IMPORTANT

Notice of Medical Visit

St Charles Spine Institute
Jason Hartman, DO
558 St Charles Drive, Suite #200
Thousand Oaks, CA 91360
Telephone No: (805) 379-2322 Fax No: (805) 379-2373
www.stcharlesspine.com

Please do not miss this medical examination. This appointment is to evaluate your medical condition.

Please bring the following:

- Picture ID such as Driver's License
- X-Rays, MRI Films, CT Scans and reports (within 2 years)
- Past EMG and Op. Reports, Medication List

All attached forms need to be completed by your appointment date.

****You will be rescheduled if forms are not completed.****

Should you need to cancel this appointment for any reason, please call our office at 805-379-2322 at least 48 hours in advance.

Thank you for your cooperation in this matter.

ST CHARLES SPINE INSTITUTE

Patient Information

Title: Mr. Mrs. Miss Dr.		Email:
Name:	Birthday:	Gender: M / F
Street Address:		Suite/Apt #:
City:	State:	Zip Code:
Home Phone:	Mobile:	Work:
Driver's License #:	State Issued:	SS Number:

Parent/Spouse/Guardian Details

Name:	Date of Birth:	Relation:
Address:		
Phone:	SS Number:	

Primary insurance info:	**Secondary insurance info:**
Insurance Co:	Insurance Co:
Member ID:	Member ID:

Employer Details

Employer Name:	Occupation:	Employment Status:
Address:	Phone:	

Background information:

Marital Status:	Married	Single	Divorced	Widowed	Separated	Live-in
Preferred language:						

Physician and Referral Details

Primary Physician:	Phone:
Referring Physician/Source:	

ST CHARLES SPINE INSTITUTE

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relation: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials: _____ Reason: _____

St. Charles Spine Institute
Jason Hartman, DO
558 St. Charles Drive, Suite # 200
Thousand Oaks, CA 91360
Tel 805-379-2322 Fax 805-379-2373

Pain Management Treatment Agreement

This document is an agreement between _____, the patient, and Dr. Jason Hartman. Patient agrees to the policies as listed below to manage chronic pain. Patient acknowledges the fact of habituation on the opioid medication as a direct consequence of its use. Because of the controlled nature of these medications, strict accountability is required. The following policies are necessary for continued treatment:

• Regularly monthly visits for patient with schedule II medication must be made to assess response and observe complications

• ALL pain medications will be prescribed by ONE physician, Dr. Jason Hartman.

• ALL pain medications prescriptions will be filled at one pharmacy, patient chooses:

Pharmacy Name: _____

Address: _____

Phone: _____

• Physician has complete liberty to discuss treatment details with the pharmacist at the dispensing pharmacy, and may ask the pharmacy for information about other medications, which have been prescribed for the patient.

• Random urine drug screens will be requested at any time. Urine must be given before given medication prescription

• Prescribed medication will be closely guarded. Please note these medications could be hazardous or lethal to another person, who is not tolerant to their effect. Patient will take as much care with medications, and written prescription, as they would their driver license or credit cards.

• Medications WILL NOT be replaced (if they are lost, fall in the toilet, eaten by pets, etc.) If your medications are lost or stolen an INCIDENT REPORT must be filed at the local police station or by a police officer. Once a hard copy of the police report is obtained, ONE exception may by made. Be sure to ask officer for turnaround time.

• Early refills will not be given. If a patient uses a month supply of medications within three weeks, the last week will be without medications.

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• All confidentiality of prescription and medication records is waived if there is any request from legal authorities for the information concerning inappropriate or unlawful use of controlled substances. Failure to adhere to these policies will result in permanent cessation of pain medication prescribed by Dr. Jason Hartman. Patient understands that he/she will not take medications or substances (prescription or recreational), which have been disclosed to the physician.

• Pursuant to Health and Safety Code section 11165.4(a), the mandatory consultation requirement requires health care practitioners to consult the CURES database to review a patient's controlled substance history under both of the following circumstances:

1. Before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time*; and
2. At least once every four month thereafter if the substance remains part of the treatment of the patient.

