PRIVIUM
SPINE.PAIN.REHAB.

TODAY'S DATE:	ACCOUNT #:

PATIENT INFORMATION / INSURANCE INFORMATION

LAST NAME:	PRIMARY INSURANCE COMPANY:
FIRST NAME:	BILLING ADDRESS:
ADDRESS:	CITY: STATE: ZIP:
CITY: STATE: ZIP:	PHONE #:
HOME PHONE #: MAY WE LEAVE A MESSAGE? Y N	ID #: GROUP #:
CELL PHONE #: MAY WE LEAVE A MESSAGE? Y N	
EMAIL*:	SECONDARY INSURANCE COMPAY:
PREFERRED METHOD TO CONTACT YOU:	BILLING ADDRESS:
DATE OF BIRTH:	CITY: STATE: ZIP:
SOCIAL SECURITY #:	PHONE #:
SEX (PLEASE CIRCLE): MALE FEMALE	ID #:
HOW DID YOU HEAR ABOUT US:	
PREFERRED LANGUAGE:	
RACE:	

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME:	PHONE #: RELATION TO YOU:

IF INSURANCE IS NOT IN YOUR NAME, PLEASE COMPLETE:

NAME OF POLICY HOLDER:	PATIENT'S EMPLOYER:
DATE OF BIRTH:	EMPLOYER ADDRESS:
SOCIAL SECURITY #:	WORK #:
POLICY HOLDER EMPLOYER:	CITY: STATE: ZIP:
EMPLOYER ADDRESS:	MAY WE CONTACT YOU AT WORK? Y N
CITY: STATE: ZIP:	MAY WE LEAVE A MESSAGE? Y N

REFERRING PHYSICIAN AND PRIMARY CARE PHYSICIAN INFORMATION:

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
PHONE #:	PHONE #:
FAX #:	FAX #:

IF WORKERS COMPENSATION OR LEGAL CLAIM, PLEASE COMPLETE:.

COMPANY NAME:	ADJUSTER NAME:
MAILING ADDRESS:	PHONE #: FAX #:
CITY: STATE: ZIP:	NURSE CASE MANAGER:
CLAIM #:	PHONE #: FAX #:
DATE OF INJURY:	INJURY YOU ARE BEING TREATED FOR:
EMPLOYER AT TIME OF INJURY:	

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**Office use* Provider _____

Appt time_____Entered _____

Ht_____Wt_____

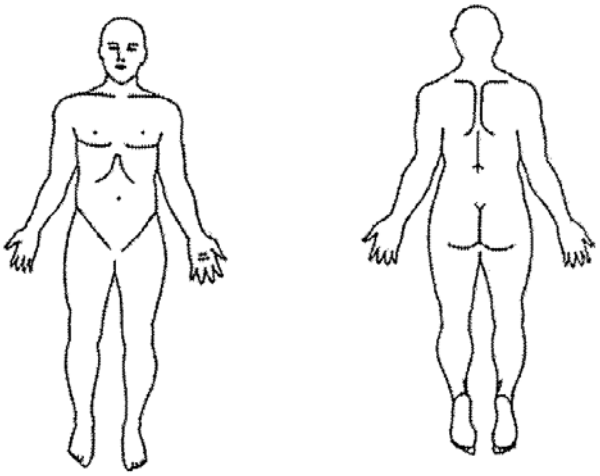
BP_____

NEW PATIENT PAIN QUESTIONNAIRE

Patient Name_____**DOB**_____**Date** _____

Chief Complaint (main problem seeking treatment)_____**Side** ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



R L **L R**

Preferred Pharmacy Name:

_____

Preferred Pharmacy Address:

_____

Preferred Pharmacy Phone:

_____

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Email _____

The onset of your pain was:

☐Motor vehicle accident

Date of Accident _____

Where you wearing a seatbelt: ☐Yes ☐No

Position during the accident:

☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work

Date of injury _____

What injury occurred? _____

☐Insidious onset

☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐constantly ☐intermittent ☐worse with activity ☐worse at the end of the day ☐worse during a activity ☐worse during cold seasons ☐worse during the day ☐worse during the night ☐worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _____ ☐day's ☐week's ☐month's ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Change in bladder function		Sexual Dysfunction	
Changes in bowel function		Shoulder numbness	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	

