ☐ Yes ☐ No If yes, please list reason/type: ______________________

This form was completed by: ______________________________

Patient Signature: ______________________________ Date: ______________

ADVANCED PAIN MANAGEMENT & REHABILITATION

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I hereby assign and authorize all medical and/or surgical benefits to which I am entitled, including Medicare, Horizon Blue Shield Blue Cross, HMO's and Commercial Insurance Companies to Advanced Pain Management and Rehabilitation. I understand that I am fully responsible for all charges whether or not they are covered by said insurance. I hereby authorize assignee to release any information necessary to secure payment on my behalf.

MEDICATION POLICY

It is important to your health that you follow the directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescriptions, over-the-counter and supplements that you are taking. We do NOT refill controlled medications in advance of their refill date, nor will we mail prescriptions. They must me given in person to you at the time of your appointment,
NO EXCEPTIONS.
Patients receiving chronic medication management will be required to sign a separate medication contract.

STAFF

We require our staff to address our patients with professionalism and we ask that our patients do the same. If at any time, our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or Practice Manager. We will document your record, and depending on the severity of the situation, you will then be discharged from the practice.

We are committed to providing the best possible treatment and care we ask you for your cooperation in the following policies.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY ALL OF THEM. I FURTHUR UNDERSTAND THAT FAILURE TO DO SO WILL RESULT IN MY DISCHARGE FROM THE PRACTICE.

Signature: ______________________________ Date: ______________

Print Name: ______________________________ Date: ______________

Practice Policies

Thank you for choosing Advanced Pain Management and Rehabilitation. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance with our policies. Your clear understanding of our policies is important to our professional relationship.

We will bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the time of service as well as required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at the time of service. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. If payment is not received from your insurance company in 60 days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interestto ensure that the correct insurance information is provided at the time of service.

If you have HMO coverage, it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit or procedure.

All patients are expected to pay at the time of service. Self-pay patients are required to pay in full at the time of service. If your insurance plan requires a copayment, it is payable at the time of service. **If you present without the copayment, we reserve the right to bill you a $15.00 administrative fee**. If for any reason a payment is dishonored by your bank, there will be a **$40.00 service fee** added to your bill and you will be required to pay by cash, certified check, money order or credit card for all future services.

We are participating providers for many insurance plans. However, we encourage you to use your out-of- network benefits for al other carriers. You will be required to show your insurance card and driver's license at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement. **In the event that your insurance carrier issues payment directly to you, it is your responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to Advanced Pain Management and Rehabilitation.**

Filing a secondary claim is a courtesy to the patient. We will only submit to your secondary carrier if they have electronic submission capability. If no response is received, the balance will be your responsibility. If we receive payment from you and your secondary carrier, a refund of the overpayment will be made to you. We will not file tertiary insurance claims, but will provide a claim to you upon request. You are responsible for all tertiary balances.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to a collection agency. **You are responsible for any interest, agency and legal fees** associated with collections.

We do accept **Worker's Compensation and Personal Injury Cases.** We will only file these claims with your regular insurance if a written denial from the workers compensation or personal injury carrier is received. We accept liens on an individual basis only for services provided by our office. Al necessary legal contact information must be provided in advance of your service to allow us time to process the necessary lien paperwork.

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports or other paperwork wil require a minimum fee of $15.00, paid in advance, related to the amount of the preparation involved. If you have not seen your physician recently, you may be required to see your physician before the form can completed. Please allow five business days for completion.

Appointments

Please be sure to provide the telephone number where you may be reached. If you have voice mail on your contact telephone number, our staff will leave a message including the time, date, and location of your appointment. You can also check our Patient Portal online for all your appointment information. We require 24 hours' notice if you intend to cancel your appointment. Should you cancel, reschedule or no- show for an appointment, we reserve the right to charge a no-show fee of $50.00. If you are scheduled for a procedure at any office and cancel without a 24 hour notice to our office, a cancellation fee of $50.00 may be billed to your directly. Missed appointments for procedures at surgery centers (including taking of medications and lack of transportation) may be billed in the amount of $100.00. If you are late for your appointment, we reserve the right to reschedule your appointment or see you as the schedule permits. If you are a new patient and do not complete your forms in advance, you are required to be at the office at least 45 minutes in advance of your appointment to complete the necessary forms. **Failure to do so may result in the rescheduling of your new patient visit.**

HIPAA Privacy

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the Offices of Advanced Pain Management and Rehabilitation. This policy explains your rights including your right to see and receive a copy of your records, to limit disclosure of your protected health information and to request an amendment to your record. You may revoke, in writing, any consent for release of your healthcare information except to
the extent the Practice has already made disclosures with your prior consent. Because of the privacy regulations, we are not at liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an Access to Medical Records form. By signing this release, you allow us to discuss your are with the specified individual(s). If a family member has concerns about your care, we may not discuss these concerns without your written permission. Our Notice of Privacy Practices provides information on your rights and is available on our website. We encourage you to read it in full. If you have any questions regarding our notice and if we change our notice, you may obtain a copy of the revised notice by contacting us at 732-414-6499 or visiting our website at **www.apmrdrchandarana.com.**

DESIGNATION OF DISCLOSURE

Designation of Certain Relatives, Close Friends, and Other Caregivers:

I agree that Advanced Pain Management and Rehabilitation may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, Advanced Pain Management and Rehabilitation will disclose information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (check all that apply):

You can disclose my health information as described below: (Please check all that apply)

1 ______ OK to leave message with detailed information at my home/cell number:
______ On my answering machine
______ with my spouse
______ with anyone answering the phone
______ leave message with call back numbers only

(______) ________________________________

2 ______ OK to leave message with detailed information at my work number:
______ leave message with call back numbers only

(______) ________________________________

3 ______ OK to fax to my work fax:
______ OK to fax to my home fax:

(______) ________________________________

4 ______ OK to **e-mail:** ________________________________
______ OK to text to my cell phone:

(______) ________________________________

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Advanced Pain Management and Rehabilitation making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. I understand that Advanced Pain Management and Rehabilitation will not disclose health information to any person not designated except in case of an emergency.

Name:________________________________ Last 4 digits of his/her SS# or DOB (required as identifier)
Name:________________________________ Last 4 digits of his/her SS# or DOB (required as identifier)

The following person(s) are not authorized to receive my Patient Health Information:

Name:____________________ Name:____________________ Name: ____________________

Signature: ______________________ **Print** ______________________ **Date** _____

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If your insurance company doesn't pay for any procedures submitted to them, you may have to pay. Your insurance does not cover everything, even some care that you or your health care provider have good reason to think you need.

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 the procedures and bill your insurance.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but the Insurance companies cannot require us to do this.
OPTIONS: Check only one box. We cannot choose a box for you.

<u>Please choose and circle one option. We cannot choose an option for you.</u>

- **OPTION 1.** I want the procedures done. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on Explanation of benefits Summary Notice (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal it by following the directions on the MSN**. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles due by the patient.

- **OPTION 2.** I want the procedures done, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed.**

- **OPTION 3.** I decline the procedures and I understand with this choice I am not responsible for payment, and Therefore I am declining the care that the Doctors has advised me to have. **I cannot appeal the insurance and it would not be billed.**

By signing below I have read and understand all and comply with the option that I have chosen.

Signature of Patient (Guardian) ______________________________ Date __________