



Pasadena Rehabilitation Institute
1017 S. Fair Oaks Ave.
Pasadena, CA 91105-2636
626.403.6200 | 800.80.REHAB
Fax - 626.403.2580
www.SynovationMedicalGroup.com

TO OUR NEW PATIENTS:

Welcome to Pasadena Rehabilitation Institute. Your care and comfort are most important to us. To make your visit with us as pleasant as possible, please sign in at the Front Desk when you arrive for your appointment, and have a seat. Coffee is available for your convenience. One of our members will be with you to collect any copayment and process the necessary paperwork as soon as he or she is available.

In order to better serve you, we have adopted the following procedures for all of our new patients. Please follow these procedures in preparing for your visit with us, as they will make your appointment go smoothly and comfortably.

1. PLEASE BRING THE FOLLOWING ITEMS WITH YOU ON YOUR FIRST APPOINTMENT:

- a) *Picture ID Card.*
- b) *Insurance Card.*
- c) *Authorization Form.*
- d) *Medical Records. (Only if seeing a physician)*
- e) *X-Rays. (Only if seeing a physician)*
- f) *For those patients who are seeing a physician, a list or bottles of all medications you are taking.*

2. PRIOR TO YOUR APPOINTMENT, PLEASE COMPLETE AND BRING IN ALL OF THE REGISTRATION PAPERWORK WE HAVE SENT YOU. YOU MUST COMPLETE THE PAPERWORK BEFORE SEEING A PROVIDER.

3. IF YOU HAVE NOT HAD THE OPPORTUNITY TO FILL OUT THE PAPERWORK PRIOR TO YOUR APPOINTMENT, PLEASE ARRIVE 30 MINUTES EARLY. THOSE ABLE TO COMPLETE THEIR PAPERWORK PRIOR TO THEIR APPOINTMENT, PLEASE ARRIVE 15 MINUTES EARLY

4. PLEASE BE ON TIME. Like you, we are extremely busy and must budget our time efficiently. If you are late for your appointment, **YOU MAY HAVE TO RESCHEDULE YOUR APPOINTMENT.**

5. IF YOU HAVE A COPAYMENT, PLEASE BE PREPARED TO PAY IT AT THE TIME OF YOUR APPOINTMENT. IF YOU DO NOT HAVE OR ARE UNABLE TO PAY YOUR COPAYMENT AT THE TIME OF YOUR APPOINTMENT, YOU WILL HAVE TO RESCHEDULE YOUR APPOINTMENT UNTIL SUCH TIME AS YOU CAN PAY IT. WE ARE SORRY, BUT THERE CAN BE NO EXCEPTIONS.

6. YOU MUST SHOW YOUR INSURANCE CARD AT EACH VISIT.

Thank you for taking the time to read this material. We are confident that these procedures will result in a more efficient and better service for you. Your cooperation is much appreciated.

Name _____ Today's Date: _____
Age _____ Date of Birth _____ / _____ / _____ Job Description _____

What is your current pain complaint? _____

- On a scale from 0 to 10 with 0 being no pain and 10 being the worse pain you can imagine, please rate (circle the correct response):

Your pain at this moment: _____

Your pain on "good days": _____

The worst pain you have: _____

Your pain on a typical day: _____

In a typical week, how many days do you experience your most severe pain? _____

- When did you pain start? _____
- Did you have similar pain complaints prior to your current one? Please explain.

- What makes your pain worse? _____

- What makes your pain better? _____

- Do you have the following symptoms associated with your pain?

