Barrington Pain and Spine Institute
600 Hart Road 3rd Floor Suite 300, Barrington, IL 60010; Tel: (847) 810-2000 Fax: 847-842-3708

REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Email_____

Patient Last Name_____First Name_____ Initial_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured Name_____How and where did you learn about this facility?_____
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City _____ State _____ Zip_____Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____Phone_____ Occupation_____ City_____ State _____Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Barrington Pain and Spine Institute all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and facility. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and facility any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and facility in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and facility to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and facility and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and facility in any attempts by such doctor and facility to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and facility against such insurers and/or employee health care plan in my name but at such doctor and facility's expenses. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

Patient Label

Barrington Pain and Spine Institute

PATIENT INFORMATION SHEET

We appreciate you being a patient at our practice. We will try our best to provide you with the highest level of quality care. Our Ambulatory Surgery Center must follow strict guidelines to demonstrate that our organization is committed to quality patient care. As a result of this, for your convenience and safety, we are able to provide you with our own surgical facility suite to perform procedures, rather than sending you to a hospital.

You will receive three explanations of benefits (EOBs) from your insurance for your procedure. These are NOT bills but only explanations of benefits paid and allowed by your insurance. Your insurance company will send one EOB for your physician, one for the ambulatory surgical facility (Barrington Pain and Spine Institute) and one for the anesthesia fee (Pinnacle Anesthesia Ltd.) The facility fee includes utilization of the OR/ Procedure Room, recovery room, all medical surgical supplies and all equipment used. Please note, although your physician may be in your insurance network, Barrington Pain and Spine Institute may not be. And, as the facility may not be in your insurance network, payment due to the facility may be sent to you directly. If that happens, we ask that you contact Barrington Pain & Spine Institute billing service at 773-284-8881 immediately and forward that payment. Your health and pain relief is very important to us so we are not going to deny anyone from receiving the care they need in our facility. We do have an outstanding billing service that may contact you for your help to expedite payment for the procedure. Our outside billing service is extremely diligent in working with your insurance carrier and they may contact you for additional assistance regarding your insurance claim.

If you have any questions regarding your insurance coverage, feel free to call our Barrington Pain and Spine Institute **billing service** at (773)284-8881 for questions relating to your facility bill or call Pinnacle Anesthesia, Ltd., billing service at (847)647-9007 for questions relating to your anesthesia bill. Thank you very much.

I acknowledge that I have read and understand the above information.

_____ _____

Patient Signature Date

_____

Printed Name

_____

Witness Signature

Barrington Pain & Spine Institute™

Place Patient Label Here

Communications Waiver

I, _____, _____/_____/_____,
(Name of Patient or Authorized Agent) (Date of Birth: xx/xx/xxxx)

Hereby request Barrington Pain and Spine Institute to keep communication regarding my health information confidential by adhering to the following communication requests:

Between the hours of 8:30 a.m. and 4:30 p.m.:

Try this phone number 1st: (_____) _____-_____ Ext: _____, which is my: Home ☐ Work ☐ Cell ☐

Try this phone number 2nd: (_____) _____-_____ Ext: _____, which is my: Home ☐ Work ☐ Cell ☐

Try this phone number 3rd: (_____) _____-_____ Ext: _____, which is my: Home ☐ Work ☐ Cell ☐

Before 8:30 a.m., call my: Home ☐ Work ☐ Cell ☐

After 4:30 p.m., call my: Home ☐ Work ☐ Cell ☐

In case of emergency, please provide the name of a contact we may call to provide your medical information:

Emergency Contact Name: _____ Phone (_____) _____-_____

You can leave a message or medical information on my answering machine or voicemail:

Home: Yes ☐ No ☐
Work: Yes ☐ No ☐
Cell: Yes ☐ No ☐

You can leave a message or medical information with the following people

Name: _____ Relationship: _____ Phone (____) _____-_____

Name: _____ Relationship: _____ Phone (____) _____-_____

Signature: _____ Date: _____
(Patient or Authorized Agent)

BARRINGTON PAIN AND SPINE INSTITUTE

HIPAA NOTICE OF PRIVACY PRACTICES ("NOTICE")

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT FURTHER DETAILS HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice describes how our practice and our health care professionals, employees, volunteers, trainees and staff may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. Typically your medical information will include symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

I. Uses and Disclosures of Protected Health Information. Your medical information may be used and disclosed for purposes of treatment, payment and health care operations. The following are examples of different ways we use and disclose medical information. **These are examples only.**

(a) Treatment. We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.

(b) Payment. We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for planned treatment, such as disclosing relevant medical information to the health plan to obtain approval for hospital admission.

