DESERT INTERVENTIONAL SPINE CONSULTANTS

NEW PATIENT REGISTRATION FORM:

Patient's Name:______________________________ SS#:______________
First MI Last

Date of Birth:______________ Male:____Female:______ Single:___Married:___Widowed:___Divorced:___Separated:___

Street Address:______________________________City/State/Zip______________________

Home Phone:______________________________Cell Phone:______________________

Employer:______________________________Employer Phone:______________________

Referring Physician's Name and Phone Number:______________________________

Pharmacy Name (Crossroads) and Phone Number:______________________________

SPOUSE INFORMATION:

Spouse Name:______________________________ Date of Birth:______________________

Spouse's Employer:______________________________Employer Phone:______________________

EMERGENCY CONTACT (NOT LIVING WITH YOU):

Name:______________________________ Relationship To Patient:______________________

Phone Number:______________________________

WORKERS COMPENSATION INFORMATION:

YES / NO Insurance Name:______________________________

Date of Injury:______________ Claim #:______________________________

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD & PHOTO ID FOR COPYING):
This section must be completed

Primary Insurance:______________________________Phone Number:______________________

>>>Primary Insured's Name:______________________________ Date of Birth:______________________

Policy #:______________Group #:______________Relationship:______________

Secondary Insurance:______________________________Phone Number:______________________

>>>Primary Insured's Name:______________________________ Date of Birth:______________________

Policy #:______________Group #:______________Relationship:______________

- *I hereby authorize the payment of medical benefits to Desert Interventional Spine Consultants, LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.*
- *I further agree to pay all collections costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts outstanding.*
- *I hereby authorize Desert Interventional Spine Consultants, LLC to release any medical information necessary to complete and process my insurance claims.*
- *I authorize Desert Interventional Spine Consultants, LLC to treat me and use my personal information for healthcare operations.*

____

Patient OR Insured's Signature (If a Minor, Responsible Party Signature) Date

DISC DESERT INTERVENTIONAL SPINE CONSULTANTS

AUTHORIZATION TO RELEASE HEALTH INFORMATION:

1. I authorize Desert Interventional Spine Consultants, LLC to obtain the health information of the individual named below:

Patient Name:______________________________ Date of Birth: ______________________

Address: ____

Phone #: _________________________________S.S #: _____________________

2. I authorize the information to be disclosed to and used by the following individual or organization:

Name: **Desert Interventional Spine Consultants, LLC** City/State: **Mesa, Arizona**

Zip Code: **85202** Phone #: **480-838-1914** Fax #: **480-838-9434**

For the purpose of: Medical Evaluation and Treatment

3. They type and amount of information to be disclosed is as follows: (specify dates where appropriate)

- ☐ Copy of Complete Medical Records
- ☐ X-ray Films
- ☐ X-ray/CT Scan/ MRI Reports
- ☐ MRI/CT Scan Films
- ☐ Laboratory Reports
- ☐ Psychological or Psychiatric Conditions

PURPOSE OF DISCLOSURE: *We may use and disclose your medical records only for each of the following purposes:*
(1) Treatment, (2) Payment, and (3) Health care operations.
We may also create and distribute de-identified health information by removing all references to individually identifiable information.

REVOCATION RIGHTS: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by sending a written notice of revocation to Releaser. I understand that the revocation will become effective upon receipt by Releaser. Any health information disclosed by Releaser pursuant to this Authorization, before the effective date of the revocations is not subject to revocation.*

Patient's Signature: ____ Date: ____________________

BILLING POLICY:

The following sets forth the general billing policy of Desert Interventional Spine Consultants, LLC. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide to Desert Interventional Spine Consultants, LLC the accurate billing information at the time of check-in and to notify this office of any changes to this information.

- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services bring rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a **$35** NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

- I understand that there is a **$50** fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if disability forms (such as FMLA) require completion, I understand that the $50 fee (payable prior to completion) is required.

