Coeur d'Alene Spine and Brain, PLLC

P: 208-765-9100 F: 208-765-9103

Jeffrey J Larson, M.D. Holly K Moore, NP-C

Date: ______________

Referring Physician: ______________________ **Phone:** ( )__________ **Fax:** ( )__________

Family Physician: ______________________ **Phone:** ( )__________ **Fax:** ( )__________

Pharmacy Name: ______________________ **Address:** ______________________

Patient (Legal) Name: ____
First MI Last

Mailing Address: ____
City State Zip

Physical Address: ____
City State Zip

Home Ph: ( )__________ **Cell/Work:** ( )__________ **Email:** ______________________

Perferred Communication: ______________________________

SSN: ______________ **Date of Birth:** ______________ **Age:** _____ **Sex:** _____ Male _____ Female

Marital Status: ______________ **Preferred Language:** ______________________

Race: **(circle one)** American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

Ethnicity: **(circle one)** Hispanic/Latino Not Hispanic/Latino Unknown Other

Employer: ______________________ **Occupation:** ______________________

Employers Address: ________________________________ **Phone:** ( )__________

In case of a medical emergency, who would you like us to notify?

Name: ______________________________ **Phone:**______________________

Relationship: ______________________________

Complete if patient has insurance coverage through someone other than their self or is a dependent:

Responsible Party: ______________________ **Relationship to Patient:** ______________

Responsible Party Address: ____
City State Zip

Phone: ( )______________ **Spouse's Name (if Applicable):** ______________________

Is this visit a result of an injury? Yes / No **Date of Injury:** ______________

Is this work related? Yes / No **Other:** ______________

Attorney (if applicable): ______________________ **Attorney Ph:** ( )__________

Insurance Information: To be used for ancillary services and authorization.

Medicare/Medicaid Patient Only: Opt Out of Medicare/Medicaid is a contract between the provider, beneficiary and Medicare where the provider or beneficiary does not file a claim to Medicare. The provider and the beneficiary (patient) will enter into a private contract that is to be executed prior to any services rendered.

Primary Insurance Company: ______________________ **Phone:**______________

Name of the Primary on Insurance: ______________________ Soc. Sec. Number: ______________

Date of Birth for Primary on Insurance: ______________ Relationship to Patient: ______________

Insurance Address: ____

Policy #: ______________________ **Group #:** ______________________

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Secondary Insurance Company: ______________________ **Phone:**______________

Name of Insured: ______________________ Soc. Sec. Number: ______________

Insurance Address: ____

Policy #: ______________________ **Group #** ______________________

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Worker's Compensation Information:

Carrier: ______________________ Claim #: ______________________

Claim Office Address: ____

Adjuster: ______________________ Phone: ______________________

Date of Injury: ______________ Employer: ______________________

Are you represented by an attorney? [ ] Yes [ ] No

Name of attorney: ______________________ Phone: ______________

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Please read the following information regarding your care and patient responsibility at Coeur d'Alene Spine and Brain. You will be asked to sign on the second page indicating you have read and understand the policies, procedures and your financial responsibility as a patient.

Patient Name: ______________________________ DOB: ____________________

Patient Financial Responsibility

Coeur d'Alene Spine and Brain appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees at the time of service.

Coeur d'Alene Spine and Brain is an out-of-network provider for all commercial insurance payers and have opted-out of Medicare and Medicaid.

You are responsible for payment in full at the time of service. Our office will provide a super bill with the necessary information for you to submit to your insurance company.

Prescription Refill Policy

Coeur d'Alene Spine and Brain providers will not fill prescriptions after set hours or on weekends. Post-surgical patients will receive prescriptions for a set period of time depending on their surgery and their adherence to the prescription directions. After this time period it is the patient's responsibility to make any necessary arrangements with their primary care physician for any further refills. It is your responsibility as a patient to manage when you will need a refill and notify the office in a timely fashion. Refills for medications should be phoned into the pharmacy to request any needed refills. Prescription refills will only be filled in accordance with the office policy (which is posted and may be subject to change). Please take time at each office visit to ensure that you are current on any prescription policy changes (both state mandated and internal).

Cancellation/ No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancelling your appointment. Patient's who "no show" without advance warning for two consecutive appointments may be discharged from care. Coeur d'Alene Spine and Brain will notify you in writing, via certified mail, if you are discharged from care.