- Numbness – Where? _____

- Tingling – Where? _____

- Pins and Needles – Where? _____

- Weakness – Where? _____

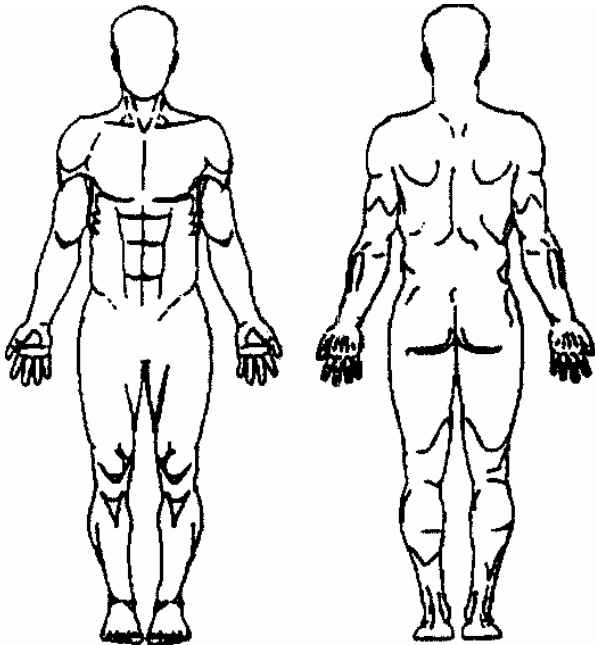
- Is your pain related to any of the following symptoms?

Bowel Problem Bladder Problems Sleep Disturbance Frustration

Sexual Dysfunction Poor Appetite Fever Depression

- What are your goals in treatment? _____

- Mark on the drawing the location of your pain:



• Have you had any of the following tests done for this problem?
 X-Rays CT Scan MRI EMG Bone Scan Other _____

• Which medications have you tried for your pain?

• What other treatment have you tried for your pain?
 Physical Therapy TENS Unit Epidural Injections Acupuncture
 Psychotherapy Other _____

• Have you been feeling sad, hopeless or helpless recently? Yes No

• Do you get anxious and/or do you worry a lot? Yes No

• Are you currently having suicidal thoughts? Yes No

• Past Medical History: Do you have any other illnesses? Yes No

High Blood Pressure Diabetes Arthritis Heart _____

Lung _____ Kidney _____ Liver _____ Stroke

Stomach _____ Other _____

• List all previous surgeries and approximate dates: _____

• List your current medications and doses: _____

• List all medications you are allergic to: _____

• Are you taking “blood thinning” medications or aspirin? (specify) _____

Do you have any of the following symptoms? (Mark all that apply)

<input type="checkbox"/> Fever	<input type="checkbox"/> Headaches	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Poor Balance
<input type="checkbox"/> Chills	<input type="checkbox"/> Ringing ears	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Swollen Joints
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Decrease hearing	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Constipation Cough	<input type="checkbox"/> Stiff Joints
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Vision changes	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea Nausea	<input type="checkbox"/> Easy Bleeding
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urine incontinence	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Skin Rashes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Fainting	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Weak legs/feet
<input type="checkbox"/> Itching	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numb arms/legs	<input type="checkbox"/> Numb hands/feet

- Who do you live with? _____
- Do you smoke? Yes No (if yes, how many packs/day _____ and for how long _____)
- How many alcoholic drinks do you have per week? _____
- Do you use any illegal drugs? Yes No (If yes, specify _____)
- Are you presently working? Yes No
- Are you receiving disability benefits? Yes No
- Are you receiving Workers Compensation? Yes No
- Are you involved in any legal action or proceeding related to your pain? Yes No

Physical Examination

- Constitutional
- Skin/Integumentary
- Head
- Eyes
- ENT
- Neck
- Chest
- Cardiac
- Abdomen
- Genitalia
- Rectal
- Extremities
- Neuro
- Back/Spine

Laboratory Results: _____

Radiology Result: _____

Assessment: _____

Plan: _____

AWARENESS SHEET

POTENTIAL OPIATE SIDE EFFECTS/RISKS

You *MUST* be aware that opiates/narcotics have the potential for significant side effects which include:

