THE BIRMINGHAM PAIN CENTER

4515 Southlake Parkway, Suite 200, Birmingham, AL 35244
Ph: 205-313-7246 • Fax: 205-939-1911

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

☐ Please initial

Therefore, I,_____(printed name of patient or personal representative), acknowledge that **The Birmingham Pain Center** has provided a written copy of its Notice of Privacy Practices for Protected Health Information for patient listed above.
(*If signing as a personal representative, documentation of your legal right to do so must be provided and attached.*)

☐ Please initial

I hereby authorize The Birmingham Pain Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. A copy of this authorization shall be valid as the original.

☐ Please initial

NONCOVERED SERVICES STATEMENT:

The services I receive from The BPC will be performed when felt necessary for maintenance of my good health and I will be responsible for payment in full of **all** services that may not be covered by my insurance, including (but not limited to) non-payments or take-backs, including coordination-of-benefit issues if I have not submitted to The BPC updated, current and correct insurance coverage information in a timely manner.

☐ Please initial

The undersigned, in consideration of services rendered to the patient, agrees to pay all sum due the physician(s), waives all claims of exemption, and agrees to pay a reasonable collection fee if referred to an attorney or collection agency, whether a suit is filed or not.

If my treatment plan is stable and I am on controlled medications for which the prescription must be processed monthly:

CHOOSE ONE OF THE FOLLOWING OPTIONS

☐ I choose to take advantage of The BPC's offer to process and create interim prescriptions between my quarterly follow-up appointments, to be transmitted or mailed directly to my pharmacy, for which I will be charged and agree to pay the minimal fee of $10.00 each month, allowing me the opportunity to save transportation costs, time, and office visit fees.

☐ My prescriptions are covered by Workers' Compensation, and I elect to use The BPC's in-house pharmacy (only available to WC patients), and my interim prescription medications will be mailed to me with no extra fee.

☐ I do not want to pay the $10.00 processing fee or use The BPC's pharmacy, and understand that monthly follow-up clinic visits will be scheduled instead of quarterly in order for prescriptions to be written.

☐ Please initial

If I do not cancel my appointment 24 hours or more in advance, I agree to pay $35.00 for each missed office visit and $100.00 for each missed procedure appointment.

⇨

_____ _____ _____/_____/20_____

Guarantor Signature | Signature of Patient or Personal Representative | Date:

To be completed by The Birmingham Pain Center:

☐ We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____ _____ _____ _____/_____/20_____

Printed Name | Title | Signature | Date