Assignment of Insurance Benefits and Statement of Service (AIBSS).

I authorize Illinois Pain & Spine Institute to receive direct payment of covered insurance benefits, including major medical benefits, from BlueCross/BlueShield, Medicare, Medigap, worker's compensation carriers, and/or other commercial insurance companies. I understand that I am financially responsible for any charges not covered by my insurance, including deductibles, co-insurance, and payments sent directly to me. I agree to pay any outstanding balance for services provided. If my account becomes delinquent and collection efforts are necessary, I agree to pay reasonable collection or attorney fees.

I assign and transfer to Illinois Pain & Spine Institute, to the extent allowed by law and my insurance or employee healthcare plan, any claims or rights I may have to insurance or healthcare benefits for medical expenses incurred. I agree to cooperate with the clinic, as necessary, in pursuing claims against insurers or healthcare plans, including legal action, at the clinic's expense if required.

If any anti-assignment provision exists within my policy or plan, I request written notification within 30 days of this assignment's receipt. If not, this assignment will remain effective and such provisions are considered waived. This assignment is valid for current and future services until revoked by me in writing. A photocopy of this assignment is as valid as the original.

I affirm that my health insurance coverage, including tie-in coverage, is active and disclosed. If prior authorization or certification is required for services, I will provide it.

I authorize the release of medical information necessary to process insurance claims, which may include records related to mental health or substance abuse. Accounts not paid in full within 45 days of becoming the patient's responsibility will incur a $10 monthly rebilling fee for each unpaid month.

Ownership Disclosure: Dr. Chadi Yaacoub and Dr. Hadi Moten have an ownership interest in Pinnacle Anesthesia Ltd.

Missed Appointment/Procedure Policy: Appointments or procedures not canceled at least 48 hours in advance may be subject to a $50 charge for appointments or $100 for procedures.

Prescription Refill Policy: Refills will only be provided during office visits.

I understand and agree to this assignment and its terms. I will promptly notify the office of any changes to my address, health insurance, or worker's compensation carrier.

Print Name: _____

Patient Signature: _____ **Date:**_____

Authorization for Medicare and Medigap Insurance Payment Medigap Lifetime Assignment Agreement

By signing below, I confirm that I have a Medigap insurance policy and authorize the following:

- Payment of Medigap benefits directly to Illinois Pain & Spine Institute for services provided to me.
- Release of medical information to the Health Care Financing Administration and its agents as necessary to determine benefits and process claims for related services.

Medigap Insurance Provider: _____

Signature: _____ **Date:** _____

Communications Waiver

I, _____hereby Illinois Pain & Spine Institute to keep communication regarding my health information confidential by adhering to the following communication requests:

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Emergency Contact

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

Contact Name: _____Relationship:_____

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Other Authorized Personnel:

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

Contact Name: _____Relationship:_____

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Contact Name: _____Relationship:_____

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Would you like to enable this feature?

1. ☐ Text ☐ Email

Print Name: _____

Patient Signature: _____ **Date:**_____

Authorization for Use and Disclosure of Protected Health Information (PHI)

I authorize Illinois Pain & Spine Institute to use and disclose my protected health information (PHI) for purposes related to **treatment, payment, and healthcare operations (TPO)**. For a more detailed explanation of these uses and disclosures, please refer to the Illinois Pain & Spine Institute's "Assignment of Insurance Benefits and Statement of Service (AIBSS)."

I acknowledge my right to review the AIBSS before signing this authorization. Illinois Pain & Spine Institute reserves the right to update the AIBSS at any time. A revised copy of the AIBSS can be requested by submitting a written request to:
Illinois Pain & Spine Institute
431 Summit Street, Elgin, IL 60120
Attn: Privacy/Compliance Officer

I further authorize Illinois Pain & Spine Institute to:

- Contact me by phone at my home or other designated location, leaving messages on voicemail or with an individual, regarding matters that support the practice's TPO activities, such as appointment reminders, insurance information, or details related to my clinical care, including laboratory results.
- Send mail to my home or other designated location, such as appointment reminder cards or patient statements, as part of their TPO activities.
- Send email to my home or other designated location with items that support TPO activities, such as appointment reminders or patient statements.

I understand that I may request restrictions on how Illinois Pain & Spine Institute uses or discloses my PHI for TPO purposes. While the practice is not obligated to agree to my requested restrictions, if it does, it will be bound by those agreed-upon terms.

