



New Patient Intake Form

Name: _____ Date of Birth: _____ Today's Date: _____

Gender: Male Female Height: _____ Weight: _____ lbs

Street Address: _____

City/State/Zip: _____

Mailing address if different from physical address: _____

Email: _____

Preferred Phone: _____ Home Mobile Work

Secondary Phone: _____ Home Mobile Work

Emergency Contact: _____ Phone: _____ Relationship: _____

Pharmacy: _____ Cross Streets: _____ Phone Number: _____

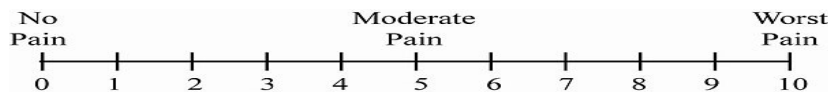
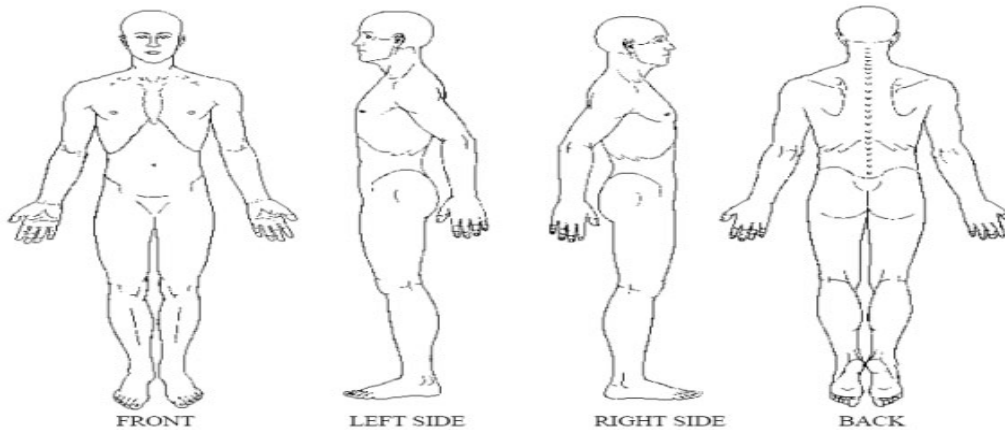
Onset of Symptoms and Reason for Visit Today

When did this pain begin? _____

What caused your current pain or injury? _____

Was the pain or injury due to a motor vehicle accident or personal injury? No Yes

Use the diagram below to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: "N"umbness "P"ins and Needles "A"ching "S"tabbing "B"urning



What is your current pain level **right now**? _____ What is your **worst** level of pain level? _____

Where is your worst area of pain located? _____

Does the pain radiate? If yes, where? Up Down the _____ to the _____

Please list additional areas of pain _____

What word best describes the frequency of your pain? Constant Intermittent

Since your pain began, has your pain Increased Decreased Stayed the Same

When is your pain at its worst? Mornings During the Day Evenings Middle of Night

Check all that describe your pain **today**:

- | | | | |
|-----------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Hot/Burning | <input type="checkbox"/> Spasms | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Numb | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling/Pins and Needles |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Stabbing/Sharp | <input type="checkbox"/> Tiring/Exhausting |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting | | |

Factors that Affect your Pain

Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down? No Yes

If yes to the above question, is your pain also alleviated with bending forward (using a shopping cart, leaning on kitchen counter, etc.)? No Yes

Please indicate any factors that affect your pain in the list below:

| | Increases Pain | Decreases Pain | No Change |
|-------------------------------|--------------------------|--------------------------|--------------------------|
| Bending Backward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending Forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Changes in Weather | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climbing Stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing/Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting Objects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Looking Forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Looking Downward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Looking Side to Side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lying Down | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rising from a Seated Position | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Activity

How many days per week do you exercise? _____ Type of Exercise _____

Does your pain interfere with any of the following? Work School Home duties Daily living

Recreational Activities

Diagnostic Tests & Imaging - Mark all of the following tests you have had related to your current pain:

MRI of the _____ Date: _____ Facility: _____
 X-ray of the _____ Date: _____ Facility: _____
 CT scan of the _____ Date: _____ Facility: _____
 EMG/NCV study _____ Date: _____ Facility: _____
 Other _____