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NEW PATIENT PAIN QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
HEAT TREATMENT			
ICE TREATMENT			
ACUPUNCTURE			
MEDICATIONS	Check mark all medication that apply below		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	Δ Methadone	Δ Tylenol	Δ Lodine	Δ Soma
☐ Demerol	Δ Morphine	Δ Aspirin	Δ Orudis	Δ Lorzone
☐ Codeine	Δ Nucynta	Δ Ibuprofen	Δ Relafen	Δ Flexeril
☐ Fentanyl (Duragesic)	Δ Butrans	Δ Naproxen	Δ Celebrex	Δ Baclofen
☐ Hydromorphone (Dilaudid,)	Δ Suboxone	Δ Daypro	Δ Toradol	Δ Zanaflex
☐ Hydrocodone (Vicodin)		Δ Indocin		Δ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		Δ Feldene		Δ Skelaxin
☐ Oxymorphone (Opana)		Δ Voltaren		Δ Valium (Diazepam)

Antidepressants		Other	
☐ Elavil (Amitriptyline)	Δ Paxil	Δ Neurontin (Gabapentin)	Δ Lyrica
☐ Pamelor (Nortriptyline)	Δ Prozac	Δ Tegretol	Δ Ativan
☐ Desipramine	Δ Serzone	Δ Dilantin	Δ Xanax
☐ Impramine (Tofranil)	Δ Cymbalta	Δ Topamax	Δ Imitrex
☐ Zoloft	Δ Savella	Δ Depakote	Δ Ergotamine

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NEW PATIENT PAIN QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?

☐Constipation ☐drowsiness ☐mental slowness ☐other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterios	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

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INTAKE AND HISTORIES

Past Medical History (please check all that apply):

- Δ Anemia, Chronic
- Δ Anxiety
- Δ Asthma
- Δ Atrial fibrillation
- Δ Breast Cancer
- Δ Chronic Pain
- Δ Colon Cancer
- Δ COPD
- Δ Coronary Artery Disease
- Δ Depression
- Δ Diabetes, Insulin Dependent
- Δ Diabetes, Non-Insulin Dependent
- Δ End Stage Renal Disease
- Δ GERD
- Δ Hepatitis
- Δ HIV/AIDS
- Δ High Cholesterol
- Δ Hyperparathyroidism
- Δ Hypertension
- Δ Hyperthyroidism
- Δ Hypothyroidism
- Δ Leukemia
- Δ Lung Cancer
- Δ Lymphoma
- Δ Multiple Myeloma
- Δ Obesity, Morbid
- Δ Obesity
- Δ PBPH
- Δ Prostate Cancer
- Δ Radiation Therapy
- Δ Seizures
- Δ Stroke
- Δ **None**
- Δ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other_____

Past Orthopedic History (please check all that apply):

- Δ Ankle Fracture
- Δ Ankylosing Spondylitis
- Δ Bursitis
- Δ DISH
- Δ Epidural Injections, Spine
- Δ Fracture
- Δ Gout
- Δ Hip Fracture
- Δ Herniated Disc, Cervical
- Δ Herniated Disc, Lumbar
- Δ Metastatic Bone Disease
- Δ Osteoarthritis
- Δ Osteopenia
- Δ Osteoporosis
- Δ Primary Bone Sarcoma
- Δ Psoriatic Arthritis
- Δ Rheumatoid Arthritis
- Δ Ricketts
- Δ RSD
- Δ Sciatica
- Δ Scoliosis
- Δ Spine Fracture
- Δ Soft Tissue Sarcoma
- Δ Spinal Stenosis, Cervical
- Δ Spinal Stenosis, Lumbar
- Δ Vertebral Body Compression Fracture
- Δ Vitamin D Deficiency
- Δ Wrist Fracture
- Δ **None**

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INTAKE AND HISTORIES

Past Orthopedic Surgery (please check all that apply):

- ☐ Ankle Fracture ORIF
  ☐Right ☐Left ☐Both
- ☐ Carpal Tunnel Decompression
  ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Femur
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Tibia
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder
  ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy
  ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Rotator Cuff Repair
  ☐Right ☐Left ☐Both
- ☐ Other _____
- ☐ **None**

Medications (please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

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INTAKE AND HISTORIES

Allergies (please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front deskreceptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (please inform us of your family members' medical history by marking the appropriate box)**:**

	Mother	Father	Sister	Brother	Daughter	Son	Other:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes							
*Other*_____							

- ☐ **No Family History** (checking this box indicates no past family medicalhistory)

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - ○ # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - ○ _____

