NEW ENGLAND SPINE CARE
Spine, Sports, and Regenerative Medicine
P: 617-547-7163 F: 617-547-7165 NeSpineCare.com

S. Ali Mostoufi, M.D.
Robert A. Rosenberg, M.D.

Cambridge
799 Concord Ave
Cambridge, MA
02138
T (617) 547-7163
F (617)547-7165

Stoneham
92 Montvale Ave
Ste 3250
Stoneham, MA 02180
T (781) 979-0140
F (781) 435-0562

Name: _____ DOB: _____ Email: _____
Address: _____City_____ State: _____ Zip: _____
Home phone: _____ Cell phone: _____
PCP: _____ Referring Doctor: _____
Insurance: _____ Insurance ID: _____
Secondary Insurance: _____ Insurance ID: _____
Emergency Contact Information: _____

Motor Vehicle accident: Yes No Work Injury: Yes No (If work Injury, provide your SS# _____)

Height: _____ Weight: _____ Primary language: _____
Race: White Hispanic Black Other : _____ Ethnicity: _____

If necessary can we call & leave messages for you on your home or mobile number? ___ Yes ___ No

Name of pharmacy & address: _____

List Your Allergies:
☐ No Allergies
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

Tell us if you are allergic to: (circle)
Contrast dye Iodine IVP dye Anesthetics
Shell Fish Latex Steroids Adhesive Tape

Your Current Medications including Vitamins with dosages

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Are you on any of the following medications? (circle)

Aspirin Aggrenox Acova Angiomax Aggrastat
Bufferin Coumadin Clopidogrel Heparin Integrilin
Iprivax Jantoven Lovenox Pradaxa Plavix Ticlid
Xarelto ReoPro Refludan Warfarin Fish oil

Please tell us if you:

Are pregnant	N/A	Yes	No	Unsure
Have a pacemaker		Yes	No	
Have or had Hepatitis		Yes	No	
Have a known Transmittable disease		Yes	No	
Are on a blood thinner?		Yes	No	

Social History

Your Job: _____ Private

Married/Partner	Yes	No	
Separated/Divorced/Widow	Yes	No	
Any Children?	Yes	No	
Any Litigation:	Yes	No	
History of drug or med abuse	Yes	No	
Smoker?	Yes	No	Quit
Heavy Drinker?	Yes	No	Quit

NOTICE: By signing below, you acknowledge receiving and agreeing with the terms of the following two documents which is pertinent to your care by "New England Spine Care" and "New England Ambulatory Surgicenter" Physicians:

1. Our Privacy Notice (HIPAA)
2. Policy Disclosure (includes Insurance Assignment and Release Authorization, Medicare and Medicaid supplement Authorization, Authorization for Release of Information, Individual Patient Authorization, Patient Rights and Responsibility, Advance Directive Policy, Ownership disclosure and Informed Consent Policy)

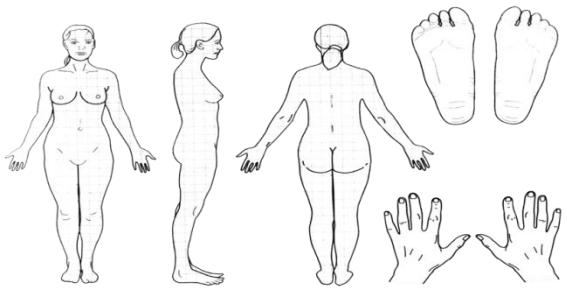
Signature: _____ Date: _____

What is your <u>Main Complaint</u>? _____

When and how it started? _____

Average daily pain: 0 1 2 3 4 5 6 7 8 9 10 (worse)

Where is the pain /symptom located?



Describe the symptoms: (circle)

Fixed pain Shooting pain Constant On/Off Dull

Night pain Sharp Burning Ache Pressure

Numbing Tingling Electrical Pins & Needles

Weakness (where: _____)

What activity makes your pain WORSE?

Sneeze Cough Bending Sitting Walking Leaning Forward

Lifting Sports Lay on side Sex Standing Arching backward

Menstrual period Lay on Stomach Laying on Back

What activity IMPROVES your pain?

Sitting Walking Standing Leaning Forward Lay on side

Arching backward Lay on Stomach Laying on Back Lean on shopping cart or a walker

Which treatment have you tried?

Physical Therapy Chiropractor Acupuncture Gym Ice Massage Heat Brace Cane

Pain medications Muscle relaxants Anti-Inflammatory

Spine Injections (What type: _____) Spine Surgery (What type: _____)

What has been the most effective treatment so far? _____

List the Medications you have tried for this problem: _____

Current Pain Medication: _____

For your spine problem, which of the following test results do you have? Where and when was it done?