Pain Treatment History - Mark the following pain treatments you have undergone PRIOR to today's visit:

| <u>Treatment</u> <input type="checkbox"/> NO PREVIOUS TREATMENTS | No Relief | Moderate Relief | Excellent Relief |
|--|--------------------------|--------------------------|--------------------------|
| Chiropractic Therapy, # of weeks _____ Date range _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Home Exercise Program, # of weeks _____ Date range _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical Therapy, # of weeks _____ Date range _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Medications</u> <input type="checkbox"/> NO PREVIOUS MEDICATIONS | | | |
| Anti-inflammatories _____ # wks _____ Date range _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other med, type _____ # wks _____ Date range _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other med, type _____ # wks _____ Date range _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Injections</u> <input type="checkbox"/> NO PREVIOUS INJECTIONS | | | |
| Joint Injection, type _____ Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| Joint Injection, type _____ Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| Epidural Steroid Injection, Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| Medial Branch Blocks/Facet Injections, Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| SI Joint Injections, Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| Radiofrequency Ablation, Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| Nerve Blocks, type _____ Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| Nerve Radiofrequency Ablation, type _____ Dates _____ % Relief (0-100) _____ Duration _____ | | | |
| Spinal Column Stimulator <input type="checkbox"/> Trial <input type="checkbox"/> Permanent Implant, Date _____ % Relief _____ Duration _____ | | | |
| Other Procedure, type _____ Dates _____ % Relief _____ Duration _____ | | | |

Current Medications

Are you taking a **prescribed blood-thinner**? if so, which one? _____

Name/phone of the doctor that prescribes your blood thinner: _____

Please list **ALL** medications you are currently taking including OTC medications, ibuprofen, aspirin and fish oil.

Attach additional sheet if necessary.

| Medication Name | Dose | Frequency | Medication Name | Dose | Frequency |
|-----------------|------|-----------|-----------------|------|-----------|
| 1. | | | 6. | | |
| 2. | | | 7. | | |
| 3. | | | 8. | | |
| 4. | | | 9. | | |
| 5. | | | 10. | | |

Allergies - Please list all allergies that you have

Medication Name that I'm Allergic to:

The Allergic Reaction I have is:

1. _____
2. _____
3. _____
4. _____

Are you allergic to any of the following?

Iodine No Yes Tape No Yes

Latex No Yes Do you require special rescue measures for your latex allergy? No Yes

I HAVE NO KNOWN ALLERGIES

Past Medical History /Problem List

Are you currently pregnant? No Yes Are you post-menopausal? No Yes

Do you plan on becoming pregnant? No Yes

Have you had two or more falls in the last year? No Yes

Have you received a pneumonia vaccination? No Yes Date _____

Have you been diagnosed with hypertension? No Yes Date _____

Mark all conditions/diseases that you have been **DIAGNOSED** with:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Hepatitis, type _____ | <input type="checkbox"/> Osteoarthritis/Osteoporosis |
| <input type="checkbox"/> Diabetes, type _____ | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | |

I HAVE NO SIGNIFICANT MEDICAL HISTORY

Past Surgical History

Do you currently have an implanted ICD, pacemaker, or defibrillator? No Yes

Please list prior surgeries or procedures in the table below. Attach an additional sheet if required.

| Date | Surgery/Procedure | Physician |
|------|-------------------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

I HAVE NO SIGNIFICANT SURGICAL HISTORY

Family History - Mark all appropriate diagnoses as they pertain to your BIOLOGICAL family members only.

- | | | | |
|---|-----------------|---|-----------------|
| <input type="checkbox"/> Anxiety/Depression | Relation: _____ | <input type="checkbox"/> High Blood Pressure | Relation: _____ |
| <input type="checkbox"/> Arthritis | Relation: _____ | <input type="checkbox"/> Kidney Problems | Relation: _____ |
| <input type="checkbox"/> Cancer | Relation: _____ | <input type="checkbox"/> Liver Problems | Relation: _____ |
| <input type="checkbox"/> Diabetes | Relation: _____ | <input type="checkbox"/> Rheumatoid Arthritis | Relation: _____ |
| <input type="checkbox"/> Headaches | Relation: _____ | <input type="checkbox"/> Seizures | Relation: _____ |
| <input type="checkbox"/> Heart Disease/Stroke | Relation: _____ | <input type="checkbox"/> Substance Abuse | Relation: _____ |

- I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY I AM ADOPTED (No Medical History Available)

Social History

- Smoking:** Current every day Current some days Former smoker Never smoker
- Alcohol:** Current alcoholism History of alcoholism Social alcohol use No alcohol use
- Marijuana:** Current use Former use Medical Marijuana Card Holder Never used
- Illegal Drugs:** Current use, list which ones _____
- Former use, list which ones _____
- Never used

Narcotic and Prescription Medications:

I have abused narcotic and/or prescription medications No Yes

If yes, please list which ones _____

Review of Systems - Mark all of the following symptoms that you CURRENTLY suffer from:

| | | |
|---|---|---|
| <p><u>Constitutional:</u></p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Difficulty Sleeping</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fevers</p> <p><input type="checkbox"/> Night Sweats</p> <p><u>Cardiovascular/Respiratory:</u></p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Swelling in the Feet</p> <p><u>Gastrointestinal:</u></p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Dark and Tarry Stools</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Nausea/Vomiting</p> | <p><u>Genitourinary/Nephrology:</u></p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Involuntary Urination</p> <p><input type="checkbox"/> Loss of Bowel Control</p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> Pelvic Pressure</p> <p><u>Ears/Nose/Throat/Neck:</u></p> <p><input type="checkbox"/> Difficulty Hearing</p> <p><input type="checkbox"/> Earaches</p> <p><input type="checkbox"/> Hay fever/Allergies</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Recurrent Sore Throats</p> <p><input type="checkbox"/> Ringing in the Ears</p> <p><input type="checkbox"/> Sinus Problems</p> <p><u>Eyes:</u></p> <p><input type="checkbox"/> Recent Visual Changes</p> | <p><u>Neurological:</u></p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Instability When Walking</p> <p><input type="checkbox"/> Numbness/Tingling</p> <p><input type="checkbox"/> Weakness</p> <p><u>Psychiatric:</u></p> <p><input type="checkbox"/> Anxiety/Stress</p> <p><input type="checkbox"/> Depressed Mood</p> <p><input type="checkbox"/> Suicidal Thoughts</p> <p><input type="checkbox"/> Suicidal Planning</p> <p><u>Musculoskeletal:</u></p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> Neck Pain</p> |
|---|---|---|

Revised Oswestry Pain Disability Questionnaire

Please Read:

This questionnaire has been designed to give your doctor/therapist information as to how your pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one box that best describes your condition today. We realize you may feel that two of the statements in any one section can relate to you, but please just mark the box which most closely describes your current condition.

| | |
|--|---|
| <p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can tolerate the pain I have without having to use pain medication. <input type="checkbox"/> The pain is bad, but I manage without having to take pain medication. <input type="checkbox"/> Pain medication provides me complete relief from pain. <input type="checkbox"/> Pain medication provides me moderate relief from pain <input type="checkbox"/> Pain medication provides me little relief from pain. <input type="checkbox"/> Pain medication has no effect on the pain. | <p>Section 6 – Standing</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without increased pain. <input type="checkbox"/> I can stand as long as I want but increases my pain. <input type="checkbox"/> Pain prevents me from standing for more than 1 hour. <input type="checkbox"/> Pain prevents me from standing for more than a ½ hour. <input type="checkbox"/> Pain prevents me from standing for more than 10 minutes. <input type="checkbox"/> Pain prevents me from standing at all. |
| <p>Section 2 – Personal Care (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can take care of myself normally without causing increased pain. <input type="checkbox"/> I can take care of myself normally, but it increases my pain. <input type="checkbox"/> It is painful to take care of myself and I am slow and careful. <input type="checkbox"/> I need help, but I can manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of my care. <input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed. | <p>Section 7 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me from sleeping well. <input type="checkbox"/> I can sleep well only by using pain medication. <input type="checkbox"/> Even when I take pain medication, I sleep less than 6 hours. <input type="checkbox"/> Even when I take pain medication, I sleep less than 4 hours. <input type="checkbox"/> Even when I take pain medication, I sleep less than 2 hours. <input type="checkbox"/> Pain prevents me from sleeping at all. |
| <p>Section 3 – Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without increased pain. <input type="checkbox"/> I can lift heavy weights, but it causes increased pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g., on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. | <p>Section 8 – Social Life</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and does not increase my pain. <input type="checkbox"/> My social life is normal, but it increases my level of pain. <input type="checkbox"/> Pain prevents me from participating in more energetic activities (i.e., sports, dancing, etc.). <input type="checkbox"/> Pain prevents me from going out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of my pain. |
| <p>Section 4 – Walking</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me walking any distance. <input type="checkbox"/> Pain prevents me walking more than 1 mile. <input type="checkbox"/> Pain prevents me walking more than a ½ mile. <input type="checkbox"/> Pain prevents me walking more than a ¼ mile. <input type="checkbox"/> I can only walk using crutches or a cane. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet. | <p>Section 9 – Traveling</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can travel anywhere without increased pain. <input type="checkbox"/> I can travel anywhere but it increases my pain. <input type="checkbox"/> Pain restricts travel over 2 hours. <input type="checkbox"/> Pain restricts travel over 1 hour. <input type="checkbox"/> Pain restricts my travel to short necessary journeys under a ½ hour. <input type="checkbox"/> Pain prevents all travel except visits to the doctor/ therapist or hospital |
| <p>Section 5 – Sitting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me sitting more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting for more than a ½ hour. <input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes. <input type="checkbox"/> Pain prevents me from sitting at all. | <p>Section 10 – Employment/Homemaking</p> <ul style="list-style-type: none"> <input type="checkbox"/> My normal homemaking/job activities do not cause pain. <input type="checkbox"/> My normal homemaking/job activities increase my pain, but I can still perform all that is required of me. <input type="checkbox"/> I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (i.e., lifting, vacuuming). <input type="checkbox"/> Pain prevents me from doing anything but light duties. <input type="checkbox"/> Pain prevents me from doing even light duties. <input type="checkbox"/> Pain prevents me from performing any homemaking/ job duties. |

General Consent and Authorization for Treatment, Evaluation, and Information Release

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended medical, physical therapy, diagnostic procedure, chiropractic care, and other modalities that may be used in your treatment so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks involved. At this point in your care, no specific treatment plan has been recommended, but Arizona Pain's healthcare providers will make recommendations for your care and treatment after evaluating your condition(s).*

This consent form gives Arizona Pain permission to perform the evaluations necessary to identify the appropriate treatment and procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is 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 Arizona Pain 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. You have the right to discuss the treatment plan with your healthcare team about the purpose, potential risks and benefits of any treatment, procedure, or diagnostic test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

For patients receiving chiropractic care: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

Fractures during chiropractic care are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Alternative treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you choose to use on of the above noted "alternative treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

For patients receiving medical treatments or procedures: If interventional treatment is recommended, you will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

Risks and Dangers of Remaining Untreated for All Patients: If you choose not to move forward with care you acknowledge that any symptoms and diagnoses have the potential of getting worse.

Agreement and Consent

By signing below, I, the undersigned patient, acknowledge and agree to the foregoing and acknowledge and agree to the following:

1. I certify that I have completed the medical history forms provided to me by Arizona Pain and those forms are complete and accurate to the best of my knowledge and ability.
2. I voluntarily request that healthcare providers at Arizona Pain provide pain management care, treatment, chiropractic care, and related services to me, as deemed reasonable and necessary. I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology, and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment.
3. I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Arizona Pain physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to the release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.
4. I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT, OR THIS CONSENT HAS BEEN READ TO ME, AND I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS.
5. I UNDERSTAND THIS WILL BECOME PART OF MY MEDICAL HISTORY.

DISCLAIMER: By typing your name below, you are signing this consent electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature (Patient or if minor Signature of parent or guardian)

Date

Name of Patient (If minor)



Financial Policy

By signing below you acknowledge that you understand and agree to abide by the following financial policies. In this policy “Arizona Pain” means Arizona Pain Specialists, LLC, and its affiliated ambulatory surgery center: Hayden Surgery Center, LLC; Arrowhead North Surgery Center, LLC; SanTan Surgery Center, LLC; or any other facility affiliated with Arizona Pain Specialists, LLC.

