Michael E. Steuer, MD PC **PATIENT REGISTRATION**

INFORMATION ---- Please complete all sections

First Name_______________________ MI _________ Last Name ___________________________

Date of Birth _______ / _______ / _______ Sex ☐ M ☐ F SSN _______-_______-____________

Mailing Address ____

→ City / State / Zip____

Physical Address ____

→ City / State / Zip ____
(If different than mailing address)

County_______________________ Home # ( ) _______ - _________ Cell # ( ) _______ - _________

Email Address ____

Emergency Contact ______________________________________ Phone ( ) _______ - _________

→ Relationship to Patient ______________________________

Marital Status	Language	Race	
Single	English	Hispanic	Other
Married	French German	Asian	Undetermined
Divorced	Vietnamese	Caucasian	Chinese
Widowed	Italian	Pacific Islander	Filipino
Other	Mandarin	Black or African American	Japanese
Separated	Spanish	Native American	Native Hawaiian
Life Partner		American Indian or Alaska	Native Multiracial
	Ethnicity		
	Hispanic or Latino		
	Non-Hispanic or Latino		
	Other or Undetermined		

Employer ______________________________________ Work # ( ) _______ - _________

Employer Address ______________________________________ City / State / Zip _______________

Referring Physician ______________________________ Physician Phone # ( ) _______ - _________

Referring Physician Address ______________________________ City / State / Zip _______________

Primary Insurance ______________________ Policy ID # _______________ Group # __________

Policy Holder ______________________ Relation to Patient ☐ Self ☐ Spouse ☐ Other

Policy Holder SS # (if different from patient)______ - ______ - ___________ DOB ______ / ______ / ______

Primary Insurance Address ______________________________ City / State / Zip _______________

Secondary Insurance ______________________ Policy ID # _______________ Group # __________

Policy Holder ______________________ Relation to Patient ☐ Self ☐ Spouse ☐ Other

Policy Holder SS # (if different form patient)______ - ______ - ___________ DOB ______ / ______ / ______

Secondary Insurance Address ______________________________ City / State / Zip _______________

Michael E. Steuer, MD PC **PATIENT REGISTRATION**

AUTHORIZATION OF PAYMENT & RELEASE --- I hereby authorize (a) payment of insurance benefits due to me to be made directly to Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC, (b) release of information including protected health information to insurance companies as needed to file for payment for services incurred, (c) Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible for payment to Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC, for charges related to services provided or incurred by me or my dependents.

I am aware that my insurance carrier may determine that certain procedure(s) may be a Investigational Service, may not be a covered service or may not be medically necessary or medically appropriate as those terms defined in my member healthcare benefits plan, I acknowledge that my insurance carrier may not pay for the service(s) and I will be responsible to pay for all costs associated with the service(s), including, by not limited to, practitioner costs, facility cost, ancillary charges and any other related expenses at an established standard fee. I also understand that Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC, verifies my insurance specialist benefits and files my insurance claims as a courtesy.

Patient Signature ____ **Date** ____________________

PATIENT CONTRACT

I, ______________________________, a new patient of Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC verify and confirm that I have no current association with any other pain treatment facility and I am aware that a certain level of bilateral trust must be developed between my doctors and me as a patient within this practice.
Accordingly, I understand that the payment I am making today is compensation to Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC, for my initial medical evaluation *only*. I have not been promised any particular medication(s) by any provider or associate in exchange for this fee *(quid pro quo).*
Additionally, no other doctor has represented to me that such medication would be prescribed for me in exchange for this fee. I further understand that if any provider or associate within Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC deems that I am currently *not* a candidate for strong pain medications, no such medication will be prescribed.
In addition, a urine specimen will be collected today as is standard for every new patient consultation. Urine drug screen will be conducted randomly throughout my course of treatment within Michael E. Steuer, MD, PC/MidSouth Interventional Pain Institute, LLC. I understand that I will be responsible for any resulting outstanding balances from charges incurred through an independent lab regardless of insurance coverage and/or payment.

Patient Signature ____ **Date** ____________________

MICHAEL E. STEUER, MD, PC
ACCIDENT INFORMATION & ASSIGNMENT

Is this appointment related to one of the following?

