# PATIENT ACKNOWLEDGEMENT:

- **FINANCIAL & OFFICE POLICIES**
- **CONSENT TO TREATMENT**
- **NOTICE OF PRIVACY PRACTICES**

COMPASS PAIN AND SPINE

Effective December 1, 2025

## 1. FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I am personally, primarily, and fully liable for payment of all charges incurred at Compass Pain and Spine, PLLC, regardless of insurance coverage, third-party responsibility, attorney representations, settlement outcomes, or any other factor.

We file insurance as a courtesy, but your insurance contract is between you and your insurer.

- **Co-pays, deductibles, co-insurance, and non-covered services are due at the time of service.**
- You are responsible for obtaining any required referrals or prior authorizations. Services rendered without them are your responsibility.
- If your insurance lapses, is terminated, or denies coverage for any reason (including retroactive denial), you are fully responsible for the balance.
- If you are being treated for a workers' compensation injury, personal injury/auto accident, or under a Letter of Protection (LOP) and you have not disclosed this or provided proper documentation, you remain personally liable for all charges.
- We will honor properly executed Letters of Protection or attorney lien letters and defer collection until your case resolves, but we reserve the right to pursue you personally if the LOP is not honored or the case resolves with no recovery.

To the fullest extent permitted by law and contract, I hereby irrevocably assign, transfer, set over, and convey directly to Compass Pain and Spine, PLLC any and all of the following benefits, proceeds, and rights for services rendered to me:

- All commercial health insurance benefits (including but not limited to Blue Cross Blue Shield, UnitedHealthcare, Cigna, Aetna, Humana, and any other private carrier)
- Medicare Part B, Medicare Advantage (Part C), and Medicare Supplemental benefits
- TRICARE (including TRICARE for Life) benefits
- Veterans Affairs (VA) Community Care / TriWest benefits
- Personal Injury Protection (PIP), Medical Payments (Med-Pay), and Uninsured/Underinsured Motorist (UM/UIM) benefits
- Any health benefit plan, employee welfare benefit plan, or third-party liability proceeds

**This irrevocable assignment specifically includes the right of Compass Pain and Spine to:**

- Submit claims and receive direct payment
- Appeal denials, underpayments, or delays
- Pursue and collect statutory prompt-pay penalties and attorney fees under Texas Insurance Code Chapters 542 and 544
- Endorse, negotiate, and deposit any check, draft, or electronic funds transfer issued to me or jointly

**RELEASE OF INFORMATION:** I authorize Compass Pain and Spine PLLC to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and commercial insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

**ASSIGNMENT OF BENEFITS:** I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

**AGREEMENT OF RESPONSIBILITY:** I understand that COPAYMENT IS DUE AT THE TIME OF SERVICE (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered

by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to Compass Pain and Spine PLLC if this matter is referred to collection.

**MEDICARE/TRICARE/VA/FEDERAL PROGRAMS AUTHORIZATION:** If a Medicare, TRICARE, VA, or other FEDERAL program beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier. I request that payment of authorized benefits be made directly to Compass Pain and Spine, PLLC for any services furnished. This signature serves as a lifetime signature on file until revoked in writing.

**2. LETTER OF PROTECTION (LOP) / PERSONAL-INJURY / ATTORNEY-LIEN POLICY**

If my care is related to an auto accident, premises liability, or any third-party claim and a valid, signed Letter of Protection or attorney lien letter is on file:

- We will defer billing and collection until the case is fully resolved (settled, tried, dismissed, or abandoned).
- We will bill at our full, usual and customary charges. We are not required to accept insurance contracted rates, write off, or proportionally reduce our balance unless we specifically agree in writing at the time of settlement.
- We are authorized to communicate directly with your attorney, case manager, opposing counsel, insurance adjuster, or any party involved in the claim.
- Your attorney is expected to protect our charges in any settlement or judgment and disburse payment directly to us before any funds are released to you.
- If the LOP is not honored, your attorney withdraws or is discharged, or the case resolves with no recovery or insufficient funds, I remain personally and fully liable for the entire outstanding balance plus interest at the maximum legal rate, reasonable collection costs, and attorney fees permitted under Texas law.

**3. ADDITIONAL FEES (not billable to insurance)**

- Missed or cancelled appointment with less than 24 business hours' notice: up to $200
- Returned checks or failed electronic payments: $35 or maximum allowed by Texas law
- Medical supplies / durable medical equipment provided in office: payable at checkout (overpayment refunded if insurance later reimburses)
- At our discretion, we may be able to assist you with completion of certain forms. (FMLA, short-term disability, attending physician statements, school/work excuses, etc.): $25–$200 depending on complexity
- Medical records copies: $25 base fee + $0.50 per page after 20 (per Texas Medical Board rates)
- Complex or after-hours physician telephone/video consultations: may be billed at the physician's discretion

**4. CONSENT TO TREATMENT**

I voluntarily consent and authorize the physicians, physician assistants, nurse practitioners, nurses, and qualified staff at Compass Pain and Spine, PLLC to perform upon me (or the minor/ward for whom I am legally responsible):

- Comprehensive history and physical examinations
- Diagnostic testing including X-rays, EMG/NCV, laboratory studies, and referral for MRI/CT/ultrasound
- Interventional pain-management procedures under fluoroscopic or ultrasound guidance (including but not limited to epidural steroid injections, facet joint injections, medial branch blocks, radiofrequency neurotomy/ablation, sacroiliac joint injections, trigger point injections, peripheral nerve blocks, sympathetic blocks, spinal cord stimulator trials, and implantation procedures)
- Prescription and management of medications, including controlled substances (opioids, benzodiazepines, stimulants) when medically appropriate and in compliance with Texas Medical Board and DEA regulations
- Minor in-office procedures (joint aspirations, Botox injections, etc.)
- Photography, video, or audio recording for medical record documentation, quality assurance, or educational purposes (identifying information removed when used outside direct patient care)
- Emergency evaluation and treatment in the unlikely event of an adverse reaction

I understand that no guarantees have been made regarding results, that all procedures and medications carry risks that will be explained to me, and that I may withdraw consent or refuse any examination, test, medication, or procedure at any time.

## 5. CONDITIONS OF TREATMENT AGREEMENT AND PATIENT CODE OF CONDUCT

To help us maintain a safe and respectful environment, we have established a set of expectations for conduct. We believe a positive and respectful relationship between patients and staff is essential for effective care.
Please read this agreement carefully.

Your signature below indicates that you understand and agree to abide by these conditions during your relationship with our clinic.

(1) **General Consent for Treatment**

- I, the undersigned patient (or legal guardian), hereby consent to the general medical care, diagnosis, and treatment provided by the physicians, nurse practitioners, physician assistants, and staff.
- I understand that I have the right to be informed about my care, discuss treatment options, refuse treatment, and ask questions at any time.
- I understand that no guarantees have been made regarding the results of any treatment.

(2) **Patient Responsibilities**

- I agree to provide accurate and complete information about my health history, symptoms, and all medications (including over the counter and supplements).
- I agree to follow the recommended treatment plan or discuss any concerns about the plan openly with my provider.
- I agree to keep all scheduled appointments or provide adequate notice for cancellations.
- I agree to adhere to the financial policies of the clinic.
- I agree to adhere to the medication policy which was offered to me in print or can be found on the clinic website.

(3) **Patient Code of Conduct: Zero Tolerance Behaviors**

We have a zero-tolerance policy for behaviors that are abusive, disruptive, or threatening to staff, providers, other patients, or visitors. The following conduct is strictly prohibited on clinic premises and during any communication with clinic staff (phone, email, etc.):

- Verbal Abuse and Disrespectful Language:
  - Yelling, screaming, or using an unreasonably loud tone.
  - Use of profanity, cursing, or obscene remarks.
  - Belittling, demeaning, or degrading comments (e.g., name-calling, personal sarcasm).
  - Making inflammatory or derogatory statements.
- Discrimination and Harassment:
  - Derogatory remarks, slurs, or jokes based on a person's race, ethnicity, national origin, skin color, religion, gender, sexual orientation, age, disability, or other personal traits.
  - Refusal to receive care or service from a staff member based on these personal traits.
  - Sexual harassment, including unwanted touching, vulgar words, or inappropriate gestures.
  - Bullying, stalking, or any actions that make staff or other patients feel unsafe or uncomfortable.
- Physical Misconduct and Safety Threats:
  - Actual or threatened physical harm or violence.
  - Throwing objects, blocking access, hitting, pushing, or spitting.
  - Possession of firearms, weapons, illicit drugs, or alcohol on clinic premises.
  - Any form of illegal activity or theft.

(4) **Consequences of Non-Compliance**

I understand that my failure to comply with the above Code of Conduct or other practice policies may result in one or more of the following actions:

- A formal verbal warning.
- A formal written warning and a required behavioral contract.
- Immediate or eventual termination of the patient-physician relationship and dismissal from the practice.

**If the relationship is terminated, I will receive written notice providing a specific timeframe (usually 30 days) to find a new healthcare provider. During this transition period, the clinic will only provide emergency care as required by law. The clinic will provide assistance in transferring my medical records to my new provider upon signed authorization.**

**I have read and understand the policies and conditions outlined in this agreement. I agree to adhere to these terms**.

## 6. OFFICE POLICIES

- Prescription refills (especially controlled substances) are not provided after hours, on weekends, holidays, or through emergency rooms. Lost or stolen prescriptions will not be replaced early. Full "Medication Policy" available on website and portal or can be requested by print format.
- Patient Portal – Registration and use is mandatory for all patients.
- Communication – We use phone, text, and email for appointment reminders and clinical messaging. You may opt out of marketing messages, but not appointment or clinical messages.
- Service Animal Policy – Only ADA-defined service animals are permitted. Emotional support animals, comfort animals, and pets are not allowed.

## 7. WORKERS' COMPENSATION / PERSONAL-INJURY CERTIFICATION

I certify that the condition(s) for which I am seeking treatment is not related to a workers' compensation claim or motor-vehicle/personal-injury accident unless I have disclosed it in writing and provided all required documentation (claim number, adjuster contact, attorney LOP, etc.).

## 8. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
We are required by federal and Texas law to protect your health information and to provide you this Notice.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION FOR:

| Purpose | Examples of Who We May Share With |
|---|---|
| Treatment | Your referring physician, specialists, hospitals, surgery centers, imaging facilities, labs, pharmacies, physical therapists, case managers, etc. |
| Payment | Your health insurer, Medicare, TRICARE, VA/TriWest, PIP/Med-Pay, UM/UIM carrier, workers' comp insurer, liability carrier, your attorney (plaintiff or defense), opposing counsel (when required by law), case manager, or any third-party payer |
| Health Care Operations | Quality review, staff training, accreditation, billing companies, auditors, attorneys, business associates |
| Family / Personal Representatives | Spouse, domestic partner, parents, adult children, or anyone you identify as involved in your care or payment (unless you object) |
| Appointment Reminders & Health-Related Messages | Phone calls, texts, emails, patient portal messages |
| As Required or Permitted by Law | Public health reporting, abuse/neglect, FDA, law enforcement, court orders, coroners, workers' compensation, national security, etc. |
| To Avert Serious Threat | Law enforcement or others if needed to prevent imminent harm |

**SPECIAL NOTES FOR PERSONAL-INJURY / LOP CASES**

When you are being treated under a Letter of Protection or on a lien basis, we routinely share records and bills with your plaintiff attorney, case manager, opposing counsel, and insurers. This is considered a permitted "payment" disclosure and does not require a separate authorization.

USES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

- Marketing (if we are paid)
- Sale of your health information
- Most psychotherapy notes
- Anything not listed above

**You may revoke an authorization in writing at any time.**

YOUR RIGHTS

- Request restrictions (we are not always required to agree)
- Request confidential communications
- Inspect and obtain copies of your records (reasonable fees may apply)
- Request amendments

- Receive an accounting of certain disclosures
- Be notified of a breach of unsecured information
- Obtain a paper copy of this Notice anytime
- File a complaint with us or the U.S. Department of Health and Human Services (no retaliation)

**QUESTIONS OR COMPLAINTS** Privacy Officer: Brianna Do 3406 N Tarrant Pkwy, Suite 230, Fort Worth, TX 76177 Phone: (817) 886-2000 Email: privacy@compasspainandspine.com
Full Notice also posted at www.compasspainandspine.com

This Notice was last revised December 1, 2025.

## 9. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, FINANCIAL POLICIES, OFFICE POLICIES, CONSENT TO TREATMENT, AND ALL OTHER TERMS ABOVE

**I have been offered and/or received the Compass Pain and Spine Notice of Privacy Practices (above in print and on clinic website).**

**I have read, understand, and agree to the Financial Policy, Office Policies, Consent to Treatment, Workers' Compensation/Personal Injury Certification, and all other terms above.**

**I have read, understand, and agree to the Condition of Treatment Agreement. I will adhere to the Code of Conduct and understand that the consequence of non-compliance is termination of the patient-physician relationship and dismissal from the practice.**

**I understand Compass Pain and Spine may update these policies; updated versions will be available in my portal, on the clinic website, or upon request.**

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|---|---|
| Signature (required) ▶ | Date |
| Printed Name | DOB |