PATIENT RIGHTS

1. The patient has the right to be treated with dignity, respect, and consideration.
2. The patient has the right to not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
3. The patient has the right not to be subjected to:
    - Abuse
    - Neglect
    - Exploitation
    - Coercion
    - Manipulation
    - Sexual abuse
    - Sexual assault
    - Restraint or seclusion
    - Retaliation for submitting a complaint to ADHS or other entity
    - Misappropriation of personal or private property by personnel member, employee, volunteer or student
4. The patient has the right to receive treatment that supports and respect the patient's individuality, choices, strengths and abilities.
5. Except in an emergency, the patient has the right to consent to or refuse treatment and may refuse or withdraw consent for the treatment before treatment begins.
6. The patient has the right to be informed of alternatives to proposed prescribed psychotropic drugs or surgery; risks and possible complications of such drugs or surgery.
7. The patient has the right to be informed of policies on health care directives, when applicable.
8. The patient has the right to provide written consent to release of information in the patient's medical or financial records, except as otherwise permitted by law.
9. The patient has the right to review, upon written request, the patient's own medical record in accordance with state law.
10. The patient has the right to participate, or have a representative participate, in development of treatment plan and decisions about treatment.
11. The patient has the right to participate in or refuse to participate in experimental treatment or research, if applicable.
12. The patient has the right to consent to be photographed, except when admitted for identification and administrative purposes.
13. The patient has the right to receive a referral to another provider if the office is unable to provide services the patient needs.
14. The patient has the right to be informed of the process to submit a complaint.
15. The patient has a right to receive the fee schedule upon request.
16. The patient has the right to receive privacy in treatment and care for personal needs.
17. The license will be posted in a conspicuous place. The inspection report will be available at the front desk along with the DHS inspection book.
18. The patient has the right to receive assistance from a family member, representative, or other person in understanding, protecting or exercising these rights.
19. Process for filing a complaint: Ask to speak to the Practice Manager or Clinic Supervisor.
20. The patient has the right to file a complaint with the Arizona Department of Health Services, 150 N. 18th Ave., Suite 450, Phoenix, AZ 85007, phone: 602.364.3030.

THE CORE INSTITUTE®
Outcomes by HOPCo

Notice of Privacy Practices
Effective: January 22, 2018

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. We will post any revised notice in a prominent location in our office and, upon request, will provide to you a copy of the revised notice.

Uses and Disclosures of Your Protected Health Information

- **Treatment**. We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. We may also disclose your protected health information to other healthcare providers who may be treating you or involved in your healthcare. For example – we may disclose your protected health information to a specialist involved in your treatment.
- **Payment**. We may use and disclose your protected health information to obtain payment for the healthcare services we provide you or to determine whether we may obtain payment for services we recommend for you. We may also disclose your protected health information to another healthcare provider, healthcare clearinghouse or health plan for their payment activities. For example – we may include with a bill to third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.
- **Healthcare Operations**. We may use and disclose your protected health information to support our business activities. For example – we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may disclose your protected health information for certain healthcare operations of another healthcare provider, healthcare clearinghouse, health plan for certain healthcare operations, and to an "organized healthcare arrangement" we participate in for its healthcare operations. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.
- **Facility Directory**. Unless you object, we may use and disclose in our facility directory your name, location in the facility, general condition and religious affiliation. All of this information, except for your religious affiliation, will be disclosed to persons who ask for you by name. Information in the facility directory may be shared with clergy.
- **Persons Involved in Your Care**. We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Notification**. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.
- **Disaster Relief**. We may use and disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.
- **Research**. We may use and disclose your protected health information to researchers whose research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose to certain third parties a limited data set containing your protected health information for research purposes.
- **Reminders.** We may use and disclose your protected health information to contact you about upcoming appointments and tests and orders, including appointment reminders, missed appointment notifications and updates regarding tests or orders my provider requests. These reminders may be communicated by using the following methods: text message, email and telephone.
- **As Required by Law**. We may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.
- **Public Health**. We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury or disability. If directed by the public health authority, we may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.
- **Abuse or Neglect**. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If we believe you are a victim of abuse, neglect or domestic violence, we also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.
- **Communicable Diseases**. If authorized by law, we may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