1. A workman's comp injury ☐ YES ☐ NO

2. Place of employment and address where injury occurred: ____

3. A motor vehicle accident ☐ YES ☐ NO
[If yes, please describe how and when the accident occurred]

____
____
____
____

4. Any other type of injury (such as slip and fall in a store, etc.) ☐ YES ☐ NO
[If yes, please describe how and when the accident occurred]

____
____
____
____

5. Are you involved in a lawsuit? ☐ YES ☐ NO

I hereby authorize all rights, benefits and interest in all plans of health insurance, cases or claims arising from my condition, whether against an insurance company, corporation, individual or any other entity, to Michael Steuer, MD, PC and MidSouth Interventional Pain Institute, LLC. Furthermore, I have been advised that Michael Steuer, MD, PC and MidSouth Interventional Pain Institute, LLC are unable to file charges resulting in an automobile or accident injury (a third party is involved) to my personal insurance carrier. I understand that I am ultimately responsible for payment of all charges if not otherwise paid (unless prohibited by law or plan contract). I further understand that any amount paid in excess of the regular charges will be refunded as appropriate to the third party payer or to the patient or guarantor. However, in cases where the patient or guarantor has other outstanding charges, the overpayment will be applied to those charges.

Patient Signature (Responsible Party) ___________________________________ **Date** ____________________

Michael E. Steuer, MD PC

Name: ____ Date: ______________

Referred By: ____

Primary Care Physician: ____

Chief Complaint (my worst pain is): ______________________________________

Other Pain Complaints:

- ☐ Abdominal Pain
- ☐ Cervical Pain
- ☐ Facial Pain
- ☐ Groin Pain
- ☐ Headache
- ☐ Hip Pain
- ☐ Buttock Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Thoracic Pain
- ☐ Right Arm Pain
- ☐ Right Hand Pain
- ☐ Left Arm Pain
- ☐ Left Hand Pain
- ☐ Right Leg Pain
- ☐ Right Foot Pain
- ☐ Left Leg Pain
- ☐ Left Foot Pain
- ☐ Right Knee Pain
- ☐ Left Knee Pain

What is the cause of your pain?

____

____

____

Gender: ☐ **Male** ☐ **Female**

Age: ________ ☐ **Right Handed** ☐ **Left Handed**

History of Pain: _____ **year(s)** _____ **month(s)** _____ **weeks(s)**

Type of Pain:

- ☐ Constant
- ☐ Intermittent
- ☐ Dull
- ☐ Aching
- ☐ Throbbing
- ☐ Burning
- ☐ Sharp
- ☐ Stabbing
- ☐ Pulsating
- ☐ Tingling
- ☐ Numb

Things that make your pain worse:

- ☐ Prolonged sitting
- ☐ Bending
- ☐ Stooping
- ☐ Lifting
- ☐ Prolonged standing
- ☐ Arching back
- ☐ Twisting at waist
- ☐ Prolonged walking
- ☐ Turning head right
- ☐ Turning head left
- ☐ Tilting head right
- ☐ Tilting head left
- ☐ Extending neck
- ☐ Raising arm right
- ☐ Raising arm left
- ☐ NONE of the above

Pain Level

Circle the number that best describes your pain on average last month:

1	2	3	4	5	6	7	8	9	10
No Pain									Unbearable Pain

Pain interferes with sleep _______ nights per week.

Things that help relieve your pain:

- ☐ Heat
- ☐ Ice
- ☐ Hot shower and bath
- ☐ Rest
- ☐ Physical therapy
- ☐ Chiropractic treatment
- ☐ Medications
- ☐ NONE of the above

Current Medications:

Medication	Dosage	Frequency/# of tabs left	Prescribing Doctor

Mark the medications you have taken in the PAST:

Opioids	NSAIDS	Tranquilizers	Anti-depressants	Mem/Stab
☐ Vicodin	☐ Advil	☐ Valium	☐ Elavil	☐ Neurontin
☐ Lorcet Plus	☐ Motrin	☐ Ativan	☐ Amitriptyline	☐ Tegretol
☐ Percocet	☐ Ibuprofen	☐ Xanax	☐ Desyrel	☐ Mexiletine
☐ Percodan	☐ Naprosyn	☐ Klonopin	☐ Paxil	☐ Depakote
☐ Tylox	☐ Relafen	☐ Seroquel	☐ Prozac	☐ Gabitril
☐ Fiorinal	☐ Daypro	☐ Buspar	☐ Zoloft	☐ Trileptal
☐ Methadone	☐ Volatren		☐ Effexor	☐ Keppra
☐ Lortab	☐ Orudis		☐ Serzone	☐ Topamax
☐ Oxycontin	☐ Celebrex		☐ Celexa	☐ Zonegran
☐ Duragesic	☐ Bextra		☐ Wellbutrin	
☐ MS Contin	☐ Mobic		☐ Zyprexa	
☐ MSIR			☐ Lexapro	
☐ OxyIR			☐ Abilify	
☐ Actiq		**Muscle Relaxers**	**Other**	**Other**
☐ Nucynta		☐ Flexeril	☐ Relpax	☐ Tylenol
☐ Roxicodone		☐ Norflex	☐ Axert	☐ Ultram
☐ Dilaudid		☐ Robaxin	☐ Maxalt	☐ Ultracet
		☐ Skelaxin	☐ DHE/Ergot Drugs	☐ Imitrex
		☐ Soma		☐ Zomig
		☐ Zanaflex		☐ Suboxone
		☐ Baclofen		

