Integrative Pain & Age Rejuvenation Centers of America.

2508 25 St, Suite D
Rock Island IL, 61201

Our Financial Policy

Thank you for choosing the Integrative Pain & Age Rejuvenation Centers of America as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial Policy.

All Patients must complete our information and insurance before seeing the doctor.
Full Payments are due at the time of service.
We accept Cash, Check, Credit/ Debit (except American Express),Auto pay installment payments

INSURANCE
We may accept assignment of insurance benefits in your visits. However, we do require payment of deductibles, co-payments, and non-covered services at the time of services. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us the correct information. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If your insurance has not paid your account in full within 90 days, the balance will automatically come from you. Please be aware that some, and perhaps all, of the services provided may be NON-COVERED services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determinations of usual and customary rates.

MINOR PATIENTS
The adults accompanying a minor and the parents (or guardians of the minors) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-Authorized to an approved payment by cash, or check at the time of service.

MISSED APPOINTMENTS
Unless canceled OR rescheduled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **$50.00** per missed visit. Only one rescheduled visit per 90 days and one cancellation per 180 days is allowed. The second cancellation/reschedule within the stated period even if it is notified within 24 hours is charged at the rate of $75.00, unless rare exceptional unforeseen circumstances. You can be discharged from the clinic if there is repeat violation and non-compliance of the above policies. Please help us serve you better by keeping scheduled appointments.

Electronic Signature

◯ I agree — By selecting "I agree" I acknowledge that this is my legally binding "Electronic Signature" for this authorization.

◯ I do not agree

DATE : _____

Please provide your Insurance Card(s) and a Photo ID for scanning Thank You

Patient Information

*Patients Legal Name: _____
Last First Middle

*Date of Birth: _____ *Social Security#: _____ Gender (choose from drop box): Female

*Age _____ Marital Status(choose from drop box): Divorced

*Patients Preferred Language (please check one or indicate other): English☐ Spanish☐ French☐ Other_____

Race(choose from drop box): Native Hawaiian or Other Pacific Islander Ethnicity(choose from drop box) Not Hispanic or Latino

*Patient Address: _____ City_____ State_____ Zip_____

Patients Home Phone _____ Cell phone: _____ Work Phone _____

*Email Address_____

Currently Employment Status (choose from drop box): Part-Time

Patients Employer Name & Address: _____

Referring Dr.: _____

Family Physician: _____

In case of an Emergency who should be notified? _____

Relation to Patient_____ Phone #: _____

May we contact Him/her RE: Bill? _____

Person that is responsible for Payment: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____
Street City State Zip

Phone: _____

To best of my knowledge the above information is correct. Any changes of the above information I hereby agree to inform the IPARCOA immediately

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DATE : _____

Primary Insurance/Guarantor

Insurance Company Name:
Subscriber # Group#
Subscribe Name Relation to Patient
Birth date Social Security#
Employed by Phone

Secondary Insurance/Guarantor

Insurance Company Name:
Subscriber # Group#
Subscribe Name Relation to Patient
Birth date Social Security#
Employed by Phone

If you have workman Comp/Liability Please Fill out Below:

WORK COMP/LIABILITY SIGNATURE AGREEMENT

PATIENT'S NAME:

Insurance Company Name& Address

Is this Work Related? **Yes** **No** **Date of Accident**

Is due To Motor Vehicle Accident? Yes **No** **Date of Accident**

Claim #

Employers Name **Phone**

Employers Address

Case Worker/Adjuster Name and Phone #

Do you have a lawyer working on your workman's compensation or a disability and any other issues that may require communication AND Medical record requests?

IF YES, Address and Phone number of YOUR LAWYER

I REQUEST THAT PAYMENT BE MADE ON MY BEHALF TO THE INTEGRATIVE PAIN CENTER FOR ANY SERVICES FURNISHED BY INTEGRATIVE PAIN CENTER AND STAFF. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE.

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I do not agree

If Medicare does not apply to you please write N/A and Sign Below

MEDICARE LIFETIME SIGNATURE AGREEMENT

PATIENT'S NAME: _____

MEDICARE INSURANCE NUMBER: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO THE INTEGRATIVE PAIN CENTER FOR ANY SERVICES FURNISHED BY DR. V.R.KARUPARTHY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE.

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◯ I do not agree

DATE : _____

Please Fill out

YEARLY SIGNATURE AGREEMENT

PATIENT'S NAME: _____

HEALTH INSURANCE NUMBER: _____

I REQUEST THAT PAYMENT UNDER _____

INSURANCE PROGRAM BE MADE TO THE INTEGRATIVE PAIN CENTER FOR SERVICES FURNISHED TO ME BY V.R. KARUPARTHY, MD, FROM DATE OF INITIAL APPOINTMENT TILL FURTHER NOTICE

Electronic Signature

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◯ I do not agree

DATE: _____

Authorization for release of Medical records & Confidential information.

I Authorize: All my treating Doctors, laboratories, hospitals, Physical Therapy, Psychiatric/Psychotherapy, Chiropractic therapy, Massage therapy, and any other relevant medical information from any other medical and para-medical professionals to release to IPARCOA (Integarative Pain & Rejuvenation Centers of America and all their staff for the purpose of my medical treatment.

Regarding _____ _____

(Patient's Name) (DATE OF BIRTH & SS#)

Date (S) OF SERVICE: Date of Initial Appointment till further notice.

