DESERT PAIN SPECIALISTS
Interventional Spine Care

Policy, Authorizations and Financial Agreement

Patient Name:_____

AUTHORIZATION AND CONSENT:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH) and Omnibus Rule. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out any and all of the following:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2. Obtaining payment from third party payers (e.g., my insurance company);
3. The day-to-day healthcare operations of Desert Pain Specialists.
4. Any other non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits for me and/or my dependent(s).

I have also been informed of and given the right to review and secure a copy of your Notice or Privacy Practices, which contains a more complete description of uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I certify that I understand the privacy risks of mail, email and phone calls. I hereby authorize a Desert Pain Specialists representative or my physician to mail, email or call me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to this requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I have the right to revoke this consent at any time by notifying Desert Pain Specialists to that effect in writing. However, if you do agree, you are then bound to comply with this restriction.

I hereby consent to evaluation, testing and treatment (including but not limited to, medication history, use of x-ray and other non-invasive procedures such as diagnostic testing) to be performed as directed by my Desert Pain Specialists physician or his or her designee. I realize that if a medical procedure is required, I will be given additional information.

FINANCIAL AGREEMENT:

I hereby authorize direct payment of my insurance benefits to Desert Pain Specialists, or the physician individually, for services rendered to me or my dependents by the physician or under his/her supervision and agree to pay any balance that is due. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

I understand that I may receive a separate bill if my medical care includes lab, x-ray and/or other diagnostic services. I understand and agree that I will be financially responsible for any co-pay or balance due that Desert Pain Specialists is unable to collect from my insurance carrier for whatever reason. I understand that I will be responsible for any additional fees incurred from the following:

• Returned Checks • Missed Appointments • Copies of Medical Records • Non-payment of co-pays/deductibles at time of service

In the event any balance is not paid as agreed upon and/or my account is referred to a collection agency, I agree to pay all collection fees. I further agree to pay court costs and reasonable attorney's fees in addition to the collection fee. I hereby authorize the facility, Desert Pain Specialists, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, mobile/cellular, wireless or similar devices for any lawful purpose. I agree to pay any fee(s) and/or charge(s) that I may incur for incoming calls from collectors, and/or outgoing calls to collectors, to or from any such number and understand I will not be reimbursed.

APPOINTMENT POLICY:

Because your appointment has been reserved for you and/or your family member(s), you are required to provide at least 24 hours advanced notice if you are unable to keep your scheduled appointment. This allows us to offer another patient that time spot and prevents a cancellation fee from being applied to your account. The No Show fee for all appointments is $50.00. It is important to note that our No Show fees are not payable by your insurance carrier(s) and will be your responsibility. Repeated missed appointments may result in termination of your physician's care. There may be a time when your physician may need to cancel your appointment for an emergency; we will make every effort to reschedule you in an appropriate time frame.

PRESCRIPTION REFILL REQUESTS:

With any long-term medications, we require regular office visits. We request a 48 hour notice if you are requesting a refill to be called into your pharmacy.

By signing the line below you are stating that you have read and agree to all portions of this contract.

_____ _____

Signature of patient or patient's representative Date

DESERT PAIN SPECIALISTS
Interventional Spine Care

Authorization to Release Medical Information

Under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are not allowed to give this information to anyone without the patient's expressed written consent. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

1. Should you ever need a copy of any and/or all of your medical records please sign below **authorizing** Desert Pain Specialists to release your medical information to yourself.

   I **authorize** Desert Pain Specialists to ***release*** my medical and/or financial information (as indicated below) to the following individual:

   I. _____ Date of Birth: _____
   (Patient Name)

2. If you wish to have any and/or all of your medical records released to someone other than yourself (e.g., family member, primary care physician, attorney) please indicate their name and relationship to you below.