Do you have allergies? ☐ **YES** ☐ **NO**

If YES, what are you allergic to? ________________________

____

____

____

Past Medical History:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Heart Problems
- ☐ Stroke
- ☐ Seizures
- ☐ Congestive Heart Failure
- ☐ Emphysema
- ☐ Asthma
- ☐ Lung Disease
- ☐ HIV/AIDS
- ☐ Cancer *if yes, Type? ____________________
- ☐ Prior Radiation Treatment
- ☐ Prior Chemotherapy Treatment
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ History of Bladder/Kidney Infections
- ☐ Thyroid Disease
- ☐ Bowel Disease
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Stomach Reflux
- ☐ Stomach Ulcers
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Schizophrenia
- ☐ History of Sleep Apnea
  (Do you use a breathing machine? ☐Yes ☐No

Previous Pain Treatments:

- ☐ Physical Therapy *If yes, circle below
  Low back Mid back Neck Hip
  Other ________________________
- ☐ Chiropractic Therapy
- ☐ TENS
- ☐ Acupuncture
- ☐ Lumbar/Cervical Blocks
- ☐ Trigger Point Injection
- ☐ Peripheral Nerve Block
- ☐ Back Brace
- ☐ Spinal Cord Stimulator
- ☐ Other __________________________

Past Surgical History:

- ☐ None
- ☐ Lumbar Laminectomy
- ☐ Cervical Laminectomy
- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Gallbladder Surgery
- ☐ Tubal Ligation
- ☐ Hysterectomy/Ovaries
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Cataracts
- ☐ Cardiac Catheterization
- ☐ Cardiac Bypass
- ☐ Knee Surgery *If yes, L or R
- ☐ Other ___________________________

Social History:

Are there any substance abuse issues in your household? ☐ Yes ☐ No

Marital Status: ☐ Married (how many years? ______) ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Lives: ☐ Alone ☐ with Family ☐ with Spouse ☐ with Significant Other ☐ with Roommate

Number of Children _______ Number of Grandchildren _______

Type of Work _____________________________ Disabled? ☐ Yes ☐ No

Pain had a significant impact on: ☐ General Lifestyle
☐ Social Lifestyle
☐ Sexual Lifestyle

Substance Utilization History:

Cigarettes ? ☐ Yes ☐ No

Packs per day? _________

Quit Smoking? ☐ Yes ☐ No

Alcohol? ☐ Yes ☐ No

# of Drinks per week: ________

# of DUI: ________

History of Alcohol Abuse? ☐ Yes ☐ No

History of Recreational Substance Abuse? ☐ Yes ☐ No

History of Prescription Substance Abuse? ☐ Yes ☐ No

Which Drugs? ☐ Alcohol ☐ Barbiturates ☐ Cocaine ☐ Amphetamines ☐ Marijuana ☐ Other

Family History

- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Migraines
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Alcohol Abuse
- ☐ Heart Disease
- ☐ Stroke
- ☐ Substance Abuse

List family members or friends that are patients here: ____

General/Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Weight Change
- ☐ Fatigue

Respiratory

- ☐ Lung Problems
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Uncomfortable Breathing
- ☐ Excessive Sputum
- ☐ Wheezing

Skin

- ☐ Bruising
- ☐ Change in Skin
- ☐ Easy Bruising
- ☐ Non-healing Sores
- ☐ Persistent Rash

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Dyspnea on Exertion
- ☐ Orthopnea (Shortness of breath lying down)
- ☐ PND (shortness of breath during sleep)
- ☐ Peripheral Edema
- ☐ Rapid Heartbeat
- ☐ Irregular Heartbeat
- ☐ Claudication (leg pain when walking)