☐ X-ray ☐ CT scan ☐ MRI ☐ PET scan ☐ Bone Scan ☐ EMG ☐ Other

Date and Location: _____

Did you have similar problems before? If yes, who treated you then? _____

<u>Currently</u>, are you experiencing any of these symptoms?

(circle)

Leg numbness / Tingling / Weakness - Left or Right

Arm numbness /Tingling / Weakness - Left or Right

Leg or Arm swelling

Genital numbness or Urinary /Stool Incontinence

Frequent falls Balance issues

Headaches Double Vision

Poor sleep Fatigue

Active infections Blood in stool

Chest Pain Short of Breath

List Previous Surgeries: _____

_____

List Family Health problems :

Mother : _____ _____ _____alive/deceased

Father:_____ ___alive/deceased

Siblings:_____ ___alive/deceased

_____

What other Medical Problems do you have? (circle)

High blood pressure Heart disease/Murmur

Cardiac stent/Valve Circulation problem

Pace maker Atrial Fibrillation

Blood clots Bleeding disorder

High Cholesterol GI bleeding /disease

Liver disease Kidney disease

Neurologic disease COPD

Asthma Diabetes

Thyroid disease Osteoporosis

Anxiety Depression

Cancer(Type)_____

NEW ENGLAND SPINE CARE
Spine, Sports, and Regenerative Medicine
P: 617-547-7163 F: 617-547-7165 NeSpineCare.com

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between New England Spine Care & New England Ambulatory SurgiCenter (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). A Responsible Party is the individual who is financially responsible for payment of medical bills. **ALL charges for services rendered are due and payable at the time of service.**

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As you are the responsible party, you are responsible if your insurance declines to pay for any reason.

Cancellation & No Show Policy: Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, New England Spine Care & New England Ambulatory SurgiCenter reserve the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advanced notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. After three "no-shows" in any 12-month period may result in termination from our practice.

The person signing on behalf of the patients as the Responsible Party must:

- Inform New England Spine Care of the current address and phone number for the patient and the Responsible Party and verify all other patient information
- Present all current insurance cards (including MVA and WC information) prior to each office visit
- Pay any required copayment at the time of visit
- Pay any additional amount owing within 60 days of receiving a statement from our office
- Give 24 hour advanced notice to New England Spine Care/New England Ambulatory SurgiCenter of appointment cancellations

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the Responsible Party for minor patients. Your signature certifies that you have read the above disclosure statement, understand your responsibilities and agree to these terms.

Patient Name: _____

Responsible Party: _____

Responsible Party Signature: _____ Date: _____

Medicare Secondary Payor Questionnaire (MSPQ)

1. Are you receiving Black Lung (BL) Benefits?
    a. Yes or No
2. Are the services being paid by a government research program?
    a. Yes or No
3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)?
    a. Yes or No
4. Was the illness/injury due to a work-related accident/condition?
    a. Yes or No
        i. If yes please state the date, WC company, policy number, and adjustors information:

        _____

        _____

        _____
5. Was this illness/injury due to a non-work-related accident?
    a. Yes or No
        i. If yes, please state the date and insurance information:

        _____

        _____

        _____
6. Are you entitled to Medicare based on Age?
    a. Yes or No
7. Are you entitled to Medicare based on Disability?
    a. Yes or No
8. Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)?
    a. Yes or No
9. Are you currently employed?
    a. Yes or No Retirement Date: _____
        i. If you are currently employed, please list your employers name and if applicable date of retirement:

        _____

        _____
10. Do you have a spouse who is currently employed?
    a. Yes or No Retirement Date: _____
        i. If your spouse is currently employed, please list your employers name and if applicable date of retirement:

        _____

        _____

Patient Name: _____ Date: _____

New England Spine Care & New England Ambulatory SurgiCenter
Patient Instructions for Discontinuing Medications before Spinal Procedures/Injections