- I understand that the office will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on: 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.

- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

- **PLEASE BE ADVISED: Notice for cancellation of office visits and procedures, must be given 24 hours in advance. A $50 fee will be assessed for office cancellations and, $75 fee for procedure cancellations.**

My signature below confirms that I have read these billing policies and my financial obligation as pertaining to this office.

Legal Signature: ______________________________

Date: ______________________________

DISC Desert Interventional Spine Consultants

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My office is required by federal regulation, known as the HIPPA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. My office will not disclose your health information except as described in this Notice.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

OUR COMMITMENT TO YOUR PRIVACY:
My office is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realized that these laws are complicated, but we must provide you with the information.

WHO HAS ACCESS TO THIS INFORMATION?
Any person or persons who designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for my services has access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceeding, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information on to those who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS:
You have the right to inspect your Protected Health Information. You also have the right to amend any errors you may find in your records.

DISCLOSURE AND CONSENT:
I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risk of non-treatment, the procedures used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

Please name all person(s) we can contact and/or discuss your medical information:

Name:_______________________________ **Relationship:** _______________________________

DOB: _______________________________ **Phone Number:** _______________________________

I hereby understand and accept the above criteria:

Patient / Other Responsible Person: _______________________________

Printed Name: _______________________________ Date: _______________

OPIOID AND CONTROLLED SUBSTANCES CONTRACT:

I understand that the treatment I receive from Desert Interventional Spine Consultants includes opioid and/or other sedative medications. I understand and agree to the following while receiving these drugs:

- I understand that the goals of prescribing these medications are to increase my activities at home and/or work and decrease pain symptoms and behavior within the time specified in my treatment plan.
- I understand that opioid medications are not the only part of my treatment plan, but agree to follow other parts of my treatment program including physical therapy, behavioral pain management, injections etc; as necessary.
- **I will not attempt to obtain any opioid or sedative medications from any source other than this clinic. If I require emergency treatments requiring controlled substance use, I will notify Desert Interventional Spine Consultants, the next working day.**
- **I understand that I must schedule monthly appointments for medication renewals. Renewals are contingent on keeping scheduled appointments. No opioid medications will be refilled over the phone.**
- **I understand that I am only to take the medications as prescribed and, all medication changes have to be discussed during office visits, not via phone.**
- **I understand that lost or stolen medications and/or prescriptions will not be replaced.** I am responsible for my own medications and it is my responsibility to verify that prescriptions are filled correctly and that the medication supply will last until my next scheduled appointment.
- I understand that I must return all unused narcotic medications in the event of medication changes.
- **I agree to use a single pharmacy** for dispensing controlled substances, and provide Desert Interventional Spine Consultants with the name and phone number of that pharmacy. I will inform this office of, any changes to my overall pharmacy/health condition.
- **I agree to random urine drug screens to monitor drug usage, and monthly pill counts during follow-up office visits**.
- **I understand that failure to follow these guidelines may require discontinuation of opioid therapy, referral to a substance abuse specialist, and termination of provider-patient relationship.**
- **I UNDERSTAND THAT THE USE OF ANY RECREATIONAL DRUG USE IS A SEVERE VIOLATION OF THE OPIOID AGREEMENT AND WILL STOP ANY FURTHER OPIOID TREATMENT.**

CAUTION: OPIOID MEDICATIONS MAY CAUSE DROWSINESS. ALCOHOL SHOULD BE AVOIDED WHILE TAKING THESE MEDICATIONS. USE CARE WHEN OPERATING A CAR OR MACHINERY. FEDERAL LAW PROHIBITS ALTERATIONS OF PRESCRIPTIONS OR DIVERSION OF THESE DRUGS TO ANY OTHER PERSON!!!!

My signature below confirms that I understand and agree to all of the above requirements to obtain opioid and/or sedative medications from Desert Interventional Spine Consultants. LLC.