- **Legal Proceedings**. We may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement**. If certain legal requirements are met, we may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes; identification and location of suspects, fugitives, material witnesses or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.
- **Coroners, Funeral Directors, and Organ Donation**. We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out her duties or in reasonable anticipation of death. Finally, we may use or disclose your protected health information for facilitating organ, eye or tissue donation and transplantation.
- **To Avert a Serious Threat to Public Health or Safety**. Consistent with applicable laws, if we believe using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; we may use and disclose your protected health information. We may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.
- **Military Activity and National Security**. When the appropriate conditions apply, we may use or disclose your protected health information: (1) for activities deemed necessary by appropriate military command authorities; (2) for determining your eligibility for benefits by the Department of Veterans Affairs; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- **Workers' Compensation**. We may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Department of Health and Human Services**. As required by law, we may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws.
- **Written Authorization**. Except as stated in this notice, we will not use or disclose your protected health information without your written authorization. You may revoke this authorization at any time, in writing, except to the extent that we have used or disclosed your information in reliance on the authorization.
- **Food and Drug Administration**. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.
- **Inmates**. We may use and disclose your protected health information if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.
- **Consent to Telephone Calls / Text Messages / Automatic Dialers***:* You acknowledge and agree that CORE, its affiliates and agents may use an automated telephone dialing system, pre-recorded or artificial voice calls, messages, and/or texting, to contact the wireless number(s) and/or residential lines you provided to CORE for appointment and payment purposes. You further agree to allow CORE and anyone who collects on its behalf to contact you about your account status, including past due or current charges, using pre-recorded or artificial voice calls messages, and/or texting, delivered by an automatic telephone dialing system to any wireless phone number(s) and/or residential lines I provide or that is provided to CORE on your behalf by your authorized representative.

Your Health Information Rights

- **Copy of This Notice**. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
- **Inspect and Copy**. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer at 18444 N. 25th Ave, Suite 320, Phoenix, AZ 85023. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice sites. If the information is stored off-site, we have up to 60 days to respond, but must inform you of this delay.
- **Request Amendment**. You have the right to request that we amend your protected health information. You must make this request in writing to our Privacy Officer. The request must state the reason for the amendment. We may deny your request if it is not in writing or

Financial Policy
Effective Date: January 22, 2018

The CORE Institute is dedicated to defining the standard of patient care through a commitment to excellence, innovation and learning. The CORE Institute has a responsibility to operate in a financially prudent manner to allow us to continue our mission; this includes collecting amounts due prior to rendering services to allow us to continue serving our communities. Amounts due include personal obligations such as copays, deductibles and past due balances.

The CORE Institute's values demand that our patients come first, we must be financially responsible to continue to serve. For those patients experiencing financial hardships we offer financial assistance options when necessary and appropriate. These options include payment plans and a charity care policy when a helping hand is desired by our most vulnerable patients.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at The CORE Institute. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that payment of co-payments, deductibles and non-covered services are to be paid at or before the time of service. The CORE Institute accepts cash, checks, MasterCard, Visa, Discover, Care Credit and Debit Cards. You may also pay your bill online from the Patient/Bill Payment section of our website.
- I understand that I may be contacted by the telephone regarding my outstanding balance with The CORE Institute. I acknowledge and agree that CORE, its affiliates and agents may use an automated telephone dialing system, pre-recorded or artificial voice calls, messages, and/or texting, to contact the wireless number(s) and/or residential lines you provided to CORE for appointment and payment purposes. I further agree to allow CORE and anyone who collects on its behalf to contact me about my account status, including past due or current charges, using pre-recorded or artificial voice calls messages, and/or texting, delivered by an automatic telephone dialing system to any wireless phone number(s) and/or residential lines I provide or that is provided to CORE on my behalf by my authorized representative.
- I understand that my credit card information will be kept securely on file. It will be automatically charged for amounts not covered by my insurance and for services rendered in accordance with this financial policy.
- I understand that if I do not have my insurance card, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand that The CORE Institute will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and The CORE Institute. If the full deductible is not applied to your claim by your insurance company, The CORE Institute will apply the overpayment to other outstanding dates of service with a patient financial responsibility before a refund is issued.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days then my account will be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that if I have made a payment plan agreement and I do not follow the terms of the agreement then my account will be placed with an outside collection agency.
- I understand that if my care resulted from an accident I am financially responsible. The Core Institute does not bill any third-party liability carrier such as auto (unless applicable in MI), homeowners or any other liability carrier.
- I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash).
- I understand that I have until 5 p.m. the day before my appointment to cancel or reschedule. If I do not show-up for my appointment and did not cancel or reschedule in time, a $40 no-show fee may be charged to my account.
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payor. The CORE Institute may participate in certain government programs and does comply with applicable billing terms and restrictions. I agree that The CORE Institute may require financial information to determine eligibility for financial assistance and/or payment plan options. Information on financial assistance is available by contacting Billing Department at 866.824.2673, or online at thecoreinstitute.com. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Notice to Patients
Relationships with Medical Device Companies

