**Mark Bouffard, M.D.**
Board Certified, Fellowship Trained

To all our future patients,

Enclosed you will find several forms which we request you to fill out prior to the consultation. Please mail or fax these forms back to our office prior to your consultation day or bring the forms back the day of your office visit. This will help expedite the process.

Please arrive at our office at least 15 minutes prior to your appointment time to complete any additional forms.

Also upon check-in, please provide your insurance cards and a copy of your ID or Driver's License to the front desk. Any Co-payments or monies due will be collected at time of service.

We look forward to meeting you at the time of your consultation with Dr. Bouffard.

Thank you.

Pain and Spine Center of the Desert, Inc.

72650 Fred Waring Drive, Suite 214, Palm Desert, CA 92260
Office: (760) 776-7999 Fax: (760) 776-7994

# Pain & Spine Center of the Desert

**Mark Bouffard, M.D.**

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## Demographic Information

DOB (mm/dd/yyyy) _____________ Gender: ____M ___F

Last name, First Name, MI, suffix____________________________________________________________

Address, city, state, zip____________________________________________________________________

Home Phone:_____________________________ Work Phone:_____________________________________

Cell phone:_______________________________ Email: _________________________________________

Marital status: ___ single___married__other Spouse/S.O. name_________________________________

Race:

- ☐ American Indian and Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Black Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islands
- ☐ White
- ☐ White Hispanic or Latino
- ☐ Refused

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused

Language Preference:

- ☐ English
- ☐ Chinese
- ☐ French
- ☐ German
- ☐ Spanish
- ☐ Other:______________

Employer name:______________________________________________________________________________

Emergency contact name:________________________________________Phone____________________

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## Pharmacy Information

Preferred pharmacy ___________________________________ Pharmacy Phone #___________________

Pharmacy address, city, state, zip____________________________________________________________

How did you hear about us? __________________________________________________________________

Referring physician __________________________________________________________________________

Rev 04/24/2020


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## Insurance Information

**Primary Insurance plan**__________________________ Group #_______________ ID#_______________

Copay amt.______

Guarantor's name (L,F,MI)_________________________________________________________________

DOB mm/dd/yyyy ___________________ Relationship to patient: ___self ___spouse ___child ___other

Insurance address_______________________________________ Insurance phone#_________________

**Secondary insurance** ____________________________ Group #_______________ ID# _______________

Copay amt.________

Guarantor's name (L,F,MI)_________________________________________________________________

DOB mm/dd/yyyy _____________________ Relationship to patient: ___self __spouse ___child __other

Insurance address_______________________________________ Insurance phone#_________________

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# PAIN MANAGEMENT AGREEMENT/INFORMED CONSENT

*****Please initial each statement if you have read and agree with*****

_____The purpose of this Agreement is to clarify and prevent misunderstanding about your treatment, certain medicines, prescription and behaviors while you are receiving your pain management care with us. This is to help you and your physician/provider to comply with the laws and regulations regarding controlled pharmaceuticals.

_____I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

## TREATMENT:

_____I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

_____I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how the medicine is helping to relieve the pain and increase my functioning, as well as any side effects.

_____I understand that there must be functional improvement in order to continue medications.

_____I understand the options and possible risks and benefits of other types of treatment that do not involve the use of opioids.

_____I will tell my physician/provider about any and all medications and treatments that I am receiving.

_____I will make my physician/provider aware of all of my current medications and any other pain medications prescribed by other physician/provider s/providers.

_____**I understand that if I break this Agreement, my doctor may stop prescribing these pain control medicines and discharge me from the practice.**

______I agree to have my spouse/partner/family member present at my office visit if requested by my physician/provider to discuss my treatment plan and/or recommendations for future medical care, especially in terms of medication treatments.

______**(Females only):** If there is a possibility that you may become pregnant or plan to get pregnant, it is your responsibility to notify our office immediately.

**MEDICATIONS:**

______**I understand that opioid (narcotic) use can lead to addiction, abuse, and misuse, which can lead to overdose and death.**

______**I will take my medications only as prescribed; if my pain is not being controlled, I will contact my physician/provider for instructions and not increase my medications unless told to do so.**

______**I will not take it upon myself to change any dosage directions for my prescribed medications without prior approval from my physician/provider.**

______I understand that the use of long term pain medication may result in certain side effects such as: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of reflexes or reaction time, physical dependence, tolerance to opioids, addiction and the likelihood that the medicine may not provide complete pain relief.