By signing this form, I consent to Illinois Pain & Spine Institute's use and disclosure of my PHI for TPO purposes. I understand that I may revoke this consent in writing, except where disclosures have already been made based on my prior authorization. I also understand that if I choose not to sign this consent, Illinois Pain & Spine Institute may decline to provide treatment.

Print Name: _____

Patient Signature: _____ **Date:**_____

Illinois PAIN & SPINE INSTITUTE

Contract for Controlled Substance Medication Prescriptions

We are committed to doing all we can to treat your pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of pain and related conditions, all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use.

1. All controlled substances have a potential for dependency and abuse.

2. All controlled substances must come from an Illinois Pain & Spine Institute provider unless specific authorization is obtained for an exception. If controlled substances are obtained from an unauthorized health care provider, the incident may be reported to the primary physician and other authorities.

3. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies our office must be informed. **Pharmacy Name & Location:** _____

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for the purpose of maintaining accountability.

5. I may not share, sell, or otherwise permit others, including spouse or family members, to have access to these medications.

6 Unannounced urine or serum toxicology screens may be requested, and my cooperation is required. The presence of unauthorized substances may result in my discharge from our practice.

7. I will consume minimal or no amounts of alcohol or THC/Cannabis (medical or recreational) in conjunction with narcotics, nor will I use, purchase, or otherwise obtain any illegal drugs. I agree to help myself by trying to change my behavior to include a healthier lifestyle including stopping smoking, diet, weight control and exercise.

8. Medication may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. My report narrating what happened is not enough.

9. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substance administration.

10.Medications are to be taken as directed. I will not increase medication myself. Early refills will not be given. Renewals are based on keeping scheduled appointments. I will not phone for prescription refills; however, I will call to schedule an appointment for that refill.

11.In the event I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.

12.It is understood that failure to adhere to these policies may result in immediate cessation of therapy with controlled substance prescribing by this physician and our practice.

13.I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept its terms.

Print Name: _____

Patient Signature: _____ **Date:**_____

Illinois PAIN & SPINE INSTITUTE

TREATING PHYSICIAN SUMMARY

Please list the NAME, LOCATION and PHONE NUMBER of any of physicians that are currently involved with your healthcare.

PLEASE CHECK OFF WHICH DOCTOR REFERRED YOU TO OUR PRACTICE.

Specialty	Name of Physician	Location	Phone Number
☐ Primary Care:			
☐ Cardiologist:			
☐ Orthopedic:			
☐ Neurology:			
☐ Psychiatry/Psychology:			
☐ Hematology/Oncology:			
☐ Rheumatology:			
☐ OB/GYN:			
☐ Physical Therapy:			
☐ Other:_____			
☐ Other:_____			

Print Name: _____

Patient Signature: _____ **Date:** _____

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, along with 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 outlined in this Notice. We understand that medical information about you is personal and are committed to safeguarding it. This Notice applies to all records of your care generated by our practice.

This Notice also details your right to access and control your medical information. The information about you includes demographic details that may identify you and relate to your past, present, and future physical or mental health or condition and related health care services. Typically, this medical information will include symptoms, examination and test results, diagnoses, treatments, and plans for future care.

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 apply to all medical information we maintain, both current and in the future. If you request, we will provide you with a revised copy, either by mail or in-person at our office.

1. Uses and Disclosures of Protected Health Information Your medical information may be used and disclosed for purposes of treatment, payment, and health care operations. Below are examples of how we use and disclose your medical information.

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 (HIE): 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.

2. Other Permitted and Required Uses and Disclosures We may use or disclose your medical information with your consent or authorization in the following instances, where you have the opportunity to agree or object to such use or disclosure. If you are unable to agree or object, your physician will use professional judgment to determine if disclosure is in your best interest.

a. Others Involved in Your Healthcare: We may disclose your medical information to a family member, relative, or close friend if it directly relates to their involvement in your healthcare. If you cannot agree or object, we may disclose this information based on our professional judgment that it is in your best interest.

b. Emergencies: We may disclose your medical information for emergency treatment. If we are unable to obtain your consent at the time of treatment, we will attempt to get your consent as soon as reasonably possible afterward.

c. Communication Barriers: If we attempt to obtain your consent but are unable to due to substantial communication barriers, we may disclose your medical information based on the reasonable assumption that you intended to consent.