Dear Patient –

Recently, you may have heard that the Federal Government completed inquiries into the practices of several large orthopedic device manufacturing companies. Although The CORE Institute was not involved in any of those investigations, we would like to make sure you have accurate information regarding our relationships with some of these companies.

As our name suggests, our physicians, engineers, scientists and graduate students are actively involved in clinical care, education and research. Because of our mission, we focus our recruitment efforts on physicians who have superior academic and clinical training, and who also are actively involved in research and education directed at advancing orthopedic surgery and improving patient outcomes. Information about our physicians' education, training and experience can be accessed on our website at www.thecoreinstitute.com.

Our Division of Research and Development and our partnership with the Banner Sun Health Research Institute allow us to be actively involved in laboratory research aimed at improving the quality of medical care. We are currently working on projects studying total knee replacement devices; ways to improve hip fracture implants; improved methods of fracture treatment; and release of antibiotics from implants in an attempt to reduce the risk of postoperative infections. We are very proud of our success in this field and believe that we have contributed to the improvement in the care of orthopedic conditions.

Because of the qualifications of our physicians and other professionals, we often are approached by companies involved in the development of medical devices, instruments and related equipment. The companies know that our physicians have invaluable hands-on experience in the treatment of orthopedic problems, and that orthopedic surgeons frequently make important contributions to the development and improvement of devices and other equipment used in the treatment of orthopedic conditions. Surgeons and researchers at The CORE Institute are currently working with at least half a dozen companies, both large and very small, to help them create and improve products for patient care. We also have developed and patented products of our own that we have and/or will license or sell to industry.

Although CORE physicians donate a great deal of their time to the advancement of orthopedic research and education, they also enter into contracts that provide payment for some of their efforts. Payment for the services provided by orthopedic surgeons may come in the form of hourly consulting fees for services provided by the physicians; royalties based on sales of products to which CORE physicians made important contributions (excluding sales of products used on our patients); and/or outright purchase of technologies. All of these transactions are compliant with all federal and state laws.

The following is a current list and the companies with whom we have contractual relationships with device manufacturers. For a complete list of our providers who have contractual relationships, please visit http://www.thecoreinstitute.com/about-us/position-statement.html.