Self Referral Notice (Pleasant View Surgical Center)

Pursuant to Section 6002 of the Patient Protection and Affordable Care Act (PPACA), with respect to transparency reports and reporting of physician ownership or investment interests, Coeur d'Alene Spine and Brain would like you to be aware that Pleasant View Surgery Center is owned in part by physicians. Jeffrey J. Larson, M.D. is part owner in the surgery center. Coeur d'Alene Spine and Brain providers may choose to refer you to have your surgery/procedure done at Pleasant View Surgical Center and may also be performing your surgery or other services in connection with your referral. Please discuss this matter with your physician so that you may exercise your right to be treated in another health care facility if desired. Upon your request, your physician will provide names and addresses of alternative facilities where you may go to obtain services.

Consent for Treatment and Authorization to Release Information

I am aware that by signing below, I authorize Coeur d'Alene Spine and Brain, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I also authorize Coeur d'Alene Spine and Brain, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

To help protect our patient's privacy, Coeur d'Alene Spine and Brain requires patient's to sign a medical records release prior to releasing any records. We understand that there are situations where another medical provider might need pertinent information in order to expedite your medical care. To help you receive timely care, Coeur d'Alene Spine and Brain will release medical information via verbal and written requests from other physician's offices without a signed release.

By signing below, I am aware that Coeur d'Alene Spine and Brain will do their best to protect my confidential information, but I understand that it is possible for someone to misrepresent themselves by telephone and/or forgery and that my right to privacy may be compromised.

Patient Initials: ______________ Date: ________________

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Notice of Privacy Practices (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Lisa R. Tansy, Administrator. Our Notice of Privacy Practices (HIPAA) describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy for your records you may request one from the front desk or you may download a copy on our website www.cdaspine.com.

I hereby authorize that I have read the Coeur d'Alene Spine and Brain Policies Acknowledgement Form in its entirety (2 pages) and understand my responsibilities and options as a patient.

Patient Signature: ______________________________ Date: ______________________

Guarantor Signature : ______________________________ Date: ______________________
(if guarantor is not the patient)

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical records system (EHR/EMR) and becomes part of your personal medical records. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plan(s), and my other healthcare provider(s).

Patient/Parent/Guardian Signature ______________________ Date ______________________

Printed Name ______________________ Relation ______________________

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Coeur d'Alene Spine and Brain New Patient History

Legal Name ____ Age ________

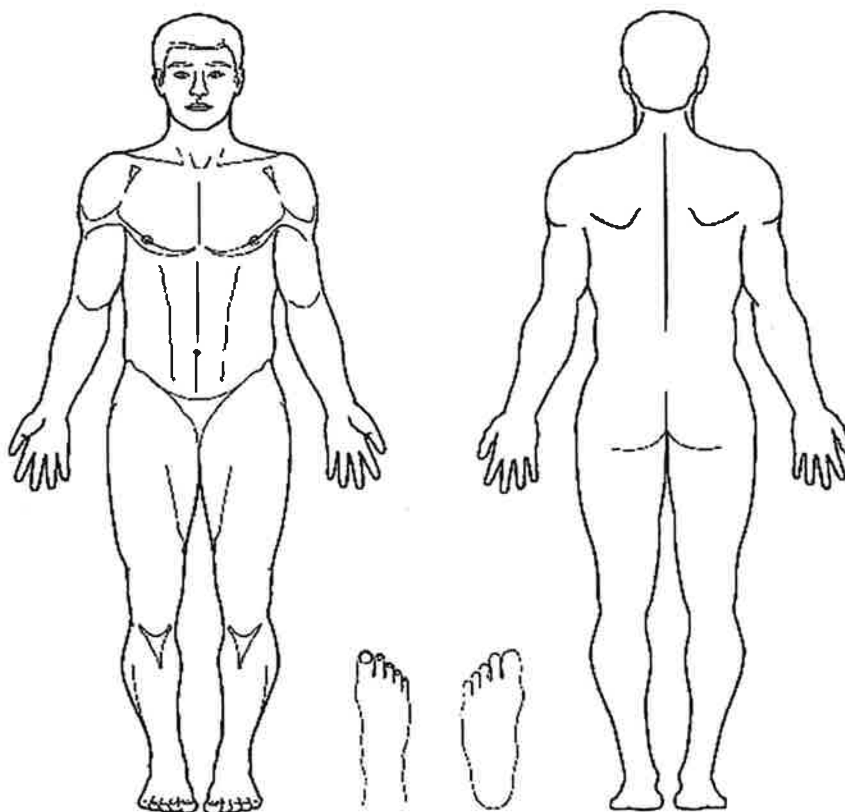
How did you find us? ☐ Chiropractor ☐ Therapist ☐ Friend/relative ☐ Internet

