Board Certified Pain & Rehabilitation Physicians

COMPREHENSIVE PAIN MANAGEMENT

www.azcpm.com

Last Name_____First_____DOB_____M/F_____

Address_____City_____State____Zip_____

Home Phone_____ OK to leave voicemail on this line with details regarding your protected health info? ☐YES ☐NO

Cell Phone_____ OK to leave voicemail on this line with details regarding your protected health info? ☐YES ☐NO

Work Phone_____ OK to leave voicemail on this line with details regarding your protected health info? ☐YES ☐NO

Social Security#_____ E-Mail Address_____Marital Status _____

Referring Doctor_____Primary Care Doctor_____

Employment Status_____Employer_____Employer Phone_____

Race: ☐American Indian ☐Asian ☐African American ☐White ☐Hispanic ☐Other ☐Prefer to Not Answer

Ethnicity: ☐Hispanic ☐Not Hispanic ☐Prefer to Not Answer Preferred Language _____

Is this a work related accident☐ Is this related to a motor vehicle accident☐Date of Injury_____

Responsible Party if Different From Above (Patient is under 18 or Power of Attorney)_____

Relationship to Patient_____DOB_____Phone_____

Address_____

Emergency Contact_____Phone_____Relation_____

Ok to release your protected health information to this person ☐ yes / ☐ no

Primary Health Insurance_____ID/Subscriber #_____Group #_____

Policy Holder_____DOB_____Relation to patient_____

Secondary Health Insurance_____ID/Subscriber #_____Group#_____

Policy Holder_____DOB_____Relation to patient_____

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.

Signature of Patient (or Responsible Party):_____Date:_____

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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

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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

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FINANCIAL POLICY

LATE CANCEL/NO-SHOW: If you fail to contact our office 24 hours prior to a scheduled appointment to cancel or reschedule and you miss the appointment, you are responsible for the following:
$125.00 for a regular office visit
$500.00 for an injection/procedure or EMG/NCV
There are no exceptions or waivers for this fee. Recurrent no-shows or late cancellations could result in discharge from the practice. *This is a busy specialist practice; we work on cancellation lists daily to try and accommodate other patients in serious pain. It is simply a courtesy to others experiencing extreme pain/discomfort that you let us know if you cannot make your appointment so we can move another urgent case up. Thank you for your understanding.

PAYMENTS: All co-payments, co-insurance, deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered. We accept VISA, Master Card, American Express, cash, or check. Returned checks are subject to a $40 charge.

HEALTH INSURANCE: As a courtesy, our office will bill your insurance for services you receive. It is *YOUR RESPONSIBILITY* to know your particular insurance plan benefits. You are ultimately responsible for all unpaid balances.

FMLA/DISABILITY/WORK STATUS FORMS

FORMS: There is a charge to fill out FMLA/Disability/work status forms: first page is $25 and $10 a page after. This fee will be collected at the time of your visit. These forms can **ONLY** be **completed at an in-person office visit with a provider**.

WORK STATUS: If you are injured and require work status/work restrictions for your employer, the status and/or restrictions can **ONLY be obtained at an in-person office visit with a provider**.

I, _____, have read and understand ALL of the above financial policies.

_____ _____

Patient Signature Date

Revised January 2018

MEDICAL HISTORY

Do you currently or have you ever had any of the following?

CONDITION	YES	NO
Heart Disease		
Heart Stent		
Pacemaker		
Asthma		
COPD		
Kidney Disease		
Stroke/T.I.A.		
Seizures		
Ulcers		
Esophageal Reflux (GERD)		
Dental Infections		
Sinus Infections		
Urinary Problems		

CONDITION	YES	NO
Hepatitis (list type)		
HIV/AIDS		
High Blood Pressure		
High Cholesterol		
Diabetes (list type) Type: Insulin dep:		
Thyroid Disease		
Bleeding Disorders		
Migraine Headaches		
Cancer		
Arthritis		
Other (Specify)		

ALLERGIES

Do you have any drug allergies? ☐ YES NO ☐ If yes, please list:

DRUG/MEDICATION	REACTION

Do you have any sensitivity/allergy to latex? ☐ YES NO ☐

Do you have any sensitivity or allergy to iodine/contrast dye/shell fish? ☐ YES NO ☐

MEDICATIONS/ SUPPLEMENTS

List any and all PRESCRIBED MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS, AND/OR DIETARY SUPPLEMENTS YOU ARE CURRENTLY TAKING. Please include things like fish oil, baby aspirin, and things you take on an "as needed" basis.

MEDICATION/VITAMIN/SUPPLEMENT	DOSE SIZE	FREQUENCY

PAST SURGERIES/HOSPITALIZATIONS

YEAR	SURGERY

YEAR	HOSPITALIZATION REASON

FAMILY HISTORY

FAMILY MEMBER	ALIVE	DECEASED	AGE	MEDICAL CONDITIONS (IF ANY)
FATHER				
MOTHER				
SIBLINGS				
CHILDREN				

SOCIAL HISTORY

Smoking Status	☐ current smoker (#___ cigarettes/day)	☐ former smoker (quit date: _____)	☐ never smoked	
Alcohol Use	☐ None	☐ 1-2/week	☐ 3-5/week	☐ 5+/week
Drug Abuse History	☐ Never	☐ previous	☐ current	
Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Children	☐ Yes #__ children	☐ None		
Education	☐ high school	☐ some college	☐ bachelors	☐ masters +
Employment	☐ Currently employed, occupation: _____	☐ Currently unemployed	☐ On disability	☐ Retired

REVIEW OF SYSTEMS

Are you <u>CURRENTLY</u> experiencing any of the following:

SYMPTOM	YES	NO
FEVER	☐	☐
INSOMNIA	☐	☐
LOSS OF APPETITE	☐	☐
WEIGHT GAIN	☐	☐
WEIGHT LOSS	☐	☐
JOINT ARTHRITIS	☐	☐
JOINT SWELLING	☐	☐
HEADACHES	☐	☐
SEIZURES	☐	☐
MEMORY LOSS	☐	☐
TREMORS	☐	☐
VERTIGO	☐	☐
LOSS OF SMELL	☐	☐
FATIGUE EASILY	☐	☐
SWOLLEN GLANDS	☐	☐
SEASONAL ALLERGIES	☐	☐
SINUS CONGESTION	☐	☐
CHEST PAIN	☐	☐
LEG SWELLING	☐	☐
SHORTNESS OF BREATH	☐	☐
HIVES	☐	☐
LUMPS/BUMPS ON SKIN	☐	☐
MOLES	☐	☐
SKIN RASH	☐	☐
COLD INTOLERANCE	☐	☐
EXCESSIVE SWEATING	☐	☐
EXCESSIVE THIRST	☐	☐
EXCESSIVE URINATION	☐	☐
HEAT INTOLERANCE	☐	☐

SYMPTOM	YES	NO
EAR PAIN	☐	☐
RINGING IN EARS	☐	☐
CURRENTLY PREGNANT	☐	☐
DATE OF LAST MENSTRUAL PERIOD: _____		
SEXUALLY ACTIVE	☐	☐
ABDOMINAL PAIN	☐	☐
BLOOD IN STOOL	☐	☐
CHANGE IN BOWEL HABITS	☐	☐
CONSTIPATION	☐	☐
DIARRHEA	☐	☐
DIFFICULTY SWALLOWING	☐	☐
HEARTBURN	☐	☐
NAUSEA	☐	☐
ABNORMAL BLEEDING/BRUISING	☐	☐
ANEMIA	☐	☐
ON BLOOD THINNERS	☐	☐
DIFFICULTY URINATING	☐	☐
BLURRED VISION	☐	☐
EYE PAIN	☐	☐
LIGHT SENSITIVITY	☐	☐
DEPRESSION	☐	☐
TROUBLE SLEEPING	☐	☐
SUICIDAL THOUGHTS	☐	☐
EATING DISORDER	☐	☐
WHEEZING/COUGHING	☐	☐

Pharmacy Name_____ Phone _____

Address / Location_____

Other Treating Physicians:

Chiropractor_____ Phone_____

Neurologist_____ Phone_____

Neurosurgeon_____ Phone_____

Orthopedist_____ Phone_____

Rheumatologist_____ Phone_____

Other Pain Mgmt_____ Phone_____

Cardiologist_____ Phone_____

Endocrinologist_____ Phone_____

Nephrologist_____ Phone_____

Oncologist_____ Phone_____

Physical Therapist_____ Phone_____

Other_____ Phone_____

Print Name: _____ Date: _____

Signature: _____