(c) Healthcare Operations. We may use or disclose medical information about you in order to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your medical information to remind you of your next appointment. We may share your medical information with third party "business associates" that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that asks the "business associate" to protect the privacy of your medical information. We may use or disclose your medical information to provide you with information about treatment alternatives, case management or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or a prescription refill reminder may be sent to you for a prescription you are currently prescribed or its generic equivalent. We may also send you information about products or services that we believe may be beneficial to you. You may contact **our Privacy Contact** to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our **Privacy Contact** to request that these fundraising materials not be sent to you.

(d) Health Information Exchange. We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange ("Exchange"). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange, we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, payment or health care operations.

II. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object. We may use and disclose your medical information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

(a) Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative or close friend your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

(b) Emergencies. We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.

(c) Communication Barriers. We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use or disclosure under the circumstances.

III. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object. We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

(a) Required By Law. We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

(b) Public Health. We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.

(c) Communicable Diseases. We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

(d) Health Oversight. We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

(e) Abuse or Neglect. We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

(f) Food and Drug Administration. We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

(g) Legal Proceedings. We may disclose medical information in the course of any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

(h) Law Enforcement. We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

(i) Coroners, Funeral Directors, and Organ Donors. We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

(j) Research. We may use and disclose your medical information for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

(k) Criminal Activity. Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

(l) Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

(m) Military Activity and National Security. If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

(n) Workers' Compensation. We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

(o) Inmates. We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information in the course of providing care to you.

(p) Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq. seq.

IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.

(a) You have the right to inspect and copy your medical information. This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format, you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format. After you have made a written request to our Privacy Contact at the following address: 600 Hart Rd., Ste. 300, Barrington, IL 60010, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial. You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact the Privacy Contact if you have any questions about access to your medical record.

(b) You have the right to request a restriction of your medical information. You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

(c) We are not required to agree to your request. If we believe it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid

us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.

(d) You have the right to request to receive confidential communications from us at a location other than your primary address. We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.

(e) You may have the right to have us amend your medical information. If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact, in writing to request our form *Request to Amend Health Information.* In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

(f) You have the right to receive an accounting of disclosures we have made, if any, of your medical information. This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.

(g) Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your medical information not covered by this Notice or required by law will be made only with your written authorization. For example, the following uses and disclosures require your authorization: (1) Most uses and disclosures of psychotherapy notes; (2) Uses and disclosures of PHI for marketing purposes unless (i) the communication occurs face-to-face; (ii) consists of marketing gifts of nominal value; (iii) is regarding a prescription refill reminder that is for a prescription currently prescribed or a generic equivalent; (iv) is for treatment pertaining to existing condition(s)and we do not receive any financial remuneration in either cash or cash equivalent; and/or (v) communication from us to recommend or direct alternative treatments, therapies, healthcare providers or settings of care when we do not receive any financial remuneration for making the communication; and (3) Disclosures that constitute a sale of PHI and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

(h) Right to be Notified of a Breach. You have the right to be notified in the event that our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.

(i) Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by obtaining a *Complaint Form* from our Privacy Contact. All complaints must be in writing. We will not retaliate against you for filing a complaint.

(j) To Contact Us: You may contact us by through our Privacy Contact as follows:

Barrington Pain and Spine Institute
Attn: Privacy/Compliance Officer
600 Hart Road
Suite 300
Barrington, Illinois 60010
847/810-2000 (telephone) 847/842-3708 (facsimile)

By signing this form, you acknowledge receiving this Notice and that you were afforded an opportunity to ask questions related to the content herein.

Signature of Patient _____ Date_____

Print Name of Patient _____

Barrington Pain and Spine Institute - PATIENT'S BILL OF RIGHTS

Reasonable, informed participation in decisions involving your health care is your right. The rights of our patients are an important component of our care for you. We respect your rights and request that you recognize your responsibilities too.