Eyes

- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Eye Pain

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Large Volumes of Urine

Neurologic

- ☐ Bowel Problems
- ☐ Dizziness
- ☐ Falling
- ☐ Headaches
- ☐ Involuntary Movements
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Memory Loss
- ☐ Restless Legs
- ☐ Seizures
- ☐ Sensory Loss (numbness)
- ☐ Sleep Disturbance
- ☐ Speech Difficulty
- ☐ Syncope
- ☐ Tingling
- ☐ Tremors
- ☐ Weakness

Gastrointestinal

- ☐ GI Symptoms
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Frequent Constipation
- ☐ Nausea
- ☐ Vomiting

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Hematologic/Lymphatic

- ☐ Excessive Bleeding
- ☐ Easy Bruising

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Hallucinations
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Severe Mood Swings
- ☐ Suicidal Thoughts
- ☐ Trouble Sleeping

Ear/Nose/Throat

- ☐ Tinnitus (ringing in the ears)
- ☐ Hearing Loss
- ☐ Swallowing Difficulties

Allergic/Immunologic	**Genitourinary**
☐ Hives ☐ Hay Fever ☐ HIV Exposure	☐ Uncomfortable Urination ☐ Urinary Frequency ☐ Urinary Urgency ☐ Urinary Hesitancy ☐ Urinary incontinence
Other (describe):	

Michael E. Steuer, MD PC • MidSouth Interventional Pain Institute

Authorization of Use of Disclosure of Protected Health Information

Person(s) Authorized to Receive Information:

Health Information collected or received by the facilities listed above about you may be disclosed to the following person/persons:

Name of Person	Relationship	Name of Person	Relationship

Uses and Disclosures of Information:
I authorize the healthcare professional(s) deemed necessary by the above listed facilities to receive **all health information** about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at these facilities.

I authorize to communicate (verbally/written) and/or send records to my treating physician(s) to better coordinate my care so all my providers are aware of my healthcare needs.

I acknowledge Michael E. Steuer, MD PC/MidSouth Interventional Pain Institute, LLC will access my state prescription monitoring report on a regular basis which will become part of my permanent record.

Authorization:
This authorization is effective throughout the course of medical treatment received at the above facilities unless revoked or terminated in writing by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization:
You may revoke or terminate this authorization by submitting a written revocation to the facilities listed above.

Potential for Re-disclosure:
The person(s) or organization(s) to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Other Uses and Disclosures:
Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent will require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

I would like the following restriction regarding the use and disclosure of my health information:

____

____

____

I acknowledge that I have received a copy of the Notice of Privacy & Practices.

Print Patient Name	**Date**
Patient Signature	**Staff Witness**
Patient Representative	**Relationship**

Michael E. Steuer, MD PC　　　　　　　　　　MidSouth Interventional Pain Institute, LLC

Patient Name: ________________ DOB: ________ Age: ______ Gender: ______ Date: ________

PATIENT/RESPONSIBLE PARTY FINANCIAL POLICY

In order to establish a complete understanding of the financial responsibilities associated with the care provided by the facilities listed above, the financial policies outlined herein are provided for your review. If you have any questions, please feel free to ask one of our Billing Department Representatives for clarification.

It is our desire that you receive the maximum benefit possible from your health insurance. In order to achieve this, we need your assistance in providing complete and accurate personal and insurance information requested on our Patient Registration Form. Please complete this form in its entirety and provide your insurance card to be copied.

We have verified your insurance coverage as a courtesy to you. We will also submit any claims to your insurance company as a courtesy. When coming in for an **office visit, your co-payment/co-insurance is due at the time of service.** Insurance companies will not tell us exactly what your portion will be until they receive the claim and review it; therefore, the payment you make will apply to your balance for that specific date of service. Then you will be responsible for only the remaining balance. Financial arrangements are available for outpatient procedures only. We accept cash, money orders, Care Credit, and Visa, MasterCard, Discover and American Express. **WE NO LONGER ACCEPT CHECKS!!..NO EXCEPTIONS.** All services rendered are the responsibility of the patient or guarantor regardless of insurance. ________ **Initials**

If your insurance company considers our Physician or Surgery Center out-of-network, we will inform you. Most insurance carriers do have out of network coverage. A billing department representative is available to discuss payment arrangements. ________ **Initials**

If payment is issued to you by your insurance carrier due to the carrier being out-of-network, it is your financial responsibility to issue payment to this facility for services that were provided. ________ **Initials**

In the event that a patient's account is turned over to a collection agency for further collection actions, the patient will be responsible for all collection, legal, and court costs related to the patient's account and unpaid balances**.** ________ **Initials**

