AZ PAIN DOCTORS | **New Patient Intake**

Welcome and Thank You for your Visit with AZ Pain Doctors!

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.

Personal Information

Todays Date:__________________

Your Name:____ Social Security Number: _______________________________________

Date of Birth: _____________________________________ Gender: Male Female

Street Address: ____

City/State/Zip: ____

Email: ____

Preferred Phone: _________________________ Secondary Phone: _____________________________

Emergency Contact: ________________________________ Phone: ____________________________ Relationship: ____________________

Marital Status: Married Single Divorced Widowed Primary Language: ______________________ Race: __________________

Ethinicity: ____________________________

Insurance Information

Primary Insurance: _______________________________________ Policy/ID Number: ____

Claims Address: ____Group: ____

Number: ____________________________________ Policy Holder: Self Spouse Other: _____________________________________

Date of Birth: ________________________________ Social Security Number: ____

Secondary Insurance: _____________________________________ Policy ID/Number: ____

Claims Address: ____Group: ____

Number: ____________________________________ Policy Holder: Self Spouse Other: _____________________________________

Date of Birth: ________________________________ Social Security Number: ____

Workers Comp Carrier: ____ Claim Number: ____

Address: ____ Date of Injury: ____

Claims Representative: ____ Phone: ____

Power of Attorney Information/ Caregiver Information (Note - Can only be listed if legal forms are available)

Do you have legal forms? ____Scanned: ____________________________ (Employee Initials)

Would you like to list the individual as the primary contact? ____

I certify that the above information is accurate, complete, and truce. I give my consent for AZ Pain Doctors to retrieve and review my medical history. I understand that this will become part of my medical record.

Signature: ____ **Date:** ______________________________________

Pharmacy Information

Preferred Pharmacy: _______________________________________ Cross Streets: ____

Have you seen an AZ Pain Doctors' provider before? ____

Who referred you to AZ Pain Doctors? ____

AZ PAIN DOCTORS

New Patient Intake Paperwork

History of Problem

Reason for visit: ____________________

Expectation from treatment:____________________

Please use 1-10 number scale (0-No pain-10 worst pain) to describe your pain:

Pain right now:__________ Worst pain: __________ Least pain:__________ Average pain:__________

Where is your worst area of pain located?____________________

Does this pain radiate? If so, where? ____________________

When did your pain symptoms start? ____________________

What caused your current pain episode? ____________________

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

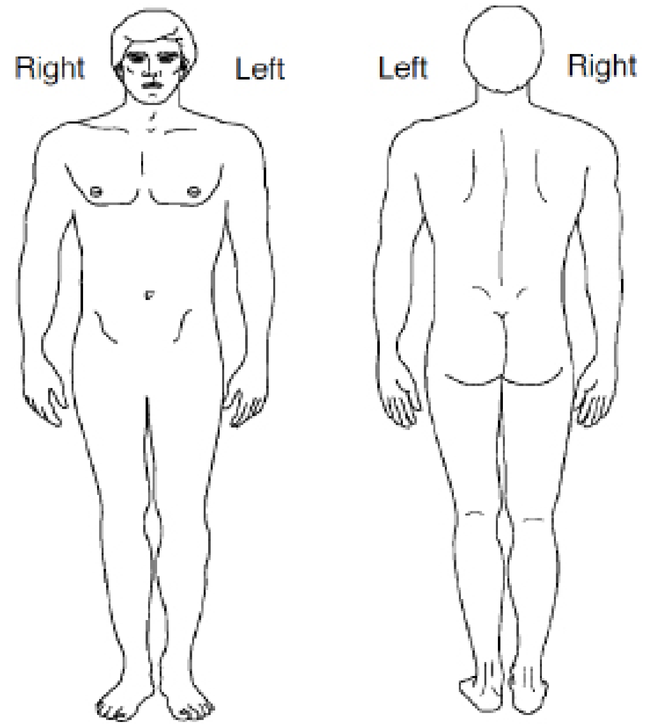
"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A" = aching



Clinical Information

Height: ____________________ Weight: ____________________

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

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

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

Do you have the following?

Weakness in your: ☐Right Arm ☐Left Arm ☐Right Leg ☐Left Leg

Numbness in your: ☐Right Arm ☐Left Arm ☐Right Leg ☐Left Leg

New or recurrent problems with bowel or bladder control? ☐Yes ☐No

Change in pain with cough/sneeze/bowel movements? ☐Yes ☐No

Diagnostic Studies

X-Ray	☐ Yes	☐ No	MRI Scan	☐ Yes	☐ No
CT Scans	☐ Yes	☐ No	Bone Scan	☐ Yes	☐ No
EMG	☐ Yes	☐ No	IF YES, where did you have done? ____________________________		

Treatment History Indicate the treatment you have received ***for your current pain condition:***

If you have tried any of the listed treatments, please indicate whether it helped with your pain or not by checking the appropriate box. If you have not tried an agent, check "never tried"