Patient's Rights and Responsibilities

1. You have the right to considerate and respectful care.
2. You have the right to every consideration of your privacy concerning your own medical care program. Case discussion, consultation, exam, and treatment are confidential and should be conducted discreetly. Those not involved in your care must have your permission to be present.
3. You have the right to obtain from your physician completed current information concerning your diagnosis, treatment and prognosis in terms that you can understand. When it is not medially advisable to give such information to you, the information should be made available to an appropriate person on your behalf. You have the right to know, by name, the physician responsible for coordinating your care.
4. You have the right to receive from your physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when you request information concerning medical alternatives, you have the right to such information. You also have the right to know the name of the person responsible for the procedures and/or treatment.
5. You have the right to expect that all communications and records pertaining to your care be treated as confidential unless required by law.
6. You have the right to expect that within its capacity the surgery center must make a reasonable response to the request of the patient for services. The center must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, you may be transferred to another facility only after you have received complete information and explanation concerning the needs for and alternatives to such a transfer.
7. You have the right to obtain information as to any relationship of the surgery center to other health care and educational institutions insofar as your care is concerned. You have the right to obtain any information as to the existence of any professional relationships or financial interests among individuals, by name who are treating you. Doctors John Prunskis, Terri Dallas-Prunskis and Chadi Yaacoub have ownership.
8. You have the right to be advised if the surgery center proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
9. You have the right to expect reasonable continuity of care. You have the right to know in advance what appointment times and physicians are available and where. You have the right to expect that the surgery center will provide a mechanism whereby you are informed by your physician, or delegate of your physician, of your continuing health care requirements following discharge.
10. You have the right to examine and receive explanation of your bill regardless of the source of payment.
11. You have the right to know what surgery center rules and regulations apply to your conduct as a patient.
12. You or your responsible other has the right to be informed of the complaint process at the surgery center. You should report any concerns about your care or safety issues you encountered during your stay. You may contact the nurse manager for information regarding initiation, review, and resolution of your complaints. You may report issues to the Illinois Department of Public Health at 1-800-252-4343, to Joint Commission at 800-994-6610 www.jointcommision.org, or if Medicare related, www.cms.hhs.gove/center/ombudsman.asp or 800-633-4227.
13. You have the right to an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive should provide a copy to the facility and his/her physician. It is the policy of this facility **NOT** to honor an advance directive. Information is available regarding Advance Directives at www.idph.state.il.us/public/books/advin.htm.
14. Your right on reporting of pain will be believed and information will be given about pain and pain relief measures. We are a concerned staff committed to pain prevention and management; health professionals who respond quickly to reports of pain management.

PATIENT IS RESPONSIBLE FOR:

1. Being considerate of other patients and personnel and for assisting in the control of noise, smoking, and other distractions.
2. Respecting the property of others and the facility.
3. You have the responsibility of honoring your financial commitments to the surgery center.
4. You are responsible for observing rules and regulations of the surgery center as they apply to your care.
5. Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
6. Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
7. Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
8. Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
9. Promptly fulfilling his or her financial obligations to the facility.
10. Asking your doctor what to expect regarding pain and pain management.
11. Discussing pain relief options with your doctor.
12. Working with your doctor to develop a pain management plan.
13. Helping your doctor assess pain and tell him if your pain is not relieved.
14. Telling your doctor about any worries you have about taking pain medications.

I have read my rights and responsibilities as a patient at this surgery center and agree to all the above.

Patient_____ **Date**_____ **Date of Initial Receipt of Rights:**_____

Signature

Last Revision: 12.18.2020

Barrington Pain & Spine Institue
600 Hart Road, Ste. 300, 3rd Floor
Barrington, IL 60010

Member Appeal Authorization Form

Date _____

Member Name _____

Member ID# _____

I hereby authorize Barrington Pain & Spine Institute billing representative to appeal (insurance company name) _____ on my behalf.

I further request that you correspond directly with said representative in all aspects of the appeal process. I understand that these communications may include the following confidential information: All medical and financial information contained in my insurance file with regard to my services at Barrington Pain & Spine Institute in connection with the determination that is being appealed. I understand that this information is privileged and confidential and will only be released as specified in this authorization or as required by law. This authorization will be valid for a period of one year.

_____
Signature of member

_____
Signature of witness or designated representative (please circle which one)

_____
Print name of witness / designated representative

_____
Title (if on provider's staff) or relationship to member

Barrington Pain and Spine Institute

Collection of Data for Illinois Department of Public Health

Notice

The following information relating to race/ethnicity and nationality is collected in order to demonstrate compliance with the Illinois Department of Public Health regulations.

The information is in no way used in the evaluation of care of our patients.

Race: (please circle one)

American Indian/Alaska Native
Asian
Black/African-American (not of Hispanic origin)
Hispanic/Latino
Native Hawaiian/Pacific Islander
White (not of Hispanic origin)
Other_____

Nationality: (please circle)

☐ African
☐ American (U.S.A.)
☐ Arabian
☐ Australian
☐ British
☐ Canadian
☐ Chinese
☐ Cuban
☐ Czech
☐ Filipino
☐ French
☐ German
☐ Greek
☐ Indian
☐ Irish
☐ Israeli
☐ Italian
☐ Japanese
☐ Korean
☐ Mexican
☐ Norwegian
☐ Polish
☐ Puerto Rican
☐ Russian
☐ Spanish
☐ Swedish
☐ Turkish
☐ Vietnamese
Other_____