*"First time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

Signature:	Date:
Print Name:	Witness:
Physician:	Date:

ST CHARLES SPINE INSTITUTE

OFFICE POLICY & INFORMATION

Financial Policies
Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. Ultimately, you and only you are responsible for understanding the specifics of your insurance plan. You bear full financial responsibility for the services rendered and products provided by Jason Hartman, DO and agree to pay in FULL at TIME OF SERVICE. Additionally, you authorize and request that insurance payments be made directly to ST. CHARLES SPINE INSTITUTE should we elect to receive such payments.

Payments that you are responsible for include, but are not limited to, any and all copayments, coinsurance, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Please note that copayments for office visits are usually higher for specialists (like orthopaedists) versus primary-care physicians. So check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurances, and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though St. Charles Spine Institute will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company or St. Charles Spine Institute. Our charges may be estimated based on each insurance company's fee schedule. After your insurance processes the claim and if a balance is due, you will receive a statement. If a refund is due, we will be happy to mail it to you.

Returned Checks
There will be a $25.00 charge for all returned or cancelled checks

Keeping Your Account Up-To-Date
It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies give us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

Delinquent Accounts
Accounts turned over to a collection agency will be assessed a $25.00 fee. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

Lab/Diagnostic Testing Results
It is the patient's responsibility to contact this office for the results of any lab work or diagnostic testing.

Release of Medical Records
There will be a $15 clerical fees, plus up to $.25 cents per page for medical records. If you need any insurance forms completed by our office, there will be a $20.00 charge on each form. You authorize us to release all medical records to the referring and family physicians and to your insurance company, if applicable. You allow fax transmittal, telephone and by mail of your medical records, if necessary.

Please note:

The surgeons at St. Charles Spine Institute may hold the patents or have worked on the development of some implants purposed for your spinal surgery. They do NOT receive any financial compensation for implanting these devices. If you have questions, please discuss this with your Surgeon during your appointment.

All copayments, coinsurances, deductible fees, and outstanding balances must be settled before seeing the physician. We reserve the right to immediately cancel your care for conduct, non-cooperation, or non-payment.
You will be responsible for your Medicare Co-insurance if you don't have secondary insurance.

☐ **I have read all policies in its entirety. I understand and accept all policies detailed above.**

Patient Signature:	Date:

Advanced Directive Status

Jason Hartman, DO
St. Charles Spine Institute

I have been informed of my right to formulate an Advanced Directive, and I have been provided with information regarding the execution of an Advanced Directive.
Please Select One:

☐ I have previously completed an Advanced Directive and have provided a copy of inclusion in my medical record

☐ I will provide a copy of my previously executed Advanced Directive to St. Charles Spine Institute for Inclusion in my medical record

☐ A copy of my Advanced Directive is on file with: _____
Name of Provider or Health Care Facility

☐ I have not executed an Advanced Directive and I am not interested in any further information

☐ I am interested in formulating an Advanced Directive and will discuss my options with my primary care physician

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Comments: Include steps taken to obtain a copy of Advanced Directive

_____

_____

_____

☐ A copy of the Advanced Directive has been requested

Signature of Group Representative: _____ Date: _____

Jason Hartman, DO

Please fill out this form in its entirety and fill in the bubbles completely.

PATIENT INFORMATION		
Patient Name:		**Date:**
Date of Birth:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? O Neck O Back O Other _____

II. Which side is affected? O Right O Left O Bilateral

Are you? O Left handed O Right handed

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV. Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other:_____

V. Pain Calculation: Questions A and B should total 100%

A. What percentage of your problem is due to back/neck pain?

O 0% O 25% O 50% O 75% O 100%

B. What percentage of your problem is due to leg/arm pain?

O 0% O 25% O 50% O 75% O 100%

VI. General Questions

How would you rate your pain? Place a vertical mark on the line below:

No pain 0 | 1 2 3 4 5 6 7 8 9 |10 very severe pain

Have you had any change in bowel or bladder function? O Yes O No

Does your pain disrupt your sleep? O Yes O No

Does pain or weakness keep you from doing your regular activities? O Yes O No

Have you had physical therapy? O Yes O No

Does your pain radiate? O Yes O No If so, where _____

VII. Pain medications?

Anti-inflammatory agent O Yes O No Drug Name:_____

Pain Medication O Yes O No Drug Name:_____

Tylenol O Yes O No

Have you had any injections/epidurals? O Yes O No

How many in the last 12 months? _____ Date of most recent injection: _____

Did you get any relief? O Yes O No

If yes, for how long? _____

VIII. Have you had any testing? O MRI O EMG/NCS O X-ray O CT Scan

Medical History

Do you have or have you had:	Yes	No		Yes	No
Asthma/COPD	O	O	Cancer	O	O
Diabetes	O	O	High Blood Pressure	O	O
Acid Reflux Disease	O	O	Heart Attack	O	O
Osteoporosis	O	O	Hypertension	O	O
Emphysema	O	O	Seizures	O	O
Stroke	O	O	Arthritis	O	O
Gout	O	O	Thyroid Disease	O	O
Kidney Problems	O	O	Blood Clots	O	O

Social History

Marital status: O Single O Married O Widowed O Divorced

Do you smoke? O Yes O No O Have Previously

If yes,

How many packs/ day? O <1 O 1-2 O >2

How many years have you smoked? O 1-4 O 5-10 O >11

Do you consume alcohol? O Yes O No

In the past did you consume alcohol? O Yes O No

How often do you consume alcohol? O Daily O Social O Never

Do you exercise regularly? O Yes O No

Working status: O Full time O Part Time O Student O Unemployed

Family History

Father	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Mother	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Siblings	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Grandparents	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease

Review of Systems

Constitutional

Fatigue	O	Yes	O	No
Weight change	O	Yes	O	No
Fever	O	Yes	O	No

Neurological

Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No
Coordination Problems	O	Yes	O	No
Neck Pain	O	Yes	O	No

Respiratory

Shortness of Breath	O	Yes	O	No
Chest Pain	O	Yes	O	No
Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No
Chronic Coughing	O	Yes	O	No
Coughing up Blood	O	Yes	O	No

Cardiovascular

Chest Pain	O	Yes	O	No
Irregular Heartbeat	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Leg/Ankle swelling	O	Yes	O	No

Spine

Severe Back Pain	O	Yes	O	No
Spine Curvature	O	Yes	O	No
Back Problems	O	Yes	O	No

Musculoskeletal

Joint pain	O	Yes	O	No
Joint stiffness	O	Yes	O	No
Joint swelling	O	Yes	O	No

Gastrointestinal

Nausea/ Vomiting	O	Yes	O	No
Stomach Ulcer	O	Yes	O	No
Diarrhea	O	Yes	O	No
Blood in stool	O	Yes	O	No

Skin

Rashes/sores	O	Yes	O	No
Skin Cancer	O	Yes	O	No
Itching/ Burning	O	Yes	O	No

Hematologic

Anemia	O	Yes	O	No
Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No

Women ONLY:

Are you pregnant or could possibly by pregnant?

O Yes O No

Allergies

Are you allergic to any medications? O Yes O No

If yes, please list: _____

Are you allergic to food or environmental substances? O Yes O No

If yes, please list: _____

Hospitalization (Please list)	Surgeries (Please list surgery type and year)

