DISC

DESERT INSTITUTE FOR SPINE CARE

Patient Handbook

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1635 East Myrtle Avenue, #400, Phoenix, AZ 85020
8630 East Via de Ventura, #210, Scottsdale, AZ 85258
3487 South Mercy Road, Gilbert, AZ 85297
Tel: 602.944.2900 Fax: 602.944.0064
www.sciatica.com

Welcome to DISC

Welcome and thank you for choosing Desert Institute for Spine Care, P.C. ("DISC"). Our mission is to provide outstanding and compassionate non-operative and operative care using the least invasive yet most effective treatment available to restore your active lifestyle.

This patient handbook is designed to provide you with information about our practice as well as provide us with information to best care for you. Please take a few minutes to read the handbook, complete the last page in its entirety and bring the handbook with you on the day of your appointment.

We encourage you to ask any questions or share any concerns you might have during your first visit. We look forward to meeting you and providing you with excellent care. Please do not hesitate to call our office if you have any questions or visit our website at www.sciatica.com .

Sincerely,

The Physicians and Staff at Desert Institute for Spine Care, PC

Please bring the following to your appointment:

- Your entire completed Patient Registration packet
- This Patient Handbook with the last page completed
- Insurance Card: we work with all insurance plans on a case-by-case basis. For insurance questions please call 602-216-6082.
- Any copay and/or deductible payment
- Photo identification
- Any MRIs, X-rays, CT scans and/or EMGs and the written report (must be less than 1 year old). If you are following up from an emercency room visit, obtain your films and hand carry them or request delivery of your films and imaging report to our office.
- Current medication list and past medication (nonsteroidal and steroidal) that you have tried for pain.
- Conservative treatment records including: pain management, chiropractic treatment, activity modification, exercise programs and physical therapy. Bring documentation and/or name and phone number of conservative treatment office, type of treatment, and length of treatment.
- Outside Medical Records—please contact your physician's office and request to pick up your medical records in person or have them fax your medical records, including imaging reports and any and all conservative treatment and past medications that have tried for pain, to our office at (602) 944-0064 or mail to DISC, 1635 E. Myrtle Ave., Ste. 400, Phoenix, AZ 85020. If you need our office to facilitate your record's request, please complete the Record Release form in this packet and include your outside physician names, phone and fax numbers.

Privacy Act Statement

To our patients**:** This notice describes how your Protected Health Information (PHI) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA). Our practice is dedicated to maintaining the privacy of your PHI. We are required by law to maintain the confidentiality of your PHI. This notice is to provide you with our legal duties and privacy practices, which we agree to abide by the terms of the notice currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains, any revised notices will be posted here and available for your request at our front desk and available on our website www.sciatica.com.

With your written consent our practice may use and disclose your PHI in the following ways:

- In order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI information to others who assist in your care, such as your spouse, children, or parents, in compliance with the State and National Laws.
- To bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We may use and disclose this information to obtain payment from third parties that may be responsible for such costs. We may use your PHI to bill you directly for services, supplies, medical records, and any other requested items.
- To be able to run our practice at the highest standards, as effectively as possible. This could be used to evaluate the performance of services provided to insure complete Quality Assurance procedures and policies.
- When we are required to do so by Federal, State, or local laws.
- We may need to call or email you to remind you of an appointment, to return a patient phone call, or leave a message. Please advise us if you do not want us to call and/or email or leave any messages for you on a voicemail, answering machine, with any answering parties at your listed contact phone number and/or email address.

Certain circumstances may require us to use or disclose your PHI without your consent, below are examples:

- To the Public Health Authorities and Health Oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a Law Enforcement Official.
- We participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.
- When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
- If you are a member of United States, or Foreign Military Forces (includes Veterans) and if required by the appropriate authorities.
- To Federal Officials for intelligence and National Security activities authorized by law.
- Correctional Institutions or Law Enforcement Officials if you are an inmate, or under the custody of a Law Enforcement Official.
- To Workers Compensation carriers.
- If you are an Organ Donor, as necessary to facilitate the organ or tissue donations and transplantation.
- To authorized Federal Officials so they may provide protection to the President, other authorized persons or foreign heads of State or conduct special investigations.
- To a coroner or medical examiner.
- For research.