Company	Website	Company	Website
Acumed	www.acumed.net	Lipogems	www.lipogems.com
Advanzeon Solutions, Inc.	www.advanzeon.com	Medartis	www.medartis.com
Arboretum Venture	www.arboretumvc.com	Medline	www.medline.com
Artelon	www.artelon.com	Medtronic	www.medtronic.com
Arthrex, Inc.	www.arthrex.com	Molnlycke Health Care US	www.molnlycke.us
Bioventus	www.bioventusglobal.com	Mylad Orthopedic Solutions, LLC	no website
Bonovo	www.bonovo-ortho.com	NuVasive	www.nuvasive.com
Catalyst	www.catalystortho.com	Onsite Medical Services	www.onsitemedicalservices.com
Cartiva, Inc.	www.cartiva.net	OREF	www.oref.org
DePuy Mitek	www.jnjmedicaldevices.com	Parcus Medical, LLC	www.parcusmedical.com
DJO Global	www.djoglobal.com	Peerwell Inc.	www.peerwell.co
DuraStat	www.durastat.com	Peleton	www.peletonsurgical.com
Endo Pharmaceuticals Inc.	www.endo.com	Plasmology4, Inc.	www.plasmology4.com
FH Orthopedics	www.fhortho.com	Radius Pharmaceuticals	www.radiuspharm.om
Flower Orthopedics	www.flowerortho.com	RTI Surgical, Inc.	www.rtix.com
Foothills Sports Medicine and Physical Therapy	www.foothillsrehab.com	Safe Independence, LLC	www.securetracks.com
FX Shoulder	www.fxshoulder.com	Skineez	www.myskineez.com
Globus Medical	www.globusmedical.com	Stryker Orthopaedics	www.stryker.com
Health Point Capital	www.healthpointcapital.com	Valley Pain Consultants	www.valleypain.org
Innovative Surgical Design	no website	Wright Medical Group N.V.	www.wright.com
Integra LifeSciences Corporation	www.integralife.com	Wright Medical Technology, Inc.	www.wmt.com
ISOI	No website	Zimmer Biomet	www.zimmerbiomet.com
ITS	www.its-implant.com	Zuko Industries	No website
Lincoln National Life Insurance	wwwlfg.com		
LIMACORPORATE S.p.A	www.lima.it		

We hope this clarifies the nature of our involvement in research and development leading to advances in orthopedic care. We are proud to remain leaders in innovation and are honored to have such a talented research staff at The CORE Institute. As always, we remain committed to complete transparency and disclosure with our patients, and we welcome your questions on this or any subject relating to your care.

If your care might involve the placement of a medical device, please feel free to ask your surgeon about his or her recommendation as to what type of device best suits your needs.

Compliance Officer, Arash Araghi, DO

Compliance Specialist, Stacy Young, CHC, CHPC

1/27/2021
Contracts Evaluated Date

General Consent for Evaluation and Management
Patient Rights Acknowledgement

Acct #:_____ Date:_____
CORE Provider:_____
For office use only

Patient Name: _____ Date of Birth: _____

General Consent for Evaluation and Management

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

By signing below, I (or my authorized representative), authorize The CORE Institute and their staff to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health. I understand that it is the responsibility of my individual healthcare providers to explain the reasons for any treatment, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.

I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. I also understand that I retain the right to refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual health care providers.

This consent provides us with your permission to perform reasonable and necessary medical evaluations, examinations, diagnosis, testing, and treatment. By signing below, you are indicating that (1) you intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Rights Acknowledgement

By signing below, I (or my authorized representative), acknowledge receipt of a written copy of my Patient Rights.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Privacy and Disclosure Acknowledgment

Your treatment, payment, enrollment or eligibility for benefits at The CORE Institute® is not dependent upon whether you sign this Acknowledgement & Authorization. You have the right to revoke this Acknowledgement & Authorization at any time by sending a written notice of revocation to The CORE Institute®, attention to the Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these Acknowledgements and Authorizations with you.

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of The CORE Institute®, which explains its legal duties and privacy practices with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, notifications when I schedule my appointment, appointment reminders, missed appointment notifications as well as updates regarding tests or orders that are processed. I understand that standard message and data rates may apply.

I understand if I choose to opt-out of receiving text message reminders, I can update my preferred method of contact to Home or Work or respond to the received text message with STOP to opt-out of any future text messages.

AGREEMENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO CERTAIN PERSONS

I hereby agree, The CORE Institute® may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Signature of Patient/Patient's Representative

Date

Printed Name of Patient/Patient's Representative

FOR OFFICE USE ONLY

If applicable, reason patient's written acknowledgement could not be obtained:

☐Patient was unable to sign ☐Patient refused to sign ☐Other: _____

Credit Card Authorization
Pre-Authorized Payments

At The CORE Institute, we keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable regardless of whether the patient responsibility is owed in one payment or in multiple payments.
Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.
I authorize The CORE Institute to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ American Express ☐ Visa ☐ Master Card ☐ Discover

Last 4 of Credit Card Number: _____

Expiration Date: _____ / _____ / _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

_____
City State Zip

I (we), the undersigned, authorize and request The CORE Institute to charge my credit card, indicated above, for balances due for services rendered that my insurance company, if applicable, identifies as my financial responsibility. I acknowledge that such balances may be paid in one payment or in multiple payments.

This authorization relates to all payments not covered by my insurance company for services provided to me by The CORE Institute.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give sixty (60) days notification to The CORE Institute in writing and the account must be in good standing.

Print Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

DMEPOS Consent Form

During the course of treatment for your medical condition, The CORE Institute® may prescribe certain durable medical equipment, prosthetics or orthotics ("DMEPOS") as part of your treatment plan. Although The CORE Institute may supply some of these DMEPOS to you, you may be required to obtain certain DMEPOS from other DMEPOS suppliers. The CORE Institute works with the following DMEPOS suppliers to provide such DMEPOS to our patients (each, a "Supplier"):

ARIZONA	MICHIGAN
All Med Health Care	Alert Medical Inc.
American National DME	B & H Medical
Apria Healthcare	Beaumont Home Medical Equipment
Arizona CPM and Medical Supply	Becker Orthopedic
Arizona Desert Orthopedic Center	Binson's Home Health Care
Banner Home Care	Dixon Medical Equipment
CareCentrix	Mystic Medical Equipment
Dynasplint Systems	Northwest Orthotics and Prosthetics
Elite Care Inc.	Pros-Tech Prosthetics and Orthotics
EMPI	Wolverine Orthotics Inc.
Hanger Prosthetics	Wright & Filipis Inc.
Ottobock Health Care	
Preferred Homecare	
POA Prosthetic Orthotic Associates	
Smith & Nephew Exogen	
Walgreens Option Care	

By your signature below, you hereby consent to and authorize one of the above suppliers to contact you by telephone below regarding furnishing any DMEPOS prescribed by or on behalf of The CORE Institute.

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____

Patient Information

Acct #: _____ Date: _____
CORE Provider: _____
For office use only

PATIENT INFORMATION

PATIENT NAME LAST FIRST M.I. | SOCIAL SECURITY NUMBER

ADDRESS STREET | DATE OF BIRTH | SEX ☐ Female ☐ Male

CITY STATE ZIP | HOME PHONE NO. | CELL PHONE NO. | WORK PHONE NO.

E-MAIL | MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED

PREFERRED METHOD OF CONTACT ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ FAX ☐ PATIENT PORTAL/SECURE E-MAIL

RACE ☐African American ☐Asian ☐Hispanic ☐Caucasian ☐Filipino ☐ Native American ☐Native Hawaiian ☐Pacific Islander ☐Other | ETHNICITY ☐Hispanic ☐Non-Hispanic

PREFERRED LANGUAGE

2ND/SEASONAL ADDRESS Street City State Zip

EMPLOYER | PATIENT'S OCCUPATION

EMPLOYER ADDRESS Street City State Zip

PHARMACY NAME | PHARMACY PHONE NO.

HOW DID YOU HEAR ABOUT US? ☐Community Event ☐CORE Patient/ Friend/Family ☐Employer ☐High School/Sport ☐Hospital/Urgent Care ☐Insurance ☐Magazine or Newspaper ☐Physician ☐Radio or Television ☐Website or Online

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.
If patient is child, please indicate if parents are: ☐ Married ☐ Separated ☐ Divorced

NAME | SOCIAL SECURITY NUMBER

ADDRESS STREET | DATE OF BIRTH

CITY STATE ZIP | HOME PHONE NO.

EMPLOYER | EMPLOYER PHONE NO.

EMPLOYER ADDRESS: Street City State Zip

If this is a job-related injury, is this the employer you were working for at the time of injury? ☐ Yes ☐ No
If due to an injury, date of loss: ____/____/____ First symptoms: _____
Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: _____
Is injury related to: ☐ Accident ☐ Auto Accident ☐ Job Related ☐ Other: _____
If job related: Claim # _____ Case Manager: _____ Phone No.: _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN | NAME OF REFERRING PHYSICIAN