Payment Policies

1. Arizona Pain will bill your health insurance carrier for you and will take all reasonable efforts to make sure your insurance plan covers all amounts it is supposed to cover for your care.
2. All co-payments and fees for non-covered services are due at the time of service. Arizona Pain accepts cash, checks, debit, and credit cards. If you made a deposit towards care at the beginning of your care with Arizona Pain, Arizona Pain will credit your account to cover your co-pays, deductibles, and co-insurance, until such deposited funds are exhausted.
3. Arizona Pain will bill your health insurance carrier for you and will take all reasonable efforts to make sure your insurance plan covers all amounts it is supposed to cover for your care.
4. Arizona Pain seeks to provide financial clarity by providing estimates concerning your out-of-pocket costs at the beginning of your care. You acknowledge and understand that amounts paid at the beginning of care are a deposit towards care with Arizona Pain. You further understand that after insurance processes your claims, you may be responsible for additional amounts that were not collected at the beginning of your care. By signing below, you acknowledge that you may receive a bill from Arizona Pain for the remaining out-of-pocket costs that are your responsibility under your insurance plan.
5. Arizona Pain designates accounts Self-Pay under the following circumstances: (1) patient does not have health insurance coverage, (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, or (4) patient does not have a valid insurance referral on file. Patients who are self-pay may join a discount management program that is accepted by Arizona Pain to receive discounted rates.
6. Arizona Pain requests at least 24-hours advanced notice be given to the office if you will be unable to keep your scheduled appointment. By signing below, you acknowledge that if you fail to attend an appointment not cancelled with 24-hours advanced notice, you will be charged a fee for each incident according to the then current fee schedule for no-shows. These charges are your personal responsibility and will not be billed to any insurance carrier. Patients who repeatedly “no show” for appointments may be discharged from the practice.

Proof of Insurance

1. You are responsible for bringing your insurance card(s) and a valid photo ID to each appointment. You are responsible for notifying Arizona Pain in a timely manner of changes to your health insurance coverage. If Arizona Pain is unable to process any of your claims within your health insurance carrier’s filing limits because of your failure to provide information in a timely manner, or you fail to respond promptly to insurance carrier inquiries, you will be responsible for all charges.
2. If your insurance carrier pays you directly, you are obligated to forward the payment to Arizona Pain immediately upon receipt. Arizona Pain reserves the right to take all reasonable steps, up to and including legal action, to obtain payment from you in such instances.

Referrals and Authorization

1. Arizona Pain has network agreements with many, but not all, insurance carriers. It is your responsibility to contact your insurance carrier to verify that you are assigned providers that participate in your plan. Your insurance carrier’s plan may have out-of-network charges that have higher deductibles and co-payments, which are your responsibility.
2. If you have an HMO plan Arizona Pain is contracted with, you need a referral or authorization from your primary care physician to receive care in our practice. Without an insurance required referral, the insurance company will deny payment for services. If we are unable to obtain the referral prior to your appointment, you will be rescheduled or asked to pay for the visit in advance.
3. Arizona Pain may provide services that your insurance carrier’s plan excludes or requires prior authorization. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

Billing

1. If we must send you a statement, the balance is due in full within 30 days of the statement date.
2. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent

Financial Policy



on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and potential legal action. The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree, in order to service your account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide.

3. We do not want patients to experience financial hardship because of out-of-pocket costs for their healthcare. Our Practice treats patients regardless of financial status. We offer financial assistance in the form of a sliding scale discount based on verifiable household income. Should you wish to apply for financial assistance, please reach out to us.
4. If you make an overpayment on your account, we will issue a refund only if there are no other outstanding balances for medical services on your account or any other account(s) with the same financial responsible party.

Additional Information

1. The Privacy Rule allows you to receive a copy of your personal medical and billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form.
2. The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. All requests require an office visit.
3. By initialing this section, I acknowledge that I have received and reviewed, or have been given opportunity to receive and review, a copy of the Practice's Notice of Privacy Practice, Public Fee Schedule, Statement of Patient's Rights and Advanced Directive Statement.

