Boston Spine CARE GROUP

PHYSICIAN

Robert J. Banco, M.D.
Orthopaedic Spine Surgeon
Associate Clinical Professor
Department of Orthopaedic Surgery
Tufts University School of Medicine

Newton-Wellesley Hospital
Medical Office Building
2000 Washington Street, Blue Bldg. Suite 104
Newton, MA 02462

Tel: 617-219-6300
Fax: 617-219-6355
bostonspinecaregroup.com

AFFILIATED HOSPITAL
Newton-Wellesley Hospital

Date: _____/ _____/ _____

Dear: ____

Appointment Date: _________________Time:___________ AM PM
Appointment with: _______________________________

Enclosed you will find directions to our **NEW OFFICE** located at **2000 Washington Street, Blue Bldg. Suite 104** and a blank patient information packet. Please read, fill out and sign all of these forms and bring them to your visit. Please make sure to also read and sign our medication policy.

Convenient Parking Available at the visitor parking lot or valet parking East entrance of the hospital.

- **Please make sure to bring your insurance card and a valid photo ID.**
- **Please bring glasses if you need them to read and a list of the medications you are currently taking with the strength and directions.**
- If your insurance is an HMO that requires you to get referrals for doctor's visits, please contact your PCP'S office to request one and, if possible, bring it with you. Check with your PCP's office the day before your appointment to make sure that the referral has been issued. If we do not have a valid referral at the time of your visit, it is possible that you may not be seen or that you may be financially responsible for the full visit fee. We also ask that you please bring your copayment with you. **For your convenience, we accept Visa®, MasterCard® and Checks. We do not accept cash.**
- We do **REQUIRE that you bring your most recent MRI or CT scan DISCs with you** for your provider to view during your visit. UNLESS YOUR IMAGES WERE DONE AT NWH, YOU STILL MUST BRING A DISC, THIS INCLUDES SHIELDS MRIs. **DO NOT** have them sent to us before your visit. Please feel free to bring any other films you feel may be helpful.

Feel free to contact us at **(617) 219-6300** if you have any questions or concerns. We kindly as that you give us 24-hour notice if you are unable to keep your scheduled appointment.

Please note: If you arrive later for your appointment, there is a possibility your appointment may have to be rescheduled due to time constraints.

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Patient____ Sex M F
Last First Middle

Date of Birth ________________ Age______ Social Security Number

Address____
Street City State Zip Code

Home PH __________________ Work PH __________________

Alternate or Cell Phone #: _________________ E-Mail_______________________

Emergency Contact____Phone_________________

Primary Care Physician Name_________________________________Phone _________________

Address____

Referring Physician Name____________________________________Phone _________________

Address ____

Primary Insurance

Name____________________________
ID#_____________________________
Group#___________________________
Subscriber _________________________
DOB of Subscriber___________________

Secondary Insurance

Name____________________________
ID#_____________________________
Group#___________________________
Subscriber_________________________
DOB of Subscriber___________________

Workers' Compensation (if applicable)

Insurance____ Claim #_______________________

Date of Injury_________________ Date Last Worked _______________________

Billing Address ____

Adjuster_______________________________ PH__________________ FX _________________

RN Manager____________________________ PH__________________ FX _________________

Utilization Review Co ____________________ PH__________________ FX _________________

Attorney: __________________________ Address:____

Attorney PH:_ _______________________

Employer: __________________________ Address: ____

Employer PH: _______________________ Occupation: ____________________

Pharmacy: _________________________ Address: ____

Pharmacy PH: ______________________

I hereby assign to the physician for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance(s. :

Signature____ Date___________

Name_______________ Date_____________

MD initials ____

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Please indicate along the line at the point that corresponds to your average BACK/NECK pain over the last few days.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Please indicate along the line at the point that corresponds to your average LEG/ARM pain over the last few days.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Are you experiencing: Numbness Yes No

Weakness Yes No

Do your legs tire/hurt if you walk too far? Yes No

If YES, how far can you walk? less than 1 block 1-3 blocks more than 3 blocks

When did your symptoms begin?

Have you had similar attacks in the past? ____

What was the cause of your pain? ____

How does each of the following affect your pain? (check your answer)

Sitting	Better	Worse	No change	Don't know
Standing	Better	Worse	No change	Don't know
Walking	Better	Worse	No change	Don't know
Lying Down	Better	Worse	No change	Don't know
Rising from chair	Better	Worse	No change	Don't know
Physical activity	Better	Worse	No change	Don't know
Heat Cold	Better	Worse	No change	Don't know
Massage	Better	Worse	No change	Don't know

Name___________________ Date__________

MD initials _____

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Have you had any of the following diagnostic procedures done for evaluation of pain? **(Provide DATE and PLACE below.)**

Bone Scan ___________ ____
CT Scan ___________ ____
Myelogram ___________ ____
EMG ___________ ____
X-Rays ___________ ____
Blood Work ___________ ____
Discogram ___________ ____
MRI ___________ ____

What kind of treatment have you received in this current episode of pain?

Best Rest	Yes	No	Medication	Yes	No
Brace	Yes	No	Physical Therapy	Yes	No
Chiropractor	Yes	No	Acupuncture	Yes	No
Facet Injections	Yes	No	Epidural Injections	Yes	No
Other Injections	Yes	No	Other: ______________________		
Spine Surgery	Yes	No	Type: ______________________		

If yes, (When/Where/by Whom):____
____

What medications are you currently taking (dose)?
____
____

Medication Allergies/Reactions ____
____

Have you had any previous complications with anesthetics? Yes No

Have you had problems with addiction to prescription or non-prescription medications? Yes No

Past surgical history (please include When/Where/by Whom):
____
____

Past medical history (please include dates):
____
____

Family medical history: ____
____

Name____________________ Date___________

MD initials ______

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Check all symptoms you now have:

Heart trouble
Chest pain
Heart skipping
Palpitations
High blood pressure
Stroke
Bleeding disorder
Easy bruising
Fainting
Lightheaded
Incontinence
Urinary frequency
Blood in urine
Menstrual changes
Jaundice
Renal disorder
Vaginal bleeding
Vision changes
Eye pain/redness
Headaches
Hearing loss
Nose bleeds

Abdominal pain
Reflux
Heartburn
Gerd
Diarrhea
Loss of appetite
Constipation
Change in bowl habits
Significant weight change
Unexplained weight loss
Pain in joints
Decreased range of motion
Swollen ankles
Leg cramps
Numbness
Muscle weakness/paralysis
Tremor dizziness
Excessive sweating
Persistent infections

Shortness of breathe
Cough
Wheezing
Bloody sputum
Throat disorder
Thyroid trouble
Swollen glands
Trouble swallowing
Mouth sores
Sore throat
Anxiety/disorders
Depression
Nervousness
Insomnia
Night sweats
Fatigue

Oral lesions
Skin lesions
Skin sores
Rash/bumps

What is your height: ________ Weight: ______
Relationship Status: Married Single Divorced Widowed Children, if so how many? _______

Smoking Status:
never smoker
current every day smoker
current some day smoker
former smoker
smoker current status unknown
unknown, if ever smoked

Years smoked _____
Packs per day: <=0.5 1.0 1.5 2.0 >2.0

Approx. quit date: ___________

Do you drink alcohol? Yes No drink(s)/week: ________________

Indicate your ethnic or racial background:

American Indian or Alaskan Native
Asian
Black or African – American
White or Caucasian

Hispanic
Aboriginal
African
Caribbean

East Indian
Middle Eastern
Other
Unknown

What is your current occupation/work status? ____
Are you currently working? Yes No
Are you currently receiving Workers Compensation? Yes No
If you are out of work, how long? ____________
Do you exercise regularly? Yes No
Are you involved in a personal injury lawsuit because of your pain? Yes No

Name_________________ Date__________

***MD initials*_____**

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Prescription Refill Policy

In order to provide outstanding quality care at Robert J Banco, MD, PC, adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our providers, this allows you to update the provider on any changes in your medication or advise them of any new or ongoing symptoms.

We understand, however, that sometimes this is not possible and in those situations it will be necessary to follow our refill policy.

It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3 business days, so please be courteous and plan ahead.

