HURAIBI
PAIN & REHAB INSTITUTE PLLC

The CRPS INSTITUTE of Michigan

13530 Michigan Avenue, 1st Floor
Dearborn, MI 48126
P: (313) 486-1030
F: (313) 731-1646
E: info@huraibiMDpLLC.com
www.huraibiPRI.com

FINANCIAL POLICY

We accept most major insurances and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the Insurance Company. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility.
3. Co-payments are due at the time of service.

Outlined below are some of the requirements of several types of insurance carriers. Our staff will be happy to assist in answering any questions you may have.

HMO/Managed Care & Participating Programs: You are responsible for paying co-pays at the time of the visit and for obtaining any referrals/authorizations your plan may require before the visit. You are responsible to obtain your referral letter prior to your office visit. As per your agreement with your carrier, if you fail to take these steps you will be responsible for the entire payment. Otherwise, we will submit all charges and follow-up with your carrier for payment.

No-Fault/Workers Compensation: You will need to provide our office with all information required to properly submit charges. Without this information, the fees mandated by the State of Michigan will be charged to reflect our private fees and you will be responsible for payment. Some no-fault carriers have deductibles on medical charges for which the patient is responsible. If you have private insurance with which we participate and obtain any referrals/authorizations, we will submit on your behalf and bill you for any unpaid balance.

Medicaid: We do not see new patients having Medicaid as their primary insurance.

Non-Participating Carriers: You are responsible for full payment of charges when your appointment is made if we do not have a participation agreement with your insurance carrier.

Liability: Carriers usually send payment to the patient or to the patient's attorney if one has been retained. Our policy does not allow us to hold accounts that are pending resolution of any liability or litigation issues. We do not bill attorneys. If you provide a letter from the liability carrier indicating they accept full responsibility and will send payment, we will submit our bill to them on your behalf. Otherwise, you may either have charges submitted to your private carrier and pay for the services and obtain reimbursement upon resolution settlement.

Self-Pay: If you are uninsured, you are responsible for payment in full: 50% when your appointment is made, with balance due at the time of service.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **HURAIBI PAIN & REHAB INSTITUTE** (*HURAIBI PRI*) the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims, until you choose to revoke it in writing.

If you require further clarification of any of the policies described here, please contact us at (313) 486-1030.

*I, the undersigned, understand and agree to the **Financial Policy** for **HURAIBI PRI**. I understand that I am financially responsible for all charges incurred for my medical treatment.*

Patient Signature _____ Date _____

Patient Authorization Signatures

Patient Name

Last:_____First:_____ MI:_____ D.O.B.____/____/____

General Signature ~ All patients . . . Read, sign and date:

*I understand that I am responsible for payment of services that are rendered to me. I understand that **HURAIBI PRI** will bill my insurance but that I am ultimately responsible for any balance not covered by my insurance, co-payments, deductibles, or uncovered services.*

Signature:_____ Date: ____/____/____

Additionally, please complete and sign each section that applies to you:

Authorize Payment & Release of Information ~ Patients with health insurance . . . Read, sign and date:

*I, the undersigned authorize payment of medical benefits to **HURAIBI PRI** for any services furnished me by **HURAIBI PRI**. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent(s) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.*

Signature:_____ Date: ____/____/____

Medicare ~ Patients with Medicare . . . Read, complete, sign and date:

*I request that payment of authorized Medicare benefits be made on my behalf to **HURAIBI PRI** for any services furnished me by **HURAIBI PRI**. I authorize any holder of medical information about me to release the information to the Health Care Financing Administration and its agents in order to determine payable benefits for services rendered.*

Medicare Policy Number:_____

Signature:_____ Date: ____/____/____

Medigap ~ Patients with Medigap (Medicare supplement insurance) . . . Read, complete, sign and date:

Do you receive payment from the carrier when a medical claim is filed and then you pay the provider? ☐Yes ☐No

*I request that payment of authorized Medigap benefits be made on my behalf to **HURAIBI PRI**. I authorize any holder of medical information about me to release to Health Care Financing Administration, its agents and my Medigap or other insurance policy that I have, any information needed to determine these benefits r the benefits payable for related services.*

Medigap Carrier Name:_____ Medigap Policy Number:_____

Signature:_____ Date: ____/____/____

Verify Non-Injury ~ Patients NOT CLAIMING work, auto or slip-and-fall injury . . . Read, sign and date:

(If you ARE CLAIMING work, auto or slip-and-fall injury, please make sure you complete the form pertaining to your injury type—Do not sign this section.)

I the undersigned agree that my illness or injury is not related to a Workers' Compensation, Automobile or other "Slip and Fall" claim in which a carrier other than my health insurance should be billed.

