SOUTHWEST INTERVENTIONAL PAIN SPECIALISTS, P.C.
DR. JAMES H. RICE, M.D. & P. DAVID PACHECO, PA-C
4700 JEFFERSON ST. N.E. SUITE #700 ALBUQUERQUE, NM 87109
PHONE: 505-881-5080 FAX: 505-872-2306

Patient Name: _____
Last First M.I.

Date of Birth: _____ SSN: _____

Email Address **(REQUIRED):** _____

Mobile Phone: _____ Home Phone: _____

Preferred Method of Communication (please circle): Email Mobile Home

Mailing Address: _____

_____

_____

Regular Pharmacy: _____
Name Phone Number

_____
Address

What ethnicity and/or race(s) do you identify with (please circle):

American Indian or Alaska Native

Asian

Black or African American

Hispanic or Latino

Native Hawaiian or Pacific Islander

White

Preferred Language: _____

Smoking History (please circle): Never Former Current

Has anyone in your family ever been diagnosed with a serious illness? If so, please specify:

_____
Relative (parent, sibling, child, etc.) Illness

_____
Relative (parent, sibling, child, etc.) Illness

_____
Patient Signature Date

JAMES H. RICE, MD, PC DBA
SOUTHWEST INTERVENTIONAL PAIN SPECIALISTS, PC
JAMES H. RICE, MD & P. DAVID PACHECO, PA-C
4700 JEFFERSON ST NE SUITE 700 ALBUQUERQUE, NM 87109
PHONE: (505) 881-5080 FAX: (505) 872-2306

AUTHORIZATION FOR USE, REQUEST, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

(PRINT PATIENT FIRST NAME, MIDDLE INITIAL, LAST NAME)

_____ _____

(SOCIAL SECURITY NUMBER) (DATE OF BIRTH)

_____

(PATIENT STREET ADDRESS, CITY, STATE, ZIP CODE)

I HEREBY AUTHORIZE JAMES H. RICE, MD, PC DBA SOUTHWEST INTERVENTIONAL PAIN SPECIALISTS, PC, TO USE, REQUEST, DISCLOSE OR RE-DISCLOSE ANY OR ALL OF MY PROTECTED HEALTH INFORMATION TO OR FROM ANY ENTITY INVOLVED IN THE DELIVERY OR PAYMENT OF MY MEDICAL CARE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME BY SENDING WRITTEN NOTIFICATION TO:

JAMES H. RICE, MD, PC
4700 JEFFERSON ST NE SUITE 700
ALBUQUERQUE, NM 87109

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT MY AUTHORIZATION IS A CONDITION OF TREATMENT AND THAT IF I DO NOT SIGN THIS AUTHORIZATION THEN I WILL NOT RECEIVE CARE AT SOUTHWEST INTERVENTIONAL PAIN SPECIALISTS, PC.

I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY PROTECTED HEATH INFORMATION TO BE USED OR DISCLOSED AS PERMITTED UNDER FEDERAL LAW (OR STATE LAW TO THE EXTENT THE STATE LAW PROVIDES GREATER ACCESS RIGHT).

I UNDERSTAND THAT I HAVE A RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

_____ _____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE

_____

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY (I.E. PARENT, LEGAL GUARDIAN, ETC.)

_____ _____

WITNESS/TITLE DATE

SOUTHWEST INTERVENTIONAL PAIN SPECIALISTS, P.C.
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4700 JEFFERSON ST. N.E. SUITE #700 ALBUQUERQUE, NM 87109
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2023 FINANCIAL AGREEMENT

I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement, or I make a different agreement with my provider.

My initials indicate that I have read and agree with each item below.