3. Without Your Consent, Authorization, or Opportunity to Object In certain situations, we may use or disclose your medical information without your consent or authorization:

a. Required by Law: We may disclose your information when required by federal, state, or local law.

b. Public Health: We may disclose your information to public health authorities for controlling disease, injury, or disability.

c. Communicable Diseases: If authorized by law, we may disclose information to individuals at risk of contracting or spreading a communicable disease.

d. Health Oversight: We may disclose your information to health oversight agencies for audits, investigations, inspections, and licensure purposes.

e. Abuse or Neglect: If we believe you are a victim of abuse, neglect, or domestic violence, we may disclose your information to the appropriate authorities.

f. Food and Drug Administration (FDA): We may disclose your information to the FDA for adverse event reporting, product defects, or post-marketing surveillance.

g. Legal Proceedings: We may disclose your information in response to a court order, administrative tribunal request, or other

legal processes.

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 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, to determine the cause of death, or to allow them 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: In compliance with federal and state laws, we may disclose your medical information if we believe it is necessary to prevent or lessen a serious and imminent threat to health or safety. We may also disclose information to law enforcement authorities if necessary for the identification or apprehension of a suspect.

l. Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations involved in organ procurement, transplantation, or tissue donation, as necessary to facilitate organ or tissue donation.

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 or similar programs that provide benefits for work-related injuries or illnesses.

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

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 health privacy regulations.

4. Statement of Your Rights with Respect to Your Medical Information This document briefly outlines your rights regarding your medical information and describes how you can exercise these rights.

a. Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy of your medical information that originated in our practice. We may charge a reasonable fee for copying and mailing your records. If we

maintain any portion of your Protected Health Information (PHI) in an electronic format, you have the right to receive this information from us in electronic format. We will charge no more than the actual labor cost to provide electronic versions of your PHI.
To request access to your medical records, send a written request to our Privacy Contact at: 431 Summit St., Elgin, IL 60120 or fax your request to (847)289-0815.
We will process your request within 30 days. If we deny your request, you will receive a written explanation of the denial. Note that you may not have the right to inspect or copy psychotherapy notes. In some cases, you may request a review of the denial decision. If you have questions, please contact our Privacy Contact.

b. Right to Request a Restriction of Your Medical Information: You may request that we not use or disclose part of your medical information for treatment, payment, or healthcare operations. You can also request that we not disclose specific information to family members or friends involved in your care or for notification purposes as described in this Notice.
To request a restriction, you must: State the specific restriction in writing and specify to whom you want the restriction to apply. You also have the right to restrict information sent to your health plan or insurer for services you paid for entirely out-of-pocket, with no claim made to your health plan or insurer.

c. Limitations on Our Ability to Agree to Restrictions: We are not required to agree to your request for restrictions. If we believe that allowing use and disclosure of your medical information is in your best interest, we may not grant your request. However, we must agree to a restriction if the disclosure is for payment or healthcare operations purposes and is not otherwise required by law or the information pertains to healthcare items or services for which you have paid in full and not through your health plan. If we agree to a restriction, we will not use or disclose your medical information in violation of that restriction, except in emergencies.

d. Right to Request Confidential Communications: You have the right to request that we send confidential communications to a location other than your primary address. We will make reasonable efforts to accommodate these requests. Please submit your request in writing to our Privacy Contact.

e. Amendment of Medical Information: If you believe that any of the medical information we have about you is incorrect or incomplete, you may request an amendment. To make this request, please contact our Privacy Contact in writing and request our "Request to Amend Health Information" form. In certain cases, we may deny your request. If we do so, you have the right to file a statement of disagreement with us.

f. Accounting of Disclosures: 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 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 Based on Written Authorization: We will not use or disclose your medical information for purposes not covered by this Notice or required by law without your written authorization. Examples of such disclosures requiring your authorization include; most uses and disclosures of psychotherapy notes, uses for marketing purposes, unless specific conditions are met (e.g., face-to-face communication, nominal value gifts, certain prescription refill reminders, etc.), & disclosures that involve the sale of PHI. You may revoke your authorization at any time, except where we have already relied on it to take action.

h. Notification of Breach: You have the right to be notified if we (or our Business Associate) discover a breach of your unsecured protected health information.

i. Complaints: If you believe your privacy rights have been violated, you can file a complaint with us or the Secretary of Health and Human Services. To file a complaint with us, obtain a Complaint Form from our Privacy Contact. All complaints must be in writing. **Note:** We will not retaliate against you for filing a complaint.

Contact Information:
Illinois Pain & Spine Institute
Attn: Privacy /Compliance Officer
431 Summit St.
Elgin, IL 60120
P (847)289-8822 F (847)289-0815

Acknowledgment
By signing below, you acknowledge that you have received this Notice of Privacy Practices and had the opportunity to ask questions related to its content.

Print Name: _____

Patient Signature: _____ **Date:** _____