Patient Signature _____ Date _____

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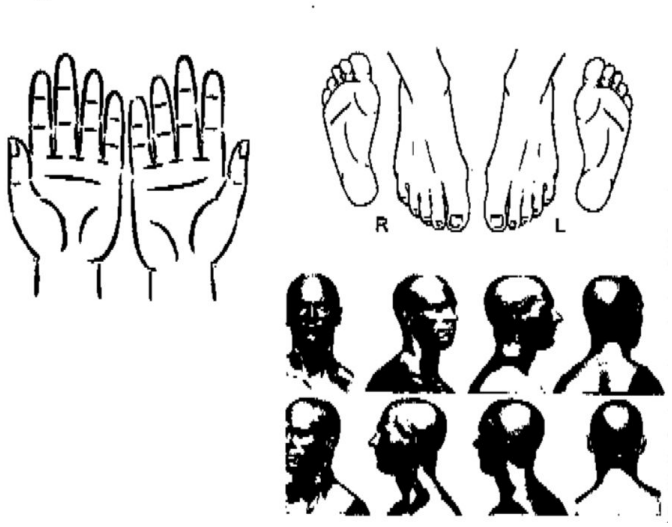
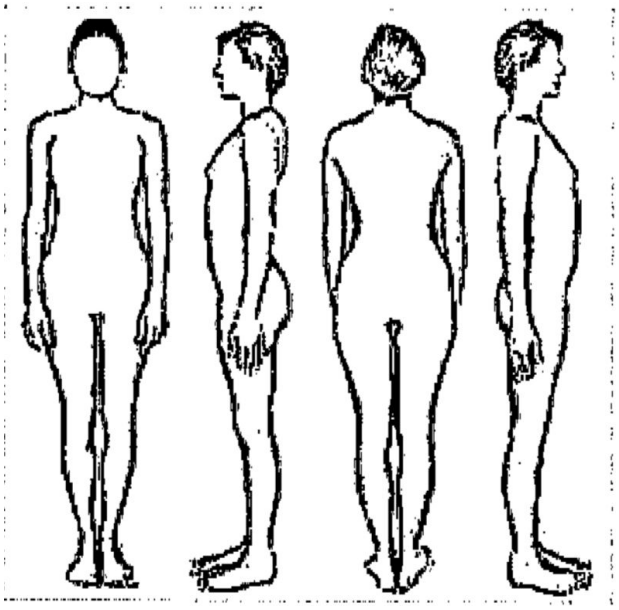
New Patient Evaluation

Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.





Describe your pain:

☐ Throbbing	☐ Heavy
☐ Shooting	☐ Burning
☐ Stabbing	☐ Aching
☐ Sharp	☐ Tender
☐ Cramping	☐ Dull

What makes your pain worse?

☐ Bending	☐ Sexual Intercourse	☐ Coughing
☐ Lifting	☐ Standing a long time	☐ Sneezing
☐ Defecation	☐ Sitting a long time	☐ Other:

What makes your pain better?

☐ Ice	☐ Activity	☐ Bending Backwards
☐ Heat	☐ Bending Forward	☐ Medications
☐ Sitting	☐ Lying Down	☐ Other:

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Medication List (continue on back side if needed)

Medications & Directions	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Any use of recreational drugs? What kind and for how long? If yes, please include if you've joined any recovery programs. If in recovery, please include how long.

Social History

How much does your chronic pain limit your abilities to perform these activities?

PHYSICAL ACTIVITIES - Lower body

Walking

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Climbing stairs

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Bending

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

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Social History (continued)

PHYSICAL ACTIVITIES - Upper body

Reaching above

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Turning your head

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

PERSONAL & HOUSEHOLD CARE

Bathing or dressing

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Getting in and out of bed

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Performing housework

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

WORK

Concentrating at work

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Working with hands

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Performing tasks at work

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

SOCIAL ACTIVITIES

Visiting family & friends

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Getting out of house

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

Pursuing hobbies & friends

☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely

St. Charles Spine
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(805) 379-2322

PATIENT/PROVIDER ASSESSMENT

_____
Today's Date

Name

First	Last	MI	Phone #
O Male O Female			

Gender (Select One)	Height	Weight	Birthdate	Age

Primary Insurance	Patient ID / Member ID

Please answer the following questions to the best of your ability.