Your written authorization is required in the following circumstances:

- To release any PHI to an attorney, any insurance company that is not currently your medical insurance carrier, or if you are changing physicians.
- If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. If you revoke your permission that was obtained as a condition of obtaining insurance coverage, other law still allows the insurance company to contest a claim under the policy.
- To use or sell your PHI for marketing purposes.
- To restrict disclosures to a health plan for a health care item or service you have paid for out of pocket in full.
- To restrict disclosures to a family member or others involved in your care after your death.

Privacy Act Statement Continued

You have the right to request a restriction or limitation on the medical information we use or disclose about you : for treatment, payment, or health care operations. **We are not required to agree to your request**. If we do agree, we will comply with your request unless the PHI is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Desert Institute for Spine Care, Attn: Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example disclosures to your spouse.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Desert Institute for Spine Care, Attn: Administrator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and must contain a statement that disclosure of all or part of your medical information that you are requesting to be communicated to you in a certain way or at a certain location could endanger you.

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include information compiled in anticipation of a legal proceeding or psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Desert Institute for Spine Care, Attn: Administrator. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request and will provide you with access and/or copies within 30 days.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

If you feel the medical information about you is incorrect or incomplete, you have the right to ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our Practice. To request an amendment, your request must be made in writing to Desert Institute for Spine Care, Attn: Medical Assistant. In addition, you must provide a reason that supports your request. We have 60 days to respond.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the PHI kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You have a right to restrict certain disclosures of PHI to a health plan where you have paid out of pocket in full for that health care item or service.

You have the right to request an "accounting of disclosures." This is a list of the discourses we have made of medical information about you. You must request this list in writing to Desert Institute for Spine Care, Attn: Administrator. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before costs are incurred.

You have a right to a paper copy of this notice that is available at front desk or may be printed from our website www.sciatica.com.

We reserve the right to change this notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Administrator at (602) 944-2900, or with the Arizona Department of Health Services at (602) 364-3030, or visit www.adhs.gov, or write to ADHS, 150 North 18th Ave, Ste. 450, Phoenix, AZ 85007, or the Medicare Beneficiary Ombudsman at https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Patient Bill of Rights & Responsibilities

Each patient has the right:

- To considerate and respectful care.
- To obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
- To participate in decisions involved in his/her care and to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment.
- To know the name of the person responsible for the procedure and/or treatment.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.
- To every consideration of his/her privacy concerning his/her medical care.
- To expect that all communications and records pertaining to his/her care, including financial records, should be treated as confidential and not released without written authorization by the patient.
- To obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by names, which are treating him/her.
- To know if research will be done and the right to refuse to participate in such research projects.
- To expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.
- To examine and receive an explanation of his/her bill regardless of the source of payment and to be informed regarding the fees for procedures performed in the center. The patient has a right to be informed of third party coverage including Medicare and Arizona Health Care Cost Containment System.
- To know what facility rules and regulations apply to his/her conduct as a patient.
- To request information about the grievance process at the facility. If a patient has grievance with the facility, he/she has the right to speak immediately with the Director of Nursing or the substitute person assigned to answer the grievances. A formal written grievance may be completed for further review of the grievance. All complaints will be reviewed within 60 days.
- To be free from chemical, physical, psychological abuse or neglect.
- To timely and appropriate pain management.
- To choose where to receive services, including a facility where his/her physician does or does not have an ownership interest.

Each patient has the responsibility:

- To read and understand all documents, consents and authorizations. If you do not understand, it is your responsibility to ask the nurse or physician for clarification.
- To fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.
- To provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and allergies and sensitivities.
- To provide a responsible adult to transport him/her home from the facility.
- To inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- To assure all financial obligations for services are fulfilled as promptly as possible and to assume ultimate responsibility for payment regardless of insurance coverage.
- To be respectful of all health care providers and staff, as well as other patients.
- To follow his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels are necessary.
- To contact the physician or nurse regarding any post-operative questions or problems.