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME | RELATIONSHIP | PHONE

ADDRESS STREET CITY STATE ZIP

INSURANCE INFORMATION

Primary Insurance		**Secondary Insurance**	
Insurance Name:		Insurance Name:	
Policy/ID #:		Policy/ID #:	
Group/Account #:		Group/Account #:	
Cardholders Name:		Cardholders Name:	
DOB:		DOB:	
Social Security #:		Social Security #:	
Relation to Patient:		Relation to Patient:	

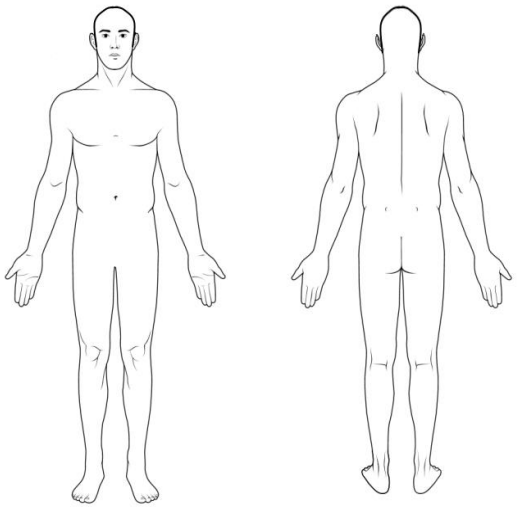
I hereby certify the above information is true and correct to the best of my knowledge. I understand that while The CORE Institute contracts with many insurance companies, it is my responsibility to verify with my plan that The CORE Institute is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that The CORE Institute will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If, however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize The CORE Institute to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines. Patient Signature_____ Date_____

Medical History – Spine

Acct #:_____ Date:_____
CORE Provider:_____
For office use only

Patient Name: _____ Date of Birth: _____

Using the appropriate symbols, mark the area(s) on your body where you feel each of the following sensations:
Numbness/Pins/Needles oooooooooooo
Burning/Aching/Stabbing XXXXXXX



R L **L R**

Prior treatments tried for your spine problem:

Oral anti-inflammatory medication Date: _____
ex.: Ibuprofen, Motrin, Advil, Aleve, Naproxen, Celebrex, Meloxicam/Mobic, Medrol/Prednisone….
Did this help? ☐ No ☐ Yes

☐ **Physical therapy** Date: _____
Did this help? ☐ No ☐ Yes

☐ **Spinal Injections** Date: _____
Did this help? ☐ No ☐ Yes

Medical tests for your spine problem:

X-Rays
Approximate Date: _____ Location: _____

MRI
Approximate Date: _____ Location: _____

CT Scan
Approximate Date: _____ Location: _____

EMG/Nerve Conduction Test
Approximate Date: _____ Location: _____

How long have you had this pain? _____

How would you describe the pain? _____
_____

How often does the pain occur? _____

Have you had to miss work because of this problem?
☐ No ☐ Yes ☐ Does not apply

Does your back pain radiate into your leg?
☐ No ☐ Yes ☐ Does not apply

Does your neck pain radiate into your arm?
☐ No ☐ Yes ☐ Does not apply

On a scale of 0-10, where 0 is no pain and 10 is worst pain, what number would you give your:
Low back pain? _____ Leg pain? _____

Neck pain? _____ Arm/hand pain? _____

Do you have any of the following?
Numbness/tingling ☐ No ☐ Yes
Weakness in the arm or leg ☐ No ☐ Yes
Sleep interrupted by pain ☐ No ☐ Yes

In the last 2 weeks, my pain symptoms are:
☐ Improving
☐ Getting worse
☐ Staying the same

What makes the pain worse? _____
_____

What makes the pain better? _____
_____

Medical History – Spine

Acct #:_____ Date:_____
CORE Provider:_____
For office use only

Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY

Do you have a history of any of the following?

Depression ☐ No ☐ Yes	Blood clots ☐ No ☐ Yes	Liver problems ☐ No ☐ Yes
Bipolar disorder ☐ No ☐ Yes	Diabetes ☐ No ☐ Yes	Peptic ulcer disease ☐ No ☐ Yes
Schizophrenia ☐ No ☐ Yes	Heart attack/disease ☐ No ☐ Yes	Stroke ☐ No ☐ Yes
Hepatitis ☐ No ☐ Yes	Osteoporosis ☐ No ☐ Yes	Kidney disease ☐ No ☐ Yes
HIV or AIDS ☐ No ☐ Yes	Cancer ☐ No ☐ Yes	Congestive heart failure ☐ No ☐ Yes

Other past medical history:

PAST OPERATIONS/HOSPITALIZATIONS

Please list any operations or hospitalizations you have had, the year, surgeon and city they took place.

TYPE	YEAR	SURGEON/LOCATION

Have you or a family member ever had a reaction to anesthesia? ☐ No ☐ Yes If yes, describe:

ALLERGIES

Do you have any history of an allergic reaction to medications?
☐ No known allergies ☐ Yes, specify:_____

Have you ever had an allergic reaction to: ☐ Iodine? ☐ Contrast? ☐ Latex? ☐ Dental Numbing Medications?

PRESENT MEDICATIONS

NAME OF MEDICATION	DOSE & FREQUENCY	NAME OF MEDICATION	DOSE & FREQUENCY
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

If you need additional room, please provide a list.

Are you currently taking any of the following BLOOD THINNER/ANTICOAGULATION medications? If so, indicate by marking the check box next to the medication.

☐ COUMADIN/WARFARIN ☐ ASPIRIN ☐ PLAVIX (CLOPIDOGREL) ☐ XARELTO (RIVAROXABAN)

☐ ELIQUIS (APIXABAN) ☐ PRADAXA (DABIGATRAN ETEXILATE)

☐ Other: _____

Medical History – Spine

Acct #:_____ Date:_____
CORE Provider:_____
For office use only

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Occupation: _____ When was the last time you worked? _____

☐ Restricted or light-duty ☐ Temporary disability ☐ Permanent disability ☐ Retired ☐ Unemployed/seeking job

Is there a worker's compensation claim? ☐ No ☐ Yes Is there a lawsuit related to your visit today? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco: ☐ No ☐ Yes How many packs per day? _____ How many years? _____ ☐ Quit _____ years ago

Alcohol: ☐ No ☐ Yes How much do you drink daily? _____ ☐ Quit _____ years ago

Have you ever been addicted to or misused illicit substances or prescription drugs? ☐ No ☐ Yes Type: _____

FAMILY HISTORY

Check here if unknown ☐

Alcohol or Drug Abuse	☐No ☐Yes	Diabetes	☐No ☐Yes	Stroke	☐No ☐Yes
Osteoporosis	☐No ☐Yes	Heart disease	☐No ☐Yes	Cancer	☐No ☐Yes, type:
Reaction to Anesthesia	☐No ☐Yes	Hypertension	☐No ☐Yes	Other:	_____

REVIEW OF SYSTEMS:

Are currently experiencing any of the following symptoms?

GENERAL:

Loss of appetite	☐ No	☐ Yes
Recent weight loss	☐ No	☐ Yes
Fever or chills	☐ No	☐ Yes

PSYCHIATRIC:

Depression	☐ No	☐ Yes
Drug/Alcohol addiction	☐ No	☐ Yes

RESPIRATORY:

Shortness of breath	☐ No	☐ Yes
Chronic cough.....	☐ No	☐ Yes

CARDIOVASCULAR:

Chest pain.....	☐ No	☐ Yes
Palpitations.....	☐ No	☐ Yes

KIDNEY/BLADDER/URINE:

Painful urination.....	☐ No	☐ Yes
Blood in urine.....	☐ No	☐ Yes

EYES:

Loss of vision	☐ No	☐ Yes
Double vision.....	☐ No	☐ Yes

GASTROINTESTINAL:

Nausea/vomiting/heartburn...	☐ No	☐ Yes
Blood in stool.....	☐ No	☐ Yes

SKIN:

Frequent Rashes.....	☐ No	☐ Yes
Skin ulcers.....	☐ No	☐ Yes

HEMATOLOGICAL/LYMPHATIC:

Easy bruising	☐ No	☐ Yes
Easy bleeding	☐ No	☐ Yes

HEAD/EARS/NOSE/THROAT:

Hoarseness.....	☐ No	☐ Yes
Trouble swallowing.....	☐ No	☐ Yes

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name: _____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Reviewed By: _____ **Date:**