

Innovative SpineCare

M. Carl Covey, M.D. ♦ Christopher K. Mocek, M.D.

General Release

Release of Information Agreement:

This document shall permit the clinic representative; physician and other licensed providers participating in my care, at their discretion, to disclose all or part of my medical record to any person or corporation which is liable for all or part of the clinic's charge, including insurance companies, worker's compensation carriers, welfare funds, Social Security Administration or its intermediaries or carriers, as well as to any corporation engaged by the clinic to make collection of any unpaid clinic charges. They may also disclose medical information to third parties to assist in collection of any unpaid balance due on this account. My employer may obtain information only when actually liable for the clinic charges incurred during this visit. I also understand and agree that, unless I request to the contrary, in writing, the clinic may release certain information about me without my specific consent including my name, age, verification of treatment, address at time of visit, and name of attending physician. Should I wish to void this agreement, I understand that my request must be submitted in writing to be honored by the clinic as of the date of receipt. This agreement shall be valid for one year from the date of treatment.

Referring Physician/Patient Care:

I authorize any employee, physician or representative of this clinic, at their discretion, to release any of my medical information to any referring physician or any other physician that is participating in my care at any time. I also authorize any employee, physician or representative of this clinic, at their discretion, to obtain any of my medical information from any referring physician or any other physician that has participated in my care at any time.

Insurance Authorization & Assignment:

I authorize Innovative SpineCare to furnish information concerning the illness and treatment of the patient named below to the insurance carriers or other responsible parties. I assign to the clinic all payments for medical services and supplies arising from the patient's treatment by the clinic. I am aware that if requested the clinic will file insurance claims for the patient. BUT I understand that I am responsible for all charges regardless of whether the patient is entitled to insurance benefits, worker's compensation benefits or reimbursement from any other third party.

Consent & Financial Agreement:

I authorize the treatment of the patient named below by Innovative SpineCare. I agree to pay all fees and charges for such treatment promptly upon presentation of a statement thereof. If the insurance carrier does not remit payment within 90 days, the balance will be due in full from the patient.

Receipt of Notice of Privacy Practices Written Acknowledgement Form:

I agree that I have received a copy of Innovative SpineCare's Notice of Privacy Practices.

Signature of Patient or Guardian

Date

Printed Name

Relationship to Patient

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Chart Number: _____

Social Security Number: _____

Date of Birth: _____

I authorize the use or disclosure of the above named individual's health information as described below. The following individual/organization and/or representative is authorized to make the disclosure:

Innovative SpineCare
M. Carl Covey, MD, Christopher K Mocek, MD
9101 Kanis Road, Suite 400 Little Rock, AR 72205

The type and amount of information to be used or disclosed includes, but is not limited to:

- ◆ My entire record; i.e. problem/diagnosis list, medication list, list of allergies, immunization record most recent history and physical, most recent discharge summary, laboratory results, x-ray and imaging reports, consultation reports, accounts receivable information.

I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.

This information may be disclosed to the following individual(s):

Name	Relationship to Patient
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Name	Relationship to Patient
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I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the clinic manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that this authorization will remain in effect until I revoke this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules.

Signature of Patient/Legal Representative

Printed Name

Relationship to Patient

Date

Innovative SpineCare Employee – Witness to Signature

INNOVATIVE SPINECARE
M.CARL COVEY, M.D. & CHRISTOPHER K. MOCEK, M.D.

Dear Patient:

As a courtesy to your physician and to ensure we can attend to your urgent needs in a more timely manner, we request that you comply with the following guidelines related to prescription refills.

1. All patients requesting early refills or changes in medication must make an appointment with the nurse to have your medication needs addressed. Nurse visits are scheduled Monday through Friday. Please call 5 days before you are out of medicine.
2. No medications will be called in to your pharmacy or mailed. You must come to the clinic to be seen by the nurse to dispense prescriptions.
3. No walk-in refill requests can be accommodated.
4. Medications cannot be refilled or changed after hours, on the weekends or on holidays.
5. Do not increase the dosage of your pain medication without the permission of your physician.
6. You must agree to receive pain medication from one physician only while under our care. Remember this is for pain medication only.
7. Only one pharmacy may be designated for pain medication prescriptions. If you have changed or need to change your pharmacy, please notify the clinic as soon as possible.
8. If your pain medication/prescription is lost, misplaced, stolen, etc., you will need to file a police report and schedule a nurse visit to discuss replacing the prescription. Bring the police report to your appointment.
9. When you receive pain medication from this clinic, you may be subject to urine or blood screening for compliance at any time.
10. You may contact the on-call nurse through the Medical Exchange at (501) 663-8400, if you have an emergency related to your spine condition. Refills are not considered emergencies. If your problem is not an emergency, please schedule a follow-up visit.
11. If you are having a serious medical emergency do not hesitate to call 911 for help.