DISC Financial Policy

All new patients must sign all required forms before seeing the doctor. In addition to your insurance information, we will need copies of your insurance card(s) and driver's license. Your insurance coverage is a private contract between you and your insurance company; **we are not a party to this contract**. You are ultimately responsible for the timely payment of your account.

As a courtesy, we will bill your insurance company; however, you are financially responsible for any unpaid or underpaid charges. Payment is due at the time of service; any other arrangements must be made in advance. We accept cash, personal checks (with proper identification), MasterCard, Visa, American Express, and Discover. There is a $50.00 charge for non-sufficient funds and 10% interest compounded monthly for unpaid balances over 90 days.

If you prefer to file your own insurance, or if your insurance company will not make payment directly to the provider, we require payment in full at the time of each visit. If you are cash pay, pre-payment is required. ***Additional charges may be required at the end of your visit***.

MEDICARE: We are participating Medicare providers and accept assignment. You are responsible for your annual deductible plus 20% of allowed charges due at the time of service unless you have a supplemental Medicare policy. Federal law requires us to collect these payments.

MEDICARE SUPPLEMENTS: We are able to file most supplemental policies for you; however, some companies will not pay us directly. In those cases, payment is due at the time of service.

WORKER'S COMPENSATION: If you have an open, accepted Worker's Compensation claim, you are required to provide us with all necessary insurance information. For ***out of state Workers Compensation claims***, your claims adjustor will need to provide written authorization prior to your scheduled appointment. Payment is accepted under The Industrial Commission of Arizona fee schedule only.

PPO/HMO PLANS: If we are contracted with your insurance company, your co-payment is due prior to being seen by the doctor. For in or out of network insurance coverage, your ***deductible and any estimated co-insurance is due prior to any office visit or procedure***. You will be sent a statement for any remaining balance that is your responsibility. This balance is due and payable upon receipt.

AHCCCS/MEDICAID: The providers at Desert Institute for Spine Care are NOT CONTRACTED with ANY AHCCCS or STATE MEDICAID PLANS. By signing below, you agree to pay in advance all charges related to your treatment. Unless you have Medicare as primary coverage, we will not submit claims to AHCCCS or any other state Medicaid plan.

CHECKS FROM YOUR INSURANCE COMPANY: After your visit(s)/procedure(s) you may receive one or more checks and explanation of benefits directly from your insurance company as payment for the services provided. You are responsible for forwarding those payments and the explanation of benefits on to us. Please endorse and forward to our office for processing at 1635 E. Myrtle Ave., Phoenix, AZ 85020. If a claim(s) need to be appealed we will assist with these appeals; however, at times we may need your help in calling your insurance company to process the claim correctly.

FORMS: Disability/FMLA or other forms requiring physician/ staff review for completion will require a payment of $40.00 for the first page, $5.00 for each additional page.

PERSONAL INJURY OR AUTO ACCIDENT CLAIMS: Unless we have a signed lien on file, you are responsible for payment at the time of service. If applicable, we will bill your private medical insurance. If we are contracted with your insurance plan, there may be a difference between what we bill and what the insurance company allows. When there is a third party claim, most insurance plans allow us to balance bill the patient.

LAB/X-RAY: If we order laboratory tests or special x-rays that are not taken in our office, you will be billed directly by the lab or x-ray facility. You are responsible for payment of that bill. If your insurance company requires for you to go to a particular facility, please let us know. Please advise us if your insurance company requires pre-certification/authorization for tests, x-rays, surgeries, physical therapy, etc.

We believe that communication with our patients regarding our financial policy assists us in providing the best service to you. If you have any questions regarding our financial policy, please let us know.

Patients undergoing procedures . . .