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INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Pain w/ breathing		
Joint swelling			Palpitations		
Difficulty Walking			Ankle Swelling		
Muscle Pain			Labored breathing w/exertion		
Weakness			Nausea		
Numbness			Vomiting		
Tingling			Diarrhea		
Fever			Constipation		
Weight Gain			Heartburn		
Rash			Ulcers		
Chest Pain			Blood in Stool		
Incontinence			Urinary Incontinence		
Shortness of Breath			Urinary hesitancy		
Suicidal thoughts			Urinary retention		
Weight loss			Blood in urine		
Chills			Genital pain		
Fatigue			Excessive bruising		
Discoloration			Excessive bleeding		
Scarring			Cancer		
Environmental Allergies			Excessive thirst		
Immunosuppression			Heat/Cold intolerance		
HIV/AIDS			Diabetes		
Blurred Vision			Thyroid Disease		
Double Vision			Joint Stiffness		
Glaucoma			Dizziness		
Eye pain			Fainting		
Ringing in the Ears			Headaches		
Loss of hearing			Tremor		
Nose bleeds			Seizure		
Hoarseness			Memory Loss		
Difficulty Swallowing			Depression		
Cough			Anxiety		
Wheezing			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker Diabetic			Hepatitis B or C		
Defibrillator			HIV/ADS		
Premedicate Prior to Procedure			Diabetes		
Hepatitis B or C					

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how National Spine & Pain Centers may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Our notice of privacy practices states that we reserve the right to change the terms described. Should this happen to you, you will receive a revised copy either by mail or in person.
- You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I hereby authorize Privium Consultants LLC to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating my treatment. Privium Consultants may also obtain my medication history for continued treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this agreement to release medical information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agreed to those terms.

MISSED APPOINTMENT POLICY

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our service. To better serve all our patients, we require a 24-hour notification, should you need to cancel or reschedule your appointment. Should you miss or reschedule your appointment with less than a 24-hour notice, you will be charged a $35.00 fee, for which payment will be due at the time of your next appointment. Your insurance company will not cover fees for missed appointments.

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications, and other information that is pertinent to our patients' care. In this event, we would discuss such information to the person that you for which you sign authorization and designate below. Please complete the following section:

I hereby authorize Privium Consultants LLC to discuss any information required in the course of my examination or treatment when I cannot be reached by phone to the following designated person(s):

Name of Designee: _____ Phone Number: _____
Relationship to Patient: _____

Name of Designee: _____ Phone Number: _____
Relationship to Patient: _____

☐ None

I agree to all the above information.

_____ _____
Patient Signature or Legal Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize Privium Consultants LLC to release medical information to Medicare, my employer's Benefits Department, or my other insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to my payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original. I am aware that I may request this release of medical information to be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

AUDIO/VIDEO RECORDING PROHIBITED

Please be advised that, to better enable us to assure compliance with HIPAA Privacy and Security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited. We reserve the right to terminate any patient as permitted under State lawif the patient or anyone accompanying the patient is found to be in violation of this office policy. We appreciate your understanding and cooperation.

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all changes incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment within 30 days, I agree to call the business office to make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy to be directly paid to Privium Consultants LLC, or designate payment for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that it is my full responsibility that any third party which I direct Privium Consultants LLC to bill, in the event of non-payment for whatever reason in accordance with the benefits of my current insurance policy, I will pay immediately. It is further agreed that if I fail to pay upon demand, my account will be referred to an outside collection agency or an attorney. I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.25% per month not to exceed 18% annum and reasonable court costs.

Please sign below that you understand this information.

_____ _____

Patient Date

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth Privium privacy practices and my rights regarding privacy of my protected health information.

PATIENT SIGNATURE (or Representative) **DATE**

FOR OFFICE USE ONLY

We have made every possible effort to obtain written acknowledgement of receipt of our notice of privacy practices from this patient but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ We were unable to communicate with the patient
- ☐ Other (please provide specific details)

Employee Signature

Date

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Your Rights as Our Patient

Quality Treatment You Can Expect

As a patient being treated in our office, you have a right to:

- Respectful care given by competent personnel.
- Consideration of your privacy concerning your own medical care.
- The names of all physicians and/or staff directly assisting in your care.
- Have medical records pertaining to your medical care treated as confidential (except as required by law or third-party contractual agreement).
- Know what rules and regulations in our practice apply to your conduct as a patient.
- Expect emergency procedures to be implemented without delay; if there is a need to transfer you to another facility, a responsible person and the facility will be notified of your condition prior to your arrival.
- Good quality care and high professional standards continually maintained and reviewed.
- Full information in layman's terms concerning diagnosis, treatment, prognosis, and possible complications.
- Give an informed consent to the physician prior to the start of each procedure.
- Be advised of participation in a medical care research program or donor program. (You will be asked to give your informed consent prior to participation in such a program, and you may refuse to continue in a program that you have previously given informed consent to participate in.)
- Refuse drugs or procedures and have a physician explain the medical consequences of your refusal.
- Medical and nursing services without discrimination based upon age, race, color, religion, national origin, handicap, disability or source of payment.
- Have access to an interpreter whenever possible.
- Access to all information contained in your medical record, within a reasonable time, unless access is specifically restricted by your attending physician for medical reasons or is prohibited by law.
- Expect good management techniques to be implemented that consider effective use of your time and to avoid unnecessary discomfort.
- Examine and receive a detailed evaluation of your bill.
- Be informed at your request of your provider's credentials.
- Be free from abuse, neglect, harassment and exploitation.
- Appropriate and professional care relating to physician orders .
- Receive information necessary to make informed decisions prior to the start of any procedure or treatment.
- Refuse treatment within the confines of the law and to be informed of the consequences of his/her actions.
- Personal and data privacy and confidentiality.
- Voice grievances and suggest changes in services.
- Exercise your rights without discrimination or reprisal.
- Receive care in a safe setting.

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By signing below, I authorize Privium Consultants, LLC to send email communications regarding the patient portal to the email address identified below and give my expressed consent for my medical information to be made available to me using the **Patient Portal**. I understand that I have the right to receive a completed copy of this consent.

Patient Name: _____
Last Name Middle First Name Date of Birth

Address: _____
Street City State Zip

Please clearly print or type the email address authorized to receive the email invitation:

_____

Please clearly re-print or re-type the email address authorized to receive the email invitation:

_____

Complete the following if the email address does not belong to the patient:

Recipient:

_____
Last Name Middle Initial First Name

_____
Relationship to the Patient

I understand that my health information is protected by federal and state law. This consent applies to records that may contain information related to the testing, diagnosis or treatment for conditions, including, but not limited to, drug and alcohol abuse; psychotherapy, mental or other behavioral health; HIV/AIDS or other communicable diseases; genetic testing; or any other condition expressly protected by state Law. This consent will remain in effect unless I deactivate my account or written notice is provided to PRIVIUM CONSULTANTS LLC.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed because of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

I understand that I may refuse to sign this consent and such refusal will not prohibit me from receiving treatment or payment for my treatment. I further understand that my refusal to sign this consent will not prevent me from receiving a copy of my medical records.

- ☐ **YES** I do wish to access my medical information and give my expressed consent PRIVIUM CONSULTANTS LLC to make my medical information available to me using the **Patient Portal.**

Patient or Representative Signature:

_____
Signature

_____
Print Name Date

_____
Relationship to Patient*

**Legal authority must be verified when an individual is signing on behalf of the patient*

PRIVIUM CONSULTANTS LLC: ***Witness Signature:***

_____
Signature

_____
Print Name Date

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LATE ARRIVAL POLICY

The appointment time you are given is when you are expected to be in the exam room or operating room. We require that new patients and established patients come in 30 minutes early to complete paperwork. If you do not arrive 30 minutes early, you may not have enough time to complete the necessary paperwork. Arriving late means not arriving 30 minute prior to the appointment time.

It is the policy of Privium Consultants LLC that patients are to arrive on time. Patients who arrive late for visits or procedures cannot expect or demand to be seen. Other patients who have arrived on time expect to be seen at their allotted appointment time. Many appointments are scheduled for only 15 minutes. Arriving late by even five minutes will affect the schedule. We have a limited number of exam rooms and only one operating room. Because of this, seeing one late patient will make the schedule run late for the rest of the day. This is not considerate to the other patients who have arrived on time.

There are many things that can occur to make patients late; i.e. car trouble, traffic, parking, etc. We understand that this can happen, but we cannot change the schedule for the rest of the day to accommodate any of these reasons.

If you arrive late for any reason, please check in at the front desk. The practice manager or office manager will check the schedule for the day, and, if possible, offer you another available time the same day. For example, if another patient has cancelled or rescheduled and there is an open slot available, you will be offered the open time slot. If one is not available, an appointment on a different day will be offered to you. Please remind the staff if your medication will run out prior to this new appointment date.

We specifically ask that all new patients and existing patients with follow-ups arrive 30 minutes early. This request is made both verbally at the time of scheduling your appointment and is heard on our recording when you are on hold with our office. We also request that patients who will be having a procedure arrive 30 minutes early when having a procedure with and without sedation. This information is also repeated on the recall slip.

There may be times when we run late, this is due to unforeseen patient clinical needs that we must accommodate. We respect out patients' time and will to all that we can to be on schedule.

I have read the late arrival policy and understand that if I arrive late I am not guaranteed that I will be seen the same day.

_____ _____

Patient Signature Date