Please sign below to indicate that you have read and understand our clinic's guidelines for patient care.

SIGNATURE: _____ DATE: _____

Innovative SpineCare Clinic Policies

Due to the high volume of patients that are seen and cared for by Dr Mocek and Dr Covey, we have had to adopt a policy for 'no show' and 'cancelled' visits. We also have patients that are on a waiting list to get into the clinic. Therefore, out of courtesy and consideration to the existing patients and people waiting to get in to the clinic, the following policies have been adopted.

NEW PATIENTS

ONE confirmed no show for a new patient evaluation; the patient must get a new referral to be rescheduled for consideration of entry into the clinic.

TWO late cancellations for appointment; the patient must get a new referral to be rescheduled for consideration of entry into the clinic.

TWO early cancellations for appointment; the patient will get one more chance to keep their appointment for consideration for entry into the clinic.

ESTABLISHED PATIENTS

THREE late cancellations for appointments in a year; the patient will be discharged from the clinic.

THREE confirmed no show for an appointment; the patient will be discharged from the clinic.

FOUR early cancellations for appointment; the patient will be discharged from the clinic.

The physicians reserve the right to deviate from the above policies for a breach of the patient-doctor relationship, a breach of any office policy, taking medications in a way not prescribed, treating the physician or staff with disrespect, or for any reason the physician thinks it is best to discharge the patient from his care.

Patient Signature

Physician Signature

PATIENT NAME: _____

DOB: _____

DESCRIBE WHAT YOUR PAIN FEELS LIKE:

WHAT MAKES IT BETTER:

WHAT MAKES IT WORSE:

HAVE YOU HAD ANY OF THE FOLLOWING:

X-RAYS: _____ **Date:** _____ **Location:** _____

CT SCAN: _____ **Date:** _____ **Location:** _____

MRI: _____ **Date:** _____ **Location:** _____

HAVE YOU EVER HAD ANY STEROID INJECTIONS: _____ **YES** _____ **NO**

If Yes, When/Where: _____

HOBBIES:

INNOVATIVE SPINECARE

M. Carl Covey, MD ♦ Christopher K. Mocek, MD

9101 Kanis Road, Suite 400 ~ Little Rock, AR 72205

Phone: 501-978-8618 ~ Fax: 501-227-4209

PAYMENT POLICY

Welcome to Innovative SpineCare. We would like to inform you of our billing and payment policy. We ask that you carefully read this information over and speak to our billing department if you have any questions or concerns.

Health Insurance

We accept any insurance that we are a provider for only if we can verify that your policy is in force for the date of service. **If your insurance cannot be verified by the time of your appointment, you are expected to be personally responsible for the payment of the bill in full.**

When your insurance has been verified, your co-insurance and deductible is due at the time of service. **All co-pays are due at the time of service.** Payments can be made with cash, check, money order, debit cards or Visa/MasterCard credit cards. **Returned checks are subject to a \$25 fee and then we will no longer accept payments made by check.**

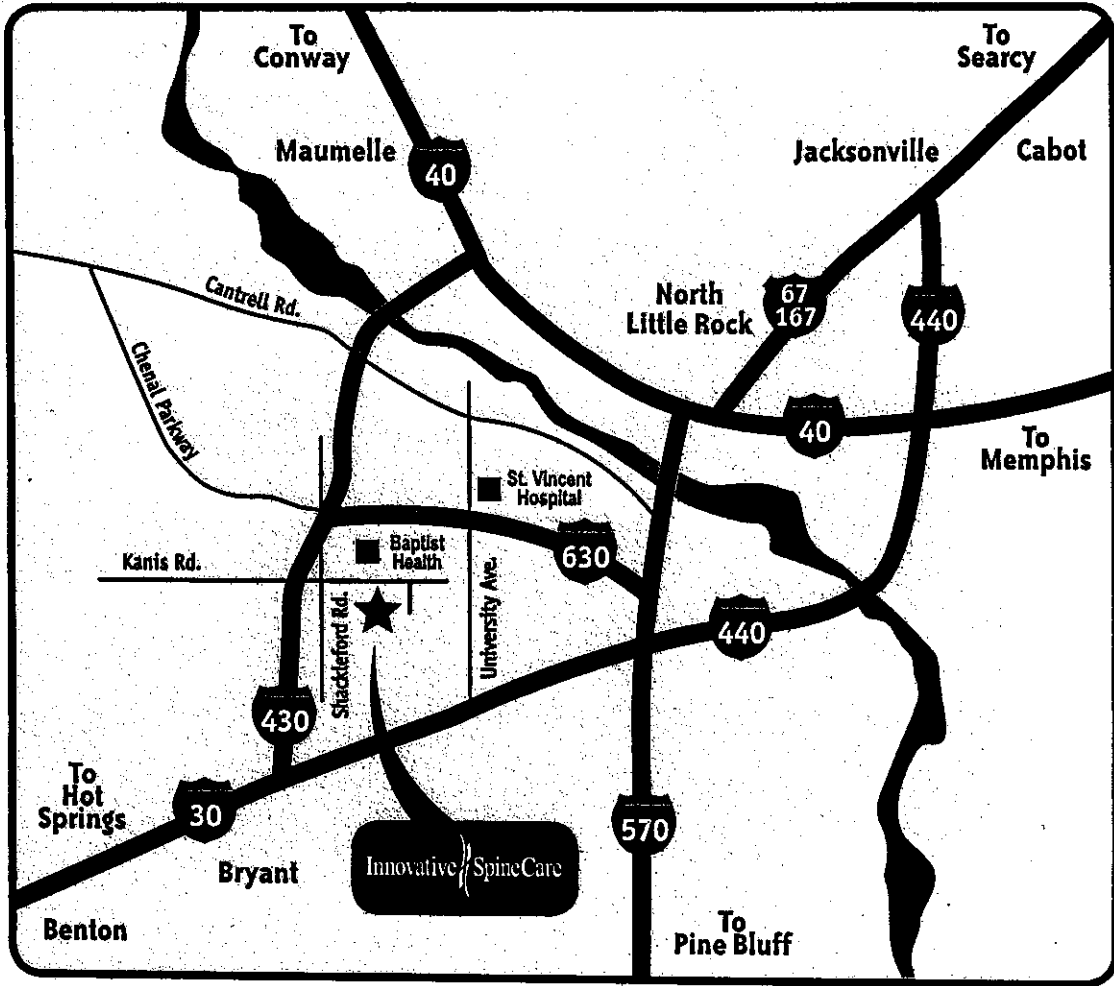
Extended Payments

Balances are due in full within 30 days of receipt of statement. In-house payment arrangements are available on a limited basis. The following payment schedule will enable you to determine what your minimum payment will be:

- A. If your account balance is less than \$100 you can pay in three (3) equal payments, with the first payment due immediately and the remaining two (2) payments payable at thirty (30) day intervals.
- B. If your account balance is more than \$100 but less than \$300 you can pay in six (6) equal payments, with the first payment due immediately and the remaining five (5) payments payable at thirty (30) day intervals.
- C. If your account balance is more than \$300 but less than \$500 you can pay in nine (9) equal payments, with the first payment due immediately and the remaining eight (8) payments payable at thirty (30) day intervals.
- D. If your account balance is more than \$500 but less than \$700 you can pay in twelve (12) equal payments, with the first payment due immediately and the remaining eleven (11) payments payable at thirty (30) day intervals.
- E. If your account balance is more than \$700 but less than \$1300 you can pay in eighteen (18) equal payments, with the first payment due immediately and the remaining seventeen (17) payments payable at thirty (30) day intervals.
- F. If your account balance is more than \$1300 you can pay in twenty-four (24) equal payments, with the first payment due immediately and the remaining payments at thirty (30) day intervals.

If your account becomes more than 45 days delinquent and you do not contact us to make arrangements to pay your bill or you default on your Payment Plan Agreement, your account may be turned over to our Collection Agency.

If you have any questions regarding this policy, please contact our billing office at 501-801-1048. We appreciate your cooperation.



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www.InnovativeSpineCare.com