

Welcome

Dr. Romeo Biboso
Pain Management

If you have any questions or concerns, do not hesitate to ask for assistance, we will be happy to help.

Patient Information:

Name:

DOB: _____

FIRST

MIDDLE

LAST

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Work/Cell Phone#: _____

How did you hear about our office? _____

SS#: _____ - _____ - _____ Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone Number: _____

City: _____ State: _____ Zip code: _____

Spouse/Parents Name: _____

Emergency Contact: _____ Phone#: _____

Is this injury due to an automobile accident? YES NO

Is this injury due to a work related incident? YES NO

I understand that I will notify the front office staff when I schedule my appointment that my medical condition involves a Personal Injury or Workmen's Compensation case and will bring all the necessary documentation at that time. Should I fail to do such or change the nature of my claim after my initial visit, a **\$35 clerical fee** will be charged to my account. **Initials:** _____

Do you have insurance? YES (if yes, please fill out the information below) NO

Policy Holders Name: _____ Date of Birth: _____
Relationship to patient: <input type="checkbox"/> spouse <input type="checkbox"/> parent/guardian <input type="checkbox"/> other: _____
Policy Holder SS#: _____ - _____ - _____ Policy Holder Employer: _____
Insurance Company Name: _____
Policy/ID #: _____ Group #: _____
(Please have your DL and insurance cards available for the patient coordinator to make a copy of)

Primary Care Physician: _____ Phone#: _____

May we contact them about your condition? Yes No Date last seen: _____

Have you been to another doctor about this condition? Yes No

*If yes, who? _____ Phone#: _____

Do you smoke? Yes No If yes, how many cigarettes a day? _____

Are you pregnant? No Yes my due date is: _____

I understand that a **24 hour notice** is required for cancellations of an appointment and should I fail to do such, a **\$35 missed appointment fee** may be charged to my account. **Initials:** _____

I have provided correct information in the questionnaire to the best of my knowledge.

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

- 1) Your provider or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) Your provider and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
- 4) Your provider and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- 1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
- 2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
- 3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
- 4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
- 5) We are permitted to use or disclose your health information in response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.
- 6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to

comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.

- 7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- 8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
- 9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 10) We are permitted to use or disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Wisconsin's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

- 1) If we have already released your health information before we receive your request to revoke your authorization.
- 2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive medical services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding

which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

1. those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. those disclosures made to you.
3. those disclosures we are permitted to make without your consent or authorization as described above.
4. those disclosures made based on an authorization you signed.
5. those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. those disclosures for national security or intelligence purposes.
7. those disclosures made to correctional officers or law enforcement officers.
8. those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact:

Romeo Biboso, M.D.

5401 Douglas Avenue, Suite A

Racine, Wisconsin 53402

(262) 681-8829

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

Patient Name Printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.

DR. BIBOSO PRICE LIST

New Patient	Procedure Code	Regular	Same Day Discount
Exam	99201	110.00	35.00
	99202	137.50	65.00
	99203	180.50	95.00
	99204	256.50	135.00
Established Patient	99211	60.50	20.00
Exam	99212	85.50	35.00
	99213	110.50	50.00
	99214	155.50	80.00
Supplies	Depomedrol	57.25	7.50
	Marcaine	25.10	10.00
Therapy	Hot/Cold Pack	20.00	10.00
	E – Stim	35.00	10.00
	Ultra Sound	35.00	10.00
Injections	Carpal Tunnel	160.50	75.00
	Ganglion Cyst	228.50	55.00
	Origin/ Injection	228.50	55.00
	Trig Point 1-2 Muscle	241.50	55.00
	Trig Point 3+ Muscle	245.50	60.00
	Interjt Inj Small Joint	214.50	50.00
	Inter jt Inj Interm Joint	228.50	55.00
	Major Joint Injection	254.50	65.00
	Sacroiliac Injection	618.50	200.00
	Occipital	844.50	105.00
	Intercostal	1406.50	280.00
	Sciatic	793.50	155.00
	C/T Facet	767.50	325.00
	Add Facet	303.50	135.00
	Lumb Facet Inj.	639.50	300.00
	Lumb Add'l Facet	307.50	115.00
Hyalgan Injection	Hyalgan	185.00	110.00
	Office Visit		80.00
	Injection		70.00

I have been informed of the prices of these services and wish to proceed with treatment.

Patient Signature

Date

AGREEMENT FOR THE MANAGEMENT OF CHRONIC PAIN

You have been diagnosed with a chronic pain condition. The physician, Romeo B. Biboso, M.D. will work with you as a patient and with other physicians to try to improve your condition. It is our hope that we can provide care that will improve your condition. This agreement is intended to help you understand your care and allows us best manage your care. It constitutes an agreement between you and the physician, and explains in broad terms how your care will be handled. Read it carefully and feel free to ask any questions.