Preoperative instructions:

Oral intake

- Nothing to eat or drink after midnight the night before surgery
- If you have been instructed to take medication the day of surgery, you can take it with a sip of water

Medications

- Obtain primary care physician clearance regarding blood thinners such as Coumadin, Plavix
- In general Plavix needs to be stopped 10 days prior to surgery and Coumadin 5 days prior , typically your instructions regarding stopping and resuming these medications are given by the physician who prescribes these medications
- Discontinue anti-inflammatory medications such as Advil (Ibuprofen), Aleve (Naproxen), Aspirin one week prior to surgery
- Discontinue herbs and vitamins such as vitamin E, Ginkgo Biloba, Ginseng, garlic, may resume supplements such as Calcium, Vitamin D, Multivitamins 1 week after surgery

Preoperative clearance

- Obtain preoperative clearance from your primary care physician and other physicians if necessary such as cardiology, pulmonologist
- Preoperative laboratory and imaging studies are often needed and will be determined on an individual basis

Postoperative instructions:

Activity

- No bending, twisting, or lifting through the spine after surgery from 6 weeks to 3 months
- No extensive activity that increases your blood pressure until cleared by your physician
- You are able to walk as tolerated. Walking will be your physical therapy. Shoot for at least 3-5 times per day. Start out small and then try to walk a little further each time. For instance, start by taking a lap around the dining room table, two laps, and then increase from one end of the house to the other, etc. Sometimes a walker, cane, or your partner is required for stability. As the weeks go by, you will start to walk further and require less help
- Physical therapy will be ordered on an individual basis

Diet

- You may resume your normal diet as tolerated when you return home.

Equipment provided by the hospital

- Possible compression stockings
    - Able to be removed while sleeping and when ambulating frequently
- Incentive spirometer
    - We recommend you use this 10 times per hour while awake for the first week following surgery

Incision care

- Incisions are typically closed with dissolvable sutures and covered with Steri-Strips
- 72 hours after surgery you will be able to remove the bandage and shower
- The incision and Steri-Strips can get wet 72 hours after surgery but we do not recommend directly washing the incision
- After showering pat the incision and Steri-Strips dry
- If there is no drainage from the incision site you can leave the Steri-Strips open to air
- You may re-cover the incision if you feel more comfortable with it covered
- Contact our office with any signs of infection; excessive redness, swelling, excessive drainage, fever, or chills
- No Jacuzzi, bath tubs, or swimming pools until cleared by your physician

Patients undergoing procedures cont.

Postoperative instructions continued:

Pain

- There will be some pain around your incision for several weeks
- Resting your back or taking the prescribed medications will help
- If you notice increased back pain or leg pain while walking, just stop and rest until it improves, then continue walking
- It is not unusual to experience lingering numbness or intermittent pain in the lower extremities
- If you had weakness in your legs prior to surgery, it can take several weeks to several months to recover

Medications

- Pain medication will be prescribed after surgery and is to be taken as directed
- NSAIDs such as ibuprofen and Aleve should be avoided for 10 days after surgery if there is **no** fusion and **6 months after surgery if there is a fusion**
- Surgery and pain medication often slow the bowels therefore supplemental stool softeners, laxatives, and in some cases suppositories or enemas may be needed
    - Examples: Colace 2 times per day, MiraLax one to 2 times per day, magnesium citrate, or over-the-counter suppositories or enemas

Lumbar or cervical brace

- If you have been dispensed a cervical brace you are to wear this 24 hrs a day until you see your physician. If you have been dispensed a lumbar brace you are to wear your brace any time that you are on your feet greater than 5 minutes, any time that you are doing physical activity or leaving your house. **YOU DO NOT HAVE TO WEAR IT WHEN YOU ARE SLEEPING/ SITTING OR USING THE RESTROOM.** You will be advised at each post op appointment how much longer you will need to be using your brace

Driving

- No driving on pain medications
- No driving if there is any weakness in the lower extremities
- Typically patients are able to drive when cleared by the physician at the 2 week postoperative appointment

Follow-up appointment

- If you didn't already schedule a follow up appointment, please call 602-944-2900 and schedule a follow up appointment with your doctor about 10-14 days from your surgery date

