SpineOne
Spine & Sport Medical Center

DISCLOSURE OF COMMON OWNERSHIP AND AFFILIATION

SpineOne, Inc. is the owner of an integrated network of healthcare facilities and licensed practitioners. SpineOne believes that this network enables better coordination of patient care and enhanced quality of care. SpineOne, Inc., which is owned by Perry L. Haney, M.D., is an owner of the following providers of healthcare services:

- The Surgery Center at Lone Tree, LLC (SpineOne, Inc. owns 100% of this company)
- Denver Metro Imaging, LLC, which uses the trade name "Park Meadows Imaging" (100% owned)

As an owner, SpineOne, Inc. may profit from that ownership interest.

Surgery and Non-Invasive Procedures: If you have preference to have your procedure performed at an ambulatory surgery center other than The Surgery Center at Lone Tree, please discuss this with your physician, as he or she will be able to discuss other facilities at which he or she may have clinical privileges.

Diagnostic Imaging: You may obtain your CT or MRI diagnostic imaging services at a facility other than Park Meadows Imaging. Please discuss this with your physician, who will coordinate the required medical orders and referrals for the facility of your choice.

To help you in making your decision on the location for the imaging procedure, here is a sample list of diagnostic imaging centers in this area that provide CT and MRI services which you could select:

Health Images
9780 Pyramid Court
Englewood, CO 80112
(303)577-3388
www.healthimages.com

Health Images
1300 South Potomac St., #100
Aurora, CO 80012
(303)750-8400
www.healthimages.com

Denver Integrated Imaging
14251 E. Fremont Avenue
Englewood, CO 80112
(720)870-7851
www.denverintegrated.com

Invision
8671 South Quebec Street
Littleton, CO 80130
(720)493-3388
www.riainvision.com

Cherry Creek Imaging
210 University Blvd., #112
Denver, CO 80206
(303)355-4674
www.cherrycreekimaging.com

This list of five facilities does not include all available imaging centers, and neither SpineOne nor Park Meadows Imaging is endorsing the named centers; this list is for your information only. You should check with your insurance carrier, if applicable, for any preferred imaging providers it may recommend.

I hereby acknowledge receipt of this Disclosure of Common Ownership and Affiliation provided by SpineOne Inc., and understand that I have a choice as to the health care providers from which I choose to receive services.

_____ _____
Patient Name (Print)/ Guardian's Name (Print) Patient's DOB

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ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities ("payers"), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of, **[SpineOne]** (**"SpineOne**" or "Office") in the amount of the full charges incurred by me at the Office, past or future, including but not limited to, charges for treatment, supplies, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("my charges"). I further grant a contractual lien to **SpineOne** with respect to my charges. For the purposes of this Agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverage: individual/group health, disability, worker's compensation, medical payments benefits, personal injury protection, lost wages, lost services, no-fault benefits, general auto coverage, uninsured and underinsured motorist coverage, liability coverage, and malpractice coverage.

I further agree that, in the event a payer refuses to pay **SpineOne**, I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to **SpineOne**, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to **SpineOne** regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of the Office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby authorize and direct **SpineOne** to file my claims with my health insurance, auto insurance, or third-party insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g., liability, med pay, attorneys, etc.), I hereby authorize and direct **SpineOne** to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I hereby direct all payers to release to **SpineOne** any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers.

I hereby authorize **SpineOne** to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents for treatment received. I further authorize **SpineOne** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition. I understand that I remain personally responsible for the total amounts due to **SpineOne** for their services.

This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **SpineOne** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **SpineOne** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **SpineOne** and me. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

_____ _____

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_____ _____

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FINANCIAL POLICY

It is the policy of SpineOne, P.C., as a courtesy to you, to file insurance claims with your individual insurance company. You will be responsible for **all deductibles, copays, and co-insurance as outlined in your individual contract.**

Office deductibles and co-insurance amounts must be paid at the time of service, and all patients must pay their co-pay before services are rendered. For those patients who are un-insured or under-insured our cash payment option offers re-priced amounts for services rendered. Payment must be made at the time of service in order to qualify. If payment is not made at the time of service, full usual and customary charges will be billed.

Our billing department will be happy to help you with questions regarding your insurance or payment options, but YOU are ultimately responsible for payment regardless of your insurance coverage. Please check with your insurance carrier prior to receiving services and be aware of any restrictions or clauses that could reduce your benefits such as, second opinions, pre-existing conditions, review for hospital admissions, referrals from your primary care physicians, etc. If you are a member of an HMO or PPO in which SpineOne, P.C. physicians are providers; this does not waive your responsibility to confirm coverage. Your benefits could be significantly reduced for all out-of-network services which become your responsibility and payment required in full, using the Cash or Care Credit options outlined above.