Treatment	Yes/No		Never Tried		Yes/No		Never Tried
Chiropractic Care	☐	☐	☐	Facet Block/ Medial Branch Block	☐	☐	☐
If yes, how many weeks? ________________				Epidural Steroid Injection	☐	☐	☐
DME/Bracing	☐	☐	☐	Radiofrequency Ablation	☐	☐	☐
Spinal Cord Stimulator	☐	☐	☐	Psychiatric/Psychological Care	☐	☐	☐
Trigger Point Injection	☐	☐	☐	Other: ____________________			
Joint injections	☐	☐	☐				

Name of prior Pain Physician(s):________________________________ ***Phone:***______________________________

Physical Therapy

Name/ Location of Practice:____

Date Began:________________ Date Completed/Continuing:__________________ Frequency (Per Month):________

Physical Therapy made symptoms better, worse, or no change? Explain: ______________________________________

____

Self Directed Physical Therapy - Continuation of previously learned physical therapy exercises for low back pain

Date Began:_________________ Duration:__________________________________ Frequency (Per Month):_________

Tried/ Did not work - Explain:____

____

Pain Psychology:____

Complementary/ Alternative Medicine Modalities (Example: Tai Chi, Art Therapy, Yoga, ect.):________________________

____

Exercise Routine:____

____

Exercise Frequency (Per Month):____

Medication History Indicate what you have used ***for your current pain condition:***

Do you have a history of the following with regards to Opiates/Narcotics:

Side-effect?	☐ Yes ☐No explain:____
Adverse reaction?	☐ Yes ☐No explain:____
Overdose?	☐ Yes ☐No explain:____

If you have tried any of the listed medications, please indicate whether it helped with your pain or not by checking the appropriate box. If you have not tried an agent, check "never tried"

Narcotics/Opiates Did it Help?

	Yes/No	Never Tried
Butrans Patch	☐☐	☐
Codeine (Tylenol #3)	☐☐	☐
Fentanyl Patch (Duragesic)	☐☐	☐
Hydrocodone (Vicodin)	☐☐	☐
Hydromorphone (Dilaudid)	☐☐	☐
Methadone	☐☐	☐
Morphine (Kadian, MS Contin)	☐☐	☐
Nucynta (Tapentadol)	☐☐	☐
Oxycodone (Percocet)	☐☐	☐
Oxycontin (Xtampza)	☐☐	☐
Oxymorphone (Opana)	☐☐	☐
Tramadol (Ultram)	☐☐	☐

Other: ______________________________

Anti-Inflammatory Did it Help?

	Yes/No	Never Tried
Acetaminophen (Tylenol)	☐☐	☐
Aspirin	☐☐	☐
Celecoxib (Celebrex)	☐☐	☐
Diclofenac (Voltaren)	☐☐	☐
Etodolac (Lodine)	☐☐	☐
Ibuprofen (Advil, Motrin)	☐☐	☐
Indomethacin	☐☐	☐
Meloxicam (Mobic)	☐☐	☐
Nabumetone (Relafen)	☐☐	☐
Naproxen (Aleve)	☐☐	☐

Other: ______________________________

Muscle Relaxants Did it Help?

	Yes/No	Never Tried
Baclofen	☐☐	☐
Carisoprodol (Soma)	☐☐	☐
Chlorzoxanzone (Lorzone)	☐☐	☐
Cyclobenzaprine (Flexeril)	☐☐	☐
Metaxalone (Skelaxin)	☐☐	☐
Methocarbamol (Robaxin)	☐☐	☐
Tizanidine (Zanaflex)	☐☐	☐

Other: ______________________________

Antineuropathics Did it Help?

	Yes/No	Never Tried
Amitriptyline	☐☐	☐
Duloxetine (Cymbalta)	☐☐	☐
Gabapentin (Neurontin)	☐☐	☐
Milnacipran (Savella)	☐☐	☐
Nortriptyline	☐☐	☐
Pregabalin (Lyrica)	☐☐	☐
Topiramate (Topramax)	☐☐	☐

Other: ______________________________

Current Medications

Do you currently have a Pacemaker or an AICD? ☐**Yes** ☐**No**

Are you currently taking Anticoagulants/Blood Thinners? ☐**Yes** ☐**No**

If yes, what type?

☐Warfarin/Coumadin ☐Aspirin ☐Lovenox ☐Pacemaker/AICD
☐Plavix ☐Eliquis ☐Heparin Other_______________
☐Pradaxa ☐Arixta ☐Herbals (Garlic, Ginko, Ginseng, Vitamin E)

Name of Doctor prescribing blood thinner____ Phone ____________________

Why are you taking a blood thinner?____

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

Allergies to Medications: ☐ **Yes** ☐ **No** **(if yes, indicate below drug and reaction)**

Drug	Reaction
___________________	___________________
___________________	___________________
___________________	___________________
___________________	___________________
___________________	___________________

Have you or a family member ever had adverse reaction to anesthesia? ☐ Yes ☐ No

If yes, please check all that you have reacted adversely to.