Medication Anticoagulant- Antiplatelet	STOP BEFORE Injection/Procedure	RESTART AFTER Injection/Procedure	AUTHORIZATION TO HOLD MEDICATION REQUIRED
ASPIRIN 500 MG	4 days	24 hours	YES
ASPIRIN 325 MG	4 days	24 hours	YES
ASPIRIN 81 MG	4 days	24 hours	YES
BUFFERIN	5 days	12 hours	YES
ABCIXIMAB/REOPRO	5 days	12 hours	YES
ACENOCOUMAROL	5 days-INR 1.3	24 hours	YES
AGGRASTAT/TIROFIBAN	24 hours	24 hours	YES
APIXABAN/ELIQUIS	72 hours	24 hours	YES
AGGRENOX	7 days	12 hours	YES
ARIXTRA/FONDAPARINUX	4 days	24 hours	YES
BRILINTA/TICAGRELOR	5 days	12 hours	YES
CILOSTAZOL/PLETAL	48 hours	24 hours	YES
CLOPIDOGREL/PLAVIX	7 days	12 hours	YES
COUMADIN/WARFARIN	5 days-INR 1.3	24 hours	YES
DABIGATRAN/PRADAXA	4 days	24 hours	YES
DALTEPARIN/FRAGMIN	24 hours	12 hours	YES
DIPYRIDAMOLE/PERSANTINE	48 hours	24 hours	YES
EFFIENT/PRASUGREL	7 days	12 hours	YES
ELIQUIS/APIXABAN	72 hours	24 hours	YES
ENOXAPARIN/LOVENOX	24 hours	12 hours	YES
EPTIFIBATIDE/INTEGRILIN	24 hours	24 hours	YES
FONDAPARINUX/ARIXTRA	4 days	24 hours	YES
FRAGMIN/DALTEPARIN	24 hours	12 hours	YES
HEPARIN IV	8 hours	24 hours	YES
HEPARIN SQ	8 hours	12 hours	YES
LOVENOX/ENOXAPARIN	24 hours	12 hours	YES
PERSANTIN/DIPYRIDAMOLE	48 hours	24 hours	YES
PLAVIX/CLOPIDOGREL	7 days	12 hours	YES
PLETAL/CILOSTAZOL	48 hours	24 hours	YES
PRADAXA/DABIGATRAN	4 days	24 hours	YES
PRASUGREL/EFIENT	7 days	12 hours	YES
REOPRO/ABCIXIMAB	5 days	12 hours	YES
RIVAROXABAN (XARELTO)	72 hours	24 hours	YES
TICAGRELOR/BRILINTA	5 days	12 hours	YES
TICLID	14 days	24 hours	YES
TICLOPIDINE	14 days	24 hours	YES
TIROFIBAN/AGGRASTAT	24 hours	24 hours	YES
VORAPAXAR	7 days	12 hours	YES
WARFARIN/COUMADIN	5 days-INR 1.3	24 hours	YES

Medication NSAIDS and Others	STOP BEFORE Injection/Procedure	RESTART AFTER Injection/Procedure	AUTHORIZATION TO HOLD MEDICATION REQUIRED
Celebrex	Do not stop	Do not stop	N/A
Daypro	5 Days	24 hours	NO
Diclofenac/Voltaren	4 Days	24 hours	NO
Dolobid	4 Days	24 hours	NO
Ecotrin	4 Days	24 hours	NO
Etodolac/Lodine	4 Days	24 hours	NO
Excedrin	4 Days	24 hours	NO
Fiorinal	4 Days	24 hours	NO
Ibuprofen	4 Days	24 hours	NO
Indocin	4 Days	24 hours	NO
Indomethacin	4 Days	24 hours	NO
Ketorolac/Toradol	4 Days	24 hours	NO
Lodine/Etodolac	4 Days	24 hours	NO
Meloxicam	5 Days	24 hours	NO
Midol	4 Days	24 hours	NO
Motrin	4 Days	24 hours	NO
Nabumetone	7 days	24 hours	NO
Naprosyn/Aleve	4 Days	24 hours	NO
Naproxen	4 Days	24 hours	NO
Oxaprozin	5 Days	24 hours	NO
Percodan	4 Days	24 hours	NO
Relafen	7 days	24 hours	NO
Salasate	4 Days	24 hours	NO
Sulindac	4 Days	24 hours	NO
Talwin/Pentazocine	4 Days	24 hours	NO
Toradol/Ketorolac	4 Days	24 hours	NO
Trilisate	4 Days	24 hours	NO
Vicoprofen	4 Days	24 hours	NO
Voltaren/Diclofenac	4 Days	24 hours	NO

Weight loss and Nutrition Supplements to be held for 5 days

(No Authorization to hold required)

Alpha Lipoic acid	*Acetyl 1 1. Carnitin*	*Cinnamon*	*Chamomile*	*Creatinine*
Echinacea	*EPHEDRA*	*Fish oil*	*Garlic*	*GINGER*
GINKGO BILOBA	*Ginseng*	*GLUCOSAMINE*	*Glutenin*	*Goldenseal*
L -Carnosine	*Licorice*	*Kava Kava*	*Milk Thistle*	
Omega-3	*Resveratol*	*Skullcap*	*St Joh's Wort*	*Vitamin E*

IF YOU HAVE ANY QUESTIONS REGARDING THESE INSTRUCTIONS CALL 617-547-7163

At home after your injection:

- You may apply an ice pack 20 minutes at a time to the injection site if you experience soreness.
- You may take a shower, but AVOID getting into baths, pools, or whirlpools for 24 hours after the injection. Keep the injection site clean and dry. You may remove the Band-Aid the day following the injection.
- You will be asked to take it easy on the day of your injection. You may return to your normal daily activities the next day.
- You may resume your Anti-inflammatory medications and BLOOD THINNERS the following day after the injection.
- You may start or resume your individualized exercise program or physical therapy as soon as 48 hours after the injection.
- If your procedure was a diagnostic injection, the effect would be limited to the day of the injection. If this is a therapeutic injection, it usually takes one week to notice the effect. Certain procedures will take up to three weeks to work.
- A small portion of our patients will experience increased pain for the first 24-48 hours. It is impossible for us to know who would respond in this manner. Taking over the counter pain killers usually controls the temporary increased pain.
- Side effects that may occur, but will go away in a few days are: briefly increased pain, trouble sleeping, facial flushing, migraine attack (in patients who have migraine headache at baseline), and local muscle spasms.

When to call the doctor:

- **Severe pain uncontrolled with ice, heat, NSAIDS, your prescribed pain killers and rest.**
- **Severe headache that gets worse when sitting up (or standing) and disappears when you lie down.**
- **Fever or chills.**
- **New incontinence (loss of bladder or bowel control).**
- **Redness or swelling around the injection site.**
- **Weakness.**
- **If the physician on call has concerns regarding your safety after injection, he/she may direct you to your local Emergency Room so a physician could examine you. This scenario is very rare. In such cases, we will setup a follow-up visit the next day to evaluate you as well.**
- **When calling us, since the person who will respond to you may not be the physician who has done the procedure, please be prepared to tell them your name, birth day, date of the procedure, name of the procedure and the side (Right or left).**

Please visit our website to find specific information and instructions on your upcoming procedure at www.NeSpineCare.com

- Caudal Injection
- Cervical Diagnostic MBB
- Cervical Epidural Injection
- Cervical Facet Injection
- Genicular Nerve Ablation
- Hip Bursa Injection
- Lumbar Epidural Injection
- Lumbar Facet Injection
- Lumbar MBB and RF
- Lumbar Transformational Injection
- Sacroiliac Joint Injection
- Shoulder Injection
- Spinal Cord Stimulator
- Stellate Ganglion Block
- Thoracic Epidural Injection
- Thoracic Facet Injection
- Trigger Point Injection

Visit www.BostonRegen.com for information on:

- PRP Injection
- Stem Cell Therapy

Procedure Date: _____

Procedure Time: _____

Medication to Hold: _____

New England Spine Care
New England Ambulatory SurgiCenter

Procedure Information Package

PLEASE REMEMBER:

No food or drink for 2 hrs prior to your procedure.
A driver is required on the day of your procedure.

We are Credentialed and Certified by CMS/Medicate and AAAHC (Accreditation Association of Ambulatory Health Care)

What is a spinal injection? Your spine specialist has recommended a spinal injection to help reduce pain and improve function. This procedure can help relieve pain by reducing inflammation. An injection can also be used as a diagnostic tool to identify the source of pain (Nerve Blocks). The type of injection you receive is based on your specific symptoms and the physical examination performed. Your spine specialist should explain the reason for receiving the injection. If you are not well informed regarding the injection you are going to receive, make an appointment and speak to your doctor. You may need one or more injection(s) for maximum effect. All patients need to see their spine specialist at the spine center 2-3 weeks after the injection(s).

Preparing for Your Injection

Before your injection, you will fill out a short questionnaire regarding your health. Please indicate any changes in your health, medications and allergies since last time you visited the spine center.

If there is the possibility that you have a cold, flu or other infection (on antibiotics), it is important that you tell us. You will have to reschedule the procedure when the infection is cleared.

For your benefit, bring your MRI or CT reports and films (or CD) with you to all scheduled injections

You will need a companion with you after the procedure.

You should not drive following the procedure since you may have some temporary numbness.

You can eat a light meal up to 2 hrs before the procedure. Do not eat if you are taking a sedative to remain calm during the procedure.

If you need to cancel your procedure, notify us 3 days in advance so we could accommodate someone else.

Notify us if you are allergic to betadine (Iodine), Lidocaine, Contrast dye, Latex or Shellfish.

Notify us if you are pregnant or even if there is a remote possibility of being pregnant.

Please note that it is recommended that you continue all prescribed medications (blood pressure, heart, diabetes, diuretics (water pills). You may continue prescribed pain medications that do not cause thinning of the blood including Ultram (Tramadol), Vicodin (Hydrocodone), and Tylenol (Acetaminophen).

STOP THESE MEDICATIONS that increase bleeding risks:

All aspirin products (including Bayer, Ecotrin, Alka Seltzer, baby or low dose aspirin, etc.) 4 days prior to your scheduled procedure. We may ask permission from your PCP for this.