Terms and conditions of chronic pain management.

1. My doctor will work closely with me to control my pain. He may consult with other doctors and try a variety of remedies to control my pain. I agree to see other consultants and try such therapies as may be offered.
2. The employees of Romeo B. Biboso, M.D. will treat me with courtesy and respect. My questions will be answered appropriately and phone calls returned as promptly as is practical. I am entitled to provide input and comments regarding my care.
3. It is possible that not all of my pain can be controlled. It is possible that I may experience side effects from my pain medication. These may include constipation, drowsiness, nausea, hypotension, vomiting, dry mouth, itchy rash, and urinary retention. Severe and life-threatening reactions include toxic megacolon, respiratory depression, and cardiac arrest. Other reactions not listed here may also occur. It is possible that I may become dependent on pain medicine to an excessive degree. For any and all these problems, I will contact my doctor and disclose problems that I may be having.
4. Because the medicine I am being given is intended to help me, I will closely follow the recommendations of my doctor. I will use the medicine I have been given exactly as I have been directed.
5. I will only seek pain medicine from Dr. Romeo B. Biboso, and will not seek medicine from other physicians without Dr. Romeo B. Biboso's approval. **I will exercise caution in handling my pain medicine, as I will not be able to obtain replacements of lost or stolen medicine. I will not seek pain medicine refills by phone.**
6. I will obtain my medicine from one pharmacy only, and I authorize my doctor to inspect those records without prior approval from me. I will bring all of my medications to the clinic or emergency room when I come to see the doctor.
7. I will keep my scheduled appointments. Unless I have a medical emergency, I will not seek additional appointments or come to the clinic or emergency room for pain management without the approval of Dr. Romeo B. Biboso. When an emergency arises and I cannot obtain approval, I will notify Dr. Biboso on the next business day by calling 262-681-8829 or 414-517-8826.
8. I understand and agree that any of the following behaviors are incompatible with my well-being and my rights under this agreement and may be grounds for dismissal as a patient.

I WILL NOT

Obtain pain medicine from multiple doctors without Dr. Biboso's permission or knowledge.

Sell or give away my medicine.

Use my medicine in an unauthorized manner or misrepresent my pain medicine use.

Use alcohol or illicit drugs while I am a pain patient.

Fail to keep appointments.

My pain doctor is Dr. Biboso and all appointments for pain control will be with that doctor.

I have read this agreement or it has been explained to me to my satisfaction, and I agree to abide by its terms.

_____ MD _____ Patient

Date: _____

Dr. Romeo Biboso, M.D.
5401 Douglas Ave, Suite A
Racine, WI 53402

Contract for Controlled Substance Prescriptions

Controlled substances (i.e. narcotics, tranquilizers, and barbiturates) are very useful in the treatment of pain; however, they present a high potential for misuse. As a result, local, state, and federal governments closely control these medications. They are intended to relieve pain and to improve function and/or the ability to work. These medications are not designed to simply feel good. Because my physician may prescribe controlled substances to help me manage my condition, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription is lost, misplaced, or stolen, or if I use it sooner than prescribed, I understand that it **WILL NOT** be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Dr. Romeo Biboso, M.D. Besides being illegal to do so, it may endanger my health. The only exceptions are medications I am already taking **THAT I HAVE TOLD** Dr. Biboso about; or medications prescribed while I am admitted in the hospital or being seen by one of Dr. Biboso's associates in the clinic under his care.
3. Refills of controlled substance medications:
 - * Will be made only during regular office hours during a scheduled office visit. Refills will not be made at night, on holidays, or weekends.
 - * Will not be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
 - * Will not be made as an "emergency". I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription.
4. I understand that if I violate any of the above conditions, my controlled substance prescription and/or treatment with Dr. Romeo Biboso, M.D. may be terminated. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my physicians, medical facilities, and other authorities.
5. I understand that the main treatment goal is to improve my ability to function and/or work. I agree to help myself reach that goal by following better health habits: exercise, weight control, and the non-use of tobacco and alcohol. I understand that only through a healthier life-style can I hope to have the most successful outcome to my treatment.

I have been fully informed by Dr. Romeo Biboso, M.D. and the staff regarding psychological dependence (addiction) of a controlled substance, which I understand is rare. I know that some persons may develop a tolerance, which might result in the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this contract and Dr. Romeo Biboso, M.D. and/or their staff has explained it to me. In addition, I fully understand the consequences of violating this contract.

Patient's Signature

Date

Witness Signature

Date