1. **Persistent constipation.** This is likely to occur. Taking medications to prevent this problem are recommended and will be available through your prescribing doctor. Please avoid the intake of bulk-forming medications such as Metamucil.
2. **Nausea and vomiting.** If this complaint becomes consistent and appears on a regular basis, notify your doctor.
3. **Excessive drowsiness and sedation.** It is *VERY IMPORTANT* for you and your family to pay attention to this potential side effect. It may seriously affect your *CAPACITY TO DRIVE* or to operate dangerous machinery. *AT THE FIRST* sign of significant sedation, please stop driving or operating dangerous equipment, and performing potentially hazardous activities (swimming alone, etc.). There are medications to treat this side effect but they need to be discussed with your prescribing doctor before taking them.
4. Other potential side effects include pruritus (itching), decreased sexual performance, mood changes and insomnia.
5. Be aware that *ALL* opiates/narcotics have the potential to create **physical dependence and/or addiction**. Physical dependence means that once started on these medications your body may “get used” to them and if stopped abruptly they may provoke a withdrawal syndrome which is *NOT* life-threatening but can be quite uncomfortable (flu-like symptoms, abdominal cramps, diarrhea, anxiety, etc.) and may last for a few days. Addiction means the psychological “craving” for these drugs. Addiction is rare in individuals who are taking pain medication for medical reasons. It is more common in individuals who have a preexisting problem of addiction to drugs or alcohol. If you have a history of addiction you must inform your physician immediately.
6. Please take your medications the way they are prescribed. *DO NOT* change the schedule, break tablets in half or take extra doses, unless this is part of a pre-established plan. Failure to take your medication as prescribed may lead to **respiratory depression, cardiac arrest and death**.

Patient Signature

Date

Print Signature

Date

Birth Date

PASADENA REHABILITATION INSTITUTE
1017 S. Fair Oaks Pasadena, CA 91105
Tel (626) 403-6200, (800) 80-REHAB
Fax (626) 403-2580

PATIENT AUTHORIZATION FORM FOR RELEASE OF
MEDICAL RECORDS

I hereby authorize you to use or disclose the specific information described below, **only** for the purposes and parties also described below:

Description of the specific information to be used or disclosed:

Person or entity requesting the information and authorized to make the requested disclosure:

Recipient of the information: _____

The information is being requested for the following purpose(s):

This authorization shall remain in effect from the date signed below until _____
(expiration date or event).

I understand that

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

PATIENT'S NAME: _____ SIGNATURE _____

PATIENT'S DATE OF BIRTH: _____

(if signed by personal representative of Patient):

NAME _____ Relationship to Patient: _____

DATE: _____

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH

INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, Pasadena Rehabilitation Institute originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Pasadena Rehabilitation Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Pasadena Rehabilitation Institute reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Pasadena Rehabilitation Institute change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, E-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient's Signature

Date of Birth

Print

Date

MEDICATION MANAGEMENT AGREEMENT

This Agreement between _____, ("Patient") and ("Doctor") is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient:

I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

I realize that all medications have potential side effects.

I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity.

I will not attempt to get pain medication from any other health care provider. If my primary care physician is willing to prescribe my medications, the Doctor will make arrangements to transfer my care to my primary care physician.

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

I understand that it is my responsibility to schedule and keep a follow-up appointment with my doctor for all medication refills. Medications will not be refilled over the phone or on a walk-in basis. Refills will not be made if you run out early.

Refills will not be made on an emergency basis.

I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with my regimen of pain control medication.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into on this _____ day of _____, 200 _.

Patient Signature

Physician

Print Signature

Witness

Birth Date

RX POLICY

DO YOU HAVE ENOUGH MEDICATION UNTIL YOUR NEXT VISIT WITH YOUR PHYSICIAN?

It is extremely important that you make sure that you have enough of the medication that you are taking to last beyond your next scheduled visit with your physician. This ensures that you will have continuous access to your medication. For the sake of your good health care, please take a moment with your physician to ensure that you have enough medication.