Patient Policy

Prescriptions: Prescriptions required between scheduled office visits may be provided at the discretion of your provider at a charge of **$25.00 per month and is due at the time the prescription is picked-up.** This charge is a maintenance fee charged directly to you, the patient, as the prescription pick-up requires staff time for receiving and placing calls, input of prescription information, as well as ensuring the integrity of the patient prescription pick-up process. ________ **Initials**

Cancelled Appointments: Cancellation of an **office visit** must be made **24 hours** in advance or a **$75.00 cancellation fee** will be charged to the patient. Cancellation of a **procedure** must be made **48 hours** in advance or a **$100.00 cancellation fee** will be charged to the patient. ________ **Initials**

Worker's Comp: All workman's compensation cases must be approved by the workman's compensation carrier. If your workman's compensation case closes/settles during your treatment at our facility, you must notify our office immediately. You will be considered a **Self-pay** patient unless you provide our office with your personal insurance information. ________ **Initials**

Motor Vehicle Accident: **WE DO NOT FILE ANY MVA CASES TO YOUR HEALTH INSURANCE!!** If you are in a lawsuit or become involved in a lawsuit, you must notify our office immediately with your attorney's information. ________ **Initials**

Phone Calls: If a representative is unavailable to take your call, please leave a detailed message with a working phone number. Your call will be returned as a staff member becomes available: multiple calls per day will not be tolerated. There is no after hour number. If you are having urgent problems after hours, on the weekends, or on holidays, you should go to the nearest ER or outpatient emergency walk-in clinic for evaluation**.** ________ **Initials**

Nurse/Medication Calls: Your call will be returned by a nurse the same day if received before 4:00 p.m. Monday through Thursday. You must give our office a working phone number and be available to answer when the nurse returns your call. There is no after hours number. If you are having urgent problems after hours, on the weekends, or on holidays, you should go to the nearest ER or outpatient emergency walk-in clinic for evaluation. ________ **Initials**

Appointments: There are no walk-in appointments. Do not walk into the clinic demanding to be seen if your do not have a scheduled appointment**.** ________ **Initials**

Primary Care Doctor: You are required to have a primary care doctor that treats all your non-pain problems. **Should you be involved in an accident, a fall or other injury, you must have this evaluated by your primary care doctor or go to the ER for evaluation. We do not treat new injuries or acute pain.** Your pain doctor does not admit to the hospital. All chronic pain is treated on an outpatient basis. ________ **Initials**

Medical Forms and Letters: This office charges for filling out forms and writing letters. This charge must be paid prior to the forms being filled out or the letter being written. Our physicians are not certified to give disability ratings or fill out functional capacity evaluation (FCE) forms. Please **DO NOT** have your lawyer or workmen's compensation carrier send forms requesting this information. ________ **Initials**

Patient Behavior: No **firearms** are allowed in the clinic. Your doctor will not see you is you have a firearm with you. We do not tolerate abusive behavior in the clinic or over the phone. We expect our patients to be pleasant and cooperative. Inappropriate or abusive behavior may result in our inability to continue your care in this practice. ________ **Initials**

Right to Refuse: Providers have the right to refuse treatment or to give prescription(s) if a patient is non-compliant with their treatment regimen designed specifically for each patient's pain management needs. ________ **Initials**

I have read, understand, and have been given a copy of the patient policy guidelines. By signing below, I am agreeing to follow these policies.

____ _______________________

Print Name **Date**

____

Patient/Guardian Signature

MidSouth Pain Treatment Center

Michael E. Steuer, MD, PC

146 Timber Creek Ste. 200 Cordova, TN 38018

Phone: 901-751-4112 Fax: 901-751-5391

ADVANCE DIRECTIVES FOR MEDICAL CARE

Under the Federal Patient Self Determination Act, we as healthcare providers are obliged to inform you that, as a competent adult or as the parent/legal guardian/patient representative, you have the right to make advance decisions regarding your healthcare.

In the event of a life-threatening emergency, it is the policy of the MidSouth Pain Treatment Center to perform Cardiopulmonary Resuscitation (CPR) as necessary to stabilize our patients for transfer to an acute healthcare facility.

In order to fulfill our obligation we must ask the following questions:

1. Do you have an Advance Directive? ( ) Yes ( ) No

2. If yes, what type of Advance Directive do you have? (Do Not Resuscitate form (DNR), Living Will, etc.)

____

3. Did you bring a copy with you? ( ) Yes ( ) No

4. Where is the original document? ____

____

I am stating that I have read the above and understand my rights in the making of advance healthcare decisions. I further understand that, if I have a **Living Will or any form of Advance Directives**, I must inform the MidSouth Pain Treatment Center of the same, and it is my responsibility to present them a copy.