Non-steroidal anti-inflammatory (NSAIDs) medications: Hold 4 days prior to the procedure (Advil, Motrin, Nuprin, Ibuprofen, Aleve, Naproxen, Relafen, Voltaren, Lodine, Mobic, etc).

Blood thinners (Coumadin, Plavix, or Ticlid, Heparin, Lovenox). Please contact our nurse (617) 547-7163 for further instructions on how to manage this. We will ask your primary care doctor for guidance.

Supplements like fish oil and vitamin E (4) days prior to the procedure.

If you are diabetic:

You will experience elevated blood sugars for up to a week after your spinal injection related to the corticosteroid used. Usually elevation is about 50 to 100 points over your normal blood sugar levels. If you are on insulin, your sliding scale could be used to adjust the blood sugars. If you are on oral agents and experience high blood sugars (over 300), call us for instructions. In most cases no specific treatment is needed and blood sugar level normalizes.

Risks and Complications

All medical interventions have benefits and risks. Alternative care could be considered including “do nothing”. Spinal injections have risks and complications that can include allergic reaction to medication, spinal headache, increased pain, bleeding (rare), infection (rare), or nerve injury (rare), Stroke (very rare) and death(very rare). As infrequent/rare as these complications are, it is important to understand the possibility and make an informed decision regarding your treatment. We perform our procedure with state of the art technology. Our surgical center environment uses sterile technique to ensure your safety according to National Standard of Care. Our center is certified by Accreditation Association for Ambulatory Health Care. Our physicians have specific training & extensive experience in performing such procedures.

Checking In for Your Procedure:

Your procedure will take place at: New England Ambulatory SurgiCenter located on the first floor of Sancta Maria Building “**799 Concord Ave, Cambridge MA 02138 (617) 547-7163** “. You will need to arrive 15 minutes prior to your scheduled injection to fill out the necessary paperwork.

Bring your insurance information with you. Make sure you come with a companion who can drive you back home. If you expect any delays or need to cancel, please call **(617) 547-7163.**

During the Procedure

- The procedure is usually brief, but your position during the procedure is important to make the injection go smoothly. You will have monitoring devices attached to you during the procedure to check your heart rate and breathing. Medical devices do make noise (beeping sounds), do not be alarmed.
- You will be consented for the procedure.
- Your skin will be cleaned with a disinfecting solution and a sterile paper drape will be placed over your skin.
- Local anesthetic (Lidocaine) is usually given near the injection site to numb the skin. This typically feels like a pin prick and some burning.
- Fluoroscopy (X-ray imaging) is used for precise placement of the needle. Iodine based Contrast dye will be injected to confirm the correct placement of the needle.
- A local anesthetic (i.e., lidocaine, bupivicaine) and/or Corticoteroids(i.e., Triamcinolone, Celestone, Betamethasone to reduce inflammation) is then injected and the needle will be removed.
- We will clean your skin again and a small bandaid will be placed at the injection site.
- You will be escorted / transported to the recovery area. Nursing staff will monitor you and go over the discharge instructions. In most cases, you will be discharged within 15 minutes after the procedure. You will leave with a pain log that you will bring with you to the follow-up appointment.

NEW ENGLAND SPINE CARE
Spine, Sports, and Regenerative Medicine
P: 617-547-7163 F: 617-547-7165 NeSpineCare.com

Important financial information regarding your upcoming procedure

In the recent years, there has been a substantial change regarding healthcare coverage. Due to these changes, you are likely to be responsible for a portion of your charges including copayments and deductible payments.

Please call your insurance company today and ask about your coverage and the exact amount of copayments, deductibles, and covered benefits prior to your upcoming procedure. Please understand that this service will be billed as an outpatient procedure and there will be TWO separate bills, a Physician Bill and a Facility Bill. **ALL PATIENTS ARE REQUIRED TO CALL AND VERIFY THEIR COVERED BENEFITS PRIOR TO ANY PROCEDURE.**

These copayments and deductibles are due at the time of your upcoming injection (pay by Check, Cash or Credit Card)**.** Please write the amount of your Co-pay below and bring it in with you to your injection appointment:

My Co pay: _____

Provider:

- ☐ Seyed Ali Mostoufi, MD (NPI # 1790753721)

Facility Name:

- ☐ New England Ambulatory Surgicenter (NPI # 1851491013 / Tax ID # 20-5110715)
- ☐ New England Spine Care Associates (NPI# 1952312795 / Tax ID # 59-3812793)

Type of procedure:

☐ Cervical/Thoracic Epidural Steroid Injection (CPT Code: 62321) ☐ Lumbar Epidural Steroid Injection (CPT Code: 62323)
☐ Cervical/Thoracic Transforaminal Epidural Steroid Injection (CPT Code: 64479) ☐ Lumbar Transforaminal Epidural Steroid Injection (CPT Code: 64483)
☐ Cervical/Thoracic Medial Branch -Facet Injection (CPT Code: 64490, 64491, 64492) ☐ Lumbar Medial Branch Block -Facet Injection (CPT Code: 64493, 64494, 64495)
☐ Cervical/Thoracic Radiofrequency Ablation (CPT Code: 64633, 64634) ☐ Lumbar Radiofrequency Ablation (CPT Code: 64635, 64636)
☐ Sacroiliac Injection (Facility Code G0260- Physician Code 27096)
☐ Discogram Cervical/Thoracic (CPT Code: 62291) ☐ Discogram Lumbar (CPT Code: 62290)
☐ Piriformis Injection (CPT Code: 64445) ☐ Large Joint (Shoulder, Hip, Knee, Coccyx) / Bursa Injection (CPT Code: 20610) ☐ Small Joint (Wrist, Elbows, Ankle) Injection (CPT Code: 20605) ☐ Digit (Finger & Toe) Injections (CPT Code: 20600) ☐ Occipital Nerve Block (CPT Code: 64405) ☐ Hamstring Injections (CPT Code: 20552) ☐ Ganglion Impar Block (CPT Code: 64520)
☐ Genicular Nerve Block (CPT Code: 64450) ☐ Genicular Nerve RFA (CPT Code: 64520)
☐ Fluoroscopy for Spinal Procedure (CPT Code: 77003) ☐ Fluoroscopy for Non-Spinal Procedure (CPT Code: 77002) ☐ Ultrasound Guidance for Procedure (CPT Code: 76882)

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.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered protected health information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities

New England Ambulatory SurgiCenter and New England Spine Care is required to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information that we collect and maintain.

We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain.

Copies of our Notice are available in our main reception area(s) and on our website.

How We May Use and Disclose Medical Information About You.

The following describes examples of the way we may use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, orally, written, facsimile and electronic communications.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. Examples may include contacting your insurance company for referrals, verification or preapproval of covered services.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. We may contact you to remind you of your appointment by telephone or reminder card unless requested otherwise.

Business Associates, BA: Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing and collection and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification: In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 60 days of the breach. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object

We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for, most uses and disclosures of psychotherapy notes; PHI for marketing purposes unless we speak with you and disclosures that constitute a sale of PHI. If you provide an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.

Marketing and Fundraising initiatives, if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights

Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to New England Ambulatory SurgiCenter and New England Physiatry. There will be a fee charged for all applicable copying and producing copy of portable media (CD, USB) up to the maximum amount as prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment and health care operations. New England Ambulatory SurgiCenter and New Enagland Spine Care will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations. *Restrictions from your health plan (insurance company)*: You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket. *Other Restrictions, Limiting Information:* You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.

We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address. We ask that you submit these requests in writing.

Email communication requests if applicable may require a separate authorization.

To exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.

For More Information or to Report a Problem

If you have questions and would like additional information please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services at 800-368-1019. Further instructions for filing a complaint can also be found at www.hhs.gov/ocr. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Telephone Number: **617 -758- 6805**

Privacy Officer: **Dr. S. Ali Mostoufi**
Security Officer: Ms. Josie Costa
Contact Officer: Ms. Josie Costa

New England Spine Care Associates
New England Ambulatory SurgiCenter

799 Concord Ave

Cambridge, MA 02138

Phone: 617-547-7163

Fax: 617-547-7165

Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (2001, 2003 and 2013)

Last Modified: December 31, 2019

Prepared by LDA and HARLLC. Given the complexity of the HIPAA Privacy, Security and HITECH laws this information is prepared as required with the understanding that LDA and HAR LLC are not engaged in rendering legal services or advice.

Patient Responsibilities

By taking an active role in your health care you can help your caregivers meet your needs as a patient or family m ember. That is why we ask that you and your family share with us certain responsibilities.

We ask that you Provide, to the best of your ability, accurate and complete information about your present condition, past illnesses, hospitalizations, medications, over the counter products, dietary supplements, allergies, sensitivities and other matters related to your health including information about home, work and Workman's Compensation that may impact your ability to follow the proposed treatment. **We ask that you f**ollow the treatment plan developed with your provider. You should express any concerns about your ability to comply with a proposed course of treatment. You are responsible for the outcome if you refuse treatment or do not follow your care provider's instructions. **We ask that you** Keep appointments or call us when you are unable to do so at least 2 business days before your appointment. **We ask that you** Provide a responsible adult to transfer you to and from home to our center when having a procedure. **We ask that you** Be considerate of other patients and our facility staff and their property. Abusive, threatening or inappropriate language or behavior will not be tolerated and may lead to discharge or transfer of care. **We ask that you** Give us any health care proxy or other legal document that may affect your decision-making ability or care, such as a power of attorney or court order. Notify us if you object to students or researchers participating in your care. **We ask that you** make known to your attending Physician, Nurse or other healthcare personnel of any concerns or complaints you may have. **We ask that you** make sure you understand all information regarding the implications of your symptoms, surgery or procedure (if applicable) and any risks related to having or declining such procedure, the expected outcome of the plan of care outlined by your Physician, and his responsibilities with regard to that plan of care, sustaining treatment, or taking part in research studies. For ensuring that the financial obligations of your healthcare are fulfilled as promptly as possible, and in the case of financial difficulty, making all reasonable efforts to meet any agreed-upon financial payment plan. Be honest about your financial needs so we may help you.

