CoastalSpine

Dear Patient,

Welcome to Coastal Spine, PC. Our staff is looking forward to meeting you. In order for our doctors to perform a comprehensive assessment on this visit. We must have all information pertinent to your condition.

Please bring the following:

- **License/Photo ID**
- **Health Insurance Cards**
- **Completed Registration Forms**
- **Co-payment** (if applicable)
- **Medication List**
- **ACTUAL Films/CD** (MRI, CT Scans, X-rays, etc.)

If this is related to an auto accident, please bring a copy of your policy declarations pages with your motor vehicle insurance carrier.

Thank you,
CoastalSpine, PC

Appointment Day: ____

Appointment Time: ____

Physician: ____

OFFICE LOCATIONS:

- 4000 Church Road, Mount Laurel, NJ 08054
  Ph:(856) 222-4444 Fax: 856-222-0049

- 102 Heritage Valley Drive, Suite C, Sewell, NJ 08080
  Ph:(856) 222-4444 Fax: 856-740-5363

- 408 Chris Gaupp Drive, Suite 250, Galloway, NJ 08205
  Ph:(856) 222-4444 Fax: 856-222-0049

- 1868 Hooper Avenue, Suite 1, Toms River, NJ 08753
  (Shore Sports Medicine) (Foot and Ankle Associates of Central NJ)
  Ph:(856) 222-4444 Fax: 856-222-0049

- 622 Eagle Rock Avenue, 3rd Floor, West Orange, NJ 07052
  (Inside JAG PT)
  Ph:(856) 222-4444 Fax: 856-222-0049

CoastalSpine

DEMOGRAPHICS

First Name: ____________________ Last Name: ______________________ Sex: Male Female Other___________

Address: ____ City:_______________ State______Zip Code:__________

Home Phone:___________________ Cell Phone:___________________ Email:_________________________________

Date of Birth: ______________ Social Security Number:___________________ Marital Status: _____________________

Primary Language: English Spanish Other:______________

Pharmacy Name: _________________________ Address:____

Primary Doctor: _____________________________ Referring Doctor:______________________________________

INSURANCE INFORMATION

Date of Accident (if applicable):_______________ Type of Accident: Auto Health Workers Comp

Primary Insurance Name:____ Auto Health Workers Comp

Phone #:__________________________ Adjuster:_____________________________ Ext:____________

Claim or ID#:_____________________________________ Subscriber:__________________________

Relationship:__________________ Subscriber Date of Birth:_______________ Subscriber SS#:______________________

Secondary Insurance Name:____ Auto Health Workers Comp

Phone #:__________________________ Adjuster:_____________________________ Ext:____________

Claim or ID#:_____________________________________ Subscriber:__________________________

Relationship:__________________ Subscriber Date of Birth:________________ Subscriber SS#:______________________

Tertiary Insurance Name:____ Auto Health Workers Comp

Phone #:__________________________ Adjuster:_____________________________ Ext:____________

Claim or ID#:_____________________________________ Subscriber:__________________________

Relationship:__________________ Subscriber Date of Birth:______________ Subscriber SS#:______________________

ACCIDENT INFORMATION

Is there a lawsuit pending related to your injury? (Circle) YES NO

Attorney Name:_________________________ Firm:_______________________ Phone #:________________________

Employer Name:_________________________ Phone #:___________________

Is your pain the result of a: (Circle) Fall Injury on the job Motor Vehicle Accident Other: _______________________

What is the date of the injury?__________________

Did you have a history of neck pain prior to this injury or accident? (Circle) YES NO

If yes, what treatment have you had?____

Did you have a history of low back pain prior to this injury or accident? (Circle) YES NO

If yes, what treatment have you had? ____

<u>**PLEASE FILL OUT THE BELOW IF YOU WERE INVOLVED IN AN AUTO ACCIDENT ONLY:**</u>

(Circle) if you were the ***Driver*** or ***Passenger***? Where you wearing a seat belt? YES NO

Did the police come to the scene? YES NO Did the airbags deploy? YES NO

Did the ambulance come to the scene? YES NO If yes, what hospital/city did you go to?______________________

Did they perform any imaging? YES NO If yes, what testing did you have? ________________________

<u>EVERYONE</u> PLEASE SIGN ONE OF THE BELOW FOLLOWING STATEMENTS:

1 This injury is **<u>NOT</u>** related to an auto accident, work injury or slip and fall. There is no litigation pending regarding this injury.