Signature:_____ Date: ____/____/____

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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.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. S 164.520

1. Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("Protected Health Information"). We must also provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to Protected Health Information and make new privacy policies effective for all Protected Health Information that we maintain. We will provide you with a copy of any current privacy policy upon your written request, addressed to our Privacy Officer, at our current address.

2. Your Complaints

You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to "Privacy Officer" at our current address, stating what Protected Health Information you believe has been used or disclosed improperly. You will not be retaliated against for making a complaint. For further information you may contact our Privacy Officer, at telephone number 734-325-6282.

3. Description and Examples of Uses and Disclosures of Protected Health Information

Here are some examples of how we may use or disclose your Protected Health Information. In connection with treatment, we will, for example, allow a physician associated with us to use your medical history, symptoms, injuries or diseases to treat your current condition. In connection with payment, we will, for example, send your Protected Health Information to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain payment for the services we rendered on your behalf. In connection with health care operations, we will, for example, allow our auditors, consultants, or attorneys' access to your Protected Health Information to determine if we billed you accurately for the services we provided to you.

4. Uses and Disclosures Which Require Your Written Authorization

Uses and disclosures other than those involving treatment, payment, and health care operations, as well as those described in the following sections of this Notice, will only be made by obtaining a written authorization from you. You may revoke this authorization in writing at any time, except to the extent that we have taken action in reliance upon your authorization.

5. Uses and Disclosures Not Requiring Your Written Authorization

The privacy regulations give us the right to use and disclose your Protected Health Information if: (I) you are an inmate in a correctional institution; (ii) we have a direct or indirect treatment relationship with you, (iii) we are so required or authorized by law. The purposes for which we might use your Protected Health Information would be to carry out treatment, payment, and health care operations similar to those described in Paragraph 1.

6. **Uses of Protected Health Information to Contact You**

We may use your Protected Health Information to contact you regarding appointment reminders or to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your Protected Health Information to contact you in an effort to raise funds for our operations.

7. **Disclosures of Protected Health Information for Billing Purposes**

We may disclose your billing information to any person that calls our billing staff or agents with billing questions after we verify the identity of the person by requesting information such as your social security number or health plan number.

8. **Disclosures for Directory and Notification Purposes**

If you are incapacitated or not present at the time, we may disclose your Protected Health Information (a) for use in a facility directory, (b) to notify family or other appropriate persons of your location or condition, and (c) to inform family, friends or caregivers of information relevant to their involvement in your care or payment for your treatment. If you are present and not incapacitated, we will make the above disclosures, as well as disclose any other information to anyone you have identified, only upon your signed consent, your verbal agreement, or the reasonable belief that you would not object to such disclosure(s).

9. **Individual Rights**

(i) You may request us to restrict the uses and disclosures of your Protected Health Information, but we do not have to agree to your request. (ii) You have the right to request that we communicate with you regarding your Protected Health Information in a confidential manner or pursuant to an alternative means, such as by a sealed envelope rather than a postcard, or by communicating to a specific phone number, or by sending mail to a specific address. We are required to accommodate all reasonable requests in this regard. (iii) You have the right to request that you be allowed to inspect and copy your Protected Health Information as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and costs to make arrangements to have the records inspected and copied. Certain records are exempt from inspection and cannot be inspected or copied, so each request will be reviewed in accordance with the standards published in 45 C.F.R. S 164.524. (iv) You have the right to amend your Protected Health Information for as long as the Protected Health Information is maintained in the designated record set. We may deny your request for an amendment if the Protected Health Information was not created by us, or is not part of the designated record set, or would not be available for inspection as described under section 45 C.F.R. S 164.524, or if the Protected Health Information is already accurate and complete without regard to the amendment. (v) You have the right to request, and thereafter receive, an accounting of the disclosures of your Protected Health Information for six years before the date on which you request the accounting. An exception to this accounting are those disclosures not allowed by law pursuant to section 164.528. Each request for an accounting will be reviewed pursuant to the rules of section 164.528. (vi) You also have a right to receive a copy of this Notice upon request.

10. **Effective Date**

The effective date of this Notice is AUG 1, 2015.

Signature of Patient or Authorized Representative: _____

Relationship**:** _____ Date**:** ____/____/____

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Personal Information:

Last Name: _____
First Name: _____
Middle Initial: _____
Previous Name(s): _____
Address: _____
City: _____ State: ____ Zip: _____
Date of Birth: _____/ _____/ _____
Social Security: _____ - _____ - _____
Gender: □ Male □ Female
Home Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Email: _____

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

Primary Care Physician: _____
Office Location (***city/state***): _____
Referring Physician: _____
Office Location (***city/state***): _____
Work Status: □ Working □ Not Working □ Disabled
Occupation: _____
Employer Name: _____
Work Phone: (_____) _____ - _____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Injury / illness related to:
□ Work □ Auto-related □ Slip-&-fall
□ Other _____

Pharmacy Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Name: _____
Phone: (_____) _____-_____
ID/Contract No. _____
Group No. _____
Subscriber: □ Self □ Spouse □ Parent □ Other: _____
Subscriber's Name: _____
Subscriber's Date of Birth: ____/ ____/ ____

Secondary Insurance Name: _____
Phone: (_____) _____-_____
ID/Contract No. _____
Group No. _____
Subscriber: □ Self □ Spouse □ Parent □ Other: _____
Subscriber's Name: _____
Subscriber's Date of Birth: ____/ ____/ ____

Auto Insurance Name: _____ Claim No.: _____

Worker's Comp Name: _____ Claim No.: _____

Adjustor's Name: _____ Adjustor's Phone: (_____) _____ - _____

Attorney's Name: _____ Attorney's Phone: (_____) _____ - _____

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HT: _____ **WT:** _____, Please check one: □ R □ L - handed, or □ ambidextrous

Is there a specific question that you or your doctor would like answered regarding your pain?

_____

The specific pain that brings you to our center today is located where? – *mark the locations on the drawing below*

_____

How long have you had your pain?

_____

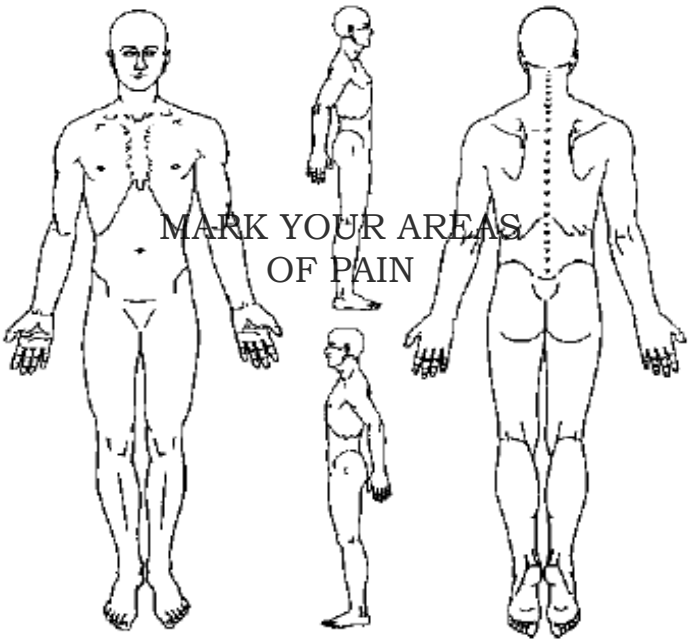
Briefly describe how your pain started:

_____

Rate how your pain has interfered with your daily activities and how it affects you personally? *On a scale of 0-10*

0 = Does not interfere, 10 = Total interference

___/ 10 Usual work routine
___/ 10 Social Life
___/ 10 Mood
___/ 10 Routine home chores
___/ 10 Enjoyment of life
___/ 10 Sleep



0 = No Pain, 10 = Worst pain imaginable

I would rate my pain today at ____/10
I would rate my worst pain at ____/10
I would rate my pain when it is under control at ____/10
I could accept or live with my pain level at a ____/10

When does your pain occur most?

□ Morning □ Night □ All day □ Comes & Goes

Does your pain affect your sleep? *No, Yes – If yes, how?*

□ Trouble falling asleep
□ Trouble staying asleep
□ Awakening frequently because of the pain

Check off the words that best describe your pain:

□ Aching
□ Cramping
□ Grinding
□ Burning
□ Cutting
□ Itching
□ Shooting
□ Stabbing
□ Electric shock
□ Throbbing
□ Dull
□ Excruciating
□ Severe
□ Sharp
□ Squeezing
□ Piercing
□ Numbness
□ Tingling

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How do the following affect your pain?			
	Decreases My Pain	***Increases My Pain***	***No Change in Pain***
Heat	□	□	□
Cold	□	□	□
Damp/Weather Change	□	□	□
Massage/Pressure	□	□	□
Being Still	□	□	□
Movement	□	□	□
Rest	□	□	□
Lying Down	□	□	□
Standing	□	□	□
Sitting	□	□	□
Walking	□	□	□
Traveling in the Car	□	□	□
Turning	□	□	□
Bending Forward	□	□	□
Bending Backward	□	□	□
Climbing stairs	□	□	□
Going down stairs	□	□	□
Exercise	□	□	□
Coughing/Sneezing	□	□	□
Urination	□	□	□
Bowel Movement	□	□	□

Which of the following have you tried in attempt to help alleviate your pain?					
□ Physical Therapy	□ Mobilization	□ Occupational Therapy	□ Exercises	□ Traction	□ Orthotics
□ Acupuncture	□ Prosthetics	□ Relaxation Therapy	□ Biofeedback	□ TENS	□ Nerve Blocks
□ Aerobic	□ Drug/Alcohol Detoxification		□ Chiropractic/Massage		□ Psychology
□ Epidural Steroid Injection	□ Facet Injection		□ Radiofrequency	□ Intrathecal Drug Delivery Pump	
□ Spinal Cord Stimulation	□ Kyphoplasty/Vertebroplasty		□ Others:		

Medical History:					
□ Cancer – Type:					
□ Tuberculosis	□ Asthma	□ COPD	□ Emphysema	□ Heart Attack	□ Sleep Apnea
□ CHF	□ Angina	□ Pacemaker	□ AICD	□ Heart Stents	□ Hepatitis
□ Kidney Problem	□ Dialysis	□ Lupus	□ Paralysis	□ Headaches	□ Seizures
□ Mini Stroke (TIA)	□ Stroke (CVA)	□ Pancreatitis	□ Cirrhosis	□ Shingles	□ Hypertension
□ Bleeding disorder	□ Heart Murmur	□ Incontinence	□ Easy Bruising	□ Psoriasis	□ Anemia
□ Numbness	□ Diabetes	□ Oxygen Use	□ Liver Problems	□ Heartburn	□ Fibromyalgia
□ HIV/AIDS	□ Gastritis	□ Gastric Ulcers	□ Thyroid Disease	□ Arthritis	□ Gout

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Allergies:

□ Latex □ Contrast Dye □ Tape/Adhesive □ Shellfish □ Balloons □ None □ Other: _____

Medications:

Do you take a blood thinner? □ No □ Yes – If yes, what are they? _____

Who prescribes your blood thinner? _____

Please list below **ALL** medications that you currently are taking:

Medication Name	*Strength*	*Direction on Bottle*

~ if you need more space, please check box ☐ and write on ***last page***

Surgical History:

Date	*Type of Surgery*	*Hospital*	*Surgeon*

~ if you need more space, please check box ☐ and write on ***last page***

Family History:

□ No Significant Family History	□ Cancer	□ Low Back Pain	□ Diabetes	□ Heart Disease
□ Rheumatoid Arthritis	□ Bleeding Disorder	□ Hypertension	□ Blood disorder	□ Airway Disease

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Social History:

What is your marital status? □ Single □ Married □ Separated □ Divorced □ Widowed

How many children do you have? _____ How many children live with you at home? _____

Do you smoke? □ No □ Yes:

If yes, how many packs per day _____ How many years have you been smoking? _____ (yrs)

Do you drink alcohol? □ No □ Yes:

If yes, how much and how often do you drink? (e.g. 2 glasses of wine each day) _____

Do you use recreational or illicit drugs? □ No □ Yes:

If yes, please describe: _____

Do you exercise regularly? □ No □ Yes:

If yes, how often? _____

Previous Diagnostic Studies related to your pain? *Check all those that apply:*

□ MRI	When:	Where:
□ CT Scan	When:	Where:
□ Plain X-ray	When:	Where:
□ EMG/NCV	When:	Where:
□ Myelogram	When:	Where:
□ Bone Scan	When:	Where:

Have you had any of the following signs or symptoms in the ***past 2 weeks***?

□ Unintentional Wt Loss	□ Nausea/Vomiting	□ Fever (> 101° F)	□ Rash	□ Cough	□ Abdominal pain
□ Swelling of extremities	□ Appetite change	□ Blood in stool	□ Jaundice	□ Chest pain	□ Blood in urine
□ Muscle weakness	□ Shortness of breath	□ Wheezing	□ Dizziness	□ Abnormal Menstrual Cycle	
□ Ringing in ears	□ Chills	□ Headaches	□ Arrhythmia	□ Bleeding gums	□ Oxygen use
□ Hearing disturbance	□ Visual disturbance	□ Can't Urinate	□ Constipation		

~Please <u>mail back</u> or <u>drop off</u> this packet as soon as possible to avoid any delays with your appointment~

OFFICE USE ONLY:

By affixing my signature below I attest that I have reviewed the information contained in the entire questionnaire and that I have reviewed the key findings with the patient and/or their family. The pertinent findings are summarized in my progress notes; however, the questionnaire may be referenced for additional details.

Pain Consultant Signature: _____ **Date:** ____/ ____/ ____

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ADDITIONAL INFORMATION:

1. _____
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