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage and assign directly to New England Spine Care/New England Ambulatory Surgicenter Physicians all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. New England Spine Care/New England Ambulatory Surgicenter Physicians may use my health care information and may disclosure such information to the my insurance company /Workman's comp insurer or MVA insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Medicare/Medicaid Supplement Authorization:

As a patient of this practice I authorized Medicare benefits and, if applicable, Medicare Supplement benefits, be made on my behalf to New England Spine Care/New England Ambulatory Surgicenter Physicians for any medical or surgical services furnished to me by the providers.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my supplement insurer, and their agents any information needed to determine these benefits or benefits for related services.

Individual Patient's Authorization:

This authorization is valid as long as you receive care by New England Spine Care /New England Ambulatory Surgicenter Physicians . This form serves to.

1. To confirm your authorization to use or disclose your protected health information for the purpose of obtaining records, imaging studies, and/or reports needed for my health care services. I understand that I may revoke this authorization at any time by giving notice in writing.

2. Release information to:
   New England Spine Care, Cambridge MA

   New England Ambulatory SurgiCenter, LLC, Cambridge MA

New England Spine Care Associates
New England Ambulatory Surgicenter

Policies Disclosure

Dear Patients

Please take a moment to review our practice policies

We thank you for allowing us to participate in your healthcare

Patient's Rights

You have the right to:

1.Receive health care that respects your cultural, psychosocial, and personal values and beliefs without being subjected to discrimination or reprisal.
2. Obtain a copy of any rules or regulations that relate to the conduct of patients, as provided below:

Privacy and Confidentiality and Safety: You have the following rights: 1.To:Know that your records and communications are confidential to the extent provided by law.2.Expect privacy during medical treatment and care, within the capacity of our center. 3.Receive care in a safe setting free of all forms of abuse and harassment.

Participation: You have the right to:1.Refuse to be examined, observed, or treated by students without jeopardizing access to other medical care.2.Refuse to serve as a research subject or receive any care or examination that is primarily for educational or informational purposes, rather than for treatment. 3.Participate in any consideration of ethical issues that arise in your care, such as resolving conflict, withholding resuscitation, forgoing or withdrawing life-sustaining treatment, or taking part in research studies. 4.Right to make suggestions and exercise rights without being subjected to reprisal or discrimination.

Information and Treatment: You have the right to:

1.Obtain the name and specialty of the physician or other health-care providers caring for you.2. Have all reasonable requests responded to promptly and adequately within the capacity of the center. 3.Expect reasonable access and continuity of care.4. Be an active participant in the development of your plan of care. Patients will receive sufficient information to give an informed consent to treatment, to the extent provided by law, including an explanation of their condition, proposed treatments, and alternative therapies, with their expected outcome, respective benefits and risks. Our Policy regarding informed consent will be provided to all registered patients as part of the "Policy Disclosure" packet prior to the procedure. You have the right to:6 Make informed decisions regarding your health care, including the decision to refuse or discontinue treatment to the extent permitted by law. If the patient is judged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf. If a state court has not adjudged a patient incompetent, any legal representative or surrogate designed by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.7.Fill out advance care directives, such as a health care proxy form to designate someone to make decisions for you in the event that you become incapable of understanding a proposed treatment or procedure, or are unable to communicate your wishes regarding your care.8.Request a complete copy of the Massachusetts Patient Rights Law (M.G.L. ch. 111 sec. 70E), which is available from Patient/Family Relations, or on the internet at www.mass.gov/legis/laws/mgl/111-70e.9.Bring an interpreter or other assistance as needed and available, when there is a language, communication or hearing barrier. 10.Inspect your medical record and receive a copy of it. If you would like a copy you may be charged a fee unless you demonstrate that your request supports a claim or appeal under any provision of the Social Security Act in any Federal or State needs-based benefit program.

