AZ PAIN DOCTORS

New Patient Intake

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call **602-795-8700** if you have any questions or are unsure how to complete any section of this form.

Patient Information

Today's Date: ______________________________

Your Name:__________________________________Social Security Number: ______________________________

Date of Birth:________________________________Age:______________________Gender: ☐ Male ☐ Female

Street Address:____

City/State/Zip: ____

Email: ____

Physical Address Same as Mailing? Yes ☐ No ☐

If not, please list mailing address:____

____

Occupation: ____ City: ________________________

Preferred Phone: _________________________________ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: ________________________________ ☐ Home ☐ Mobile ☐ Work

Email:________________________________Driver's License # ________________________ State: __________

Emergency Contact Name: ____

Phone: ____ Relationship: ____________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _______________________________

Race ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Refuse to Report

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Primary Language ☐ English ☐ Spanish ☐ Other ____

Preferred Pharmacy

Pharmacy Name: __________________________ Phone Number:

Street Address: ___________________________ City: __________________ State:_________Zip: ___________

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Primary Insurance Plan

Payer (e.g. BC/BS): ______________________________ Plan: ____

Policy/I.D. Number:_______________________ Group Number: ____

Complete this box if you are Not the policy holder for your primary insurance

Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: ____

Policy Holder Name:______________________________________ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _________________________ Social Security Number: ________________________________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): ______________________________ Plan: ____

Policy/I.D. Number:_______________________ Group Number: ____

Complete this box if you are Not the policy holder for your primary insurance

Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: ____

Policy Holder Name:_____________________________________ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _________________________ Social Security Number: ________________________________

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim.

Workers Comp Company: ____

Agent Name:_____________________________State of Injury: ____

Phone number:____________________________ Fax number: ____

Claim Number:________________________Date of initial injury: ____

Injury Claim

Is your pain the result of a motor vehicle accident or other accident, which occurred within the last two years, and was caused by the fault or negligent of another? ☐ yes ☐ no

Have you hired an attorney for purposes of making any claims arising from that accident? ☐ yes ☐ no
If yes to either question, you will be asked to complete two additional forms.
I certify that the above information is accurate, complete and true.

Patient Signature:____Date:______________________________

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Clinical Information

Today's Date: ______________________

Your Name: ______________________

Height: ______________________ Weight: ______________________ Lbs: __________

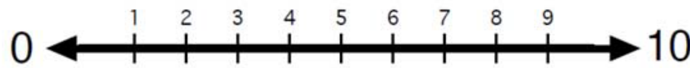
Referral

Were you referred to our clinic by another physician? If so, whom? ______________________

If not, how did you hear about us? ☐ TV ☐ Radio ☐ Insurance ☐ Company ☐ Family ☐ Friend ☐ PCP

☐ Facebook ☐ Twitter ☐ YouTube ☐ Other Website: ______________________

Pain Description



Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

__________ What number on the pain scale (0-10) best describes your pain **right now**?

__________ What number on the pain scale (0-10) best describes your **worst pain**?

__________ What number on the pain scale (0-10) best describes your **least pain**?

__________ What number on the pain scale (0-10) best describes your average pain over the **last month**?

Where is your worst area of pain located? ______________________

Does this pain radiate? If so, where? ______________________

Please list any additional areas of pain: ______________________

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Onset of Symptoms

Approximately when did this pain begin? ______________________________

What caused your current pain episode? ______________________________

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

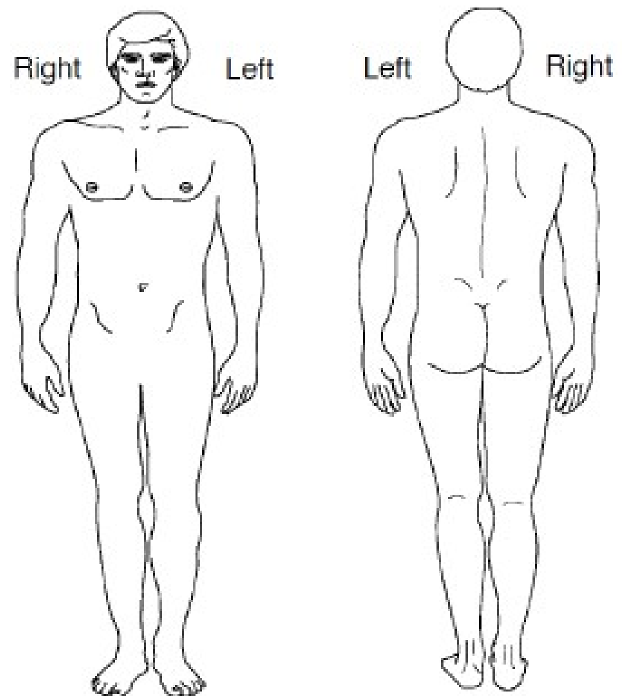
"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A" = aching