When an office visit or procedure has been pre-authorized or pre-certified, this does not guarantee full payment by your insurance company. Please contact your insurance company with any questions.

In addition to SpineOne, P.C. facilities and physician charges, you may receive charges from other entities including, but not limited to, anesthesia and outside diagnostic laboratory services.

If you have retained an attorney and your case is being handled on a lien basis we still require that you provide our office with your health insurance information; however, the attorney lien will be considered the primary responsible party for your case until the time of your settlement or the termination of attorney/client relationship, whichever occurs first.

By my signature, I confirm that I have read and understand the above information; I understand that SpineOne, P.C., its physicians and/or staff are not responsible for my insurance coverage, pre-authorization, or any other insurance decisions.

Please initial one of the following options:

☐ **This illness/injury IS work-related**

☐ **This illness/injury IS NOT work-related**

_____ _____

Patient Name (Print)/ Guardian's Name (Print) Patient's DOB

_____ _____

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Balance Billing Disclosure Form

Surprise Billing – Know Your Rights
Beginning January 1, 2020, Colorado state law protects you from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?
If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:
Emergency Services
If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider
The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

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BILLING DISCLOSURE CONTINUED:

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider, facility, agency, or OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.
Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

_____ _____
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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature below that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to request restrictions to how your protected health information is used and disclosed for treatment, payment, or healthcare operations: however, the practice is not required to agree with any restrictions. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows the use of protected healthcare information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing at any time; however, such a revocation will not be retroactive.

By signing this form, I understand that:

- My protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by the law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical information with any other party? (Circle One) YES NO

If YES please name the parties allowed:

_____

_____

_____

_____ _____

Patient Name (Print)/ Guardian's Name (Print) Patient's DOB

_____ _____

Patient Signature (or Patient's parent or Guardian) Today's Date

10 Year Discloser

Destruction of patient health information by our organization or provider will be carried out in accordance with federal and state law pursuant to a proper written retention schedule and destruction policy approved by appropriate organizational parties. Records involved in any open investigation, audit, or litigation must not be destroyed until the litigation case had been closed.

As with record retention, there is no single standard destruction requirement. Colorado state requires our organizations to notify you, the patient, that we will destroy your records after 10 years. Our organizations will ensure paper and electronic records are destroyed with a method that provides for no possibility of reconstruction of information.

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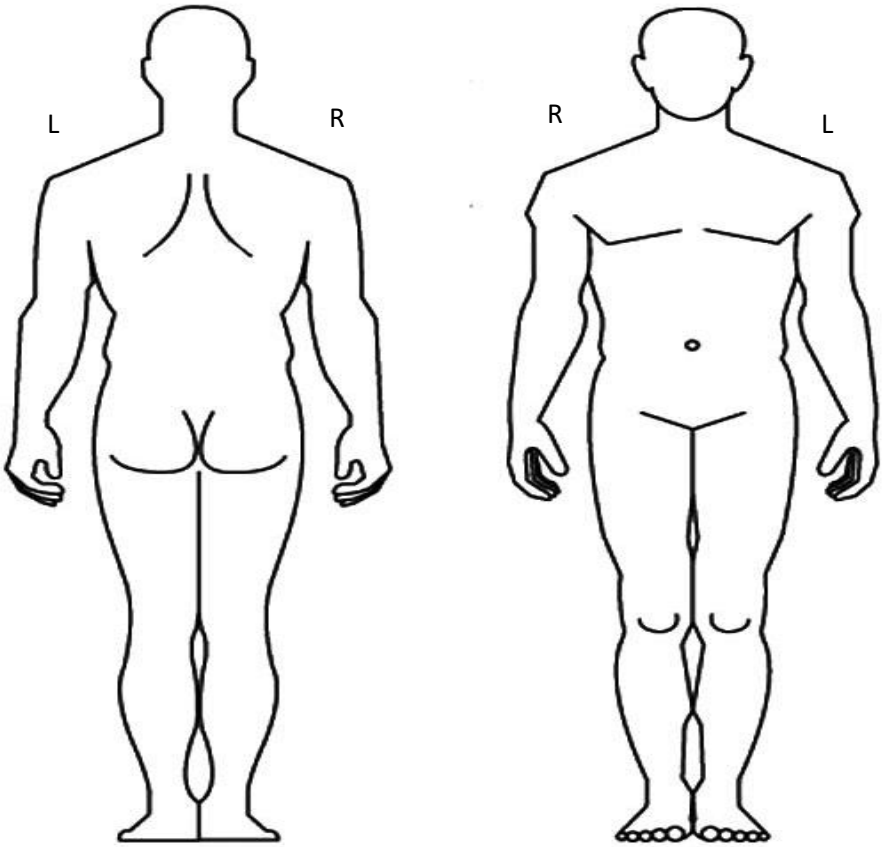
COVID Screening		PT Temp	

