Charles J. Nivens, M.D. ***Spine Medicine***
Phone 843-705-7471
Fax 843-705-7475
Website: www.nivensspine.com

PATIENT INFORMATION

Last name:	First:	Middle:	Marital status:
Email Address:			

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Birth date:	Age:	Sex: ○ M ○ F
Address:				

Social Security #:	Home phone no.:	Cell phone no.:
Reason for visit (Type of illness or injury):	Date of injury:	Language:

Do you have an Advanced Care Plan? If so, which type? (Circle One)

Living Will Durable Power of Attorney for Healthcare Do Not Resuscitate (DNR) Order
Do Not Intubate None

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist)

The person who comes to our office for medical care is responsible for the charges unless a third-party payer is authorized in advance. There is a $185.00 minimum payment required at the time of the initial visit for our self-pay patients ($60 deposit payable at time of scheduling for self-pay patients) (No Insurance, No MVA, and No WC), and it will be cash or $200 credit card. All co-pays and deductibles are due at the time of service. Patients will be charged a $40 no-show fee for missed appointments that have not been cancelled within 24 hours of said appointment.

Method of Payment:

○ Medicare ○ Insurance ○ Worker's Compensation ○ Letter of Protection (Attorney Case)

☐ Self-Pay ☐ Cash ☐ Check ☐ Credit Card ☐ Other

Name of PRIMARY insurance:	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:			

Name of SECONDARY insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Charles J. Nivens, MD PA or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures:
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Charles J Nivens, MD PA. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

(continued on next page)

Individual Rights
You have certain rights under the federal privacy standards. These include:

1. the right to request restrictions on the use and disclosure of your protected health information
2. the right to receive confidential communications concerning your medical condition and treatment.
3. the right to inspect and copy your protected health information/
4. the right to amend or submit corrections to your protected health information
5. the right to receive an accounting of how and to whom your protected health information has been disclosed.
6. the right to receive a printed copy of this notice.

Charles J Nivens, MD PA Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revise notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information by submitted in writing. You may obtain a form to request access to your records by contacting our receptionists or our office manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
Charles J Nivens, MD PA
Post Office Box 3828
Bluffton, SC 29910

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.
Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is:

Office Manager
Charles J Nivens, MD PA
Post Office Box 3828
Bluffton, SC 29910

Effective Date: This notice is effective on or after April 14, 2003

Acknowledgement of Receipt of Notice of Privacy Practices

Charles J Nivens, MD PA reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Charles J Nivens, MD PA

Patient Name (Printed): _____ Date_____

Signature_____

To ensure accurate billing and timely processing of your claims, it is your responsibility to provide our office with complete, current, and accurate insurance information at each visit.
This includes, but is not limited to:
• Insurance carrier name
• Member ID and group number
• Policyholder information
• Any changes in coverage or eligibility
Please notify our office immediately of any updates to your insurance coverage.

Important:
If services are rendered and your insurance claim is denied due to incorrect, incomplete, or outdated insurance information provided by you, the patient, you will be held financially responsible for the full cost of those services.
We encourage you to verify your coverage and benefits directly with your insurance provider prior to your appointment.

If you have any questions or need assistance updating your information, please contact our office.
Thank you for your cooperation and understanding.

Patient Signature:_____

Printed Name:_____ Date:_____

HIPAA PERMISSIONS

Please keep in mind, we confirm all appointments 2 -3 days in advance, if we cannot contact you or you do not call back to confirm your appointment, it will be cancelled.

What method can we use to contact you about your appointments?

☐ Phone? Preferred Phone Number_____

☐ Email (notice: our email is not encrypted) Preferred Email _____

May we leave messages on your voicemail with your specific appointment information?

☐ Yes ☐ No

May we release your complete medical records to your referring physician and/or your primary care physician?

☐ Yes ☐ No

I, the patient hereby authorizes Charles J. Nivens, M.D. to release my medical information (appointments, lab/x-ray results, diagnoses. Treatments, medications, surgeries, etc.) Via postal mail, telephone, fax, or email to the following family members:

Name	Date of Birth	Relationship

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor	Phone #	Clinic

Patient Name (Printed): _____

Patient /Guardian Signature: _____ Date: _____

PLEASE HELP US BY ANSWERING THE QUESTIONS BELOW ACCURATELY

Patient Name: _____ Date: _____

Is this appointment related to any type of injury? YES ☐ NO ☐

Were you involved in a Motor Vehicle Accident and your case is still active and open?
YES☐ NO☐

Is this appointment related to your MVA? YES☐ NO☐
If yes: Date of Accident _____
State where Accident happened _____

Were you involved in a work-related accident and your case is still active and open?
YES☐ NO☐

Is this appointment related to your work injury? YES☐ NO☐
If yes: Date of Accident _____
State where Accident happened _____
Have you filed a claim with your employer?
YES☐ NO☐