INITIALS:

Professional Fees:

_____Any co-payment or co-insurance is due in full at time of service.
_____Special financial arrangements must be discussed prior to any appointment.
_____Parents/Guardians are financially responsible for payment for services provided to minors or other legal dependents.
_____A $25 processing fee will apply for any returned check.
_____Fees may include charges for other professional services such as

1. Report writing (excludes medical notes as a course of care)
2. Telephone conversations
3. Preparation of records or treatment summaries
4. Legal proceedings, including preparation time and transportation
5. Above fees will be discussed in advance

Payment for Services:

_____It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes pain management services. I will call my plan administrator with any questions. I will pay for any services I receive that are applied to my deductible or coinsurance, not covered or denied by my insurance plan.

_____I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self pay basis. I will present my insurance card(s) at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

_____I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

_____Acquiring a referral to come to Southwest Interventional Pain Specialists, is my responsibility. I need to call my insurance company/or my primary care provider to find out if I need a referral. If my insurance company denies payment because of no referral, I will be responsible for all of the charges.

_____Due to the ongoing changes in health care, it is becoming increasingly difficult to determine if Southwest Interventional Pain Specialists and our providers are "in-network" with your insurance company. It is my responsibility to check with my insurance company as to our "in-network" status. If I am seen at Southwest Interventional Pain Specialists and it is later determined that we were NOT "in-network", I will be responsible for all of the charges.

_____I understand that, if after 90 days, my insurance company has not responded, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

_____I understand that, if my account is referred to a collection specialist due to non-payment, I will pay any applicable legal or collection fees.

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Policy for Missed Appointments and Cancellations:

_____I agree that I must give proper notification to avoid late, cancellation or no-show fees of $80.00. I agree to call at least **TWO (2) BUSINESS DAYS** in advance to cancel or change my appointment.

I HAVE READ THIS FINANCIAL AGREEMENT, ASKED ANY QUESTIONS I HAVE ABOUT IT, AND AGREE TO ITS TERMS

_____
Patient or (Authorized Parent/Guardian Name) **Printed**

_____ _____
Patient or Authorized Parent/Guardian signature Date

Medication List

Patient Name: _____
Last **First** **M.I.**

Date of Birth: _____

Drug Allergies: _____ _____ _____

Medication	Dosage	Frequency	Route of Administration (i.e. Oral Tablet, Oral Capsule, Patch, Ointment, Cream, etc.

Patient Signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____
Patient

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____
Staff signature **Date**

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives it offers, or other health benefits or services that may be of interest to you.

YOUR RIGHTS

You have the right to:

- Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. Marketing revokations may be submitted to the Practice via telephone or email.
- Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- Restrict disclosures to your health plan when you have paid out-of-pocket in full for health care items or services provided by the Practice.
- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice may charge you a fee (to cover costs incurred by the Practice to reproduce records) for the cost of copying, mailing or other supplies associated with your request.
- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by

the Practice (unless the originating individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

- Receive an accounting of non-routine disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
- Receive a paper copy of this Notice of Privacy Practices from the Practice upon request.
- To file a complaint with the Practice, please contact the Practice's Privacy Officer. All complaints must be in writing. If your complaint is not satisfactorily resolved, you may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights. Our Privacy Officer will furnish you with the address upon request.
- To obtain more information, or have your questions about your rights answered, please contact the Practice's Privacy Officer.

PRACTICE'S REQUIREMENTS

The health care office:

- Is required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Practices upon request.
- Is required to abide by the terms of this Notice of Privacy Practices.
- Reserves the right to change the terms of this Notice of Privacy Practices and to make the new Notice of Privacy Practices provisions effective for all of your PHI that it maintains.
- Will not retaliate against you for making a complaint.
- Must make a good faith effort to obtain from you an Acknowledgment of receipt of this Notice.
- Will post this Notice of Privacy Practices in its lobby and on the Practice's web site, if the Practice maintains a Web site.
- Will inform you if there is a case of a breach of unsecured health information.

www.InstaCode.com

Privacy Notice to Patients

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR HEALTH CARE INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- Care – In order to provide care to you, the Practice will provide your PHI to those health care professionals directly involved in your care so they may understand your medical condition and needs and provide advice or treatment. For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.
- Payment – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services you received from the Practice so the Practice may be properly reimbursed.
- Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you. **Note:** Genetic information is protected by law and is not considered part of Health Care Operations.
- Fundraising – To the extent that the Practice engages in fundraising activities (i.e. appeals for money, help, or event sponsorships), certain types of PHI may be disclosed for these purposes, unless you specifically 'opt out' of receiving notification. To 'opt out', call or email the Practice to be excluded from fundraising campaigns.