Medication refills will only be addressed during regular office hours (8:30 AM to 4:00 PM). T he afterhours call service or answering machine will not return any phone calls regarding refills. Please contact the office on the next business day to place your refill request.

In order to effectively process your prescription refill request, we will need the following information:

- Date that the request is made
- Spell your first and last name
- Your date of birth
- Spell the name of the medication and dosage
- Date that the current prescription will run out
- State how you are currently taking the medication
- Name and location of your pharmacy
- Contact information were we can reach you

The following guidelines will be followed when processing your refill request:

- There will be NO refills given on Friday's after 12 PM, weekends, or Holidays.
- A process time of **3 days** minimum will be needed for **all** requests.
- There will be no early refills, patient must follow prescription directions.
- Requested medications cannot be picked up at the office.
- Prescription medications that are lost or stolen will not be replaced.
- No refills will be processed for prescriptions not initiated by our providers.
- Some medication refill requests will require a follow up appointment.
- New symptoms and/or events will require an office appointment.
- Signed "Prescription Refill Policy" is required for all medication prescriptions.

By signing below I understand, agree and accept the policy listed above. Failure to comply may subject immediate termination of prescriptive medications.

Patient Signature: ____________________________________ Date: _____________________

Print Name: ____

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Patient/Provider Opioid Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management. It is also to assure that you and your health care provider comply with state and federal regulations concerning the prescribing and use of controlled substances. Opioids (narcotic analgesics) are a class of medications that are prescribed to help with pain. They can be very helpful in the management of acute episodes of pain and acute postoperative pain. It is important to understand some of the side effects of these medications. Opioids may cause drowsiness that can be worsened by the use of alcohol, benzodiazepines, and other sedating medications. If you are unsure about mixing any medication with an opioid, please ask your health care provider or pharmacist. You must avoid any activity that may be dangers to you or someone else if you feel drowsy or are not thinking clearly.

The long-term use of opioids for pain management is controversial because of uncertainty regarding the extent to which they provide long term benefit. It is the practice and policy of Robert J Banco, MD, PC not to prescribe long term maintenance opioids to our patients. Any prescription for opioids will strictly be for an acute episode (i.e. spine surgery, acute strain or injury), of short duration not to exceed three (3) months, and all patients will be tapered off the medication with a weaning schedule **at the provider's discretion.** If the patient is unable to follow the agreed upon schedule or requires more than three (3) months of prescription medications, he or she may be referred back to the primary care physician or pain management specialist for continued pain management.

Patients entering the practice while currently on a maintenance course of prescribed opioids for chronic pain will need to obtain their maintenance prescription medications from the original prescribed.

Physical dependence will develop with regular use. This does not indicate addiction, but means that a physical withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain relieving effects of opioids, meaning that pain relief may decrease over time. In chronic pain states, this usually occurs slowly, if at all.

Some pain conditions, including post-operative pain, may not improve with opioids. A frequent need to increase doses may indicate that opioids are not effective for a particular pain problem. It could also indicate an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may occur if pain relief is not adequate in spite of escalating doses, persistent side effects, if goals of opioid therapy are not being met, or there is inability to comply with the treatment agreement.

Opioid medications have potential for abuse or diversion and strict accountability is necessary. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician/physician assistant (PA) whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

Name___________________ Date____________

MD initials______

1. All prescriptions must come from the physician/PA whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

2. All prescriptions **must be obtained at the same pharmacy,** whenever possible. Should the need arise to change pharmacies, you should try to stay within the same pharmacy chain and you **MUST** inform our office. The pharmacy that you have selected is:

   ____ Phone: ________________________

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes maintaining accountability.

5. Stopping opioids abruptly can cause flu-like withdrawal symptoms such as nausea, vomiting, diarrhea, and sweating. While not dangers, this can be uncomfortable. It is best to wean from opioids as instructed by your health care provider.

6. You **CANNOT** share, sell or otherwise permit others to have access to these medications.

7. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people. It is expected that's you will take the highest possible degree of care with your medication and prescription. It is best to lock up your medication in a safe or lock box. You should not leave your medications wh3ere others might see or have access to them.

8. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, have been stolen, etc. If is your responsibility to keep your medications safe.

9. Early refills will generally not be given. Prescription refills may be issues early if the physician/PA

10. or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

11. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends as covering providers will not prescribe refills for narcotics.

12. It should be understood that any medical treatment is initially a trial, and that continued opioid prescription is contingent on evidence of benefit. The risks and potential benefits of these therapies are explained in the informational piece of this agreement.

13. It is understood that failure to adhere to these policies may result in cessation of therapy with opioid prescribing by this physician/PA or referral for further specialty assessment.

14. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

______________________	______________________
Provider Signature	Patient Signature
______________________	______________________
Provider Name (printed)	Patient Name (printed)
Date: ____________________	Date: ____________________

NOTICE OF PRIVACY PRACTICES
EFFECTIVE 9-01-2015

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

Robert J Banco, MD, PC may record, transmit, or maintain, either on paper or electronically, personal information about you, your medical history and your healthcare treatment as part of providing you with healthcare services.
This Notice of Privacy Practices ("Notice" describes how we may use and disclose such information, our obligations regarding the use and disclosure of your medical information, and your rights with respect to the use and disclosure of your medical information. This Notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA".

OVERVIEW

We are legally required to protect the privacy of information that identifies you or could be used to identify you, and relates to your past, present or future physical or mental health condition(s or the provision of past, present, or future healthcare services (including payment for those services. This information is called "protected health information" or "PHI" for short.
We are legally required to follow the privacy practices that are described in this Notice. We reserve the right to change our privacy policies and the terms of this Notice at any time. Before any important policy change goes into effect, we will change this Notice.
We will post a copy of this Notice in all our registration areas for public viewing and on our website at **www.bostonspinecaregroup.com**. You may also request a copy of this Notice at any time by contacting Robert J Banco, MD, PC's Compliance Officer at 2000 Washington Street, Blue Bldg. Suite 104, Newton, MA 02462.

USE AND DISCLOSURE OF YOUR PHI BY Robert J Banco, MD, PC

We may use or disclose your PHI to carry out its responsibilities as a healthcare provider. **We** may use or disclose your PHI without your written authorization for the following reasons:
• **Treatment. We** may disclose PHI to physicians, nurses, technicians, hospitals, medical students or other personnel who are involved with the administration of your care at or other locations.
• **Payment.** We may use and disclose PHI so that payment for the treatment and services you receive at Robert J Banco, MD, PC or from other entities, such as an ambulance company, may be billed to and collected from you, or an insurance company or third party. We may also need to disclose this information to insurance companies to establish insurance eligibility benefits for you.
• **Healthcare Operations.** "Healthcare operations" at Robert J Banco, MD, PC include activities related to improving quality of care, staff training, medical education, and business management.
• **Appointment Reminders, Information about Healthcare Related Benefits and Treatment Alternatives.** We may use and disclose medical information to contact you as a reminder that you have an appointment for a treatment or medical care to inform you of treatment alternatives or other healthcare services or benefits that we offer.
• **As Required By Law. We** will disclose PHI when required to do so by federal or state law, including in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process. **We** may also disclose PHI to law enforcement personnel or similar persons to avoid a serious threat to the health or safety of a person or the public.

Name___________________ Date____________

MD initials______

In addition, **we** may use your PHI without your written authorization under the following circumstances:
• Emergency situations when your authorization cannot be reasonably obtained, including for disaster relief purposes;
• To business associates (outside vendors or consultants that perform services on behalf of Robert J Banco, MD, PC and are contractually required to appropriately safeguard your information);
• To other healthcare facilities where **the** physicians and healthcare professionals have privileges or to physicians from other healthcare facilities who see patients at Robert J Banco, MD, PC;
• With your agreement, to a family member, relative, close personal friend, or any other person you identify;
• To facilitate organ or tissue donation if you are an organ donor;
• In connection with workers' compensation claims;
• To report abuse, neglect, or domestic violence as required by state of federal law;
• For public health and health oversight activities, such as preventing or controlling disease or investigations; or
• To coroners, medical examiners, or funeral directors as necessary to carry out their duties.

Certain actions, such as most uses of disclosures of psychotherapy notes, the use and disclosure of PHI for marketing purposes, and disclosures that constitute a sale of PHI, will be made only with your written permission (authorization). Other uses or disclosures of PHI that are not covered by this Notice or applicable laws also will be made only with your written permission. Massachusetts provides special privacy protections for particularly sensitive conditions or illnesses such as HIV/AIDS, mental health, and substance abuse. **We** will disclose such information only in a manner that is consistent with these laws. You may revoke your permission at any time by writing to the compliance officer at the address below. Once you revoke your permission, we will stop using or disclosing such information for the reasons covered by your written authorization. However, we cannot take back any disclosures made with your permission. We will retain our records of the care provided to you as required by law.

YOUR RIGHTS REGARDING YOUR PHI

Although your medical information is the property of Robert J Banco, MD, PC, you have certain rights regarding your PHI, including the right to:
• **Inspect and Copy.** With certain exceptions, you have the right to inspect or receive a copy of your medical information or both. We may charge a fee for these services. We may deny your request in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by Robert J Banco, MD, PC will review your request and our denial.
• **Request an Amendment.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend information that is kept by or for Robert J Banco, MD, PC. We may deny your request if you ask us to amend information that (a) was not created by Robert J Banco, MD, PC; (b) is not part of the medical information kept by or for Robert J Banco, MD, PC; (c) is not medical information you are permitted to inspect or copy; or (d) is accurate and complete in the record.
• **Request an Accounting of Disclosures.** You may request a list of the disclosures we have made of PHI that were for purposes other than treatment, payment, healthcare operations and certain other purposes, or disclosures made with your written authorization within the last six (6) years. You may be charged a fee in connection with this request.
• **Restrict or Limit Use or Disclosure.** You may ask us to restrict or limit the use or disclosure of your PHI, including the disclosure of information to someone who is involved in your care or the payment for

Name___________________ Date____________

MD initials______

your care, like a family member or friend. Your request must state: (1) what information you want to limit; (2) whether you want to limit the physicians use, disclosure or both; and (3) to whom the limits apply, for example, disclosures to your spouse. We are not required to agree to your request, unless it relates to an item or service you paid for in full and out of pocket. In this case, you may request that we not share health information pertaining only to that product or service with your health plan for the purposes of carrying out payment or healthcare operations and we will comply with your request unless the information is needed to provide you emergency treatment or except as required by law.

• **Confidential Communications.** Generally, we will use the address, telephone number and, in some cases, the email address you give us to contact you. You may ask us to communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

• **Notification in the Event of a Breach.** Consistent with federal and state laws, we will notify you in the event unsecured PHI is used or disclosed by an unauthorized individual.

All requests must be submitted in writing to the address below. Your request must be specific and be signed by you or an authorized representative.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by writing to the address below or by calling Robert J Banco, MD, PC's compliance officer at 617-219-6300. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or through the regional office at J.F.K. Federal Building – Room 1874, Boston, MA 02203. The complaint must be filed within 180 days of the alleged violation. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have questions, would like to submit a written request, or need further assistance regarding this policy, please contact Kirsten Gage at:

2000 Washington Street, Blue Bldg. Suite 104, Newton, MA 02462
Phone: 617-219-6300
Fax: 617-219-6355

EFFECTIVE DATE

This Notice of Privacy Practices is effective **December 2, 2024**.

Boston Spine CARE GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (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, or as a result of a liability or worker's compensation claim.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, I acknowledge that I have been offered/received a copy of Robert J Banco, MD, PC's Notice of Privacy Practice document.

Patient Name: ____D.O.B. ___________________

Signature: ____DATE: ___________________

Relationship to Patient: ____

Please list below the names, relationships, and phone numbers of any authorized individuals with whom we may discuss your medical or financial information. This permission will extend to making and verifying appointments, billing information, discussing test results, and general care with either the office staff and/or providers.

NAME	RELATIONSHIP	PHONE

OFFICE USE ONLY

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

Date:	Initials:	Reason: Refused Communication Barrier Emergency Other

Name__________________ Date______________

***MD initials*_____**