Patient Signature: ______________________________ Date: ____________________

Staff Signature: ______________________________ Date: ____________________

Physician Signature: ______________________________ Date: ____________________

DESERT INTERVENTIONAL SPINE CONSULTANTS

NEW PATIENT HEALTH QUESTIONNAIRE:

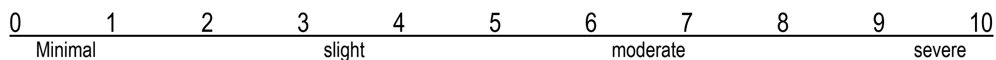
Please complete prior to your first appointment. Your careful answers will help us to understand your pain symptoms and design the best treatment program for you.

1. Name: ______________________ DOB: __________ Sex: □Male □Female
   Last First
2. Referring Doctor: ______________ Primary Doctor: ______________
3. Pain Location: ______________
4. When did you first start having pain? __________ (month / day / year)
5. Are symptoms related to an injury (including repetitive strain injury)? Yes / No ***If **YES**, the date of injury. __________
6. Was the injury: □ Work related □ Motor vehicle injury □Falling injury □ twisting □ Lifting injury □ Repetitive Strain Injury □ Whiplash
7. Please describe **HOW** your injury started in as much detail as possible: ______________
8. Please mark the location(s) of your pain with and "X" and show where it goes with an arrow. If whole areas are painful, shade in the painful area. Circle the words which best describe your pain.

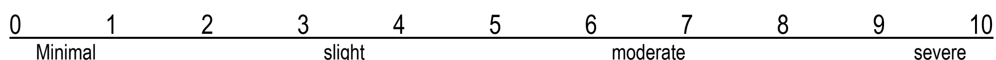
Sharp Throbbing Cutting Dull, Aching Pressure Muscle Pain Pins and needles Cramping Shooting		Electric-like Weakness Numbness Burning Skin sensitivity to light touch, cold, abnormal swelling, hair/nail growth Abnormal sweating Abnormal skin color changes Abnormal skin temperature Limited movement

9. Pain Intensity: Circle your current pain intensity with "0" representing **NO PAIN**, and "10" representing **THE MOST SERVERE PAIN IMAGINABLE**

Circle your **LEAST** pain in the last 7 days



Circle your **WORST** pain in the last 7 days



Do you have other pain problems? If so, what are they?

____

____

____

10. Previous pain treatments:

Treatment	How many, when, by whom	Relief: Excellent	Moderate	None
Epidural steroid injects:		□	□	□
Surgeries		□	□	□

11. Previous diagnostic studies: Please include when and where:

MRI / CT Scans____

X-Rays ____

EMG's ____

12. Please check the medications that you're currently on. Indicate the dosage and number of pills you are taking per day. Cross out medications you have tried in the past, indicate the reason for stopping.

OPIOIDS	**ANTIINFLAMATIONS**	**ANTI - DEPRESSANTS**
□ Codeine	□ Aleve	□ Celexa
□ Darvocet (Propoxyphene)	□ Celebrex	□ Cymbalta
□ Demerol (Meperidine)	□ Mobic (Meloxicam)	□ Elavil (Amitriptyline)
□ Dilaudid (Hydromophone)	□ Ibuprofen (Motrin, Advil)	□ Effexor (Venlafaxine)
□ Fentanyl (Duragesic patch)	□ Indomethacin (Indocin)	□ Desyrel (Trazodone)
□ Levorphanol	□ Lodine (Etodolac)	□ Lexapro
□ Lortab	□ Naprosyn (Naproxen)	□ Norpramin (Desipramine)
□ Methadone	□ Relafen (Nabumetone)	□ pamelor (Nortripyline)
□ Morphine	□ Toradol (Ketoralac)	□ Prozac (Fluoxetine)
□ MS Contin	**SLEEP MEDICATIONS**	□ Serzone (Nefazodone)
□ Oxycodone	□Ambien (Zolpidem)	□ Sinequan (Doxepin)
□ Oxycontin	□ Lunesta	□ Wellbutin (Bupropion)
□ Percocet		□ Zoloft (Sertraline)
□ Tylenol with Codeine	**BIOOD THINNERS**	**Others**
□ Vicodin (Hydrocodone)	□ Aspirin	□ Lidorderm
□ Norco	□ Coumidin	□ Depakote (Valproic Acid)
	□ Plavix	□ Dilantin (Phenytoin)
ANTISPASMODICS	**ANTI-ANXIETY**	□ Lamictal (Lamotrigine)
□ Baclofen (Lioresal)	□ Ativan (Lorezapam)	□ Lyrica
□ Flexeril (Cyclobenzaprine)	□ Buspar (Buspirone)	□ Nuerontin (Gabapentin)
□ Norflex (Orphenadrine)	□ Halcion (Triazolam)	□ Phenobarbital
□ Robaxin (Methocarbamol)	□ Klonopin (Clonazepam)	□ Tegretol (Carbamezapine)
□ Soma (Carisoprodol)	□ Serax (Oxazepam	□ Topomax (Topiramate)
□ Zanaflex (Tizanidine)	□ Valium (Diazepam)	□ Ultram (Tramadol) Ultacet
		□ Savella

13. List additional medications. Please include anti-biotics, local anesthetics, or materials.

1.	3.	5.
2.	4.	6.

14. Please list any allergies to medications (Ex: Latex, contrast dye, iodine)

1.	3.	5.
2.	4.	6.

15. Review of symptoms. **(CIRCLE ALL THAT APPLY).**

General	Fever Unplanned weight loss Night sweats
ENT	Difficulty swallowing Hoarseness Hearing loss Dentures? Full / Partial
Heart	Chest pain Previous heart attacks Heart murmur Dizzy spells Congestive heart failure (last 6 months)
Lungs	Wheezing Shortness of breath Cough Tuberculosis Valley Fever HIV Sleep apnea
GI	Abdominal pain Heartburn Diarrhea Constipation Incontinence Rectal bleeding Hepatitis
GU	Sexual dysfunction Urinary retention
Musculoskeletal	Knee pain Shoulder pain Restricted movement Fibromyalgia
Neurological	Seizures Dizziness Weakness Drowsiness Trouble walking Problems controlling bowel / bladder
Psychiatric	Difficulty falling or remaining asleep Excessive fatigue Feeling depressed Memory loss
Endocrine	Heat / Cold intolerance Diabetes Thyroid disorder
Hematology	Easy bruising Low platelet count Enlarged lymph nodes Bleeding Blood clots

16. Past medical history: Have you ever had any of the following health problems?

□ Diabetes	□ Stroke (TIA)	□ Seizure or epilepsy	□ Other – please list below
□ High blood pressure	□ Asthma	□ Bleeding	
□ Chest pain, heart attack	□ Chronic cough	□ Cancer	
□ Kidney disease	□ Arthritis	□ Hepatitis A / B/ C	

17. Please list any surgeries you have had in the past. **(List approximate dates)**

1. ____________	4. ____________	7. ____________
2. ____________	5. ____________	8. ____________
3. ____________	6. ____________	9. ____________

18. Is there any possibility that you may be pregnant? YES / NO / NA

19. Have your ever abused alcohol? YES / NO / NA

20. Have your ever abused drugs? YES / NO / NA If yes, please explain:____________

21. Are a current smoker? YES / NO / NA How many packs per day? ____________

22. Are you currently employed? YES / NO Full time / Part time

Current occupation/employer: ____________________________

23. I hereby authorize the release of the reports of my evaluations and treatments to my physicians and to other relevant persons listed below:

PHYSICIANS / PROVIDERS / ATTORNEY/ CASE MANAGER	**Address City & State**	**Phone / Fax**
Referring physician:		
Primary Care Physician:		
Work Comp adjuster:		
Case manager:		
Attorney:		

Patient Signature:____ Date: ____________________________