☐Local anesthesia ☐Epidural ☐General anesthesia ☐IV Sedation

Does your mother or father suffer from the same pain complaint? ☐ Yes ☐ No

Past Surgical History (be as specific as possible, including surgery type and year of surgery):

	Date	Surgery		Date	Surgery
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Social History:

Are you currently working? ☐ No ☐ Yes ☐Full time / Part time☐ Occupation: ______________________________

Do you have any lawsuits pending? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐No
How often? ______________________________

Do you use tobacco/smoke? ☐Yes ☐No
How often? ______________________________

Do you have a FAMILY history of: (circle all that apply)

Alcohol Abuse / Drug Abuse / Rx Abuse

Do you use Marijuana ☐ Yes ☐ No
How often?______________________________

Do you have a PERSONAL hx of:
Alcohol Abuse ☐Yes ☐No
Illegal Drug Abuse ☐Yes ☐No

*Have you ever been discharged (fired) from a pain managmenet practice in the past? If so, please explain:*______________
____

Past Medical History (check all that apply)**:**

Autoimmune

☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Other: ______________________________
☐ Lupus ______________________________

Cardiac

☐ High Blood Pressure ☐ Congestive Heart Failure ☐Heart Attack ☐Rheumatic Fever
☐ Angina ☐ Irregular Heartbeat ☐Heart Murmur ☐Vascular Disease
☐ Pacemaker ☐ Blood Thinners ☐Valvular Disease

Pulmonary

☐ Pneumonia ☐ Emphysema ☐Asthma ☐COPD
☐ Sleep Apnea ☐ Bronchial Disease ☐Tobacco

Renal

☐ Dialysis ☐ Renal Insufficiency ☐Kidney Stone ☐Prostate Problems

Neurological

☐ Stroke/TIA ☐ Seizures ☐Nerve Damage

Infectious

☐ Valley Fever ☐ Tuberculosis ☐HIV/AIDS

Hepatic

☐ Jaundice ☐ Cirrhosis ☐Hepatitis ☐ Gall Bladder

Gastrointestinal

☐ Hiatal Hernia ☐ GERD ☐ Gastric Ulcers ☐Colitis

Endocrine

☐ Thyroid Disease ☐ Parathyroid Disease ☐Diabetes Mellitus

Psychological

☐ Depression ☐ Bipolar ☐Addiction

☐ Anemia/Bleeding ☐Arthritis ☐Obesity ☐Alcoholism

Other

Explain: ____

Do you have a Psychologist? ☐ Yes ☐ No
If yes, what is their name?______________________________

AZ PAIN DOCTORS

Review of Symptoms

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

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
☐ Nosebleeds ☐ Recurrent Sore Throats ☐ Ringing in the Ears ☐ Sinus Problems

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

AZ PAIN DOCTORS

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 me completing a written “Patient Authorization for Use and Disclosure of Protected Health Information” form, available at its facility and on its website.

I understand that data collected during assessment or treatment may be utilized for research and teaching purposes and all identifying demographic PHI will remain confidential.

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 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 reserves 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.

Initials_________

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.

Initials_________

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.

Initials_________

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.

Initials_________

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.

Initials_________

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.

Initials_________

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.

Initials_________

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.

Initials_________

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.

Initials_________

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.

Initials_________

11. **RELEASE OF INFORMATION -** I hereby authorize 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.

Initials_________

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.

AZ PAIN DOCTORS

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, Ste#140, Casa Grande, AZ 85122
__Chandler: 725 S. Dobson Rd, Ste#100, Chandler, AZ 85224
__Gilbert: 201 W. Guadalupe Rd, Ste#202, Gilbert, AZ 85233
__Glendale: 7200 W. Bell Rd, Ste#F101, Glendale, AZ 85308
__Goodyear: 1325 N. Litchfield Rd, Ste #120, Goodyear, AZ 85395
__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 Doctors' 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-9)

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

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	2-3 Days	4-5 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
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _______+_______+_______

Add Totals Together _______________________

10. If you checked off any problems, how difficult have those problems made it for you to do you work, take care of things at home, or get along with other people?
☐Not difficult at all ☐Somewhat difficult ☐ Very difficult ☐ Extremely difficult

FOR PROVIDERS ONLY
PATIENT RESULT: ☐ POSITIVE ☐ NEGATIVE ☐PATIENT DECLINED SCREENING ☐ PATIENT ADVISED TO FOLLOW UP WITH PRIMARY CARE PROVIDER ☐ PATIENT HAS A CURRENT DIAGNOSIS AND CARE PLAN ____
FOLLOW-UP: ☐ 1-2 WEEKS ☐ 2-3 WEEKS ☐ 3-4 WEEKS ☐ NO F/UP NEEDED
RESULT NOTES:
SIGNATURE: