Desert Interventional Spine Consultants

2022 NEW PATIENT REGISTRATION FORM:

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

Date of Birth:__________ Male:____Female:____ Single:____Married:___Widowed:___Divorced:___Separated:___

Race: ☐ American Indian/Native American ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ White ☐ Other/Refuse

Street Address:__________________City/State/Zip__________________

Home Phone:__________________Cell Phone:__________________

Email: __________________

Employer:__________________Employer Phone:__________________

PRIMARY CARE PHYSICIAN & Phone Number:__________________

Pharmacy Name (Crossroads) and Phone Number:__________________

How did you hear about us: **___ Friend or Family** **___Doctor** **___Website** **____Insurance** **___Other**

SPOUSE INFORMATION:

Spouse Name:__________________ Date of Birth:__________

Spouse's Employer:__________________Employer Phone:__________________

EMERGENCY CONTACT (NOT LIVING WITH YOU):

Name:__________Phone Number:__________ Relationship to Patient:__________

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:__________

WORKERS COMPENSATION INFORMATION:
YES / NO Insurance Name:__________________

Date of Injury:__________ Claim #:__________________

AUTO ACCIDENT INFORMATION:
YES / NO Insurance Name:__________________Claim #:__________________

Date of Injury:__________ Attorney Contact Information: __________________

- *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.*

X____

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

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 Friend/Relative: ____
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. Please describe HOW your injury started in as much detail as possible:____
   ____
7. 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 Dull, Aching 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 Other

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

   0 1 2 3 4 5 6 7 8 9 10
   Minimal Slight Moderate Severe

9. Previous pain treatments:

   Treatment _______________How many, when, by whom ___________________________ Relief: Excellent / Moderate / None

   Epidural steroid injects: ____ ◻ ◻ ◻

   Surgeries ____ ◻ ◻ ◻

10. Please list the medications that you're currently on. Indicate the dosage and number of pills you are taking per day.

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

12. Is there any possibility that you may be pregnant? YES/ NO/ NA
13. Have you ever abused alcohol? YES/ NO/ NA
14. Have you ever abused drugs? YES/ NO/ NA
15. Are you a current smoker? YES/ NO/ NA If yes, How Often ___________________
16. Do you have an advanced directive? YES/ NO
17. Review of symptoms **(MARK ALL THAT APPLY)**

General	□ Fever □ Unplanned weight loss □ Night sweats
Heart	□ Chest pain □ Heart murmur □ Dizzy spells
Lungs	□ Wheezing □ Shortness of breath □ Cough □ Tuberculosis □ Sleep apnea
GI	□ Abdominal pain □ Heartburn □ Diarrhea □ Constipation □ Incontinence □ Rectal Bleeding
Musculoskeletal	□ Joint Pain, if yes please specify:
Neurological	□ Seizures □ Dizziness □ Weakness □ Incontinence
Psychiatric	□ Memory loss □ Anxiety □ Depression
Endocrine	□ Heat/Cold intolerance □ Diabetes □ Thyroid disorder
Hematology	□ Easy bruising □ Low platelet count □ Enlarged lymph nodes □ Blood clots

18. 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	

19. Past surgical history: Please list any surgeries you have had in the past. (List approximate dates)

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

20. 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/	Name	Phone
Primary Care Physician:		
Referring Physician:		
Attorney (if any)		

Patient Signature: ____**Date:** ____________________________

SOAPP® Version 1.0 - SF

Name: ______________________________________ Date: ______________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________________ DATE:________________

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or 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 are 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 so figety 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	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these 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 ______

DESERT INTERVENTIONAL SPINE CONSULTANTS

BILLING POLICY:

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

- I understand that it is my responsibility to provide to Desert Interventional Spine Consultants, 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 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 any outstanding balances must be **paid in full** prior to my next appointment. Any balances not satisfied could results in appointment cancellations.

- ***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 same day cancellations/no show.***