Patient's Rights (continued)

11.You have the right to: Receive prompt life-saving treatment in an emergency without discrimination or delay based on economic or payment concerns.12.Receive prompt and safe transfer to the care of other medical centers when our center is unable to meet your request or need for treatment or service. 13.Receive a copy of an itemized list of charges submitted by us to your insurer or another third party regarding your care, the amounts covered by the third-party payer.14.Upon request, to receive from a person designated by the facility any information which the facility may have available to financial assistance, payments plans and free health care.15.Obtain an explanation of any relationship (including financial) the facility or your physician has with another health-care facility or educational institution to the extent that the relationship relates to your care. 16.Have the ability to change provider for another available, qualified provider in our center.17.To know services available such as provisions for after-hours or emergency care, educational material available and policies concerning payment policies and fee for services.18.Register complaints or grievances and seek solutions to problems with Practice Administrator. You have the right to file a grievance with our center if you have concerns regarding your care and treatment. 19. Notify the surgical center's administrator of concerns or complaints regarding patient's care, business practices or suggestions for improvement at (617) 456-4700.

You may also register a complaint with Massachusetts Department of Public Health, Division of Health Care Safety and Quality 99 Chauncy Street Boston, Massachusetts 02111 Hotline: 1(800)462-5540; with Mass. Board of Registration in Medicine: (800)377-0550, or through the website for the Office of Medicare Beneficiary Ombudsman , http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Patient Grievance

The physicians and staff of New England Ambulatory SurgiCenter and New England Spine Care are committed to serving their patients and families with the highest standard of care. We strive to continuously improve our standards through education, technology and awareness of health care costs to meet the ever-changing needs of our patients. We look on feedback, both positive and negative, as an opportunity to continuously improve our service.

Grievance process: Once Grievance is received our Administrator / Director of Nursing / Medical Director will address all Grievances on case by case basis. This prompts an investigation into the matter. The goal would be to reach a decision that is mutually satisfactory to all parties involved. The center will communicate the results of the investigation and resolution to the patient within 45 days. To file Grievance contact: Practice Administrator,799 Concord Ave. Cambridge, MA 02138.(617) 547-7163.
If you are not satisfied with our response to the issue after filing an internal complaint, you may contact one of the following agencies:Office of Medicare Beneficiary Ombudsman,1-800-633-4227, http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html Massachusetts Department of Public Health,Division of Health Care Safety and Quality,99 Chauncy Street Boston, Massachusetts 02111,Hotline: 1(800)462-5540

Informed Consent Policy

It is the policy of New England Physiatry and New England Ambulatory Surgicenter to obtain an informed consent from every patient (or legal guardian) before any procedure is performed at 'New England Ambulatory SurgiCenter' or at any other site of service. It is the responsibility of the treating physician to obtain informed consent from each patient undergoing a procedure by our physicians. A copy of this informed consent will be filed in the patient's medical record.

The purpose of informed consent is to:

1.Ensure that the patient understands the nature of the treatment, including potential complications2.To indicate that the patient's decision was made without pressure. 3.To protect the patient against unauthorized procedure. 4. To protect New England Physiatry and 'New England Ambulatory SurgiCenter' physicians against legal action by a patient who claims that an unauthorized procedure was performed.

Disclosure of Ownership

We recognize that you have the right to choose the provider of your healthcare services. We are pleased that you have chosen New England Spine Care physicians and New England Ambulatory SurgiCenter for your medical care.The following physicians maintain a partnership interest in New England Ambulatory SurgiCenter, LLC and New England Spine Care : Ali Mostoufi,MD,.Robert Rosenberg,MD

Advanced Directive Policy

New England Ambulatory SurgiCenter and New England Spine Care recognizes that all patients have the right to participate in their own health decisions and to make an Advance Directive or execute Powers of Attorney that authorize others to make decisions on their behalf based on patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. New England Ambulatory SurgiCenter and New England Spine Care respect and uphold these rights. State Law recognizes the following types of advance directives: 1.Living Will- a document that tells the physician and health care provider what life-sustaining treatments or procedure the patient wants when in a terminal condition or a persistently unconscious state.2.Appointment of Health Care Proxy (AHCP)- a legal document that allows the patient to appoint another person to make medical decisions should he or she become temporarily or permanently unable to make those decisions.3.Do Not Resuscitate (DNR) consent form- A legal document prepared by the patient stating his or her desire to not have cardiopulmonary resuscitation in the event of cardiac or respiratory arrest.4.If you would like more information regarding an Advance Directive, we have packets available.
It is the policy of New England Ambulatory SurgiCenter and New England Spine Care to make sure that patient wishes for medical care and treatments are respected, in accordance with accepted principles of medical practice, ethics, and law. Patients with advance directives are responsible for informing their physician of their wishes and providing the appropriate document. If no information is provided, in case of unforeseen medical emergency, our policy is to stabilize the patient and transport him/her to the nearest hospital for further care