1. **My current pain developed**: ☐ Gradually ☐ Suddenly Date of onset ___/___/_____
   ☐ Work injury: State:____ Claim #________________ Manager:____________________
   ☐ Motor vehicle accident Attorney:____
   ☐ Other:____

2. Please make a mark on the line below to show your average pain level over the past week.

   No Pain 0________________5________________10 Worst Pain Imaginable

   Please use the following key to shade in the distribution of your pain on the figures:
   Numbness .... **Pins and Needles** 00000000 **Pain** //////////////



3. My pain is best described as (check all that apply): ☐ Constant ☐ Intermittent
   ☐ Dull ☐ Sharp ☐ Throbbing ☐ Burning ☐ Tingling
   ☐ Aching ☐ Stabbing ☐ Shooting ☐ Electrical

4. My pain is worse with (check all that apply): ☐ Bending forward ☐ Bending backward
   ☐ Sitting ☐ Standing ☐ Walking ☐ Laying down
   ☐ Looking up ☐ Looking down ☐ Turning left ☐ Turning right
   ☐ Cough/ sneeze ☐ Lifting ☐ Pushing / pulling

5. **My pain is better with**: ☐ Laying down ☐ Sitting ☐ Standing ☐ Therapy
☐ Changing positions ☐ Pain meds ☐ Ice ☐ Heat ☐ Nothing

6. **Have you experienced new bowel or bladder leakage/accidents recently?** ☐ Yes ☐ No

7. **Have you had any of the following tests for the current problem in the last 2 years?**
☐ X-rays ☐ CT scan ☐ MRI ☐ EMG ☐ Bone scan
☐ Diagnostic Spinal Injections (e.g. epidural, facet/sacroiliac joint block, discogram)

8. **Have you tried the following treatments for my pain** (Circle those that helped):
☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ Massage
☐ Spinal Injections ☐ Surgery ☐ Traction ☐ Home/gym exercises

Place of Service: ____________________

9. **Have tried the following medications for my pain** (Circle those that helped. X out those that didn't):
☐ Anti-inflammatories (Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, Diclofenac, Steroids)
☐ Muscle relaxants (Soma, Flexeril, Carbamazepine, Zanaflex, Skelaxin, Robaxin, Methocarbamol)
☐ Anti-seizure drugs (Neurontin, Gabapentin, Lyrica)
☐ Anti-depressants (Paxil, Zoloft, Nortriptyline, Amitriptyline)
☐ Narcotics (Lortab, Hydrocodone, Oxycodone, Oxycontin, Ultram, Vicodin, Percocet, Methadone)

10. **Medication Allergies**: ☐ None ☐ Iodine ☐ Contrast dye ☐ Steroids ☐ Local Anesthetics
☐ Latex ☐ Other: ____________________
Allergic Reaction that occurred: ____________________

11. **Are you currently taking any blood thinning/anticoagulation medications?** ☐ Yes ☐ No
(Coumadin, Warfarin, Pradaxa, Plavix, Aggrenox, Aspirin, Flax seed, Fish Oil etc.)

12. **Pertinent Medications**: ____________________
____

13. **Medical History**: Please check the following medical problems you have now, or have had:

☐ Anemia	☐ Thyroid problems	☐ Easy bleeding	☐ Osteoarthritis
☐ Asthma	☐ Epilepsy	☐ Colon disease	☐ Ulcers
☐ Cancer	☐ Migraines	☐ High blood pressure	☐ Kidney problems
☐ Stroke	☐ Depression	☐ Hepatitis/HIV	☐ Bladder problem
☐ Anxiety	☐ Osteoporosis	☐ Fibromyalgia	☐ Lung Disease
☐ Heart Problems	☐ Diabetes	☐ Rheumatoid arthritis	☐ Vascular Problems
Explain: ________	Type: ________		

☐ Other: ____________________

Have you had previous back or neck problems? ☐ Yes ☐ No
Have you received care from a mental health professional? ☐ Yes ☐ No ☐ Still seeing ________
Have you ever had an infection with MRSA? ☐ Yes ☐ No

14. **Surgical History:** Spine surgery? ☐ None ☐ Neck/Cervical ☐ Mid-back/Thoracic ☐ Low back/lumbar
Orthopedic surgery? ☐ None ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot
Heart surgery or lung surgery? ☐ Yes ☐ No Cardiac or peripheral stents? ☐ Yes ☐ No

15. **Family History**: Please check those illnesses that your family members have had

	Hypertension	Diabetes	Neurologic Problems	Heart Disease	Cancer	Arthritis
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐

Father: ☐ Living ☐ Deceased (Age) ___ Mother: ☐ Living ☐ Deceased (Age) ____

16. **Social History**: Do you now, or did you ever smoke? ☐ No ☐ Yes Packs per day?____ Quit?_____

Do you drink alcohol?___________ ☐ No ☐ Yes ☐ daily ☐ rarely

Do you now, or have you ever had a drug or alcohol problem? ☐ No ☐ Yes

Please explain:____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

17. **Vocational History**:

☐ Employed Full Time ☐ Employed Part time ☐ Retired ☐ Regular Duty

☐ Light Duty ☐ Disability (reason) ______________________________

Employer:____

Job Description:____

Years at current job:__________ Date last worked:__________

Rate your current job satisfaction: ☐ Very Satisfied ☐ Satisfied ☐ Indifferent ☐ Dissatisfied

Have you ever been on disability? ☐ No ☐ Yes: ______________________________

How physically demanding is your job? Check one.

☐*Very heavy (lifting > 100 pounds)* ☐*Heavy (lifting > 60 pounds)* ☐*Moderate (lifting > 30 pounds)*

☐*Light (lifting > 10 pounds)* ☐*White collar (no lifting)*

18. **Review of Systems**: Please check any of the symptoms you have had during the past year.

☐*Fever* ☐*Chills* ☐*Unintentional weight loss of >10 #*

☐*Rashes* ☐*Skin infections* ☐*Itching of skin*

☐*Cataracts* ☐*Glaucoma* ☐*Double vision* ☐*Loss of vision*

☐*Ear infections* ☐*Mouth sores* ☐*Sore throat* ☐*Nasal congestion*

☐*Chest pain* ☐*Leg swelling* ☐*Irregular heart beat*

☐*Short of breath* ☐*Cough* ☐*Wheezing*

☐*Nausea* ☐*Vomiting* ☐*Abdominal pain*

☐*Blood in urine* ☐*Painful urination* ☐*Difficulty urinating*

☐*Dizziness* ☐*Seizures* ☐*Ringing in ears* ☐*Memory loss*

☐*Face numbness* ☐*Arm numbness* ☐*Leg numbness* ☐*Sudden weakness*

☐*Joint pain* ☐*Muscle pain* ☐*Difficulty walking*

☐*Depression* ☐*Anxiety* ☐*Hallucinations*

☐*High blood sugar* ☐*Thyroid disorder* ☐*Anemia*

The information I have provided in this document is true and accurate to the best of my knowledge.

______________________________ ______________

Patient Signature Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this Authorization.

Name of patient: ______________________________ Date of Birth: ____________

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **CDA SPINE AND BRAIN (CDA SPINE)**

to release to: ______________________________

(Persons/Organizations authorized to *receive* the information) (Address, street, city, state, zip code)

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received – **OR**

☐ Only the following records or types of health information (including any dates):

____

____

b. I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information[1] (A separate authorization is required to authorize the disclosure or use of psychotherapy notes.)

☐ HIV test results

☐ Alcohol/drug treatment information

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; ***OR*** ☐ Other

____

____

EXPIRATION

This Authorization expires ____________:
(Date)

Authorization will expire in 12 months if not specified.

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

3320 N Grand Mill Lane, Coeur d'Alene, ID 83814

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.[4]

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

SIGNATURE

Date: ______________________________

Time: ______________________________ am/pm

Signature: ______________________________

(Circle one: patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: ______________________________

____

Witness: ______________________________

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

[2] If any of the HIPAA-recognized exceptions to this statement apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

[4] The requestor is to complete this section of the form.

Identification Number

Group Number

Patient's Name

Provider of Service

Dates of Service

Accidental Injury Questionnaire

WE CANNOT PROCESS YOUR CLAIM UNTIL YOU COMPLETE AND RETURN THIS QUESTIONNAIRE

Was this condition the result of an ***injury/accident***? ❑ YES ❑ NO **If NO, sign below, date this form and return it to us.**

For a description of an injury accident check your policy.

Provide a detailed account of how and where the injury occurred and a brief description of the injury. Please use the back of this form for additional space if necessary.

Date of Injury ________________ (mm/dd/yy)

Place of Injury ❑ **Home** ❑ **Work** ❑ Other (give location) (ex. auto, motorcycle, snowmobile or boat)

How Injury Occurred

Work Related?

Was the injury or illness sustained while performing work required by your employment? ❑ **YES** ❑ **NO**

Are you covered by Workers' Compensation? ❑ **YES** ❑ **NO** Are you self-employed? ❑ **YES** ❑ **NO**

If Workers' Compensation has been denied, please attach a copy of denial.

Name and address of your employer

Are you covered by insurance coverage other than Workers' Compensation for work-incurred injuries? ❑ **YES** ❑ **NO**

Name and address of other insurance carrier

Other Party Information

Was another person or parties responsible for your injury? ❑ **YES** ❑ **NO**

Name and address of responsible party

Please provide responsible party's insurance carrier information

Have you received settlement from the responsible party? ❑ **YES** ❑ **NO**

Do you intend to make a claim against the responsible party? ❑ **YES** ❑ **NO** ❑ **POSSIBLY**

Have you filed or do you intend to file a claim against your own insurance coverage (e.g., automobile, homeowner's, etc.)? ❑ **YES** ❑ **NO**

Please provide adjuster's name, address, & phone number:

Is an attorney representing you in this matter? ❑ **YES** ❑ **NO**
If so, please give your attorney's name and address
(Blue Cross of Idaho may be contacting your attorney regarding this matter):

Have you purchased prescription drugs related to this accident using a prescription drug card? ❑ **YES** ❑ **NO**

Signature	Home Phone	Business Phone	Date

Form No. 5-118 (03-07)

DETAILED INJURY ACCOUNT ***(continued)***

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

- A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
- A nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.

Providers and facilities should NOT give these documents to an individual:

- Who is seeking items or services from in-network providers only,
- Who has Medicare, Medicaid, or any form of coverage other than as previously described, or
- Who is uninsured.

These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420 with respect to both form and manner of delivery, the state-developed documents will meet the federal specifications regarding the form and manner of the notice and consent documents.

These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law. To use these documents properly, the nonparticipating provider or facility must fill in any blanks that appear in brackets with the appropriate information. Providers and facilities must fill out the notice and consent documents completely and delete the bracketed italicized text before presenting the documents to patients.

In particular, providers and facilities must fill in the blanks in the "Estimate of what you could pay" section and the "More details about your total cost estimate" section before presenting the documents to patients.

The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary. The documents must meet applicable language access requirements, as specified in 45 CFR 149.420. The provider or facility is responsible for translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements. The standard notice must be provided on paper, or, when feasible, electronically, if selected by the individual or authorized representative. The individual or authorized representative must be provided with a copy of the signed consent document in-person, by mail or via email, as selected by the individual or authorized representative.

If an individual makes an appointment for the relevant items or services at least 72 hours before the date that the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, at least 72 hours before the date that the items and services are to be furnished. If the individual makes an appointment for the relevant items or services within 72 hours of the date the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, on the day the appointment is scheduled. In a situation where an individual is provided the notice and consent documents on the day the items or services are to be furnished, including for post-stabilization services, the documents must be provided no later than 3 hours prior to furnishing the relevant items or services.

NOTE: The information provided in these instructions is intended to be only a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

DO NOT INCLUDE THESE INSTRUCTIONS WITH THE STANDARD NOTICE AND CONSENT DOCUMENTS GIVEN TO PATIENTS.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 1.3 hours per

response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Estimate of what you could pay if you give up your protections

Patient name:____
Out-of-network provider(s)or facility name:______________________________
____

Total cost estimate of what you may be asked to pay:	

▶ **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

▶ **Call your health plan.** Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.

▶ **Questions about this notice and estimate?** Contact [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]

▶ Questions about your rights? Contact [Insert contact information for appropriate federal or state agency. The federal phone number for information and complaints is: 1-800-985-3059]

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

More information about your rights and protections

Visit [Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers] for more information about your rights under federal law.

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from (select all that apply):

☐ *Jeffrey Larson MD and Holly Moore NPC*

☐ *Coeur d Alene Spine and Brain, PLLC*

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on ___/___/_____ that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

______________________________	or	______________________________
Patient's signature		Guardian/authorized representative's signature
______________________________		______________________________
Print name of patient		Print name of guardian/authorized representative
____________________		____________________
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.