Mark Circle if Answer is Yes

O Are you pregnant?	O Do you have a pain or insulin pump?
O Do you have a pacemaker or defibrillator?	O Do you have any electrical or metal implants or sensors of any kind?

SECTION 1 **Regarding your health**

[1A] Have you ever been diagnosed with any of the following cardiovascular disease or symptoms?

O Do you have diabetes?	O Peripheral Vascular Disease *(PVD - Circulation disorders in blood vessels)?*
O Do you have, or had you had, gangrene?	
O Ateriovenous Fistula (Abnormal Connection between veins & arteries)?	O Embolism of the upper limb/limbs *(Artery obstruction in the arms)?*
O Diabetes Type I with circulatory disorders?	O Atherosclerosis of the Aorta? (Plaque build up in the Aortic Artery)
O Diabetes Type II with circulatory disorders?	
O Do you have or have you had chronic ulcer(s)? (Stage II, III, or IV).	O Do your hands and feet get cold easily?
O Have you ever experienced vision loss?	O Transient Cerebral Ischemia (TIA)? *(Mini Stroke)*
O Do you experience disturbance in your speech?	O Cerebrovascular Disease (CVA)? *(Stroke)*

[1B] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

O Do you have high cholesterol?	O Raynaud's Syndrome *(discoloration of fingers and/or toes when exposed to changes in temperature (cold or hot) or emotional event)*?
O Do you have hypertension *(high blood pressure)*?	
O Do you often experience abdominal pain?	
O Do you often feel fatigued (tired)?	O Beurger's disease *(inflammation of clotting in blood vessels in hands or feet)*?

[1C] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

O Type I Diabetes with neurological symptoms?	O Type II Diabetes with neurological symptoms?
O Do you ever have pain in your arms and/or legs?	O Reflex Dystrophy (Chronic Pain in Limbs after injury, stroke or heart attack)?
O Do you ever notice a disturbance in the sensation of your skin (Tingling or numbness)?	
O Peripheral Neuropathy (a result of damage to your peripheral nerves, often causes weakness, numbness, and pain, usually in your hands and feet)?	O Reflex Sympathetic Dystrophy (marked by burning pain, swelling, and motor and sensory disturbances especially of an extremity after an injury)?
O Edema (swelling in arms and/or legs?	O Idiopathic Peripheral Neuropathy? When the cause can't be determined, it's called idiopathic neuropathy. Includes numbness, tingling and pain in legs and/or feet.
O Degenerative Disease?	

[1D] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

O Hypotension (very low blood pressure)?	O Dizzy and/or light headed when you stand up?
O Rapid Heart Rate (Tachycardia)?	O Do you experience hyperhidrosis (Excessive sweating)?

SECTION 2 **Regarding your personal and family health history.**

O Do you smoke or have you ever smoked?	O Has anyone in your immediate family (blood relatives) passed away from Sudden Cardiac Death Syndrome (SCD)?
O Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD), or have had a heart attack?	O Do you have a history of CVA or TIA (Stroke or mini stroke)?

NOTICE OF HIPAA AND PRIVACY PRACTICES: This office protects your privacy as well as optimize your quality of care through access to your healthcare data. As part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and educational purposes pursuant to HIPAA guidelines.

Patient Signature	Provider Signature

FOR OFFICE USE ONLY	Continuous BP (XXX/XX mmHg) BP1: _____ BP2: _____ BP3: _____

The Pittsburgh Sleep Quality Index (PSQI)

Name: _____ **Date:** _____

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month Please answer all questions During the past month,

1. When have you usually gone to bed? _____

2. How long (in minutes) has it taken you to fall asleep each night? _____

3. When have you usually gotten up in the morning? _____

4. How many hours of actual sleep do you get at night? (This may be different than the number of hours you spend in bed)_____

Please check the appropriate blank below.