Patient Name: ____________________________________ Date: ______________

Patient Signature: ________________________________

Patient Representative Signature: ____________________________

Witness (Staff): __________________________________ Date: ______________

ADVANCE DIRECTIVE INFORMATION

POLICY:

The Center shall provide each adult individual the choice to formulate Advance Directives with respect to the patient's rights of self-determination.

OBJECTIVE:

To enable this Center to protect each adult patient's right to participate in healthcare decision making to the maximum extent of his or her ability.

PROCEDURE:

1. The Center shall provide the patient, or as appropriate, the patient's representative in advance of the date of the procedure, with information concerning the Center's policies regarding the right to make healthcare decisions and to formulate Advance Directives, and the way such decisions and directives will be implemented in the Center.
2. This Center shall provide upon request, written information describing:
   a. An individual's rights under applicable statutes.
   b. Official state advance directive forms
3. The Center shall document in the individual's medical record whether or not the individual has executed an Advance Directive. For purposes of this policy, an Advance Directive means a written instruction that related to the provision of healthcare when the individual is incapacitated, such as a Durable Power of Attorney for Healthcare, a Declaration pursuant to the National Death Act, or a Living Will.
4. This Center shall comply with applicable statutes and court decisions regarding Advanced Directives.
5. This Center shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.
6. This Center shall provide education to staff on issues that concern Advance Directives.
   a. Educational information about Advance Directive and the Center's policy and procedure regarding Advance Directives will be provided to the medical and nursing staff.
7. For purposes of this policy, the following terms shall be interpreted in accordance with their respective definitions as set forth below:
   a. <u>Medical Decision Making:</u> authorization for treatment, the withholding of treatment, or the withdrawing of treatment (including life-sustaining treatment) obtained from the patient or, in the event of the patient's incapacity, from the patient's surrogate decision maker.
   b. <u>Life-Sustaining Treatment:</u> any medical intervention, including the administration of fluids and nutrition by artificial means that sustains life for a particular patient.
   c. <u>Advance Directive:</u> a written instruction, such as a Living Will, Durable Power of Attorney for Healthcare, or other documentary evidence recognized by the courts of this state, relating to the provision of medical care when the author is incapacitated.
   d. <u>Surrogate Decision Maker:</u> an individual other than the patient to whom healthcare providers appropriately look for medical decision making regarding the patient's care when the patient is incapacitated. This individual may be formally appointed (e.g., by the patient in a Durable Power of Attorney for Healthcare, or by a court in a conservatorship of guardianship proceedings) or, in the absence of a formal appointment, may be informally authorized by virtue of a relationship with the patient (e.g., the patient's next of kin or, in the absence of next of kin, close friend).
   e. <u>Incapacitated:</u> a condition of the patient where the capacity to make informed decisions regarding care is temporarily lost (e.g., due to unconsciousness, being under the influence of mind-altering substances, or otherwise suffering from treatable mental disability), is permanently lost (e.g., irreversible coma, persistent vegetative state, or untreatable brain injury, rendering understanding by the patient impossible), or never existed (e.g., congenital retardation rendering understanding by the patient impossible or severe brain injury as a child).

Michael E. Steuer, MD PC
MidSouth Pain Treatment Center, LLC
MidSouth Interventional Pain Institute, LLC

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2015
This notice was most recently revised on: January 1, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Lisa Gillespie
Mailing Address: 122 Airways Place Southaven, MS 38671
Telephone: 662-349-9990
Fax: 662-349-2620
E-mail: lgillespie@midsouthpain.com

About this Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of you PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?

Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How we may use and disclose your PHI

We may use and disclose your PHI in the following circumstances:

For Treatment. We may use your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose your PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person were you with respect to disclosures of your PHI.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities, We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral directory so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PhI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny you request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets electronically (for example, an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

Right to Receive Notice of Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of you Unsecured PHI.

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for you request. We may deny your request 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 (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (4) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures", which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. You request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we

may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in you care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or cal you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You can get a copy of this Notice at our website http://midsouthpain.com.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes to This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filling a complaint.

Optional Provisions to be Included as applicable:

Medical Residents and Medical Students. Medical residents or medical students may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.

Newsletters and Other Communications. We may use your PHI to communicate to you by newsletter, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Psychotherapy Notes. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law.