   I **authorize** Desert Pain Specialists to ***release*** my medical and/or financial information (as indicated below) to the following individuals:

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ Relation to patient: _____

***Release** of the following healthcare information:

[ ] All medical records

[ ] Other records as specified _____

This authorization will remain in effect:

[ ] From the date of this Authorization until: _____

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Date

DESERT PAIN SPECIALISTS
Interventional Spine Care

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: _____ Sex: ☐ Male ☐ Female

Mailing Address: _____ Date of Birth: _____ /_____ /_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Social Sec. # _____

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ American Indian ☐ African American ☐ White ☐ Other: _____ ☐

Ethnicity: ☐ Non Hispanic or Latino ☐ Hispanic or Latino ☐ Decline

Preferred Communications: ☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email

***Referring and/or Primary Care Physician (REQUIRED): _____

EMERGENCY CONTACT *REQUIRED*

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

GUARANTOR INFORMATION *Complete this section the patient is a minor or if there is a power of attorney*

Name: _____ Relationship to Patient: _____

Mailing Address: _____ Date of Birth: _____ /_____ /_____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____ Social Sec. # _____

INSURANCE INFORMATION *Insurance cards must be provided at time of visit*

Primary Insurance: _____

Policy Holder: _____ Date of birth: _____ SS#:_____

Secondary Insurance: _____

Policy Holder: _____ Date of birth: _____ SS#:_____

_____ _____

Signature of patient or patient's representative Date

MEDICAL HISTORY

Do you have a history of any of the following?

- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding problems
- ☐ CAD coronary artery disease
- ☐ Cancer
- ☐ Chest pain
- ☐ CHF congestive heart failure
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hypertenstion
- ☐ HIV or AIDS
- ☐ Infection problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Shortness of breath
- ☐ NONE of the problems listed
- ☐ Other: _____

ALLERGIES

Have you ever had an allergic reaction to any of the following?

☐ Adhesive tape ☐ Anesthesia ☐ Aspirin ☐ Latex ☐ Iodine/Shellfish/Contrast Dye ☐ Other: _____

Do you have any history of medication allergies?

☐ No known allergies ☐ Yes, please specify: _____

SURGICAL HISTORY

Please list all previous surgeries. Type of Surgery	Approximate Year/Date	Doctor and/or Location

FAMILY HISTORY

Is there a history of any of the following in your **immediate family**? **M** – Mother **F** – Father **S** – Sister **B** – Brother

	M	F	S	B		M	F	S	B		M	F	S	B
Anesthesia problems					Headache/Migraines					Mental illness				
Arthritis					Heart disease					Osteoporosis				
Bleeding disorders					High Blood Pressure					Seizures				
Cancer					Hypertension					Stroke				
Chronic pain					Kidney disease					Substance abuse				
Diabetes					Liver disease					Other:				

SOCIAL HISTORY

Occupation: _____

☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student

Do you use tobacco? Smoke: ☐ Yes ☐ No Chew: ☐ Yes ☐ No How many packs per day? _____ For how many years? _____

Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

Have you ever abused alcohol? ☐ Yes ☐ No

Have you ever used any illicit substances? ☐ Yes ☐ No Type: _____

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

PRESENT MEDICATIONS

Are you currently taking any blood thinners or anti-coagulants? Yes ☐ No ☐

If YES, which ones? ☐ Aspirin ☐ Aggrenox ☐ Coumadin ☐ Lovenox ☐ Plavix ☐ Pradaxa ☐ Other: _____

Please list all prescription, OTC, herbal and/or vitamin (nutritional) supplements you are currently taking.

Name of Medication, OTC, herbal and/or vitamin	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

PRIOR MEDICATIONS

Please ONLY list medications you have used in the past for your current pain condition. (OTHERWISE LEAVE BLANK)

Anti-Inflammatory	Did it help?
Celebrex	☐Yes ☐No
Diclofenac (voltaren)	☐Yes ☐No
Flector Patch	☐Yes ☐No
Ibuprofen (advil, motrin)	☐Yes ☐No
Naproxen (aleve)	☐Yes ☐No
Tylenol (acetaminophen)	☐Yes ☐No

Muscle Relaxants	Did it help?
Carisoprodol (soma)	☐Yes ☐No
Cyclobenzaprine (flexeril)	☐Yes ☐No
Skelaxin (metaxolone)	☐Yes ☐No
Methocarbamol (robaxin)	☐Yes ☐No
Tizanidine (zanaflex)	☐Yes ☐No

