Board Certified Pain & Rehabilitation Physicians

COMPREHENSIVE PAIN MANAGEMENT

www.azcpm.com

Apellido_____Nombre_____Fecha de Nac._____M/F_____

Direccion_____Cuidad_____Esatado____Codigo postal_____

Tel. de Casa#_____¿Está bien dejar el correo de voz en esta línea con detalles sobre su información de salud protegida? ☐SI ☐NO

Cellular#_____¿Está bien dejar el correo de voz en esta línea con detalles sobre su información de salud protegida? ☐SI ☐NO

Tel. del Trabajo#_____ ¿Está bien dejar el correo de voz en esta línea con detalles sobre su información de salud protegida? ☐SI ☐NO

Seguro Social#_____ Correo Electronico_____Estado Civil _____

Doctor de referencia _____Doctor Primario_____

Estado de Empleo_____ Empleador_____ Tel.del empleador _____

Origen étnico: ☐American Indian ☐Asian ☐African American ☐White ☐Hispanic ☐Otro ☐Prefiero no responder

Idioma Preferida _____

¿Es este un accidente laboral? ☐ ¿Está esto relacionado con un accidente auto? ☐Fecha de Accidente_____

Persona responsible si es diferente del de arriba (Si el paciente es menor de 18anos)_____

Relacion al Paciente_____Fecha de Nac._____Tel.#_____

Direccion_____

Contacto de Emergencia_____Tel.#_____Relacion_____

Esta bien revelar su informacion de salud a su contacto de emergencia? ☐ yes / ☐ no

Aseguranza de salud Primaria_____ID del Miembro#_____Numero de Grupo#_____

Nombre de la Persona Primaria en la Aseguranza_____Fecha de Nac._____Relacion al Paciente_____

Aseguranza de Salud Secundaria_____ ID del Miembro#_____ Numero de Grupo#_____

Nombre de la Persona Primaria en la Aseguranza _____ Fecha de Nac _____ Relacion al Paciente _____

CONSENT FOR TREATMENT AND INSURANCE AUTHORIZATION AND ASSIGNMENT: I give consent for treatment by Comprehensive Pain Management (CPM). I authorize and release all of my medical information necessary to process my insurance claims. I authorize payment of medical benefits directly to CPM. I understand that this office may bill my inurance carrier as a courtesy to me, but that I am financially responsible for all fees incured and I agree to pay them in full. I allow a photocopy of my signature to be used to process my insurance claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my healthcare policy and what I am required to do to secure those benefits. I further agree to pay all collection costs(33%), attorney fees, interest and other collections costs that may be incurred to enforce the collection of any outstanding amounts I owe. I understad that CPM may utilize a facility (North Valley and Biltmore Surgery Center) in which one of our providers has a financial interest; I am not obligated to use that facility and may choose to seek treatment elsewhere. Filling out the preliminary documentation will not be reviewed by a physician until the date of the office visit and is not intended to establish a physician-patient relationship.

Firma del paciente (o persona responsable):_____Fecha:_____

Board Certified Pain & Rehabilitation Physicians
COMPREHENSIVE PAIN MANAGEMENT
www.azcpm.com
3811 E. Bell Road, Suite 207 Phoenix, AZ 85032 Phone (602) 971-8200 Fax (602) 971-8201

Initial Pain Management Consultation Patient Acknowledgement

I understand that I will be seen for a *consultation* with Comprehensive Pain Management (CPM) to *evaluate* my pain problem. This means that CPM will obtain a medical history and perform a physical examination. I understand that the purposes of this *evaluation* are to try to identify the *causes* of my pain problem, to possibly make diagnostic or treatment recommendations, and to forward this information to my primary care (or other referring) physician. I understand that this appointment does not, in any way, guarantee that CPM will provide medical treatment for me after this consultation. **The decision to go forward with future medical treatment must be mutually agreed upon by *both* me and the physician**. I understand that CPM will not provide narcotic medications to me at the end of this initial evaluation, ***regardless*** of whether (1) I have run out of medication, (2) I have just moved to Arizona and need my medication, (3) my primary doctor told me that CPM would be prescribing my medicine from now on, or (4) for any other reason. The determination to prescribe medication may take place at the *second visit*, should a doctor-patient relationship be mutually established *after this consultation*.

I also understand that CPM, in trying to reduce my pain and improve my quality of life, may prescribe medications for *off-label uses.* This means that some medications may be prescribed for uses that are not specifically sanctioned or approved by the United States Food and Drug Administration (FDA). These medications *may, or may not,* have been thoroughly studied in controlled investigational drug trials for the off-label uses for which they are being prescribed. Although drugs prescribed for such uses may not have proven efficacy (effectiveness) in clinical trials for off-label use, the general *safety* of such medications has been established; such drugs have already been approved for *other* uses by the FDA. I understand that no drug prescribed by CPM can be considered absolutely safe, regardless of whether the drug is being prescribed for off-label uses or FDA-approved uses. *I understand that all drugs have inherent risk, inherent potential toxicity, and potentially lethal side effects.* I also understand that it is ultimately my decision to take the medications prescribed by CPM. Although I understand that it would be unreasonable to expect CPM to explain *every* risk of *every* medication being prescribed, I am aware that I can ask my physician questions about any of the medications that he prescribes. I further understand that the medications that are *currently* being prescribed and are *currently* considered generally safe, may in the future be determined to be unsafe; new risks or toxicities of any prescribed medication may be identified *in the future*. I accept that CPM cannot be held responsible for such future discoveries.

Examples of families of drugs that may be prescribed for off-label uses include, but are not limited to, antiepileptic drugs (drugs for epilepsy), cardiac drugs, drugs for control of blood pressure, antidepressant medication, medications for Alzheimer's disease, sedatives, muscle relaxants, steroids, and medications for psychiatric disorders. I understand that any of the medications prescribed by CPM may negatively affect my judgment, my coordination, my ability to operate heavy equipment or automobiles, and my ability to make critical decisions. I understand that it is ultimately my responsibility to identify such impairment and report it to CPM so that medication adjustments or changes can be made.

I understand and accept all of the explanations given above. I am aware that I may ask any questions about medications prescribed by my physician and CPM *now and in the future*.

_____ _____/_____/_____

Print name Date

_____

Signature

Updated January 2018

Board Certified Pain & Rehabilitation Physicians
COMPREHENSIVE PAIN MANAGEMENT
www.azcpm.com
3811 E. Bell Rd., Suite 207 Phoenix, AZ 85032 Phone (602) 971-8200 Fax (602) 971-8201
James KellerShabrokh, D.O. • Steven Giacoppo, D.C., FNP

PATIENT CONSENT FORM

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

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it its appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, as some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy policy notice.

Date:_____

I_____ have received a copy of this notice.
Print Name

_____
Sign Name

Board Certified Pain & Rehabilitation Physicians
COMPREHENSIVE PAIN MANAGEMENT
www.azcpm.com

3811 E. Bell Road, Suite 207 Phoenix, AZ 85032 Phone (602) 971-8200 Fax (602) 971-8201
James KellerShabrokh, D.O. ● Steven Giacoppo, FNP

POLIZA FINANCIERA

TARDE CANCELAR / NO-SHOW: Si no se comunica con nuestra oficina 24 horas antes de una cita programada para cancelar o reprogramar una cita y pierde la cita, usted es responsable de lo siguiente:

$ 125.00 por una visita regular a la oficina

$ 500.00 para una inyección / procedimiento o EMG / NCV

No hay excepciones o exenciones para esta tarifa. Si no se presenta o las cancelaciones tardías pueden resultar en el alta de la práctica. * Esta es una práctica especializada ocupada; Trabajamos diariamente en listas de cancelación para tratar de acomodar a otros pacientes con dolores graves. Es simplemente una cortesía para otras personas que experimentan dolor / incomodidad extrema que nos avisa si no puede asistir a su cita, por lo que podemos presentar otro caso urgente. Gracias por su comprensión.

PAGOS: Todos los copagos, coseguros, deducibles y aranceles por servicios no cubiertos por su póliza de seguro vencen en el momento en que se presta el servicio. Aceptamos VISA, Master Card, American Express, dinero en efectivo o cheque. Los cheques devueltos están sujetos a un cargo de $ 40.

SEGURO DE SALUD: Como cortesía, nuestra oficina le facturará a su seguro los servicios que reciba. Es SU RESPONSABILIDAD conocer los beneficios de su plan de seguro particular. En última instancia, usted es responsable de todos los saldos pendientes de pago.

FMLA / DISCAPACIDAD / FORMAS DE ESTADO DE TRABAJO

FORMULARIOS: Hay un cargo para completar los formularios de estado de FMLA / Discapacidad / trabajo: la primera página cuesta $ 25 y $ 10 cada página después. Esta tarifa se cobrará en el momento de su visita. Estos formularios SOLAMENTE se pueden completar en una visita al consultorio en persona con un doctor.

ESTADO DE TRABAJO: Si está lesionado y requiere estatus de trabajo / restricciones de trabajo para su empleador, el estatus y / o las restricciones SOLAMENTE se pueden obtener en una visita al consultorio en persona con un doctor.

Yo, _____, he leído y entiendo TODAS las polizas financieras anteriores.

_____ _____

Firma del Paciente Fecha

Revised January 2018

Board Certified Pain & Rehabilitation Physicians
COMPREHENSIVE PAIN MANAGEMENT
www.azcpm.com

3811 E. Bell Road, Suite 207 Phoenix, AZ 85032 Phone (602) 971-8200 Fax (602) 971-8201
James KellerShabrokh, D.O. • Steven Giacoppo, F.N.P.

CUSTOMARY AND USUAL CHARGES/INJURY INFO

You have requested that we treat you for personal injuries arising from an incident where a third party is apparently liable for your injuries. We have agreed to provide treatment to you under these circumstances; without limitation, based upon the following:

All services for treatment will be billed to you based upon our customary charges. A list of the most common types of treatment, and their respective customary charges, are available for you preview at our front desk. **By signing below, you agree that our charges are customary and usual for our office and this geographical community.** Our agreement to treat you is contingent upon this agreement by you, and we are relying upon your agreeing not to later challenge the validity of our charges as being customary as stated herein. You agree you have had a fair opportunity to make any inquiry you desire, including consulting with an attorney, and are fully satisfied with our charges as being customary before signing below. Further, you direct any attorney who may represent you, either now or in the future, to accept our charges as being customary and specifically not to challenge our charges in any way.

YOU AGREE TO PAY, IN FULL, OUR USUAL AND CUSTOMARY TOTAL CHARGES. YOU AGREE THAT THE CHARGES LISTED AT OUR FRONT DESK, FOR YOUR REVIEW, ARE USUAL AND CUSTOMARY. YOU UNDERSTAND THAT WE ARE RELYING UPON THIS AGREEMENT IN AGREEING TO PROVIDE TREATMENT TO YOU FOR THIS ACCIDENT CASE.

Further, you agree to furnish the following information to the best of your ability:

Fecha del Accidente: _____Cuidad Y Estado del accidented _____
¿ERAS EL CONDUCTOR, PASAJERO, PEDESTRE, O DESLIZAMIENTO Y CAÍDA: _____

Nombre De Su Seguro De Auto: _____ Numero de póliza #: _____
Numero de Reclamo#: _____ Nombre / Numero del Ajustador: _____

Nombre Del Seguro De Auto De La Persona Culpable: _____ Numero de póliza #: _____
Numero de Reclamo#: _____ Nombre / Numero del Ajustador: _____
Nombre del conductor en falla: _____

Nombre del Abogado: _____
Paralegal / Asistente_____ Numero de telefono _____

This information is correct and completed to the best of my knowledge/ability. In order to ensure that the parties responsible for payment of your claim (insurance companies) are fully aware of the fact that CPM is extending credit to you for your care in our office, we will be filing a county medical lien. Responsible parties will receive notification that the lien has been filed via certified mail or fax. The filing and releasing fees (once payment is received) of this lien involves administrative costs of approximately $100.

Signature_____Date_____

January 2019

Board Certified Pain & Rehabilitation Physicians

COMPREHENSIVE PAIN MANAGEMENT

www.azcpm.com

Historia Medica

			Historia
Enfermedad Del Corazon	☐Si	☐No	_____
Problemas Para Respirar	☐Si	☐No	_____
Enfermedad Del rinon	☐Si	☐No	_____
Accident Cerebrovascular	☐Si	☐No	_____
Convulsiones	☐Si	☐No	_____
Ulceras	☐Si	☐No	_____
Agruras	☐Si	☐No	_____
Infeccion Dental	☐Si	☐No	_____
Infeccion Sinusal	☐Si	☐No	_____
Problemas Urinarios	☐Si	☐No	_____
Hepatitis	☐Si	☐No	Tipo_____
VIH/Sida	☐Si	☐No	_____
Presion Arterial Alta	☐Si	☐No	_____
Colesterol Elevado	☐Si	☐No	_____
Diabetes	☐Si	☐No	_ Dependiente de Insulina ☐Si ☐No
Enfermadad de Tiroides	☐Si	☐No	_____
Enfermadad de Sangre(Cuajos)	☐Si	☐No	_____
Migranas	☐Si	☐No	_____
Cancer	☐Si	☐No	Tipo_____
Artritis	☐Si	☐No	Tipo_____

Porfavor escriba calquier otra condicion medica:

_____

_____

_____

Alergia a Medicamentos

Medicamentos Allergicos	Reaccion al medicamento
_____	_____
_____	_____
_____	_____
_____	_____

Tiene alguna sensibilidad o alergia al latex? ☐SI ☐NO

Tiene alguna sensibilidad o alergia al yodo(Iodino)? ☐SI ☐NO

Medicamentos

Nombre	Dosis(mg)	Frecuencia
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Cirugias:	Ano
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizaciones:	Ano
_____	_____
_____	_____
_____	_____
_____	_____

Historia Familiar

Su Padre Vive? ☐Si ☐No Edad (____)
Su Madre Vive ? ☐Si ☐No Edad (____)
Cuantos Hermanas/os tiene ? Hombres _____ Mujeres___
Cuantos Hijas/os tiene ? Hombres____ Mujeres____

Antecedentes Familiares ; Por ejemplo: Cancer, Accidente Cerebrovascular, Attacke al corazon, Presion Arterial Alta, Colesterol Elevado, Diabetes, Etc.
Padre: _____
Madre:_____
Hermanas/os:_____

Historia Social

Fuma Fumador Actual (___ cigarros/al dia) Ex Fumador (ultimo dia: _____) nunca fumado
Alcohol SI: ☐1-2 por semana ☐3-5 por semana ☐5+ por semana ☐NO
Abuso de Drogas historial_____
Marital Status: ☐Soltera/o ☐Casada/o ☐Divorciada/o ☐Separada/o ☐Viuda/o
Hijos ☐SI: Cuantos? ☐NO
Nivel de Educacion: ☐<high school ☐high school ☐Colegio Completado

Empleada/o ☐ **SI** ☐ **No**
Occupacion _____

Revisión de sistemas

Constitucional **Si la respuesta fue si explique:**

- **Fiebre** ☐ **SI** ☐ **No** _____
- **Insomnia** ☐ **SI** ☐ **No** _____
- **Pérdida de apetito** ☐ **SI** ☐ **No** _____
- **Aumento de peso inexplicable** ☐ **SI** ☐ **No** _____
- **Pérdida de peso inexplicable** ☐ **SI** ☐ **No** _____

Musculoesqueléticos

- **Artritis en los conjuntos** ☐ **SI** ☐ **No** _____
- **Hernia de disco** ☐ **SI** ☐ **No** _____
- **Cirugias en los conjuntos** ☐ **SI** ☐ **No** _____
- **Inflamacion en los conjuntos** ☐ **SI** ☐ **No** _____

Neurologia

- **Dolor de cabeza** ☐ **SI** ☐ **No** _____
- **Convulsiones** ☐ **SI** ☐ **No** _____
- **Pérdida de memoria** ☐ **SI** ☐ **No** _____
- **Tremblores** ☐ **SI** ☐ **No** _____
- **Vértigo** ☐ **SI** ☐ **No** _____
- **Pérdida de olfato** ☐ **SI** ☐ **No** _____

General

- **Cansada/o con facilidad** ☐ **SI** ☐ **No** _____
- **Swollen Glands** ☐ **SI** ☐ **No** _____
- **Skin Rash** ☐ **SI** ☐ **No** _____

Alergias ☐ ☐

- **Comezon el los ojos** ☐ **SI** ☐ **No** _____
- **Congestion nasal** ☐ **SI** ☐ **No** _____

Cardiologia

- **Dolor de pecho** ☐ **SI** ☐ **No** _____
- **Ritmos Cardiaco Irregular** ☐ **SI** ☐ **No** _____
- **Hinchazon en las piernas** ☐ **SI** ☐ **No** _____
- **Dificultad para respirar** ☐ **SI** ☐ **No** _____
- **Dificultad para Respirar haciando sus actividades normales** ☐ **Si** ☐ **No** _____

Dermatologia

- **Urticaria** ☐ **SI** ☐ **No** _____
- **Lumps/bumps** ☐ **SI** ☐ **No** _____
- **Lunar** ☐ **SI** ☐ **No** _____
- **Salpullido** ☐ **Si** ☐ **No** _____

Endocrinologia

- **Intolerancia al frio extremo** ☐ **SI** ☐ **No** _____
- **Sudoracion Excesiva** ☐ **SI** ☐ **No** _____
- **Sed Excesiva** ☐ **SI** ☐ **No** _____
- **Miccion Excesiva** ☐ **SI** ☐ **No** _____
- **Intolerancia al color extremo** ☐ **SI** ☐ **No** _____

Otorrinolaringologia (Oido, Nariz y Garganta)

- **Dolor en Oido** ☐ **SI** ☐ **No** _____
- **Zumbido en los oidos** ☐ **Si** ☐ **No** _____

Reproductor Femenino

- **Estas embarazada?** ☐ Si ☐ No
- **Fecha de la ultima menstruacion** _____ ☐ None
- **Sexualmente activo** ☐ Si ☐ No
- **Embarazos** ☐ Si ☐ No **Cuantos** _____

Gastrointestinal

- **Dolor Abdominal** ☐ Si ☐ No _____
- **Sangre en las heces** ☐ Si ☐ No _____
- **Cambio en los hábitos intestinales** ☐ Si ☐ No _____
- **Estreñimiento** ☐ Si ☐ No _____
- **Diarrea** ☐ Si ☐ No _____
- **Dificultad para deglutir** ☐ Si ☐ No _____
- **Acidez** ☐ Si ☐ No _____
- **Náuseas** ☐ Si ☐ No _____

Hematología

- **Sangrado anormal / moretone** ☐ Si ☐ No _____
- **Anemia** ☐ Si ☐ No _____

Reproductor Masculino

- **Dificultad para orinar** ☐ Si ☐ No _____

Oftalmología

- **Visión borrosa** ☐ Si ☐ No _____
- **Dolor en los ojos** ☐ Si ☐ No _____
- **Fotofobia (sensible a la luz)** ☐ Si ☐ No _____

Psicología

- **depresión severa** ☐ Ahora ☐ Antes ☐ nunca
- **Alteración del sueño** ☐ Ahora ☐ Antes ☐ nunca
- **pensamientos suicidas** ☐ Ahora ☐ Antes ☐ nunca
- **trastorno de la alimentación** ☐ Ahora ☐ Antes ☐ nunca
- **hospitalización psiquiátrica** ☐ Ahora ☐ Antes ☐ nunca
- **Asesoramiento** ☐ Ahora ☐ Antes ☐ nunca

Respiratorio

- **Dificultad para respirar** ☐ Si ☐ No _____
- **Dolor de pecho** ☐ Si ☐ No _____
- **Mocos** ☐ Si ☐ No _____
- **Resollar** ☐ Si ☐ No _____
- **Tos** ☐ Si ☐ No _____

NOTAS

_____

_____

_____