5. During the past month, how often have you had trouble sleeping because you...	**Not during the past Month (0)**	**Less than once a week (1)**	**Once or twice a week (2)**	**Three or More times a week (3)**
a. Cannot get to sleep within 30 minutes	a. _____	_____	_____	_____
b. Wake up in the middle of the night or early morning	b. _____	_____	_____	_____
c. Have to get up to use the bathroom	c. _____	_____	_____	_____
d. Cannot breathe comfortably	d. _____	_____	_____	_____
e. Cough or snore loudly	e. _____	_____	_____	_____
f. Feel too cold	f. _____	_____	_____	_____
g. Feel too hot	g. _____	_____	_____	_____
h. Have bad dreams	h. _____	_____	_____	_____
i. Have pain	i. _____	_____	_____	_____
j. Other reason(s), please describe, include how often you have had trouble sleeping because of this reason(s):	j. _____	_____	_____	_____
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?	6. _____	_____	_____	_____
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	7. _____	_____	_____	_____
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	8. _____	_____	_____	_____
	Very good (0)	**Fairly good (1)**	**Fairly bad (2)**	**Very bad (3)**
9. During the past month, how would you rate your sleep quality overall?	9. _____	_____	_____	_____

Physician Determined Global PSQI Score: _____

St. Charles Spine Institute
Jason Hartman, DO
558 St. Charles Drive, Suite #200
TAX ID: 20-4657944 NPI: 1790717965

ASSIGNMENT OF BENEFITS AGREEMENT
Direct Payment to Doctor

I hereby authorize _____ Insurance Company to pay by check made payable to and mailed directly to Jason Hartman, DO for Medical expense benefits allowable, and otherwise payable to, under my current insurance policy, as payment towards charges for professional services rendered.

Financial Responsibility

I understand that I am financially responsible to reimburse Jason Hartman, DO for any charges not covered by health care benefits. It is my responsibility to notify Jason Hartman, DO of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

Assignment of Benefits

I hereby assign all medical benefits, to include any surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance or any other health/medical plan, to issue payment directly to Jason Hartman, DO
I have requested medical services from Jason Hartman, DO on behalf of myself and/or my dependents, and understand by making this request that I become fully financially responsible for any and all charges incurred during the course of treatment authorized.

Name of Person Financially Responsible (Print): _____

Relationship to Insured: _____

Signature of Insured: _____

Today's Date: _____

St. Charles Spine Institute
Jason Hartman, DO
558 St. Charles Drive, Suite #200
Thousand Oaks, CA 91360
20-4657944

OUT OF NETWORK FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____

RE: Date of Service: _____

It has come to our attention that your insurance company may not assign benefits of your policy to Dr. Jason Hartman, meaning payment may go directly to you. Please note that your policy with your insurance company is an agreement between you and your insurance carrier. Dr. Jason Hartman rendered excellent medical care to you and it is your responsibility to ensure that he and his practice are paid. To avoid being responsible for the entire claim amount, please follow our guidelines.

When the insurance company sends you a check for services provided by Dr. Jason Hartman for the above referenced date of service, or other dates of service not listed above, please follow the process below:

1. Open the communication and explanation of benefits you receive from your insurance in a timely manner.
2. When the check is received, please NOTE it is not necessary to case the check. We would ask you to endorse the check in the following manner:
    a. Sign your name on the upper portion of the check
    b. Directly under your signature, write the following: "For further endorsement to Jason Hartman, DO"
    c. Place the endorsed check in the enclosed envelope and mail to the address preprinted on envelope
3. Upon receipt of the endorsed check, we will deposit and post the funds to your account with Dr. Jason Hartman. If there are any additional monies owed to Dr. Jason Hartman, you will receive a traditional statement that will explain in detail the balance due after insurance – if there is a balance. Please note that they payment you are receiving is the insurance payment, which does not include any co-insurance amounts, deductible, co-payments, or out-of-pocket expenses owed by you, the patient.

Your satisfaction is important to us and we hope that you understand our collection policies for payments not sent directly to our office, but instead to the patient. Our goal is to minimize any inconvenience, and we appreciate your assistance with helping us keep your account balance in order.

Signature: _____ Date: _____