When to contact your physician

- Contact our office at 602-944-2900 if you develop:
    - Fever greater than 101° for 24 hours
    - Excessive nausea and vomiting
    - Inability to urinate
    - Excessive pain not responding to medications
    - Excessive redness, swelling, excessive drainage or warmth to the touch along the incision

Referral Information

Please let us know how you learned about our office:

- ❒ Doctor Referral Name:_____
- ❒ Patient Referral Name:_____
- ❒ Attorney Referral Name:_____
- ❒ Insurance Plan Name:_____
- ❒ Hospital Referral Name:_____
- ❒ Phoenix Magazine Ad
- ❒ Az Republic
- ❒ Business Journal article
- ❒ Medical Magazine article
- ❒ Television
- ❒ DISC website: www.sciatica.com
- ❒ Spine Universe website
- ❒ Caring for Arizona website
- ❒ AZ Diamondbacks, AZ Rattlers, LA Dodgers, Cincinnati Reds, Colorado Rockies
- ❒ State Compensation Fund
- ❒ Other: _____

Pain Medications and Driving

I consent to the treatment prescribed by my providers at DISC, and I understand in the course of my treatment I may be prescribed medication(s) including narcotic pain medication(s).

- Patients on narcotic therapy choosing to drive may be charged for driving under the influence of drugs.
- Desert Institute for Spine Care, PC is not responsible if a patient chooses to drive while taking prescribed medications which may cause drowsiness or decrease reaction time.
- If the manufacturer of a medication advises that a patient not drive while taking said medications, then it is the policy of Desert Institute for Spine Care, PC to follow the recommendations of the manufacturer and instruct the patient not to drive while taking such medication(s).
- Patients assume the inherent risk of operating a vehicle while taking the medication(s).

Name of Patient/Legal Representative **Signature** **Date**

Acceptance of DISC Policies & Procedures

Patients, please read the following and sign below.

- My signature indicates that I have received and read the DISC Patient Handbook containing the HIPAA Privacy Act Statement, Patient Bill of Rights, DISC Financial Policy and Consent to Treatment and Release of Liability, etc.
- I have had the opportunity to ask questions regarding the information in this handbook prior to signing this agreement.
- I understand and agree to abide by any and all of the rules and regulations contained in this Patient Handbook.

Name of Patient/Legal Representative	Signature	Date

Authorization to Pay

I request payment of authorized Medicare and/or insurance benefits to be made on my behalf to Desert Institute for Spine Care, PC (DISC) for any services provided for my care by their physicians/providers.

I authorize any holder of my medical information to release all information necessary to the Health Care Financing Administration/Center for Medicare/Medicaid Services, and other Insurance Companies I have listed, and its agents to determine benefits payable for medical treatment received at DISC.

I authorize any holder of my medical information including Government, Medicare/Medicaid, Primary Care Physician, and Insurance companies to release all information necessary to determine benefits payable for medical treatment received at DISC.

Name of Patient/Legal Representative	Signature	Date

Authorization to Use and Disclose Protected Health Information

I hereby permit Desert Institute for Spine Care, PC (DISC) to use and disclose my Protected Health Information (PHI) to any third party **payor**, or to any party involved in my health care. By signing this Authorization, I understand the following (1) I have the right to revoke this Authorization, by sending **written** notification to DISC. Once DISC receives the written revocation this Authorization will be revoked, except to the extent that DISC has already taken action in reliance upon this Authorization; (2) 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; (3) This Authorization shall be enforced as long as I am a patient of this practice. **Unless**, I give written notice to revoke my Authorization; and (4) I have a right to refuse to sign or revoke this Authorization as DISC may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization.

Name of Patient/Legal Representative	Signature	Date

Consent for Release of Medical Information

I hereby authorize Desert Institute for Spine Care, PC to convey to any physician and/or any medical facility directly involved with my care, my medical history, laboratory reports, x-rays, and any other material services, consultations, and treatments which I received while under his/her care.

Name of Patient/Legal Representative	Signature	Date