______I understand that risk of death due to an overdose is **nearly 4 times higher when the use of opioids and benzodiazepines** (e.g., Xanax, Valium, Ativan, and Klonopin) together compared to taking opioids alone.

______I understand that **physical dependency** is **NOT** the same as **addiction**.

- **PHYSICAL DEPENDENCE** means that if my pain medicines use is significantly decreased or stopped, I may experience withdrawal symptoms and have signs and symptoms such as runny nose, yawning, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches through the body or flu-like feeling.

______I will not share, sell or trade my medications with anyone.

## PERSCRIPTIONS:

______I agree that refills on my prescriptions for pain medicines will be made only at the time of an office visit or during regular business hours and that I will give the office at least 72 hours (3 business days) to process the refill request. **No refills will be available during evenings, weekends, or holidays.**

_____I understand that controlled substance prescriptions will only be given at the time of an appointment unless approved by the physician/provider. For most patients this means a monthly face- to-face appointment.

_____I understand that the transmission of your prescriptions electronically to the pharmacy of record is and option however, there is the potential of them not being received by the pharmacy of record. If this occurs the choice of resubmission electronically or having you pick up a hard copy prescription will be up to your medical provider in this office.

______I will not change, alter or forge any medications on my prescription, and I understand that this will cause me to be discharged immediately from the practice.

**______I will not attempt to obtain any opioid pain medicines (narcotics) from any other doctor/provider, unless agreed upon with both physician/providers.**

______I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. **If in any case my prescription is stolen I must obtain a police report before a new prescription is given.**

**BEHAVIOR:**

______I will not use any illegal controlled substances, including marijuana, heroin, cocaine, methamphetamines, etc.

______I understand **not** to drink alcohol while taking pain medications because the co-ingestion of alcohol with an opioid may result in increased plasma levels and a potentially fatal overdose from the opioid.

______I understand that any abusive behavior or profanity in the office or on the phone to the staff or medical providers will not be tolerated under any circumstances, and this may result in discharge from the practice.

______I understand that I will be subject to random drug testing at any time if requested by my physician/provider. Refusal of this request may result in discharge from the practice.

______**I understand that opioid (narcotic) use can lead to addiction, abuse, and misuse, which can lead to overdose and death.**

- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the State Board of Pharmacy and the Drug Enforcement Administration, in the investigation of any possible misuse, sale, or other diversion of my controlled substance medications.
- I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this.

______________________________ ____________________
Patient signature Date

______________________________
Print patient name

Rev 4/24/2020

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# PATIENT PRIVACY POLICY CONSENT & ACKNOWLEDGMENT FORM

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conducts, plan and direct treatment and follow-up and be involved in treatment, directly or indirectly.

In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose information in order to treat you, to obtain payment for services and to conduct day to day health care operation.

The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosure of your health information may include care and services, follow-up care from another health professional, disclosure or your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third-party payer or insurer.

You have the right to restrict the use or disclosure made for purposes of treatment or healthcare operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

**I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and healthcare operations. I have received a copy of the Notice of Privacy Practices from this office.**

______________________________ ____________________
Patient signature Date

______________________________ ____________________
Print patient name Relationship to patient

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# Office Policies
# Effective January 1, 2020

• Due to the rising cost of keeping in compliance with the DEA, California Medical Board, California Board of Pharmacy and other regulatory agencies, there will be a $1 fee per paper prescription given without an office visit. Please be advised prescription given in advance (i.e. second month opioid prescription during an office visit) will also be subject to the fee. Electronic prescriptions will not be subject to the fees.

• If you are **15** minutes or more late for your appointment you may be requested to reschedule your appointment.

• The office will need **72** hours (3 business days) to process all medication refill requests. It is your responsibility to plan accordingly. If you are requesting for the prescription(s) to be picked up the same day, there will be a $10 surcharge per prescription.

• There may be at least **$25.00** administrative fee for any forms that need to be completed including prior authorizations for medications. Completing a prior authorization request does not guarantee the medication will be approved. We will contact you before we initiate the request to get verbal authorization. Completion of the forms will be at the discretion of Dr. Bouffard.

• Your co-payment, co-insurance, deductibles, and outstanding balance are required at the time you check-in for your appointment. All patient balances that are past due may accrue and interest charges of 5% will be added to your outstanding balance.

• You may be charged a *"Missed Appointment"* charge of **$25.00** for office visit appointments that you miss and fail to give at least 24 hours' notice and **$50.00** for procedure appointments. If you need to cancel your appointment, please note who you spoke to when you called to cancel your appointment, including the date and time. Failure to remit payment for your missed appointments may cause a delay in your appointment scheduling.

• Please be advised that your consultation visit may **not** include any injections/procedures or refill for any pain medications.

• As a courtesy please turn off or silence your cell phones while in the office.

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## Patient Acceptance of Financial Responsibility

The practice of Pain and Spine Center of the Desert, Inc. will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. For your convenience, our office accepts personal checks, credit cards, and cash. In the event that services rendered are not covered by your insurance company, we will require that you remit payment to Pain and Spine Center of the Desert, Inc. Additionally, if your insurance company does not remit payment in a timely manner (within 90 days from the time your claim is billed),we will transfer the balance to your responsibility and require that you remit payment to Pain and Spine Center of the Desert, Inc. for all outstanding insurance balances over 90 days. The outstanding balances may include, but are not limited to:

> - Office visit co-payments; Interest charges for overdue patient due balances; Annual deductibles; Administrative charges for co-payments not paid at the time of service; Services that are not covered by your health plan.

In addition, your insurance company may require an authorization or precertification for certain procedures, services, drugs and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment, and expedite payment for your services. We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement.

We frequently experience difficulty with insurance plans in receiving timely payment. Our policy is that we will bill you primary and secondary policies. If we do not receive payment within 90 days of the date we bill your insurance, then we will transfer the balance to your responsibility and require that you remit payment to Pain and Spine Center of the Desert, Inc. To prevent this, we suggest that you stay in communication with your insurance company to assure they are paying for the services we render. Often, insurance companies are more responsive when they are contacted by their policy holders. In addition, should our billing office contact you for assistance in obtaining payment from your insurance company, your prompt response to their calls would be appreciated. RES Medical Billing, our billing service, may be reached at (760) 459-1411 and they will work with you in obtaining payment on your claims. We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement.

**You may be charged a *"Missed Appointment"* charge of $25.00 for office visit appointments that you miss and fail to give at least 24 hours notice and $50.00 for procedure appointments. If you need to cancel your appointment, please note who you spoke to when you called to cancel your appointment, including the date and time. Failure to remit payment for your missed appointments may cause a delay in your appointment scheduling.**

**Your co-payment, co-insurance, deductibles, and outstanding balance are required at the time you check-in for your appointment. All patient balances that are past due may accrue and interest charges of 5% will be added to your outstanding balance.**

I understand and agree that I (or the person financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance within 10 days of receipt of my monthly statements. I also understand that if my insurance plan does not pay Pain and Spine Center of the Desert, Inc. within 90 days of the services billed, the balance will be transferred to my responsibility and payment will be due at that time.

______________________________________
Patient's Printed Name

______________________________________
Patient's Signature

______________________________________
Date

Or

______________________________________
Responsible Party's Printed Name

______________________________________
Responsible Party's Signature

______________________________________
Date

# Pain & Spine Center of the Desert

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## ADVANCE BENEFICIARY NOTICE ALL INSURANCES

**Name:______________________________** **Date of Birth:__________________**
**Subscriber ID:____________________________** **Group No.:________________________**

Provider: **Mark Bouffard, M.D.**
Provider Tax ID: 45-3592790

By signing below, I agree to pay Provider for those services determined for the reason(s) specified below not to be covered under my Benefit Agreement:

- ☑ Not Medically Necessary
- ☑ Primarily for comfort and convenience; or
- ☑ Otherwise not a covered benefit or excluded under my coverage

I understand that a provider may not charge me for service determined to be not medically necessary unless I specifically agree to pay for it. I also understand that the provider and/or I may appeal any determination that a service is not medically necessary by filing a grievance or appeal with my insurance or the Department of Managed Health Care ("DMHC") pursuant to the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage ("EOC"). I also understand that I may have the right to Independent Medical Review through the DMHC, as described in my Benefit Agreement or EOC.

For the services listed below, I also understand that I am responsible for the difference between the covered expenses for any covered services and the Total Cost listed below, even though they may not be shown on my Explanation of Benefits (EOB) as my responsibility. If the Total Cost of the Service is not a covered expense under the applicable Benefit Agreement, I understand that I am responsible for the Total Cost.

Date of Service:_______________________________________________________________

IC/OV/Injection(s)/Procedure: _____________________________________________________

Total Cost Member's (Patient's) Responsibility________________________________________
(IC: $428, OV:$280, Urine Drug Screen: $_____)

_________________________________ _____________________
Patient's signature Date

**In addition to being responsible for this amount, I understand that I will be billed and held responsible for any applicable co-payment, deductible, and/or coinsurance as stated in my Member's Benefit Agreement. **