The policy of physicians at PRI with respect to prescribing (or refilling) medications over the phone is:

- 1. Non-narcotic medications which have been previously prescribed by a PRI physician will be considered for phone renewal if deemed appropriate.*
- 2. Narcotic medications will be refilled ONLY at the time of your appointment.**
- 3. Make your next appointment for triplicate renewal at least one month from today with your doctor to ensure that you will have a visit scheduled in adequate time with PRI.*

Signed _____ Date _____

Print Signature _____

Birth Date _____ Date _____

Witness _____ Date _____

Adding Quality To Life

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical practice, that as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim in the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper addition party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date of notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services. _____

Patient or Patient's Representatives Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Duly Authorized Representative's Signature Date

By: _____
Patient's Signature Date

Print or Stamp Name of Physician,
Medical Group or Association Name

Print Patient's Name

By: _____
Signature of Translator (if applicable) Date

By: _____
Patient's Representative Signature Date

Print Name and Relationship to Patient

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. Your information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy Policies Revision Number _____ .

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At the Pasadena Rehabilitation Institute, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 01/01/2002, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the Pasadena Rehabilitation Institute a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves us a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the Pasadena Rehabilitation Institute, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Pasadena Rehabilitation Institute is required to:

- Maintain the privacy of your health information,

- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Matt Talbot at 626-403-6200 ext. 330.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

OFFICE POLICY

PAYMENT IS DUE WHEN SERVICE IS RENDERED. We will bill most insurance companies for you as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to you, e.g. physician consults, epidurals, facet blocks, IDET. Any deductibles, co-payments, or balances not paid by the insurance company are your financial responsibility. This applies to all insurances including Medicare.

CO-PAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED. Insured patients are responsible for all charges not paid by the insurance company within 45 days after the date of service. Payment arrangements can be made on an individual basis AT OUR DISCRETION. We reserve the right to withdraw the extension of credit.

CANCELLATION POLICY. Patients who fail to cancel an appointment within 24 hours of the appointment time will be subject to a \$50.00 fee billed directly to the patient.

RETURNED CHECKS POLICY. PLEASE BE ADVISED THERE IS A SERVICE FEE OF \$25 ON ALL RETURNED CHECKS.

PATIENT AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS. I agree to pay reasonable attorney's fees and costs should legal proceedings be necessary to collect any portion of the bill or to enforce this agreement. I also agree to permit any Physician to consult with any other Physician should he/she believe it necessary and I agree to pay for said consult. If any surgical procedures are to be performed, I authorize my Physician to engage the services of another Physician and I agree to pay for said services. I hereby authorize my Physician to release any information acquired in the course of my examination and treatment. I further authorize payment of insurance benefits to be paid directly to my Physician.

AGREEMENT TO DISCLOSE INFORMATION. I hereby state that my ailment, injury (ies), etc., are not due to any type of personal injury, motor vehicle accident, etc., for which I am seeking damages. I agree that if at any time after receiving treatment as a direct result of any type of motor vehicle accident or personal injury, I will disclose this information to Pasadena Rehabilitation Institute and sign the appropriate lien (s) in favor of Pasadena Rehabilitation Institute. I understand that the disclosure of insurance and other information is necessary in order that the services I receive are paid in full. The non-disclosure of the information to Pasadena Rehabilitation Institute pertaining to my legal case for said injury might make me personally responsible for all charges incurred at Pasadena Rehabilitation Institute.

Initial _____ **CONSENT TO TREATMENT.** I understand that the treatment to be received by me at Pasadena Rehabilitation Institute will be administered only upon full and complete disclosure of benefits, potential risks, and complications of said treatments, and that my informed consent to the treatment to be received by me will not be obtained prior to my receiving said treatment. The medical doctors working at Pasadena Rehabilitation Institute are not employed by Pasadena Rehabilitation Institute. Each of the physicians working at Pasadena Rehabilitation Institute uses his or her independent medical judgment when providing you with medical care. The physician seeing you and not Pasadena Rehabilitation Institute is responsible for the medical care you receive at Pasadena Rehabilitation Institute.

I declare under penalty of perjury under the laws of the State of California that I have read the foregoing, that I understand it, and that by executing this document on this ___ day of _____, 201___, in the City of Pasadena, I accept and agree to its contents.

Patient's Signature _____ Date of Birth _____

Print Name _____ Date _____

Parent/Guardian _____ Date _____