

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

Today's 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: _____
 Ethnicity: _____

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 true. 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? _____

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: _____

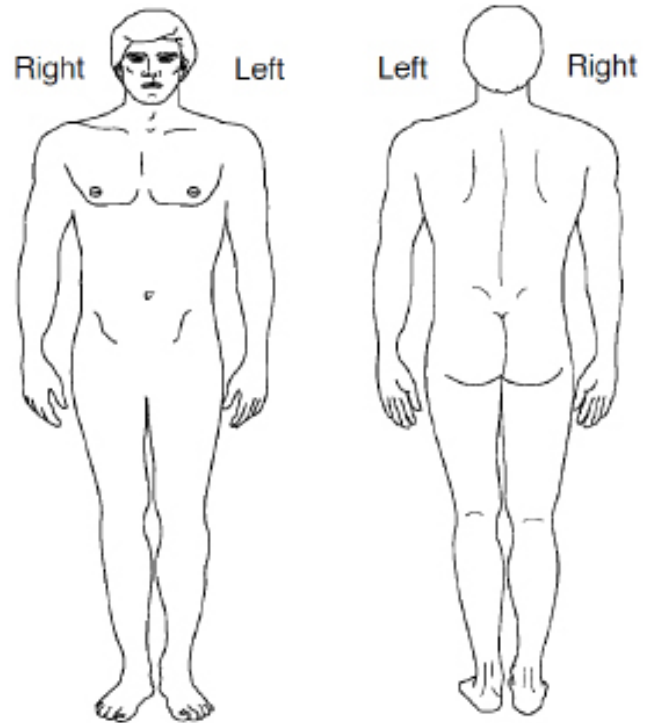
Where is your worst area of pain located? _____

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:

- | | | | |
|-----------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Numbness | <input type="checkbox"/> Spasming | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling/Pins & Needles |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing/Sharp | <input type="checkbox"/> Tiring/Exhausting |
| | | | <input type="checkbox"/> 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"

	Yes/No	Never Tried		Yes/No	Never Tried
Treatment					
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facet Block/ Medial Branch Block	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, how many weeks?	_____			Epidural Steroid Injection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
DME/Bracing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiofrequency Ablation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Spinal Cord Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Psychological Care	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Trigger Point Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	
Joint injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine (Tylenol #3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl Patch (Duragesic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocodone (Vicodin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydromorphone (Dilaudid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morphine (Kadian, MS Contin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nucynta (Tapentadol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxycodone (Percocet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxycontin (Xtampza)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxymorphone (Opana)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tramadol (Ultram)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Anti-Inflammatory Did it Help? Yes/No Never Tried

Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celecoxib (Celebrex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diclofenac (Voltaren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Etodolac (Lodine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Advil, Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indomethacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meloxicam (Mobic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nabumetone (Relafen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naproxen (Aleve)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Muscle Relaxants Did it Help? Yes/No Never Tried

Baclofen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carisoprodol (Soma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlorzoxazone (Lorzone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclobenzaprine (Flexeril)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metaxalone (Skelaxin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methocarbamol (Robaxin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tizanidine (Zanaflex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Antineuropathics Did it Help? Yes/No Never Tried

Amitriptyline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duloxetine (Cymbalta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gabapentin (Neurontin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milnacipran (Savella)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nortriptyline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregabalin (Lyrica)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Topiramate (Topramax)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

- | | | | |
|--|----------------------------------|--|---|
| <input type="checkbox"/> Warfarin/Coumadin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Lovenox | <input type="checkbox"/> Pacemaker/AICD |
| <input type="checkbox"/> Plavix | <input type="checkbox"/> Eliquis | <input type="checkbox"/> Heparin | Other _____ |
| <input type="checkbox"/> Pradaxa | <input type="checkbox"/> Arixta | <input type="checkbox"/> 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. _____	_____

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:

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

Eyes:

- Recent Visual Changes

Ears/Nose/Throat/Neck:

- Nosebleeds
- Dental Problems
- Recurrent Sore Throats
- Earaches
- Ringing in the Ears
- Hearing Problems
- Sinus Problems

Cardiovascular:

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

Respiratory:

- Shortness of Breath on Exertion/Effort
- Cough
- Wheezing
- Shortness of Breath at Rest
- Pulmonary Embolism

Gastrointestinal:

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

Musculoskeletal:

- Joint Swelling
- Back Pain
- Muscle Spasms
- Joint Pain
- Neck Pain
- Joint Stiffness

Genitourinary/Nephrology:

- Erectile Dysfunction
- Blood in Urine
- Flank Pain
- Decreased Urine Flow/Frequency/Volume
- Painful Urination
- Pelvic Pressure

Neurological:

- Instability When Walking
- Carpal Tunnel Syndrome
- Numbness/Tingling
- Dizziness
- Seizures
- Headaches

Psychiatric:

- Suicidal Thoughts
- Depressed Mood
- Suicidal Planning
- Feeling Anxious
- Stress Problems

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 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 your 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 _____

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 _____

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 your 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: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> PATIENT DECLINED SCREENING <input type="checkbox"/> PATIENT ADVISED TO FOLLOW UP WITH PRIMARY CARE PROVIDER <input type="checkbox"/> PATIENT HAS A CURRENT DIAGNOSIS AND CARE PLAN _____	
FOLLOW-UP: <input type="checkbox"/> 1-2 WEEKS <input type="checkbox"/> 2-3 WEEKS <input type="checkbox"/> 3-4 WEEKS <input type="checkbox"/> NO F/UP NEEDED	
RESULT NOTES: 	
SIGNATURE: _____	