Agreement and Assignment of Benefits

By signing below, I, the undersigned patient, acknowledge and agree to the foregoing and acknowledge and agree to the following:

I have read and understand the Financial Policy of Arizona Pain, and I agree to abide by its terms. I understand that I am financially responsible for all services I receive from Arizona Pain and I may be financially responsible for care my health insurance denies payment for.

I irrevocably assign and convey directly to Arizona Pain (including all legal entities named on the top of this Financial Policy) your designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by Arizona Pain, regardless of its managed care network participation status. I grant to Arizona Pain the right by me to (1) obtain information regarding my insurance claims to the same extent I have such right, (2) submit evidence, (3) make statements about facts or law, (4) make any request including providing or receiving notice of appeal proceedings,

(5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Arizona Pain may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Arizona Pain's own expense. This assignment is valid for all administrative and judicial reviews under relevant state or federal law. A copy of this assignment is to be considered as valid as the original.

DISCLAIMER: By typing your name below, you are signing this policy electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature (Patient or if minor Signature of parent or guardian)

Date



Authorization for Credit Card/HSA Card on File

I, _____, authorize Arizona Pain Specialists, LLC, to charge my credit card/HSA card for any outstanding balances after applicable insurance reimbursements have been applied for medical services received at Arizona Pain Specialists, LLC, or any of its affiliated surgery centers (Hayden Surgical Center, LLC; SanTan Surgery Center, L.L.C., and Arrowhead North Surgery Center, LLC). I also understand that this card on file will be ran for any no show fees, cancellation fees, or past due balances, as applicable, in accordance with the policies of Arizona Pain Specialists, LLC and its affiliated surgery centers. I understand that all copays are due at the time of service provided and my card will be charged accordingly.

Type of Card: Mastercard Visa Discover American Express

Full Name on Card: _____

Card Number: _____

CV Code (3 digits on back): _____ Expiration Date: ____/____

Zip Code: _____

Cardholder Signature: _____

Date: _____

Please note: If the balance, after insurance benefits are applied, exceeds \$500, you will receive a courtesy call prior to your card being charged.






NOTICE TO PATIENTS

According to Arizona law, a physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). Arizona Pain supports this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that Physicians of Arizona Pain have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services Arizona Pain has prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

-  **Arrowhead North Surgical Center LLC**
-  **Hayden Surgical Center LLC**
-  **SanTan Surgery Center LLC**

ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS?

 **Yes** _____ **No** **If yes, which ones:**

Interventional Pain Procedures at Honor Health and other accredited facilities

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file; you are entitled to a copy if you so choose.

ACKNOWLEDGEMENT: I/We have read this "Notice to Patients" form, and I/We understand the disclosures that it contains.

DISCLAIMER: By typing your name below, you are signing this acknowledgement electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature (Patient or if minor Signature of parent or guardian)

Date

Notice of Privacy Practice

Effective Date November 2022

This Notice Describes How Medical Information About You May Be Used, Disclosed and How You Can Get Access to This Information. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer at 480.563.6400.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information in a reasonable and appropriate manner. We create a record of the care and the services you receive at Pain Doctor, Inc. and its affiliates (PDI). We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you, your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and practices concerning medical information about you; and
- follow the terms of this notice that is currently in effect.

How We May Use and Disclose Medical Information About You. The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

- **For Treatment.** We can use your health information and share it with other professionals who are treating you.
- **For Payment.** We can use and share your health information to bill and get payment from health plans or other entities.
- **For Health Care Operations.** We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- **Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We can share and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
- **Individuals Involved In Your Care or Payment for Your Care.** When appropriate, we can share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.
- **OHCA:** We participate in an organized health care arrangement (OHCA) consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of health care to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.
- **Research.** Under certain circumstances, we can share and disclose Health Information for research. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
- **As Required by Law.** We can share and disclose Health Information about you when required to do so by federal, state or local laws.
- **To Advert a Serious Threat to Health or Safety.** We can share and disclose Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **For All Other Uses and Disclosures.** All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization.
- **Organ and Tissue Donation.** We can share health information about you with organ procurement organizations.
- **Workers’ Compensation, Law Enforcement and Other Government Agencies.** We can share health information about you for workers’ compensation, for law enforcement purpose and healthcare oversight agencies for activities authorized by the law, or special government functions such as military, national security and presidential protection.
- **Public Health Risks.** We can share Health Information about you for certain situations
 - to prevent or control disease;
 - to report births and deaths;
 - to report child abuse or neglect;
 - to report reactions to medications or problems with products;
 - to notify people of recalls of products that they may be using;
 - notify a person who may have been exposed to a disease or may be at risk.
- **Lawsuits and Legal Disputes.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