Pre-Screening Safety Questionnaire (Please circle YES or No for each question)		
Do you have a cardiac pacemaker or monitoring device?	YES	NO
Do you have **ANY** implanted device(s) in your body?	YES	NO
Do you have a history of working with metal? (Welding/Grinding)	YES	NO
Do you have a history of claustrophobia or anxiety?	YES	NO
Is there any possibility of pregnancy?	YES	NO
Are you taking any blood thinners?	YES	NO
Are you allergic to any medications?	YES	NO
Are you allergic to latex?	YES	NO

Please indicate on the diagram the areas where you are experiencing symptoms using the suggested marks below to describe the symptoms:

Pain **^ ^ ^**
Numbness **= = =**
Pins & Needles **0 0 0**
Burning **X X X**
Stabbing **/ / / /**



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_____ _____ _____
Emergency Contact Name Relationship Phone #

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FOR CLINIC USE ONLY

Room #: _____

Doctor/PA: _____

Studies: _____

Chronic or MVA: _____

MR#: _____

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MEDICATION LIST

First Name: _____ Last Name: _____

DOB: _____ Today's Date: _____

Medication Name Drug Brand Name or Generic Name	**Reason for Taking Medication**	**Dosage** Mg/ mL/ # of pills	**Frequency** How often	**Last Taken** Date and time

Today's Date: _____

Patient Name: _____

DOB: _____

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Review of Systems Checklist

Are you *currently* experiencing any of these symptoms? (Check all that apply)

Respiratory
___Spitting up blood
___Shortness of breath
___Asthma or wheezing
___Frequent coughing
___None in this category

Gastrointestinal
___Stomach pain
___Blood in stool
___Change in bowel movements
___Nausea or vomiting
___Frequent diarrhea
___Constipation
___Painful bowel movements
___Loss of appetite
___None in this category

Skin and breasts
___Rash or itching
___Change in skin color
___Change in hair or nails
___Nonhealing sores
___Change in appearance of a mole
___Breast pain
___Breast lump
___Breast discharge
___None in this category

Mind/Stress
___Nervousness
___Depression
___Sleep problems
___Memory loss or confusion
___None in this category

Heart and Cardiovascular
___Chest pains
___Sudden heartbeat changes
___Swelling of feet, ankles, hands
___Heart trouble
___None in this category

Women Only:
___Irregular periods
___Painful periods
___Vaginal discharge
___None in this category
___Date of last menstrual period: _____

Neurological
___Frequent or recurrent headaches
___Lightheaded or dizzy
___Convulsions or seizures
___Numbness or tingling sensations
___Tremors
___Stroke
___Have you ever had a head injury?
___Have you ever been in an auto accident?
___None in this category

Genitourinary
___Sexual difficulty
___Kidney stones
___Burning or painful urination
___Blood in urine
___Change in force or strain with urination
___Incontinence or dribbling
___Frequent urination
___None in this category

Hematologic/Lymphatic
___Swollen glands
___Easily bruise or bleed
___Anemia
___Phlebitis
___Transfusion
___Slow to heal after cuts
___None in this category

General (constitutional)
___Recent weight change
___Fever
___Fatigue
___None in this category

Eyes and vision
___Wear glasses/contact lenses
___Blurred or double vision
___Glaucoma
___Eye disease or injury
___None in this category

Endocrine
___Thyroid problems
___Diabetes
___Excessive thirst or urination
___Cold extremities
___Heat or cold intolerance
___Change in hat or glove size
___Dry skin
___Glandular or hormone problem
___None in this category

Musculoskeletal
___Joint stiffness or swelling
___Weakness of muscles/joints
___Muscle pain or cramps
___Muscle weakness
___Neck pain
___Upper or mid back pain
___Low back pain
___Joint pain
___Difficulty in walking
___None in this category

Ears, nose, throat
___Bleeding gums
___Bad breath or bad taste
___Sore throat or voice change
___Swollen glands in neck
___Mouth sores
___Ringing in the ears
___Earaches or drainage
___Sinus problems
___Nose bleeds
___Hearing loss
___None in this category

Any additional problems or conditions you would like to disclose: _____

Medical & Family History

8500 Park Meadows Drive Suite 200 Lone Tree, CO 80124 phone 303.367.2225 fax 303.343.8702