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

Legal Signature: ____

Date: ____

OFFICE POLICIES AND PROCEDURES

1. D.I.S.C has a very strict **ZERO** tolerance policy for abusive or aggressive behavior toward its staff and providers; we do not permit patients to swear at our staff, be rude, aggressive, belligerent or disruptive. Thank you for remaining calm and friendly.
2. All patients with pain perceive their symptoms to be extraordinary and urgent. We acknowledge that you may be experiencing physical and emotional distress. However, other patients referred to this clinic feel the same urgency to obtain treatment. Please know that we will do everything possible to serve you in a timely and effective manner within our limitations. Occasionally, a medical emergency arises which may delay the day's schedule- we appreciate your patience in these situations.
3. Chronic pain is **NOT** considered to be a medical emergency. Therefore, emergency access to our clinic is rarely indicated. You may refer to your primary care physician or to an emergency facility if we cannot accommodate your urgent needs. Please do not wait until the last minute to seek care for an escalating problem.
4. Our office has a fifteen-minute late policy. THERE ARE NO EXCEPTIONS. If you arrive fifteen minutes after your scheduled appointment, we will not be able to see you. We will reschedule your appointment for the next available time. Arriving late routinely for your scheduled appointments may be reason for dismissal from the clinic. Please keep in mind this rule does not apply to the last appointment before lunch nor the last appointment of the day. There is NO leeway for those appointments. Out of courtesy, please call the office if you are running late to confirm if we are still able to see you.
5. Missed appointments will be rescheduled at the next available time. We will not refill medications in the interim so try not to miss scheduled appointments. Missing several appointments may be cause for dismissal from the clinic.
6. When you call the clinic, you may be routed to a mailbox. Please leave your message, we listen to messages daily and will return your call within 24-48 business hours. Multiple phone calls on the same day for the same problem are disruptive and may cause delay in a call back. If you do this, you will be given a warning to desist.
7. If narcotics or other potent medications to treat your pain are prescribed, you will be asked to enter into a formal narcotic agreement that outlines rules, risks, and conditions of continued access to these medications. **Please remember it is up to the physician's discretion if opiate medications are prescribed.**
8. Pain medication prescriptions are written for a 28-day supply. Medications are refilled once a month during a scheduled office visit. Lost or stolen medication will **NOT** be replaced with a new prescription. Pain medication should be taken as directed and we do **NOT** provide early refills. Six months of pharmacy records may be required before a narcotic prescription can be issued. Non-urgent calls regarding medication may be returned within 72 hours. Medication changes are addressed during scheduled office visits. Before leaving the office, it is recommended the patient schedule their next appointment to avoid any last-minute requests for appointments that we may not be able to accommodate.
9. Obtaining pain medication elsewhere without our specific written or verbal approval may be considered a sign of possible narcotic addiction and may be reason for dismissal from the clinic.
10. It is your responsibility as the patient to inquire if you are due for a urine drug screen test. Please ask the front desk upon arrival if you are due for one before using the restroom. If a UDS is required, you may **NOT** leave the lobby/office once you have checked in. If you do leave the office your urine is considered a failure and you may not receive your prescription, this could lead to a possible dismissal from the practice. Furthermore, if reason is found, you may be given a specific time limit to complete your UDS.

Following these guidelines is important to the continued success in managing your pain. If the clinic guidelines are unacceptable to you, you may choose to seek care from another source more suited to your desires. Thank you for your understanding, we consider it a privilege to see you. We look forward to a happy and productive working relationship.

DISC DESERT INTERVENTIONAL SPINE CONSULTANTS

OPIOID AND CONTROLLED SUBSTANCES AGREEMENT:

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 change; before prescribed new medication
- **I agree to random urine drug screens to monitor drug usage, and monthly pill counts during follow-up office visits**.
- I agree for an outside laboratory might be used for clinical urine drug testing services and I understand that my insurance may be billed for services rendered. I understand that I am responsible for any co-pays, deductibles, or other fees that my insurance provider deems my responsibility.
- **I agree that if I am unable to leave a urine sample at my appointment time, I will have 24 hours after my appointment to complete the urine drug screen (urine sample or labs), otherwise, it will count as a failed urine drug screen.**
- **I UNDERSTAND THAT VIOLATION OF THIS AGREEMENT CAN RESULT IN DISCONTINUATION OF CARE AND DISCHARGE FROM OUR FACILITY AND WILL STOP ANY FURTHER OPIOID TREATMENT.**

CAUTION: OPIOID MEDICATIONS MAY CAUSE DROWSINESS. ALCOHOL IS TO 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: ____________________

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 HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. The 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:
The 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.

I authorize Desert Interventional Spine Consultants to leave detailed information regarding my care at the phone number listed on my demographics and the email I provided.

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

Name:_______________________________ **Relationship:** _______________________________

DOB: _______________________________ **Phone Number:** _______________________________

****If you need to add any more people use the bottom of the page, please include name, phone and relationship****

I hereby understand and accept the above criteria:

Patient / Other Responsible Person Signature: ____

Printed Name: ____ Date: ____________________

DISC DESERT INTERVENTIONAL SPINE CONSULTANTS

AUTHORIZATION TO RELEASE HEALTH INFORMATION:

Please fill #1 and sign, this form will remain in your chart in case you are hospitalized or visit an UC and we need to obtain your medical records.

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

Patient Name:______________________________ Date of Birth: ______________

Address: ____

Phone Number: ____

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: **Gilbert, Arizona**
1410 W Guadalupe Rd, Bldg. 4, Ste 125
Zip Code: **85233** Phone #: **480-838-1914** Fax #: **480-838-9434**

For the purpose of: **Medical Evaluation and Treatment**

3. The 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

From: ______________________________**DOS:** ______________________

Fax: ______________________________

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: ______________