Pain Description - Check all of the following that describe of your pain:

☐ Aching
☐ Cramping
☐ Dull
☐ Hot/Burning
☐ Numbness
☐ Shock-like
☐ Shooting
☐ Spasming
☐ Squeezing
☐ Stabbing/Sharp
☐ Throbbing
☐ Tingling/Pins & Needles
☐ Tiring/Exhausting

Pain Frequency

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

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

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Mark all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life ☐ Normal Work ☐ Sleep
☐ General Activity ☐ Recreational Activities ☐ Walking
☐ Mood ☐ Relationship with people ☐ Other: ______________________
☐ My goal is to resume normal activities

In the past three months have you developed any new:

☐ Balance Problems ☐ Fevers ☐ Nausea ☐ Vomiting
☐ Difficulty Walking ☐ Sleep ☐ Chills
☐ Numbness/Tingling- Where? ☐ Bowel incontinence ☐ Others: ______________________

☐ I Have Not Recently Developed Any of the Above Conditions

Diagnostic Tests and Imaging

☐ MRI of the______________________Date:______________Facility: ______________________
☐ X-ray of the______________________Date:______________Facility: ______________________
☐ CT scan of the______________________Date:______________Facility: ______________________
☐ EMG/NCV study of the________________Date:______________Facility: ______________________
☐ Ultrasound of the____________________Date:______________Facility: ______________________
☐ Other diagnostic testing: ____
☐ **I Have Not Had Any Diagnostic Tests Performed For My Current Pain Complaints**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

☐ Chiropractic ☐ Physical Therapy ☐ Psychological Therapy ☐ Podiatrist Treatment
☐ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar
☐ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar
☐ Joint Injection – Joint(s) ____
☐ Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar
☐ Nerve Blocks – Area/Nerve(s) ____
☐ Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar
☐ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant
☐ Spine Surgery
☐ Trigger Point Injection – Where? ____
☐ Vertebroplasty / Kyphoplasty – Level(s)____
☐ Other: ____

☐ **I Have Not Had Any Prior Treatments For My Current Pain Complaints**

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Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐ No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐ No

Which type of anesthesia did you react adversely to? Please check all that apply.

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

☐ Gallbladder removal ______________________

☐ Appendectomy ______________________

☐ Other ______________________

Female Surgeries

☐ Caesarean section ______________________

☐ Hysterectomy ______________________

☐ Laparoscopy______________________

☐ Ovarian______________________

☐ Other ______________________

Heart Surgery

☐ Valve replacement ______________________

☐ Aneurysm repair ______________________

Joint Surgery

☐ Shoulder ______________________

☐ Hip ______________________

☐ Knee ______________________

Spine / Back Surgery

☐ Discectomy (levels)______________________

☐ Laminectomy ______________________

☐ Spinal fusion (levels)______________________

Other Common Surgeries

☐ Hemorrhoid surgery ______________________

☐ Hernia repair ______________________

☐ Thyroidectomy ______________________

☐ Tonsillectomy ______________________

☐ Vascular surgery ______________________

☐ Other ______________________

Please list any other surgeries and dates (attach an additional sheet if necessary): ______________________

____

____

☐ **I Have Never Had Any Surgical Procedures Done**

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Current Medications

Are you taking a prescribed **blood-thinner** medication? ☐ Yes ☐ No If yes, please check which one:

☐ Aggrenox ☐ Coumadin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pleta ☐ Pradaxa

☐ Ticlid ☐ Warfarin ☐ Xarelto ☐ Other ____________________

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name: **Allergic Reaction Type:**

____

____

____

____

____

Please check if you are allergic to ☐ Iodine or ☐ Tape Are you allergic to shellfish? ☐ Yes ☐ No

***Are you allergic to latex?** ☐ Yes ☐ No *If yes, you will be asked to complete a separate questionnaire

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Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: ____

☐ **I Have No Significant Family Medical History** ☐ **I Am Adopted (No Medical History Available)**

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No If so, are you currently pregnant? ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar school ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Current Alcoholism ☐ Daily Limited Alcohol Use ☐ History of Alcoholism

☐ Never Drinks Alcohol ☐ Social Alcohol Use

Tobacco Use: ☐ Current Tobacco ☐ Former Tobacco User ☐ Never Used Tobacco

Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs (Which:_______________________)

☐ Currently Using Someone Else's Prescription Medications

☐ Formerly Used Illegal Drugs (not currently using) (Which:_______________________)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No (Which:_______________________)

Have you ever been discharged (fired) from a pain management practice in the past?

If so, please explain here:____

____

____

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Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type ______________
- ☐ Diabetes – Type _____________
- ☐ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraines

Cardiovascular / Hematologic
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Pacemaker/Defibrillator
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Stroke

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema / COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Valley Fever

Gastrointestinal
- ☐ Bowel Incontinence
- ☐ Acid Reflux (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation

Musculoskeletal
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid arthritis
- ☐ Tennis Elbow
- ☐ Vertebral Compression Fracture

Genitourinary/Nephrology
- ☐ Bladder Infection(s)
- ☐ Dialysis
- ☐ Kidney Infection(s)
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Hepatic
- ☐ Hepatitis A
active / inactive / unsure)
- ☐ Hepatitis B
(active / inactive / unsure)
- ☐ Hepatitis C
(active / inactive / unsure)

Neuropsychological
- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Prescription Drug Abuse

- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Reflex Sympathetic Dystrophy/CRPS
- ☐ Other Diagnosed Conditions

Who and (approximately when) was the last provider to prescribe you pain medications or other controlled substances?

____

____

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Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.

Constitutional:
☐ Chills
☐ Difficulty Sleeping
☐ Easy Bruising
☐ Excessive Sweating
☐ Excessive Thirst
☐ Fatigue
☐ Fevers
☐ Insomnia
☐ Low Sex Drive
☐ Night Sweats
☐ Unexplained Weight Gain
☐ Unexplained Weight Loss
☐ Weakness

Eyes:
☐ Recent Visual Changes

Ears/Nose/Throat/Neck:
☐ Dental Problems
☐ Earaches
☐ Hearing Problems
☐ Sinus Problems
☐ Nosebleeds
☐ Recurrent Sore Throats
☐ Ringing in the Ears

Cardiovascular:
☐ Bleeding Disorder
☐ Chest Pain
☐ Deep Vein Thrombosis
☐ Fainting
☐ High Blood Pressure
☐ Irregular Heartbeat
☐ Lightheadedness
☐ Shortness of Breath During Sleep
☐ Swelling in the Feet

Respiratory:
☐ Cough
☐ Wheezing
☐ Pulmonary Embolism
☐ Shortness of Breath on Exertion/Effort
☐ Shortness of Breath at Rest

Gastrointestinal:
☐ Abdominal Cramps
☐ Acid Reflux
☐ Constipation
☐ Coffee Ground Appearance in Vomit
☐ Dark and Tarry Stools
☐ Diarrhea
☐ Hernia
☐ Vomiting

Musculoskeletal:
☐ Back Pain
☐ Joint Pain
☐ Joint Stiffness
☐ Joint Swelling
☐ Muscle Spasms
☐ Neck Pain

Genitourinary/Nephrology:
☐ Blood in Urine
☐ Decreased Urine Flow/Frequency/Volume
☐ Erectile Dysfunction
☐ Flank Pain
☐ Painful Urination
☐ Pelvic Pressure

Neurological:
☐ Carpal Tunnel Syndrome
☐ Dizziness
☐ Headaches
☐ Instability When Walking
☐ Numbness/Tingling
☐ Seizures

Psychiatric:
☐ Depressed Mood
☐ Feeling Anxious
☐ Stress Problems
☐ Suicidal Thoughts
☐ Suicidal Planning

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Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize AZ Pain Doctors and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for AZ Pain Doctors to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review AZ Pain Doctors Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the AZ Pain Doctors to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize AZ Pain Doctors to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that AZ Pain Doctors will not release my Protected Health Information to any other party (including family) without my completing a written “Patient Authorization for Use and Disclosure of Protected Health Information” form, available at its facility and on its website.

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed:__________________________________ Date: ____

AZ PAIN DOCTORS

AZ Pain Doctors believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT -** is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment AZ Pain Doctors reserve the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). If a prepayment is made for any services and a refund is due after insurance processes, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. **INSURANCE -** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

AZ Pain Doctors only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **TOXICOLOGY LAB -** In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.

