



## FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, I need your assistance, and your understanding of our payment policy.

### **PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED**

We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a \$25.00 service fee and you will lose your privilege to write checks in all of our centers. Coastal Spine & Pain Center currently uses Check Velocity, a returned check company who will automatically debit your account for the amount of the returned check plus the applicable service fee.

### **HMO/PPO INSURANCE COVERAGE**

CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with these insurance companies, we will file your insurance.

### **MEDICARE**

Your deductible and 20% of the allowable charges are due at the time of service; however, since we are Medicare providers we will file your Medicare. If we do not know the allowable charge for a specific service, you will be billed after payment is received from Medicare. Please bring your Medicare Explanation of Benefits to show that you have met your deductible.

### **WORKER'S COMPENSATION**

We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance.

### **AUTOMOBILE ACCIDENTS**

We will file your insurance claim when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

### **LABORATORY BILLING PROCEDURE**

I have been informed that all laboratory procedures done outside of the office (blood work, cultures, pap smears, etc.) will not be included in the charges for Coastal Spine & Pain Center. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab. Coastal Spine and Pain Center will send my lab specimens to a laboratory that accepts my insurance.

### **NO SHOW POLICY**

\_\_\_\_\_ There will be a \$25.00 charge if you fail to show for your scheduled office visit appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your appointment.

\_\_\_\_\_ There will be a \$50.00 charge if you fail to show for your scheduled procedure appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your procedure appointment.

**FINANCIAL POLICY, page 2**

**CONSENT FOR MEDICAL TREATMENT**

I am the patient, or the patient’s duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary in the judgment of my physician or his/her designee for myself, my minor child or other. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

**CHILDREN OF DIVORCED PARENTS**

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, NO MATTER WHO IS RESPONSIBLE BY ORDER OF THE DIVORCE DECREE.

**FORM COMPLETION FEE**

Due to the large volume of forms that we are required to complete, our office reserves the right to charge a \$25 fee for forms greater than 1 page and less than 3 pages in length. For forms 4 pages or greater, our fee is \$50 for form completion.

**PRIVACY POLICY**

I have received a copy of Coastal Spine and Pain Center privacy policy and have been give the opportunity to have my questions, if any, answered.

**FINANCIAL AGREEMENT**

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILIY FROM THE DATE SERVICES ARE RENDERED. Collection action will be taken for any charges, including those that insurance has not paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Physicians Group Services, dba Coastal Spine and Pain Center.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# COASTAL SPINE & PAIN CENTER

## Informed Consent and Agreement for treatment with Opiate Analgesic Medications

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**The purpose of this Agreement** is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your pain management physician to comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my pain management physician undertakes to treat me based on this Agreement.

I have agreed to use opioid analgesics (morphine-like medications) as part of my treatment for acute/chronic pain. I understand that these drugs could be useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my pain management specialist is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of this agreement, and at the sole discretion of my pain management specialist or the medication utilization review committee, may result in the termination of our physician/PA/NP-patient relationship. In this case, my provider will stop prescribing these pain-control medicines and will taper off the medication over a period of several days, as necessary, to lessen withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

1. I am responsible for my pain medications. I agree to **take the medication only as prescribed** and to contact my physician before making any changes.

- I understand that increasing my dose without the close supervision of my pain management specialist could lead to drug overdose, causing severe sedation, respiratory depression and death.
- I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh," abdominal cramps and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to several weeks.

2. I will not request or accept a prescription for opioid pain medicines from any other physician or individual while I am receiving such medication from my pain management physician. Prescriptions for controlled stimulants, or anti-anxiety medicines need to be coordinated with your pain management physician.

3. I understand the **side effects** that are related to opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty, jerkiness, change in personality, sleep changes, potential for increased pain, risks to unborn children, changes in appetite, coordination, sexual desire and performance. Most side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my pain management specialist of any side effects that continue or are severe (such as sedation or confusion). I am also responsible for notifying my pain management specialist immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.

4. I understand that the opioid medication is strictly for **my own use**. I will not share, sell or trade my pain medication with anyone. If children are in the house, a childproof top is mandatory.

5. I understand I must contact my pain management specialist before taking benzodiazepines (drugs like Valium, Xanax or Ativan), sedatives (drugs like Soma or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. **I cannot consume alcohol or use recreational/illegal drugs** (including cocaine, heroin, etc.) while on opioid analgesic medications. If consumed, the consequence will be termination from the program. I understand that opioid prescriptions will not be mailed. During the time that my dose is being adjusted, I will be expected to return to the Center no less frequently than one time a month. After I have been placed on a stable dose, I will return to the Center whenever instructed by my pain management specialist.

6. I am responsible for my opioid prescriptions. I understand that **refill prescriptions**:

- Can only be written for a one-month supply and will be *filled at the same pharmacy* (as designated below)
- Shall be made *during regular office hours 8 AM – 5 PM*, Monday through Friday, and can be picked up only in person. Refills will not be made at night, on holidays or on weekends. Prescriptions will not be mailed.
- Refills shall not be made if I "run out early", "lose a prescription" or spill or misplace my medication.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

## Informed Consent and Agreement for Treatment with Opiate Analgesic Medications, page 2

- I am responsible for keeping track of the amount of medication remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician. Lost or stolen medicines will likely not be replaced.
- Shall not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least one week ahead to schedule pick-up for my prescriptions.

7. While physical dependence is to be expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification. I agree, if this is the case, that I may need to be admitted for detoxification to appropriate facility

- **Physical dependence** is common to many drugs, such as blood pressure medications, anti-seizure medications and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal.
- **Addiction** is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping," when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the opioid trial and he or she may be discharged.
- **Tolerance** is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.

8. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the pain management specialist that there is no improvement to my daily **function** or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the pain management specialist.

9. I agree to submit to **urine, saliva and/or blood screens** at any time as determined by my pain management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my medication in at any time for the pain management specialist to inspect.

10. I further understand that if I do **not follow** any of the above conditions or provisions, I may (at my physician's discretion) no longer receive any type of opioid medication.

- Controlled medication therapy may be discontinued if patients: develop tolerance which cannot be managed; have side effects, which cannot be controlled. Discharge from Coastal Spine & Pain Center will occur if: patients become addictive or abusive of other medications and substances (this includes alcohol), or increase their medications without prior approval from my pain management specialist, obtain non-authorized controlled medications from other practitioners; fill prescriptions at multiple pharmacies; sell, give away or otherwise divert the medications from their intended use; alter prescriptions; other serious concerns arise. We always cooperate with authorities if illegal activities occur.
- I also understand that if I have a problem or question with any of the above paragraphs, I must make an appointment to discuss this with the pain management specialist and receive clarification before a problem or crisis situation arises.

11. I **authorize the release** of any information and medical records by the pain management specialist, his or her designee and my pharmacy to other healthcare providers, pharmacist, my family, my employer, my insurance company or other reimbursing agencies. I also authorize the doctor, his or her designee and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I 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.

Pharmacy name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

**By signing below, I certify that I have read the above information, I have received a copy of the contract and all my questions regarding the treatment of pain with opioid analgesic medications have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/PA/RN: \_\_\_\_\_ Date \_\_\_\_\_

# COASTAL SPINE & PAIN CENTER

## RECORDS RELEASE AUTHORIZATION

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby authorize you to release any information including the diagnosis and records of any treatments or examinations rendered to:

<b>Ferdinand J. Formoso, D.O.</b> 11555 Central Parkway, Suite 304 Jacksonville, FL 32224 phone 904-265-7755 fax 904-265-7754	<b>Kenneth A. Powell, D.O.</b> 421 Kingsley Ave, Suite 402 Orange Park, FL 32073 phone 904-264-8801 fax 904-621-0566	<b>Alan E. Miller, M.D.</b> 1551 South 14 <sup>th</sup> St., Suite B Fernandina Beach, FL 32034 phone 904.321.2422 fax 904.321.2434
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Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number