Patient Signature ___________________________________ Date __________________________

2. This injury **<u>IS</u>** related to an auto accident, work injury, or slip and fall. *<u>I have provided Coastal Spine, P.C. with all claim and litigation information pertaining to this injury.</u>*

Patient Signature ___________________________________ Date__________________________

HISTORY AND PRESENT ILLNESS

Current Height: ___________ Current Weight: ____________

Do you have any allergies? (Circle) YES NO

If yes, please list them: ______________________________

Medical History:
(Circle all that apply)

Heart Attack	Pacemaker	Stroke	Embolism	Hypertension
Diabetes	A-Fib	Clots	Cancer	Infection
Cholesterol	Thyroid	COPD	Other_____________________	

Surgical History

Date	Type

Family History: *Please indicate who (Father, Mother, Sibling, Grandparent, etc.)*

Heart Attack ________________________________
Stroke________________________________
COPD________________________________
Hypertension________________________________
Diabetes________________________________
A-Fib________________________________

Clots________________________________
Infection________________________________
Cholesterol________________________________
Thyroid________________________________
Embolism________________________________
Cancer________________________________

Social History:

List any Recreational Drugs you are taking? ______________________________
Smoke: (Circle) YES NO If Yes: _____ packs per (Circle) Day | Week | Month
Are you prescribed marijuana? YES NO
Alcohol: (Circle) YES NO If Yes: _____ drinks per (Circle) Day | Week | Month

Present Illness:

Which of the following describes you currently? (Circle) Working Not Working Unemployed Retired Disabled Student
Job requires: (Circle) Lifting Standing Sitting
How long can you: Sit? ____________ Stand? ________________ Walk? _______________

What medicine for your pain has failed?______________________________

Circle what you are seeing us for:

Neck Mid Back Low Back Right Leg Left Leg Right Arm Left Arm

Do you have weakness? (Circle) YES NO If yes, where? ___________________________

Are you experiencing numbness? (Circle) YES NO If yes, where? ___________________________

Have you lost control over your bowel or bladder? (Circle) YES NO

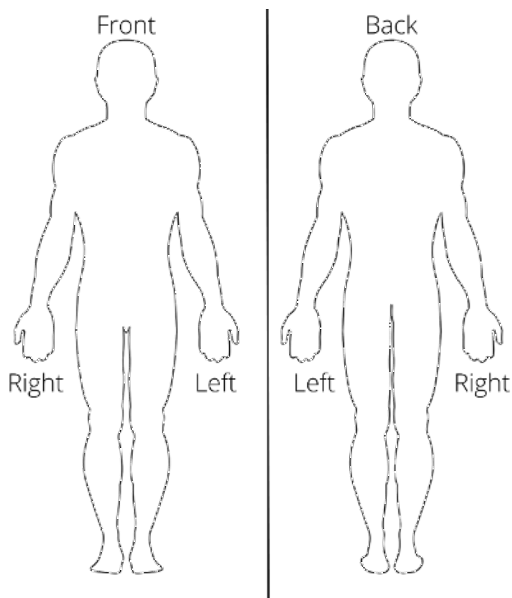
What testing/treatment have you had? (Circle)

MRI CT Scan X-Rays EMG Bone Scan Chiropractor Bracing TENS Unit

Have you had Physical Therapy? (Circle) YES NO Did it help? YES NO # of Weeks ___________
Have you had Chiropractor care? (Circle) YES NO Did it help? YES NO # of Weeks ___________
Have you had an Epidural? (Circle) YES NO Did it help? YES NO How many? ____________
Pain Management Doctor: _____________________________ City: _________________

MEDICATIONS: *Please Include Over the Counter Vitamins*

	Name	Dose	Amount	Frequency
Ex.	Lipitor	40mg	1	Twice a day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				



Draw on the body diagram using the following abbreviations where your pain is located:

Ache = A
Pins and Needles = P
Burning = B
Stabbing = S
Numb = N
Other = O

Circle your pain level on a scale of 1 to 10.
10 being unbearable, or the worst imaginable, pain.

1 2 3 4 5 6 7 8 9 10

Review of Systems: *(Circle all that apply)*

Headache	Chest Pain	Cough	Incontinence	Transfusions
Dizziness	Weakness	Weight Gain	Arthritis	Hepatitis
Memory Loss	Rapid Beat	Urinary Burning	Depression	Bladder Incontinence
Numbness	Edema	Wheezing	Bleeding Bowel	Shortness of Breath
Blurriness	Diarrhea	MRSA	AIDS/HIV	Swallowing Issues
Deafness	Weight Loss	Insomnia	Anxiety	Other: ___________
Ringing	Cough Blood	Constipation	Fatigue	

I consent that all the above is accurate to the best of my knowledge.

Patient Signature ____ Date ______________________________

Financial Responsibility / Consent for Treatment

RELEASE OF INFORMATION
I authorize Coastal Spine, P.C. to release or disclose to any insurance company, governmental agency, managed care organization or any other entity or person who may be required to pay all or part of the costs of my treatment, all medical records or other information from Coastal Spine, P.C. records relating to my identity, diagnosis, prognosis and treatment. I understand that the specific type of information to be disclosed may include, but is not limited to diagnosis, discharge summary, history and physical, progress notes, doctors' orders, laboratory, operative and/or radiology reports, nurses' notes, consultations. The purpose of this disclosure is to enable Coastal Spine, P.C. to secure payment of my physician bill from such insurance companies, governmental agencies, managed care organizations or other entities that may be required to pay on my behalf. I authorize Coastal Spine, P.C. to release my medical record information to any physician or caregiver participating in my care while I am being treated at Coastal Spine, P.C. and to any physician or caregiver involved in my continuing care. For Worker's Compensation, I give consent to release to my employer all medical records or other information from Coastal Spine, P.C. records relating to my identity, diagnosis, prognosis and treatment (including follow-up visits and related additional treatment or related testing) for any employment-related testing/injury/illness.

REVOCATION
This consent is subject to revocation (withdrawal) at any time except to the extent that Coastal Spine, P.C. has released or disclosed information because I have signed this consent. If I do not revoke this consent in writing, it will terminate one year from date of signature. I understand that this consent shall operate as a complete release of liability to Coastal Spine, P.C., its trustees, officers, employees and agents for the release of the information authorized to be released on this form.

DISCLOSURE OF FINANCIAL INTEREST
As per the Principles of Medical Ethics of the American Medical Association (H-140.984), the physicians at Coastal Spine, P.C. are required to inform their patients that they do hold a financial interest in Radiology services provided at Coastal Spine, P.C. The physicians may also have financial interest in other services such as Fellowship Surgical Center and various device companies that may be used in your treatment.

Please be reminded there is video surveillance in and around the building.

I acknowledge the receipt of the Coastal Spine, P.C. privacy policy, and I am aware that the privacy policy is available at the front desk for review.

PATIENT SIGNATURE: ____

PERSON SIGNING ON PATIENT'S BEHALF: ____________________________________

PARTICIPATING HEALTH INSURANCE PLANS
CoastalSpine, P.C. participates with the following health benefits plans: AmeriHealth Administrators, Independence Administrators, Independence Blue Cross, Independence Personal Choice, Keystone Health Plan East, QualCare and Medicare. *IF YOUR INSURANCE IS NOT LISTED, PLEASE SIGN THE OUT-OF-NETWORK ANDVANCE PATIENT NOTICE FORM.*

FACILITY AFFILIATIONS
CoastalSpine P.C. physicians are affiliated with the following health care facilities: Fellowship Surgical Center, Jefferson Health System of Cherry Hill, NJ, and Virtua Health System of Voorhees, NJ.

CONSENT FOR TREATMENT
I authorize the medical staff, employees and contracted healthcare providers of Coastal Spine, P.C. to provide necessary medical treatment to me, including routine laboratory tests, diagnostic procedures and medical care. Physician, nursing or other healthcare personnel who are in training may be observing and participating in my care under the supervision of Coastal Spine, P.C. and I hereby give my consent to such observations and/or participation.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY
I acknowledge that I have been provided with a copy of Coastal Spine, P.C.'s Assignment of Benefits and Financial Responsibilities form, which is effective as of today's date.

PATIENT SIGNATURE: ________________________________ **DATE** ______________

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY FORM
FOR ALL HEALTH INSURANCE & MVA/PIP

Assignment of Benefits and Claims

I hereby assign and transfer to Coastal Spine, P.C. and/or its physicians all of my rights, title and benefits payable by my insurance carrier and/or benefits plan for services performed by Coastal Spine, P.C. and/or its physicians.

I hereby authorize Coastal Spine, P.C. and/or the physicians to submit claims to my insurance carrier or intermediary for all services rendered by Coastal Spine, P.C. and/or its physicians and to exercise any appeals and other rights under my policy or benefits plan on my behalf.

I authorize and assign to Coastal Spine, P.C. and its physicians the right to file suit and to obtain counsel and enter into legal or other actions on my behalf and/or in my name, including arbitration/dispute resolution processes, for any claims against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor or third party.

I authorize Coastal Spine, P.C. and/or its physicians to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits and all other insurance benefits through the carriers themselves, plan administrator, payor or third party. I authorize Coastal Spine, P.C. and/or its physicians to obtain an attorney to represent me directly in appealing a claim to the appropriate state or Federal Agency for all state and federal plans.

I authorize Coastal Spine, P.C. and/or the physicians to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I direct my insurance carrier, or its intermediaries, to issue a payment check directly to Coastal Spine, P.C..

If my insurance carrier will not directly pay Coastal Spine, P.C. and/or its physicians, I authorize and direct the insurance company to send all checks and copies of Explanation of Benefit forms in connection with the services of onset date of service to present to my home address and/or the billing company and/or the attorney representing Coastal Spine, P.C. and/or the physicians so that we may forward checks to Coastal Spine, P.C., 4000 Church Rd, Mt Laurel, NJ 08054. All such checks must be made out to me and Coastal Spine, P.C. jointly.

If my insurance carrier requires a referral prior to commencement of treatment, I agree to obtain this prior to any examination or treatments.

Financial Responsibility

I understand that I am responsible for co-payments, deductible payments, and other charges not covered by my health care benefits. It is my responsibility to notify Coastal Spine, P.C. of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by Coastal Spine, P.C. of the health insurance company if the submitted claims or any part of them are denied for payment.

In the event that I receive direct payment from my carriers or benefits plan of any amounts due to Coastal Spine, P.C. and/or its physicians for services rendered, I agree to forward immediately to Coastal Spine, P.C. any checks made payable to me. I agree to notify Coastal Spine, P.C. upon receipt of such check and to endorse the checks appropriately "Pay to the Order of Coastal Spine, P.C.." and immediately mail the check and any Explanation of Benefits to Coastal Spine, P.C., 4000 Church Rd, Mt Laurel, NJ 08054, keeping copies of the check and Explanation of Benefits for my record.

Coastal Spine maintains the right to collect from the patient and may intiate collection efforts against me. I agree that I am responsible for all collection costs incurred, including but not limited to, attorney fees, interest, expert fees and/or court costs.

I have read and understand the terms and conditions of the ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY outlined above and accept full responsibility for this account. I understand my signature below creates a valid contract between the patient and the provider.

PRINTED PATIENT NAME: ____

AUTHORIZED SIGNATURE: ____ **DATE**:________________

WITNESS: ______________________________________

NAME & RELATION OF PERSON PROVIDING AUTHORIZATION ____________________________________
(if different from patient):

OUT-OF-NETWORK ADVANCE PATIENT NOTICE FORM

CoastalSpine P.C is out-of-network with your insurance company. By coming to CoastalSpine P.C. you are seeking out-of-network services.

By placing my signature on this waiver form below, I acknowledge the following:

- I am aware that Coastal Spine, P.C., is out-of-network and does not participate with my insurance company.
- I understand that the amount or estimated amount that Coastal Spine, P.C. will bill for the services to be provided is available upon my request. If requested, Coastal Spine, P.C. will provide me with the Current Procedural Terminology (CPT) codes and charges associated with the services that I am expected to receive, absent unforeseen medical circumstances that may arise. I understand I can contact my insurance company with the given CPT codes to help provide me a better understanding of what my insurance company will agree to pay, and what my responsibility may be.
- I understand that I am financially responsible for the costs applicable to my health care services in excess of my copayment, deductible, or coinsurance.
- It is advised that I contact my insurance carrier before obtaining services:
  - i) for further consultation on costs and ii) to obtain prior authorization if needed.
- I understand that associated services may also be out-of-network. If I am to receive anesthesiology, laboratory, pathology, radiology, or assistant surgeon services, I was provided with the contact information for those providers. I understand that I should contact my insurance carrier to determine the related costs and the network status of these additional providers.
- I am now knowingly, voluntarily, and specifically selecting Coastal Spine, P.C. as my provider on an out-of-network basis.

You may receive checks and explanations of benefits directly. If you have an insurance company that process checks and correspondence to the member, you will be required to comply with the guidelines below. If those guidelines are not met, you will be responsible for payment in full of Coastal Spine, P.C.'s fees, and Coastal Spine, P.C. reserves the right to forward all outstanding account balances to an outside collection agency. Once the account is transferred to the collection agency the total account balance **WILL BE THE PATIENT'S RESPONSIBILITY. If the patient defaults on payment and the matter is deferred to a collection agency the patient shall be liable for and any all legal/attorney fees and costs.**

- All checks AND correspondence MUST be forwarded to our office within **10 days of receipt. If you receive Explanations of Benefits without checks they also must be forwarded,** including denials, so that we may investigate. We must receive the detailed pages.
- It is the patient's responsibility to request replacement explanations of benefits if they have been misplaced. Coastal Spine, P.C. cannot process payments without Explanations of Benefits. The patient may also need to request their policy documentation from insurance.
- If Coastal Spine, P.C. does not receive insurance checks and all Explanations of Benefits from you, you will be responsible for payment of the TOTAL outstanding account balance. Our agreement to accept your deductible amount and not bill you for the coinsurance is contingent upon your compliance with the terms and conditions stated above.
- The patient is ultimately responsible for any and all unpaid or denied services regardless of deductible and co-insurance agreements stated above as noted in the **Assignment of Benefits and Financial Responsibility** form in the required New Patient packet. If your insurance company refuses to pay for services for any reason, the patient understands that they are personally responsible for any unpaid charges which would void the deductible and co-insurance agreement.
- The patient is **required** to assist in the appeal process and may be asked to provide an authorized signature to consent to appeal on your behalf. No assistance may result in full balance billing.
- Failure to comply with this procedure will result in cancellation of future appointments with our physicians or therapists and prescriptions.

Please enter your signature below stating that you understand and will comply with the above agreement.

______________________	______________________	______________
(Printed Name)	(Signature)	(Date)

______________________ ______________________

(Witness) (Name & relation of person providing authorization if different from patient):

Member Consent for Provider to File an Appeal on my behalf with Health Insurance Plan

1. Provider Name: ___Coastal Spine, PC____
2. Provider Plan ID Number: __01-0767058____________________________________
3. Provider Address: _4000 Church Road Mount Laurel, NJ 08054____________________
4. Provider Phone Number: _(856) 222-4444_____________________________________
5. Description of services that are being appealed:
   ____

   ____
6. Date(s) services were or are to be provided: ________________________________
7. I agree to allow this health care provider to file an appeal on my behalf with the following health plan, if there is a question about coverage for the services listed above.
8. I understand that:
   - If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
   - I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
   - This consent shall be automatically rescinded if my health care provider does not file an appeal, or discontinues my appeal.
   - I have read this consent or have had it read to me, and it has been explained to my satisfaction.
9. I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Please fill out the information below:

a. Member Signature: ___________________________ b. Signature Date: ________________

c. Print Member Name: _________________________ d. Member Date Of Birth: __________

e. Health Insurance Company: ____________________ f. Member ID#: __________________

g. Member Address: ____

____

CoastalSpine

Opioid (Narcotic)Agreement/Contract

I understand in order to receive care for the treatment of pain at CoastalSpine, I **MUST** comply with the following rules:

1. I **UNDERSTAND** that narcotic and controlled drug prescriptions are **MY RESPONSIBILTY** once they are given to me. I **UNDERSTAND** that if anything happens to this prescription (i.e. lost, stolen, flushed down the toilet, etc.) I am personally responsible, and the physician and physician assistants **WILL NOT** rewrite the prescription until the designated time.
2. Prescriptions **WILL NEVER** be refilled after hours or on the weekends.
3. All prescriptions should be obtained at the **SAME PHARMACY**. Should the need arise to change pharmacies, CoastalSpine must be informed.
4. I **WILL** take medications at the dose and frequency prescribed. Any changes in the dose or frequency will be discussed with my physician and/or physician assistants at CoastalSpine. If my medications are prescribed on an every six-hour basis, I **WILL** take these medications every six-hours. I **UNDERSTAND** that if I use more than the allowed amount or use up my medication before my appointment date, **NO ADDITIONAL MEDICATION WILL BE GIVEN**.
5. I **WILL** receive prescriptions at the interval determined by the physician or physician assistants at CoastalSpine.
6. I **WILL NOT** receive controlled substances for the treatment of pain from any other source.
7. I **WILL** consent to random drug testing. **I will NOT drink any alcoholic beverages with pain medications.** I will **NOT** use any illegal substances (cocaine, heroin, crystal methamphetamine, PCP, ecstasy, ketamine, etc) or use any other controlled substances which are not prescribed from our practice while being treated with controlled substances at CoastalSpine. Refusal of such testing or positive results will result in prompt termination of care from CoastalSpine.
8. I **UNDERSTAND** taking both narcotic medications and Benzodiazepines (Valium, Ativan, Xanax, Klonopin, Restoril, Prosom, etc.) is **PROHIBITED**. Due to potential serious side effects.
9. I **WILL** safeguard my prescribed medications. I understand that these medications may be lethal or hazardous to a person that is not tolerant to its affects, especially a child.
10. I **UNDERSTAND** that there is a possibility of impairment of thought processes, especially if this narcotic is combined with a sedative, a sleeping pill, tranquilizer or alcohol.
11. I **UNDERSTAND** the possible adverse effects and dependencies associated with these medications. Overdose of medication may result in injury or possible death. Other side effects may include, but are not limited to constipation, difficulty in urination, fatigue, drowsiness, nausea, itching, loss of appetite, confusion, sweating, flushing, sexual dysfunction, and or depressed respiration.
12. I **UNDERSTAND** that if I plan to become pregnant or become pregnant, I have to inform the physician or physician assistants at CoastalSpine immediately. I **UNDERSTAND** that if I become pregnant, a child WILL likely be physically dependent at birth if I continue narcotics.
13. You are expected to **INFORM OUR OFFICE** of any new medications or medical conditions, and of any adverse effects, you experience from any of the medications that you take.
14. I **UNDERSTAND** that changing date, quantity or strength of medication or altering a prescription in any way, shape, or form is against the law. Forged signatures are also against the law. If there is a violation, this will be reported to the patient's pharmacy, local authorities and DEA.
15. I realize that it is **MY RESPONSIBILITY** to keep others and myself from harm, including safety of driving and the operation of machinery.
16. I **UNDERSTAND** continuous cancelation of appointments will ultimately lead to no prescriptions and a discharge from CoastalSpine.
17. I **UNDERSTAND** if I violate this contract, all medications from CoastalSpine **WILL** thereafter **CEASE**.
18. I **UNDERSTAND** post-op surgery, my physician or physician assistants will determine when to cease medications.
19. I **UNDERSTAND** this mode of treatment will be stopped if any of the following occurs:
    a) I giveaway, sell, or misuse the medication or use other people's medication or illegal substances;
    b) I am noncompliant with any of the terms of this contract;
    c) I disrespect or harass any CoastalSpine personnel;
    d) I do not follow up regularly or as requested by my physician, physician assistants.

I **UNDERSTAND** to request prescription refills, all calls will be made **48-72 hours prior** to needing a refill, and a message will have to be left on CoastalSpine's **PRESCRIPTION REFILL LINE**, promt 3, during regular business hours Monday-Friday 9am-4pm. (excluding holidays). You will receive an automated call from CoastalSpine if an electronic script was sent.

YOU ARE INFORMED that you have the right and power to sign and be bound by this contract, and that you have read, understand and accept all of its items. If our physicians feel that you do not require further surgery or injections; but you are in need of long term medication, be assured that we will direct you to another pain management physician to help you cope with your condition.

Print Name ______________________ Patient Signature ______________________ Date ______________

CoastalSpine

Authorization for Health Information Disclosure
4000 Church Road, Mount Laurel, NJ 08054
Phone: (856) 222-4444 Fax: (856) 222-0049

PATIENT INFORMATION

Patient Name: ____________________________ Date of Birth:_______________ Phone: _________________

Street Address: ____________________________ City: _________________ State: __________ Zip Code: ___________

REQUESTOR/RECIPIENT INFORMATION

I give permission to disclose the following information from my health records to Coastal Spine. Any information listed below that is not checked off may not be released. I give consent for the following information to be released.

I give permission for CoastalSpine to disclose the following information from my health records. Any information listed below that is not checked off may not be released. I give consent for the following information to be released.

(Please circle)

Complete Health Record | History and Physical Examinations | Consultations Reports | Progress Notes
Imaging Reports/ Imaging Films | Discharge Summary | Laboratory Results | Billing Statements

Specify dates of treatment/notes if applicable: ____________________________ Other:________________________________

I also give my consent for messages from CoastalSpine to be released to:

Spouse/Family Member	Doctor	Attorney	Other
Name: ____________________	Name: ___________________	Name: ___________________	Name: ___________________
Phone:____________________	Phone: ___________________	Phone: ___________________	Phone: ___________________
	Fax: ___________________	Fax: ___________________	Fax: ___________________

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the above-named health care provider/health plan authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary and is not a condition of treatment, payment, enrollment or eligibility for benefits. I understand that if I have any questions about disclosure of my health information, I may contact the healthcare provider/health plan listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

____ ______________________________
Signature of Patient or Authorized Representative | Date

____ ______________________________
Description of Representative's Authority (witness signature required) | Signature of Witness

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Purpose: *This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.* ***You may review our Notice of Privacy Practices posted in the waiting room or view a copy on our website; www.coastalspine.com ***

I have reviewed an available copy of this office's Notice of Privacy Practices. * You have the right to refuse to sign this document*

______________________________ ______________________________ ____________________
(Please Print Name) | (Signature) | (Date)

Office Use Only:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but the acknowledgement could not be obtained because:
☐ Communications conflicts prohibit us from obtaining the acknowledgment
☐ The patient or individual refused to sign this document
☐ An emergency situation prevented us from obtaining acknowledgment
☐ Other (Please Specify) ______________________________