4. **COLLECTION -** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. AZ Pain Doctors reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay AZ Pain Doctors for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at

any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

5. **RETURNED CHECKS -** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

6. **ACCOUNTING PRINCIPALS -** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. **FORMS AND CONSULTS FEES -** Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

8. **CANCELLATIONS OR MISSED APPOINTMENTS -** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a $150.00 missed procedure fee. Any missed visits may result in discharge from the practice.

9. **RESPONSIBILITY FOR PAYMENT -** I understand that I, personally, am financially responsible to AZ Pain Doctors for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS -** I hereby assign, transfer, and set over directly to AZ Pain Doctors sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize AZ Pain Doctors to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to AZ Pain Doctors. I authorize AZ Pain Doctors to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **RELEASE OF INFORMATION -** I hereby authorize the and direct AZ Pain Doctors to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy of AZ Pain Doctors and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from AZ Pain Doctors. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to AZ Pain Doctors. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable)__________________________________Date:______________

Please print the name of the patient ____

AZ PAIN DOCTORS

Patient Authorization for Use and Disclosure of Protected Health Information

AZ Pain Doctors will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes AZ Pain Doctors to release your medical records to parties indicated.

AZ Pain Doctors takes your privacy seriously!

Your Name:____Date of Birth: ________________________________

Authorized Parties

By signing below, I authorize AZ Pain Doctors, its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party Relationship

____

____

____

Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorized Parties

I acknowledge that I have had the opportunity to review AZ Pain Doctors Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at AZ Pain Doctors. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

Privacy Officer
AZ Pain Doctors
20280 N 59th Ave, Ste 115-617
Glendale, AZ 85308

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): ____________________

Signature

Signature of Patient or Legal Guardian____________________Today's Date ____________________

Relationship to Patient ____________________

AZ PAIN DOCTORS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO AZ PAIN DOCTORS

***Patients Name:**____ *** Date of Birth**:______________________

***I hereby authorize** ____

*** Phone:**________________________________ *** Fax:**______________________________________

or its agent(s) to disclose my health information as described in this authorization to AZ Pain Doctors
Office 602-795-8700 Fax 602-795-8701

***Choose Physicians Location**
__Biltmore: 2222 E Highland Ave Ste#220, Phoenix, AZ 85016
__Casa Grande: 1760 E. Florence Blvd #120, Casa Grande, AZ 85122
__Chandler: 725 S. Dobson Rd, Ste#100, Chandler, AZ 85224
__Glendale: 7200 W. Bell Rd, Ste#F101, Glendale, AZ 85308
__Goodyear: 1325 N Litchfield Rd Ste#120, Goodyear, AZ 85395
__Mesa: 1950 S Country Club Lane Ste#102, Mesa, AZ 85210
__North Scottsdale: 33747 N. Scottsdale Rd, Ste#135, Scottsdale, AZ 85266
__Paradise Valley: 10565 N Tatum Blvd Ste#B116, Paradise Valley, AZ 85253
__Sun City West: 14420 W Meeker Blvd Ste#211, Sun City West, AZ 85375

***The health information is being disclosed for the following purpose: (check appropriate box):**
☐ Change of Insurance or Physician ☐ Continuation of Care

***Health information to be disclosed: (check appropriate box)**
☐ 2 years prior from last date seen by the healthcare provider ☐ The following health information (be specific):

____

*I understand I may revoke this Authorization at any time by sending written notice of my revocation to AZ Pain Doctor's health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event, or condition. If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.
* *I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.*
*I understand that AZ Pain Doctors may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

***I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.**

X____ ________________________

Signature of Patient / Parent / Guardian or Authorized Representative Date

(Guardian or Authorized Representative must attach documentation of such status.)

____ ________________________

Printed name of Authorized Representative and Telephone Number Relationship / Capacity to

Patient Health Questionnaire (PHQ-2)

Patient Name: ____ **Date of Visit:** ______________

DOB: ______________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Column Totals _______+_______+_______

Add Totals Together ______________________

FOR PROVIDERS ONLY

PATIENT RESULT: ☐ POSITIVE ☐ NEGATIVE ☐PATIENT DECLINED SCREENING

☐ PATIENT HAS A CURRENT DIAGNOSIS AND CARE PLAN ________________________________

☐ PATIENT GIVEN PHQ-9 ON ____________________ RESULT ____________________

FOLLOW-UP: ☐ 1-2 WEEKS ☐ 2-3 WEEKS ☐ 3-4 WEEKS ☐ NO F/UP NEEDED

RESULT NOTES:

SIGNATURE: