CAROLINA
NEUROSURGERY & SPINE
ASSOCIATES

SUMMARY NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT OF RECEIPT: Under federal law, Carolina Neurosurgery & Spine Associates, P.A. ("CNSA") is required to protect the privacy of certain parts of your protected health information ("PHI") we hold in our files. Upon your request, CNSA must give you a notice (referred to as our "Notice to Privacy Practices") of our legal duties and privacy practices concerning the permitted uses and disclosures of your PHI and your rights regarding our use and disclosure of your PHI. You have the legal right to review our Notice of Privacy Practices before you sign the consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notices by accessing our website (www.carolinaneurosurgery.com) or contacting CNSA's Privacy Officer as listed below. You have a right to request us to restrict how we use and disclose your PHI for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement with you. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI on reliance on your consent. By signing this form, you are granting consent to CNSA to use and disclose your PHI for the purposes of treatment, payment, and health care operations.

I hereby acknowledge that I have been provided this Summary Notice of Privacy Practices and understand that I may at any time request to receive the full Notice of Privacy Practices from CNSA. Privacy Officer, 225 Baldwin Ave. – Charlotte, NC 28204 (phone): 704-376-1605

_____**Accept** _____**Decline**

FINANCIAL POLICY: Our financial policy is an essential element of your care and treatment. To give you the best care and service possible please read the following financial policy. Should you have any questions, feel free to discuss them with a member of our staff. Unless prior arrangements have been made, by either yourself or your insurance carrier, full payment is due at time of service. The accompanying adult to a minor patient is responsible for payment. For your convenience, we accept Visa and MasterCard. **If you have Medicare coverage, you will not be billed for services until after Medicare has processed your claim. You will receive a statement from our service after we receive payment from Medicare.** We will bill those plans with which we have a prior agreement with and will collect required co-payments at the time of service. If your health plan determines a service to be "**not covered**", you will be responsible for the complete charge or remaining balance. Payment is due upon receipt of that statement. If you are covered by an insurance plan with which we **DO NOT** have an agreement, we will prepare and send a claim to your insurer which in return will send the payment directly to you. Therefore, charges for your care and treatment will **be due at the time of service.** Our office will also bill your health plan for **all** services we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office. Co-payments are due at the time of service. As stated in our contract with your insurance company, we are not permitted to bill you for these services. Failure to pay these co-payments may result in your account being turned over to an outside collection agency. This action will not compromise your medical care. Authorization from insurance companies may be required for office visits in order to receive full benefit coverage. **If you are not sure authorization is required for your plan, please contact your insurance company, employer, or primary care physician. If required, an authorization must be received by our office prior to your visit.** Failure to provide Carolina Neurosurgery & Spine with proper authorization may result in delay or rescheduling your appointment. You will also be responsible for **all** services related to your office visit. **I have read and understand the financial policy set forth by Carolina Neurosurgery & Spine Associates, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.**

_____**Accept** _____**Decline**

PAIN MEDICATION & PRESCRIPTION POLICY: Carolina Neurosurgery & Spine Associates can only provide pain medication for patients who require a surgical procedure, to relieve pain prior to surgery, and to assist with recovery from surgery. Our practice does not provide long-term pain management services. Patients may be prescribed pain medication during our initial evaluation and surgical preparation period. If surgery is not required, the patient will be referred back to his or her primary care physician to manage pain or make additional referrals. If surgery is necessary, pain medication will be prescribed prior to surgery, if needed. Pain medication may also be prescribed for a predetermined period of time after the procedure is preformed. During this recovery process, the amount of medication will be gradually reduced to help the patient avoid dependency of the drug. Pain medication is to be taken as prescribed. Patients are not to increase medication dosages without consulting a nurse, physician assistant or physician to Carolina Neurosurgery & Spine Associates. **Improper use of medications can lead to the termination of the physician-patient relationship.** So that we may carefully review all patient records, we require a 24-hour advanced notice for prescription refills. Requests for prescription refills can only be accepted during regular office hours. Because we must have access to a patient's medical records, prescriptions cannot be filled in the evening, on weekends or holidays. If long-term pain management is required, the patient will be referred to a pain clinic or to his or her primary care physician. **I have read and understand the above stated pain medication and prescription policy for Carolina Neurosurgery & Spine Associates.**

_____**Accept** _____**Decline**

Signature of Patient or Responsible Party:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

Name of patient (please print)_____ **Account** _____