- Comply with the Law. We will share information about you if state or federal laws require it, including with Health and Human Services should it want to see we are complying with federal privacy law.
- Coroners, Medical Examiners and Funeral Directors. We can share Health Information to a coroner, medical examiner or funeral director when an individual dies.

Uses and Disclosures That Require Us To Give You An Opportunity To Object and Opt Out.

In these cases, you can tell us what we can share:

1. Share information with your family, close friends, or others involved in your care.
2. Share information in a disaster relief situation
3. Include your information in a hospital directory
4. Contact you for fundraising efforts. We may contact you, but you can tell us not to contact you again.

Your Written Authorization Is Required For Other Uses And Disclosures.

In these cases, we never share your information unless you have given us written permission:

1. Marketing Purposes
2. Sale of your information
3. Sharing of psychotherapy notes

If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But any disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights.

You have the following rights regarding Health Information we have about you:

- Right to Inspect and Obtain a Copy of Your Medical Records. You can ask to see or get an electronic copy of your medical record or other health information we have about you. If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your records be given to you or transmitted to another individual or entity. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Right to Correct Your Medical Records. You can ask us to correct health information about you that you think is incorrect or incomplete. We may also say “no” to your request, but we will tell you why in writing within 60 days. To request an amendment, you must make your request, in writing, to our Privacy Officer.
- Right to an Account of Disclosures. You can ask us for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures. We will provide one accounting per year for free. There will be a reasonable, cost-based fee if you ask for another accounting within the 12 month period. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.
- Right to Limit Information We Share. You have the right to ask us not to use or share certain Health Information for treatment, payment, or health care operations. We are required to agree to your request, unless it would affect your care. If you pay for services out-of-pocket in full, for a specific item or service, you can ask that your Protected Health Information is not shared with your health insurer for the purposes of payment. We will say yes unless a law requires us to share that information.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing to our Privacy Officer. We will say yes to all reasonable requests.
- Right to a Paper Copy of This Notice. You have right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer. You may obtain a copy of this notice at our websites at www.arizonapain.com or www.paindoctor.com
- Changes to this Notice. We reserve the right to change this notice and make a new notice that applies to the Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.
- Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office by contacting our Privacy Officer at 480.563.6400. The Secretary of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be in writing. You will not be penalized for filing a complaint.

Our facility is licensed as an Outpatient Treatment Center and we are inspected regularly by AZDHS. The inspection report is available to all patients upon request.

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. This form is for use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____ **Date of Birth:** _____

I. My Authorization

I authorize Arizona Pain Specialists, LLC, its agents and employees to use or disclose the following health information.

- All of my health information
- My health information for the following condition(s): _____
- I do not authorize disclosure of my health information

Arizona Pain may disclose this health information to the following recipient(s), please include medical providers, family, and friends:

Name, relationship and/or organization _____

II. My Rights

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

DISCLAIMER: By typing your name below, you are signing this authorization electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

- Patient is a minor: _____ years of age
- Patient is unable to sign because: _____

DISCLAIMER: By typing your name below, you are signing this authorization electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Authorized Representative: _____ Date: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- I consent to have the above information released.
- I do not consent to have the above information released.

DISCLAIMER: By typing your name below, you are signing this authorization electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Patient or Authorized Representative: _____ Date: _____

Patients Have the Right To:

- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
- Receive privacy in treatment and care for personal needs;
- Review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- Receive a referral to another health care institution if this facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
- Participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
- Participate or refuse to participate in research or experimental treatment;
- Receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights;
- Be treated with dignity, respect, and consideration;
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault or except as allowed in R910-1012(B), restraint or seclusion;
- Not be subjected to retaliation for submitting a complaint to the Department or another entity;
- Not be subjected to misappropriation of personal and private property by any clinic personnel member, employee, volunteer, or student;
- Consent to or refuse treatment, except in an emergency and to refuse or withdraw consent for treatment before treatment is initiated;
- Be informed of alternatives to medications or surgical procedure and associated risks and possible complications of medications or surgical procedure, except in an emergency;
- Be informed of the clinic's policy on health care directives, and the patient complaint process;
- Consent to photographs before a patient is photographed, except that a patient may be photographed for identification and administrative purposes;
- Provide written consent to the release of information in the patient's medical records or financial records, except as otherwise permitted by law.

Patients Have the Responsibility To:

- Be honest about matters that relate to you as a patient.
- Provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertaining to your health.
- Report any perceived risks in your care.
- Report any unexpected changes in your condition to those responsible for your care and welfare.
- Follow the care, service, or treatment plan developed.
- Ask any questions when you do not understand or have concerns about your plan of care.
- Understand the consequences of the treatment alternatives and not following your plan of care.
- Know the staff who are caring for you.
- Be considerate and respectful of the rights of both fellow patients and staff.
- Honor the confidentiality and privacy of other patients.
- Be considerate of the property of Arizona Pain Specialists.
- Assure the financial obligations of your healthcare are fulfilled as promptly as possible.

How to File a Complaint

Patients or patient's representatives that have any concerns about patient rights, safety, or complaints or grievances, please contact the Clinical Manager for that clinic or call 602-354-5310 and ask to speak with the Clinical Manager. Written correspondence will be forwarded to the Clinical Manager for the patient. Any patient or patient's representative may submit a grievance without retaliation.

Patients also have the right to contact the Department of Health at any time at:

Arizona Department of Health Services Attn: Licensing Medical Facilities
150 N. 18th Ave., Suite 450 Phoenix, Arizona 85007
(602) 364-3030

- or -

www.medicare.gov/ombudsman/resources.asp

Per A.R.S. § 36-436.01(C) - The Practice's schedule of rates is available for review upon request. Per A.R.S. § 36-425(D), State inspection records are maintained in the Administrative office located at 2340 W Parkside Lane, H-107 Phoenix, AZ 85027. Requests may be made by calling 602-563-6400 and asking to speak with the Program Manager for Clinical Compliance.



Arizona Pain Automated Messaging Consent Form

Dear Patient,

The Federal Communications Commission now requires consent to receive automated emails/text messages.

****Please fill out this form to ensure you continue to receive appointment emails and text messages****

Arizona Pain Relief utilizes an automated notification service to send you email and text messages to provide you with important information about your upcoming appointments and marketing communication. We will utilize the notification service to notify you of upcoming appointments, rescheduling, cancellations communicate new products/services and our marketing outreach.

Patient Name (Please Print): _____

Primary Phone Number for Text Messages: (____) _____ - _____

Primary Email Address: _____

By signing this form, you are authorizing Arizona Pain Relief to use an automated system to periodically deliver automated informational emails or text messages to the phone number(s) and email address provided above. Standard message & data rates may apply. If you change your phone number or no longer want to receive automated emails or texts, you agree to inform Arizona Pain Relief immediately. You agree that this consent will remain valid and you will continue to receive automated phone calls until you revoke consent.

Patient Signature: _____ **Date:** _____

Arizona Pain Telemedicine Consent Form

Telemedicine involves the use of electronic and video communications to enable your medical provider to evaluate and manage your care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and medical record. By signing below, I acknowledge the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to request all information obtained and recorded in the course of a telemedicine interaction.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I have read and understand the information provided above regarding telemedicine and have discussed it with my provider. All my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in the course of my medical care.

I hereby authorize Arizona Pain Relief to use telemedicine in the course of my diagnosis and treatment.

Patient/Guardian Signature

Date

Patient Printed Name

Guardian Printed Name



ADVANCED DIRECTIVE STATEMENT

An “Advance Directive” is a general term that refers to your oral and/or written instructions about your future medical care, in the event that you become unable to speak for yourself.

Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like a copy of the Official AZ State advance directive forms, please visit http://www.azsos.gov/adv_dir/.

If you have a Living Will or Medical Power of Attorney, we encourage you to provide us with a copy to be placed in your chart. This will only be used in the unlikely event that you are unable to make your own decisions.