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AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

1. De-Identified Information – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.

2. Business Associate – To a business associate, who is someone the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and/or health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate and their subcontractors will appropriately safeguard your PHI.

3. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

4. Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

5. Federal Drug Administration – If required by the Food and Drug Administration to report adverse events, product defects, problems, biological product deviations, or to track products, enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

6. Abuse, Neglect or Domestic Violence – To a government authority, if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes the disclosure is necessary to prevent serious harm or if the Practice believes you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.

7. Health Oversight Activities – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

8. Family and Friends - Unless expressly prohibited by you, the Practice may disclose PHI to a member of your family, a relative, a close friend or any other person you identify, as it directly relates to

that person's involvement in your health care. If you do not express an objection or are unable to object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment.

9. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

10. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.

11. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

12. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

13. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board, the de-identification of your PHI before it is used, and the requirement that protocols must be followed. Individuals have the option to 'opt out' of certain types of research activities.

14. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

15. Specialized Government Functions – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI

to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

16. Inmates – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.

17. Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

18. Disaster Relief Efforts – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

19. Marketing - Face to face communication directly with the patient, prescriptions that have already been prescribed, or promotional gifts of nominal value do not require authorization as long as the Practice receives no financial remuneration for making the communication. All other situations require separate authorization.

20. Required by Law – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization. These authorizations may be revoked at any time, however, we cannot take back disclosures already made with your permission.

We also will NOT use or disclose your PHI for the following purposes, where applicable, without your express written Authorization:

- Marketing - This does not including marketing communications described in item #19. The Practice will obtain prior authorization before disclosing PHI in connection with marketing activies in which financial remuneration is received.
- Sales - The Practice may receive payment for sharing your information in specific situations (i.e. public health purposes or specific research projects - see #12 above).
- Specially protected information - Certain types of information such as psychotherapy notes, HIV status, substance abuse, mental health, and genetic testing information require their separate written authorization for the purposes of treatment, payment or healthcare operations.

SOUTHWEST INTERVENTIONAL PAIN SPECIALISTS
JAMES H. RICE, MD, PC & P. DAVID PACHECO PA-C

4700 Jefferson St. NE Ste. 700 Albuquerque, NM 87109, P: (505) 881-5080 F: (505)872-2306

Please identify the extent of your pain today (circle one):

1 2 3 4 5 6 7 8 9 10

Within the last 72 hours, have you had (check one per list item):	**Yes**	**No**
A fever?		
Chills?		
Antibiotics?		

Since your last visit or within the last three months, have you had (check one per list item):	**Yes**	**No**
Numbness in arms?		
Numbness in legs?		
Weakness in arms?		
Weakness in legs?		
Trouble walking?		
Bladder incontinence, i.e. urine accidents?		
Bowel incontinence, i.e. fecal accidents?		

Please report the following (circle one per list item):

Marital Status:	Single	Married	Widowed	Divorced
Employment Status:	Employed	Unemployed	Retired	Disabled
Housing:	House	Apartment	Assisted Living	Other
Alcohol Use:	Daily	Weekly	Occasionally	Never
Tobacco Use:	Daily	Weekly	Occasionally	Never
Illicit* Drug Use:	Daily	Weekly	Occasionally	Never

* Illicit Drug Use does not include CERTIFIED use of medical cannabis *

Print Name: _____ **Signature:** _____ **Date:** _____