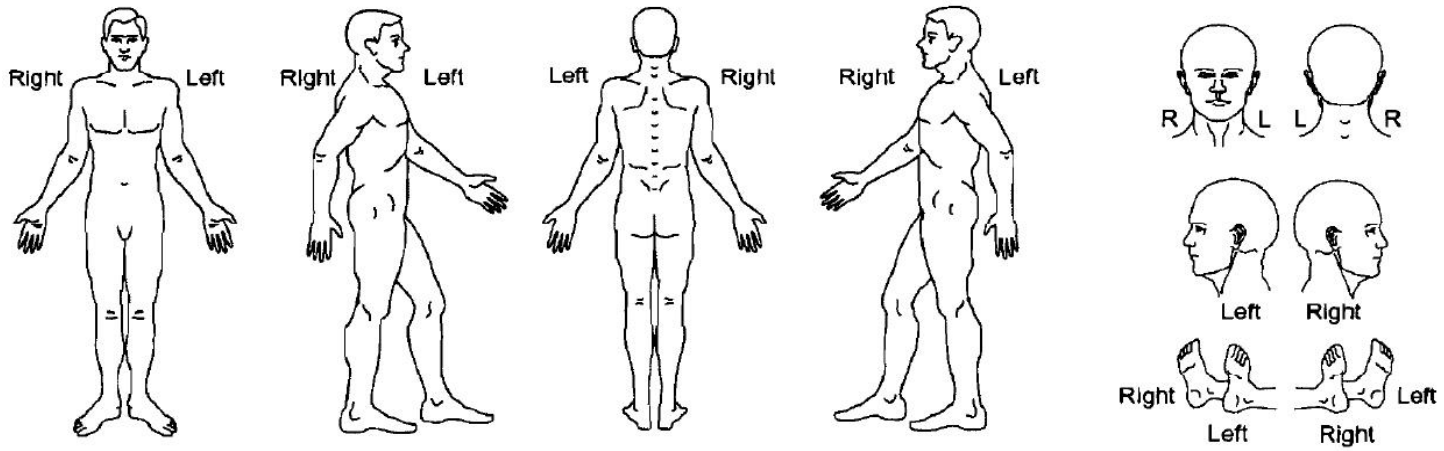
Narcotics/Opiods	Did it help?
Fentanyl Patch	☐Yes ☐No
Hydrocodone (vicodin)	☐Yes ☐No
Hydromorphone (dilaudid)	☐Yes ☐No
Methadone	☐Yes ☐No
Morphine, MS Contin	☐Yes ☐No
Nucynta (tapentadol)	☐Yes ☐No
Opana	☐Yes ☐No
Oxycodone (Percocet)	☐Yes ☐No
Oxycontin	☐Yes ☐No
Suboxone	☐Yes ☐No
Tramadol	☐Yes ☐No
Tylenol with codeine	☐Yes ☐No

Nerve Medications	Did it help?
Amitriptyline (elavil)	☐Yes ☐No
Cymbalta	☐Yes ☐No
Effexor	☐Yes ☐No
Gabapentin (neurontin)	☐Yes ☐No
Lidoderm Patch	☐Yes ☐No
Lyrica	☐Yes ☐No
Nortriptyline	☐Yes ☐No
Savella	☐Yes ☐No

Other	
	☐Yes ☐No

PAIN DIAGRAM

Please use the diagram below to indicate the area of your pain. Put an "X" on the area that hurts the most.



PAIN HISTORY

Patient Name: _____ Height: _____ Weight: _____

Chief Complaint (Reason for your visit): _____

Briefly describe under what circumstances your pain first began: _____

_____

Is your pain the result of a work-related injury? Yes ☐ No ☐ Date of Injury: _____

Is your pain the result of an auto accident? Yes ☐ No ☐ Date of Injury: _____

PAIN DESCRIPTION

How long has your current pain problem existed? _____Years _____Months _____Weeks _____Days

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

Does your pain radiate? Yes No If yes, where? _____

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

How often does your pain occur?

☐ Constantly (100 % of the time) ☐ Frequently (75 % of the time)
☐ Intermittently (50 % of the time) ☐ Occasionally (25 % of the time)

What time of day is your pain at its **WORST**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What time of day is your pain at its **BEST**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

If "0" is no pain and "10" is the most severe pain imaginable, how would you rate your pain?
Right now: _____ At its worst: _____ At its best: _____

How would you describe your pain (choose as many adjectives as apply)?

