Twin Cities Pain Clinic & Surgery Center

PACT
Personalized Activated Care & Training

Consent for PACT Program

You have been referred by your provider for participation in the PACT (Personalized Activated Care and Training) program. Please review and sign this consent form to ensure understanding of the PACT program and your important role in preventing chronic pain, addiction, and ongoing treatment.

Purpose of PACT. You have the most control over how quickly you recover from the pain condition. Chronic pain is real and preventable. PACT will help you learn to identify and reduce the causes of your pain condition by implementing self-care strategies that will help your pain improve long-term. The causes of chronic pain are called risk factors such as repetitive strain, tensing habits, poor posture, diet, sleep, social and emotional stress that can occur as part of your daily life. The presence of several risk factors can lead to delayed recovery and chronic pain. Self-care actions such as exercise, healthy diet, good sleep, stress reduction, and mindfulness are protective and can heal strained tissues and help you recover from pain. Since the PACT program helps you learn self-care, it often reduces the need for costly long-term treatments for your pain and ultimately saves money and your health.

Your responsibilities in PACT. PACT requires your participation in several activities to be successful in relieving your pain long-term. These include:

1. Registering in PACT and completing the assessments
2. Reviewing the micro-lessons on the changes that are needed to relieve your pain
3. Scheduling and meeting with a telehealth coach to support you in daily action plans to relieve pain. ***Since these are scheduled specifically for you, please make every effort to keep each visit.***
4. Developing and implementing your daily self-care action plan in each realms of your life.
5. Completing the progress report before each new module of lessons.

Financial Policy: We will adhere to the following financial policy in order to consistently deliver high quality care and services with PACT. The services provided by PACT are generally covered by health plans as preventative services outside of deductibles and co-pays. However, I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same and vary by employer group. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received. The clinic is not responsible or able to know every policy available. It is the patient responsibility to verify applicable coverage prior to receiving the services. If you are uninsured, or your insurance company chooses to not cover the cost (due to reasons of contract, deductible, co-insurance, or other reasons) you, the patient, become liable for the cost of care.

The cost of the PACT program may include a combination of the below charges;

1. Risk Assessments (CPT 96150) is $50.00 per assessment
2. Risk Reduction Training Lessons with telehealth coaching per time (CPT 98960)
3. Charge for no-show visit is $60 per missed visit. If your insurance does not pay, you will be billed the cost of the no -show.

In the absence of insurance coverage, we require a payment of 50% at the time of service with the remainder due at the time of billing unless other arrangements have been made previously with the billing office. *With Medicare, Medicaid, and Medical Assistance, and Advance Benefit Notification is required to be signed to ensure acknowledgement of patient responsibility for fees.*

Consent for Participation in the PACT Program: I, with my signature, authorize PACT and the PACT coaches working under the direction of the health professional, to provide self-care risk reduction training, telehealth coaching risk assessments for me, or to this patient for which I am the legal guardian. Even though health plans have indicated they will cover these prevention services, I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I understand that if I have an insurance co-payment, I am expected to make payment when receiving the bill. This consent allows us to contact and discussion with your other health care professionals as needed.

Consent Related to Privacy Notice: This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information. I have had a chance to review the Terms of Service and Privacy HIPAA policy as part of this registration process in PACT. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions of PHI use, it is bound by that agreement.

Patient Name: _____ **DOB:** _____

Name of Insurance: _____

PACT provides preventative services that is covered by health plans. However, if health plans do not cover outside of deductible and co-pays, you are responsible for the costs.

Patient Signature: _____ **Date:** _____