Worker's Compensation Claim # _____

Worker's Compensation Adjuster Name, Number & Address:
_____
_____
_____

DO YOU HAVE AN ATTORNEY INVOLVED FOR AN INJURY/MVA/WC?
YES☐ NO☐
If you checked yes, please provide us with the attorney's name and phone number. **THIS INFORMATION IS NECESSARY AND A REQUIREMENT TO CONTINUE TREATMENT WITH OUR OFFICE.**

ATTORNEY NAME:
TELEPHONE NUMBER: ( )

PATIENT FINANCIAL POLICY AND PROCEDURE

Introduction:
Dr. Nivens' practice is a professional business providing non-surgical spine medicine including health related diagnostic and therapeutic services. These services are provided to its patients and clients with the expectation of making the profit needed to financially support its employees, to pay its necessary expenses, and to develop future new services.

A professional relationship requires honest financial accountability. This document states the policy by which Dr. Nivens' office will hold itself and its patients and clients accountable

Appointments:
Please contact our office to schedule time to see your Doctor. You can expect to be in our office for approximately 1-2 hours. Walk INS are accepted, if the schedule is booked, we will make every effort to work you in as soon as possible, however, you may have to wait longer than the normal waiting time for scheduled appointments. Please understand that our staff is working very hard to give the best care and would appreciate your patience in this matter.

Confirmation policy:

Due to the nature of patient's problems and the volume of patients in Dr. Nivens practice, the office staff confirms all upcoming appointments. A member of the office staff will call to confirm your appointment. If you cannot be reached by the day prior to your appointment to confirm, your appointment will be cancelled and will have to be rescheduled. Please inform office staff of any changes to your contact numbers to ensure you can be reached.

Cancellation policy:
If you need to cancel an appointment; a 24- hour notice policy applies. Due to the nature of our patient's problems, this will allow us to schedule someone in severe pain in your spot, if we know about the cancellation far enough in advances. There is a $40.00 fee for missing an appointment without a 24- hour cancellation notice.

Charges for Professional Services:
All services will be charged to the patient according to a fee schedule determined by the office Contractual discounts to third party payers, agreed to by the office, will be honored in good faith. No fee or charge can be reduced or waived without the permission of only the administrator or billing manager. Upon request, these fees can be issued to the client.

Monthly statements of payment transactions and the total amount owed will be sent until the debt is totally satisfied.

Payment:
Payment for services is considered the patient's responsibility. All co-payments, co-insurance, balances and deductibles will be collected at the time of service. Dr. Nivens' reserves the right to request payment of the total negotiated fee on the date due unless directed otherwise by contract. Cash, check, money order, and certain credit cards will be acceptable methods of payment.

Non-urgent professional service may be delayed or terminated within the guidelines of good medical practice for bad-faith patient noncompliance with this financial policy.

Insurance:
Health insurance is primarily a contract between the patient and the insurance company. However, Dr. Nivens' office also has contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Dr. Nivens' office will make available substantial resources to facilitate insurance payment and will dedicate its resources towards its own contractual obligations with these entities.

Credit:
Credit will be extended for 60 days to patients with valid insurance policies applicable to the charges for services after

fulfillment of appropriate co-payments. After 60 days, this credit will be revoked, and all payments will be immediately due. It is a SC State law that insurance companies have 60 days after receiving a medical claim to make payment to the provider.

Collection Agencies:
Dr. Nivens' office will use all reasonable means to collect owed funds. Defaults in payment of agreed amounts will be automatically referred to a collection agency for payment.

Responsibilities of the Patient:
The patient is expected to have knowledge of the benefits provided through their insurance carrier or third-party payer. A telephone number on the back of the insurance card can usually be used to obtain this information.

At each office visit or patient encounter, the patient will provide a current mailing address and telephone number as well as current third-party information necessary for billing purposes. This information must be given to the receptionist upon signing in, or to our medical assistant as the patient is being checked out. The doctor will need to know the identity of the insurance company to make proper referrals under the managed care contract, thus, proper identification is mandatory.

The patient is to contact his or her insurance company if payment is not made within 60 days.

The patient is to immediately make total payment when the debt is due.

The patient is to inform the office if payment arrangements need to be made, due to extenuating circumstances.

Responsibilities of the office:
The office will make a good effort to obtain necessary pre-certifications for requested procedures required by contracted third parties to facilitate approval for payment. Failure to obtain pre-certifications or approval from the insurance company does not necessarily mean that the requested procedure is not medically necessary; in this circumstance, the patient may be financially responsible for services ordered or rendered.

Upon receiving accurate insurance/third party information the clinic will file an appropriate American Medical Association-approved claim to the appropriate entity (for example: insurance company, employer, worker' compensation plan). The office will make a good-faith effort with help from the patient to follow up these claims to facilitate payment.