☐ Aching ☐ Deep ☐ Shooting ☐ Tightness
☐ Burning ☐ Dull ☐ Stabbing ☐ Tingling
☐ Cramping ☐ Sharp ☐ Throbbing ☐ Other: _____

Has your pain been associated with any of the following factors?

☐ Bladder/Bowel dysfunction ☐ Instability ☐ Rash ☐ Tingling
☐ Chills ☐ Itching ☐ Redness ☐ Visual disturbances
☐ Fever ☐ Muscle weakness ☐ Stiffness ☐ Warmth
☐ Grinding ☐ Numbness ☐ Swelling ☐ Other: _____

Which of the following factors seem to aggravate your pain?

☐ Bending ☐ Lifting ☐ Sneezing ☐ Twisting
☐ Coughing ☐ Pulling ☐ Standing ☐ Walking
☐ Driving ☐ Pushing ☐ Stress ☐ Weather
☐ Exercise ☐ Sitting ☐ Touch ☐ Other: _____

Which of the following factors help alleviate your pain?

☐ Exercise ☐ Lying down ☐ Relaxation ☐ Stretching
☐ Heat ☐ Meditation ☐ Sitting ☐ Walking
☐ Ice ☐ Position change ☐ Standing ☐ Other: _____

What areas of your life have been affected by your pain?

☐ Appetite ☐ Mood ☐ Relationships ☐ Work
☐ Finances ☐ Personal care ☐ Sleep ☐ Other: _____
☐ Intimacy ☐ Physical activity ☐ Travel

Which of the following previous treatments have you tried that **WERE** helpful?

- ☐ Acupuncture
- ☐ Chiropractic care
- ☐ Counseling
- ☐ Epidural steroids
- ☐ Heat
- ☐ Home exercise program
- ☐ Ice
- ☐ Massage
- ☐ Pain medication
- ☐ Physical therapy
- ☐ Radiofrequency ablation
- ☐ Surgery
- ☐ TENS unit
- ☐ Traction
- ☐ Trigger point injection
- ☐ Back Brace

Which of the following previous treatments have you tried that **WERE NOT** helpful?

- ☐ Acupuncture
- ☐ Chiropractic care
- ☐ Counseling
- ☐ Epidural steroids
- ☐ Heat
- ☐ Home exercise program
- ☐ Ice
- ☐ Massage
- ☐ Pain medication
- ☐ Physical therapy
- ☐ Radiofrequency ablation
- ☐ Surgery
- ☐ TENS unit
- ☐ Traction
- ☐ Trigger point injection
- ☐ Back Brace

DIAGNOSTIC TESTS AND IMAGING

Mark all of the following tests you have had that are related to your current pain complaints:

- ☐ **MRI** of the: _____
- ☐ **X-ray** of the: _____
- ☐ **CT** scan of the: _____
- ☐ **EMG/NCV:**_____

REVIEW OF SYMPTOMS

Constitutional
- ☐ Body aches
- ☐ Chills
- ☐ Difficulty sleeping
- ☐ Fatigue
- ☐ Weight gain
- ☐ Weight loss

Cardiovascular
- ☐ Blood clots
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Lightheadedness
- ☐ Swelling in feet or legs

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Groin pain
- ☐ Painful urination
- ☐ Urinary incontinence

Endocrine
- ☐ Diabetes
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Increased fatigue
- ☐ Low sex drive

Head/Ears/Nose/Throat
- ☐ Difficulty hearing
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Vertigo

Respiratory
- ☐ Asthma
- ☐ Cough
- ☐ Shortness of breath at rest
- ☐ Short of breath on exertion
- ☐ Wheezing

Hematologic/Lymphatic
- ☐ Bleeding disorder
- ☐ Easy bruising
- ☐ Excessive bleeding

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Stress problems
- ☐ Suicidal thoughts

Eyes
- ☐ Blurred vision
- ☐ Sensitivity to light
- ☐ Use of glasses or contacts

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bowel incontinence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcer

Neurological
- ☐ Confusion
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches/Migraines
- ☐ Memory loss
- ☐ Numbness and tingling
- ☐ Seizures
- ☐ Stroke
- ☐ Tremors

Musculoskeletal
- ☐ Arm pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Leg pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Neck pain

Integumentary
- ☐ Rash
- ☐ Changes in pigmentation