PURPOSE OF RELEASE: Sharing Medical Information for my treatment.

I know and accept that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), behavioral or mental health services or treatment for alcohol and drug abuse. I know and accept that the confidential information released because of this Authorization may be re-released by the recipient and no longer protected under the Privacy Rule. I know and accept that this Authorization may be cancelled by completing the Authorization Revocation Form at any time unless APMI has already released information. If not cancelled, this consent will be in effect until Physician-Patient relationship has officially terminated by either party. The physician/patient relationship also considered terminated if patient is not returned for follow up visit for 6 months. I know that I have the right to look over the information that I have authorized to be released. I know and accept that I may refuse to sign this Authorization. I do not have to sign this form in order to receive treatment except in situations where research related treatment is provided or where care is provided solely for the purpose of creating protected health information for disclosure to a third party (e.g. drug screening, fitness for duty examinations, pre-employment of life insurance physicals). If I do not sign this Authorization, no information will be released.

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Metal Health and Development Disabilities Act and/pr under the Federal Act of July 1, 1975, Confidentiality alcohol and drug abuse Patient Records, and under the Illinois HIV /AIDS Confidentiality Act- no such records, nor information from such records may be further disclosed unless the person who consented to this disclosure specifically consents, in writing, to such re-disclosure. A general Authorization for release of medical or other information is not sufficient for this purpose.

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DATE : _____

NOTICE OF PRIVACY PRACTICES

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I understand I have the right to review the Integrative Pain Center's Notice of Privacy Practices prior to signing this document. The Integrative Pain Center's Notice of Privacy Practices is provided for me to read. I may ask for a copy if I so desire. Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or the performance of health care operations of the Integrative Pain Center. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. This Notice of Privacy Practices also describes my rights and the Integrative Pain Center's duties with respect to my protected health information.

I understand that the Integrative Pain Center may call my home or designated location and leave a message on voice mail or in person regarding appointment reminders, insurance items and any call pertaining to my clinical care. Also, the Integrative Pain Center may mail to my home or other designated location any items such as recall reminders and patient statements as long as they are marked personal and confidential.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. The Integrative Pain Center is not required to agree to the restrictions that I may request. However, if the Integrative Pain Center agrees to a restriction that I request, the restriction is binding on the Integrative Pain Center.

The Integrative Pain Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by asking for one at the time of my next appointment or calling the office and requesting a copy be mailed to me.

Electronic Signature

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◯ I do not agree

DATE :

Integrative Pain & Age Rejuvenation Centers of America.

2508 25 St, Suite D
Rock Island IL, 61201

Date:

Re:
DOB:

Mr./Ms.

After our detailed discussion, you agreed to continue and implement our Tandem Integrative Pain Solutions (TIPS) protocol Our protocol includes nerve blocks, yoga, Ayurveda, acupuncture, physical modalities (chiropractic & massage therapies) and other modalities like diet, nutrition and weight management.

If you are a candidate for detoxification counseling, IPARCOA is ready to provide the information.

Your quality of life with chronic pain syndrome is important for us, Because you have chronic, complex, intractable pain syndrome, we are willing to consider giving low, fixed dose of Opiate medications for breakthrough/incidental/ pain, one of the following once per month twice in half quantities.

☐ Hydrocodone- Acetaminophen 5-325mg 1 TAB PO BID Qty:60
☐ Oxycodone-Acetaminophen 5-325 5-325mg 1 TAB PO BID Qty:60
Other _____,

If you are coming to us with high maintenance doses of opiates, IPARCOA will wean you down to lowest possible doses for breakthrough pain control over a period of 3 months under Tandem Integrative Pain Therapies

The breakthrough pain medication quantity will never be changed and early refills are not allowed.

Please sign this form and return back to us.

Sincerely,

IPARCOA Authorized Staff

Electronic Signature

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◯ I do not agree

DATE :

Integrative Pain & Age Rejuvenation Centers of America

2508 25 Street, Suite D
Rock Island, IL. 61201
309-762-PAIN (7246)

Print Name_____ Initials_____

Long –Term Controlled Substances Therapy for Chronic Pain

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term, benefit. There is also a risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of these risks is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substance to treat your chronic pain.

1. All controlled substances must come from the physician/s, licensed mid level pracatitioners of IPARCOA whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ _____
Pharmacy Name Phone

_____
Pharmacy Address

3. You are expected to inform our office of any new medication or medical conditions, and of any adverse effects you experience from any of the medication that you take.
4. The prescribing physician has permission to discuss all the diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit other to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder or discharge of care from our practice.
8. Prescription an bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. Medications should not be left where others might see or otherwise have access to them.
9. Prescription monitoring will be used at all times.

10. Original containers of medications should be brought in to each office visit.
11. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you much keep them out of reach of such people.
12. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane,car etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made but not always.
13. Early refills will generally not be given.
14. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
15. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
16. It is understood that the failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician/s at IPARCOA.
17. Renewals are contingent on keeping scheduled appointments. Please **do not call the clinic** for prescription refills. You should call your pharmacy and ask them to call us or give fax refill request.
18. It should be understood that any medical treatment is initially a trial, and continued prescription is contingent on evidence of benefit.
19. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

☐ You affirm that you have the full right of power to sign and be bound by this agreement, and that you have read, understood, and accept all of this terms.

Electronic Signature

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◯ I do not agree

DATE: _____