The office will fairly enforce this policy and procedure upon all patients.

I state that I have read this financial policy and procedure and have been given an opportunity to ask questions. I accept this policy and procedure and will comply with it as part of my professional relationship with Dr. Nivens' offices.

_____
Patient or Responsible Party Printed Name

Patient /Guardian Signature: _____ Date: _____

_____
Witnessed By

Charles J. Nivens, MD, PA Narcotics Policy

Taking pain pills can sometimes prolong the pain that you are in. If narcotics are blocking pain stimulus to your brain when you have injured yourself, you may be more active than you normally would be. At this time, the painful area may feel okay, but when the pain pills wear off, you may find yourself worse in the long run.

Anti-inflammatory pills such as Ibuprofen, Celebrex, or Relafen are much different. They reduce pain by treating the problem--inflammation. They work similar to putting ice on a painful area.

Your brain also makes its own pain blockers called endorphins. They are natural pain reducing chemicals that help block the pain. If you are taking narcotic pain medicine when you begin to have pain, your brain will not make endorphins. This could make your pain worse once the medicine wears off.

All narcotic pain medicines are in the same family as heroin and morphine. Most people become **dependent** on these medicines after ***2-3 weeks*** of taking them. Breaking such a dependency is very difficult. Many patients have this type of problem when they first present to our office. We try not to add to this problem.

Our philosophy is to help your pain, not block your pain. This is usually done best with anti-inflammatory medicines, injections, and rehabilitative therapy. If there is acute pain or pain after an injection, we will give you short term narcotics. Otherwise, we have a No Narcotic Policy. Please do not expect us to refill your pain medications automatically. There is a 24 to 48 hour turn-around on refill requests.

It is important that there is only one physician giving a patient pain medication. If Dr. Nivens prescribes pain medication, then he is to be the only physician doing so. **If a patient is receiving narcotic prescriptions from another physician, this could result in a discharge from Dr. Nivens practice for failure to comply with this narcotic policy.** The patient is to use the pain medication ONLY as prescribed. Patients are NOT to increase their pain medication without first consulting Dr. Nivens.

After Hours Narcotic Policy

There will be no narcotic medications prescribed after the close of the business day. Our office hours are Monday thru Thursday, 8 am- 5 pm and Friday 8 am – 2 pm. All medication requests will be assessed and dispensed with Dr. Nivens' approval, only during these hours. If for any reason you anticipate the need of any narcotic medications over the weekend all requests must be done so within the week, as there will be no requests taken over the weekend.

Pain associated with, or extending from, having an injection is encouraged to be reported, as these situations will be taken care of in a direct and responsive manner. For assistance after hours, you may contact our regular business phone; the answering service will in turn contact Dr. Nivens.

I, _____, have read and understand Dr. Nivens' Narcotics policy.

Patient /Guardian Signature: _____ Date: _____

Medical Questionnaire

Please answer the following questions regarding your past and current medical history and PLEASE MAKE SURE TO PRINT.

1.) Please list any allergies to medications, latex, and/or x-ray or contrast dye (past or present):

☐ NONE

_____

_____

_____

2.) Please list all medications taken on a daily basis including vitamins, supplements and ANY BLOOD THINNERS (i.e. aspirin, Pradaxa, Plavix, coumadin, Warfarin, Brillanta, etc…)

☐ NONE

_____

_____

_____

3.) Please list current Health conditions, (i.e. Heart Disease, High Blood Pressure, Diabetes, GERD, etc…)

☐ NONE

_____

_____

_____

_____

B.) Please list any history of Cancer, if any:

_____

_____

4.) Please list prior epidural steroid injections within the past 12 months with dates.

☐ NONE

_____

_____

_____

_____

5.) Please list past surgeries (minor or Major).

☐ NONE

_____

_____

_____

_____

(continued on next page)

6.) Family History

Arthritis ☐ Osteoporosis ☐ Scoliosis ☐

Chronic neck/back pain ☐ Unknown ☐

7.) Social History:

Alcohol Use: Never☐ Occasionally/Socially☐ Rarely☐ Daily☐

Tobacco Use: Never☐ Occasionally/Socially☐ Rarely☐ Daily☐

Do you have a history of abusing prescription medication? ☐ No ☐ Yes

Any past or present illicit drug use or abuse? ☐ No ☐ Yes

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

Employment Status: Full Time☐ Part Time☐ Self Employed☐
Unemployed☐ Retired☐ Disability☐

Have you ever tested positive for HIV, Hepatitis (A, B or C) or Tuberculosis Test/Screening?

☐ Yes ☐ No

8.) Please list all physicians you see on a regular basis; (Cardiologist, Urologists, Primary Doctor, etc.)

Name	Specialty	Phone Number

Patient /Guardian Signature: _____ Date: _____