SPINE INSTITUTE OF ARIZONA

Acknowledgment of Receipt of Notice of Privacy Practices

I, ____, acknowledge that I have received a copy of Spine Institute of Arizona's 'Notice of Privacy Practices'. This Notice described how Spine Institute of Arizona may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____	____
Patient or Legally Authorized Individual Signature	Date
____	____
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

SPINE INSTITUTE OF ARIZONA

Documentation of Good Faith Efforts

To Obtain Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: ____

Date of Patient Encounter: ____

The patient presented to the office and was provided with a copy of the office's Notice of Privacy Practices. A good faith effort was made to obtain from the patient or patient's representative, if applicable, a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign.

☐ Patient Representative refused to sign.

☐ Patient was unable to sign or initial because:

____

____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):

____

____

Signature of Employee Completing Form: ____

Date: ______________________

Effective Date of this Notice: April 14, 2003

SPINE INSTITUTE OF ARIZONA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Spine Institute of Arizona may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Spine Institute of Arizona's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Spine Institute of Arizona reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Spine Institute of Arizona's Privacy Officer at 9735 North 90th Place, Scottsdale, Arizona 85258.

With my consent, Spine Institute of Arizona may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Spine Institute of Arizona may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Spine Institute of Arizona may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Spine Institute of Arizona restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Spine Institute of Arizona's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Spine Institute of Arizona may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____________________________________ ________________________
Patient's Printed Name Date

____
Print Name of Patient or Legal Guardian

© Spine Institute of Arizona

Edward J. Dohring, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Paul R. Gause, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Mark J. Wang, M.D.
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Allan L. Rowley, M.D.
Board Certified
Physical Medicine and Rehabilitation
Interventional Pain Management

Vibhooti H. Dave, D.O.
Board Certified
Physical Medicine and Rehabilitation
Electrodiagnostic Medicine (EMG's)

Monte D. Hessler, D.C.
Certified Chiropractic Sports Physician

Brock P. Auten, D.C.
Board Certified Chiropractic Physician
Board Certified Physiotherapist

Bill Balogh, P.A.-C.
Board Certified Physician Assistant

Donna M. Lahey, R.N.F.A.
Office Administrator
Registered Nurse First Assist

Main Office
9735 North 90th Place
Scottsdale, Arizona 85258

West Valley Office
18700 N. 64th Dr, Suite 202
Glendale, Arizona

East Valley Office
16515 South 40th Street, Suite 119
Ahwatukee, Arizona

Gilbert Office
3483 S. Mercy Rd, Suite 102,
Gilbert, AZ

Tel. 602/953.9500
Fax 602/953.1782
www.spineaz.com

Spine Institute of Arizona

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

As a patient at the Spine Institute of Arizona, you may or may not be prescribed a controlled substance. If you are prescribed a controlled substance, we ask that you agree to our controlled substance protocol. If you will not accept our protocol, we cannot treat you and you will need to work with another physician.

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but they have high potential for misuse and are therefore closely controlled by the local state and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If I am prescribed such medication, I agree to the following:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from the Spine Institute of Arizona physicians.
3. Refills of controlled substance medication:
    A. Will be made only during regular office hours Monday through Friday 8 am to 4 pm. Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription. Refill calls made on Friday will be filled on Monday.
    B. Will not be made if I "run out early." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
    C. Will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow."
4. If requested, I will bring in the containers of all medications prescribed by my physician, even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.
5. Upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be the sole discretion of the Spine Institute of Arizona to discontinue my narcotic pain medication.
6. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following my doctor's instructions regarding my health care.

Controlled substances are known to cause psychological dependence (addiction), which I understand is real. I know that some persons may develop a tolerance to medications in which my body does not respond as well to the medication, and I feel the need to have more or a higher dose of the medication. I know that I can become physically dependent on the medication. This will occur if I am on the medication several weeks, and when I stop the medication I must do so under medical supervision or I may have withdrawal symptoms.

____

____

I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from the Spine Institute of Arizona.

Patient	Date	Witness	Date

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Spine Institute of Arizona

CAUTIONS REGARDING THE USE OF LONG TERM NARCOTICS

1. Narcotics are drugs that act like morphine. These include drugs: Lortab, Percocet, Demerol, Darcon, Ultram, Tylenol #3, and others.
2. The drug you have been prescribed is extremely dangerous, capable of being abused, and an over-dose can be lethal
3. When taken in excess, the individual will first become sleepy, fall asleep, will be difficult or unable to arouse and finally, will stop breathing. The level of sedation depends upon the amount of drug ingested.
4. Keep these drugs in a locked box.
5. Be responsible for the drug. No early refill will be given.
6. These drugs can cause physical dependence. This means when you stop taking the drug you will experience a withdrawal reaction. Physical dependence occurs after approximately one week on the drug. This does not mean the drug cannot be stopped, however, it usually must be tapered in order to avoid withdrawal symptoms. A withdrawal reaction can be characterized by severe nausea, vomiting, diarrhea, abdominal pain, muscle aches, low-grade fever, tremor, rapid heart rate, sweating, and chills.
7. Physical dependence is not the same as addiction. Physical dependence means that if you stop the drug suddenly, you will develop a withdrawal reaction (nausea, diarrhea, sweats, shaky, and flu-like symptoms). Addiction is a psychological diagnosis characterized by cravings for the drug, uncontrollable use of the drug even when it causes harm to you and others.
8. There are numerous side effects, which can occur as a consequence of the use of these medications. These include:
   A. Sedation. If you experience this side effect, even slightly, you should not be driving an automobile until the effect wears off. It generally takes one to two weeks for this side effect to wear off. You should then be safe to operate an automobile. If confusion, mental changes or excessive sleepiness occur, report this to your physician or present to the nearest emergency room immediately.
   B. Constipation. If this occurs you will not adapt to this effect. You should drink eight 8 ounce glasses of water per day, take daily doses of Senokot S or Dulcolax, use milk of Magnesia no more than every third day for no bowel movement and notify your physician that you are experiencing this complication. People over the age of 60 are especially at risk for this complication.
   C. Urinary retention. This means it is difficult to start your stream. Males over the age of 60 are especially at risk for this complication.
   D. Itching. These drugs can cause itching in some patients.
   E. Sweating. Profuse sweating can occur at any time with the use of these medications.
   F. Nausea and vomiting. If this occurs, notify your physician.
   G. Decreased sex drive.
   H. Mild suppression of the immune response.

I understand these cautions and am willing to take the drugs as prescribed by my doctor.

__________________________ __________________________
Patient Date

__________________________ __________________________
Witness Date

SPINE INSTITUTE
of Arizona

9735 NORTH 90TH PLACE
SCOTTSDALE, ARIZONA 85258
PHONE: 602-953-9500
FAX: 602-953-1782

FINANCIAL STATEMENT

It is the policy of the Spine Institute of Arizona to collect co-pays and any outstanding patient balances before each visit. If you cannot pay your co-pay and any outstanding balance your appointment will be rescheduled.

We will verify that your courage is effective prior to your first visit. Our business office will bill your medical insurance for the services rendered in our office. Payment is not guaranteed by your insurance. You are ultimately responsible for all charges. The insurance process normally takes approximately 60-90 days. You will receive monthly financial statements to include any outstanding charges on your account. Once insurance has processed payment, your financial statement will reflect any deductibles and/or co-insurance due from you as per your insurance.

It is your responsibility to know and understand your insurance policy and benefits. We do see patients with OON benefits. You are responsible for your portion of any charges not covered under your OON benefits as per your insurance. We will bill secondary insurance as a courtesy.

Our providers are not contracted with any AHCCCS / Medicaid insurance programs. We do not accept any third party liability or motor vehicle insurance, nor do we accept liens. You will be responsible for outstanding balances.

If your insurance has lapsed, is inactive, or for any reason does not cover the expenses that you have incurred at the Spine Institute of Arizona, you will be responsible for the full charges that have been billed to your insurance company. Payment for these charges must be received within 30 days from receipt of your bill.

If you choose to pay by check and your check does not clear, you will be responsible for paying the bank administrative charge of $35.00 plus the amount of your original check.

If we have had no response or contact from you within 60 days to pay off your balance, the Business Office will turn your account over to our collection agency.

SELF-PAY PATIENT POLICY:
We do see patients on a self-pay basis. The charge for services will be collected prior to the service being rendered. Cash, debit card with VISA/MasterCard guarantee, or credit card payment is the only accepted form of payment for self-pay patients. Sorry, no personal checks are accepted.

INJECTIONS/SURGICAL PROCEDURE POLICY:
If you become a candidate for injections or surgery, it is our policy to collect any deductible or co-insurance that may be due in advance. Cash, debit card with VISA/MasterCard guarantee, or credit card payment are the only accepted forms of pre-payment for these services. Sorry, no personal checks are accepted. Payment must be received no later than 48 hours prior to the injection or one (1) week prior to surgery or your procedure will be cancelled. To determine any financial responsibility to the facility, please contact the facility prior to your procedure.

DISABILITY / MEDICAL LEAVE FORM POLICY:
If you need a disability / medical leave form filled out there will be a $20.00 charge for each form. By signing this agreement, you understand that you will need to prepay the $20.00 charge for this form to be completed and subsequently released.

Thank you for your understanding of our financial policies at the Spine Institute of Arizona. If you have any questions, please do not hesitate to give our Business Office a call at 602-953-9500.

____ ____________________
Patient Signature Date

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SPINE INSTITUTE *of Arizona*

Patient Name: ______________________________

Date: ______________________________________

This form must be filled out at each office visit.
We are required to have documentation of medications and allergies for each office visit; because of this we are unable to accept "no change" or "same as before" answers on this form.

Medications currently taking **Dosage** **Frequency**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

Allergies:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

Pharmacy:

Name: ____

Address: _______________________________________

Phone: ____

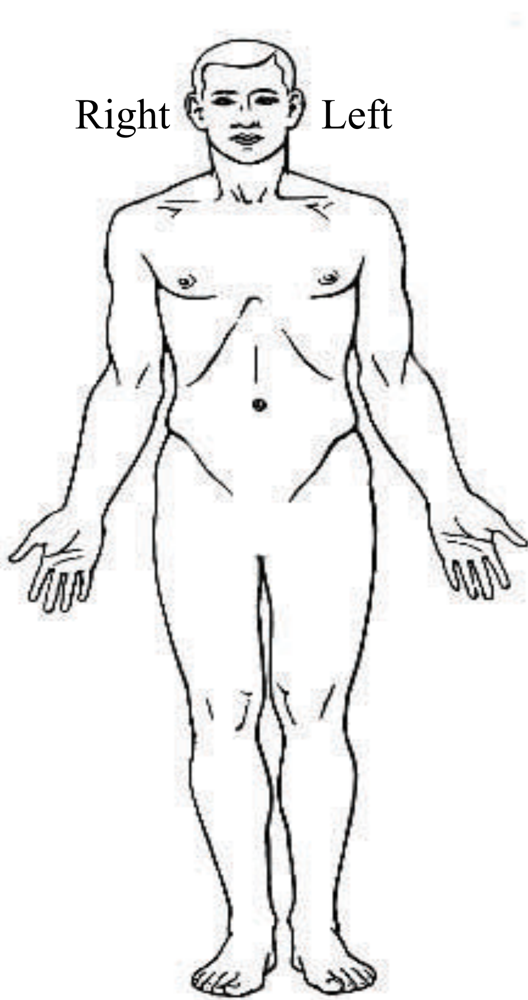
EMG Pain Diagram

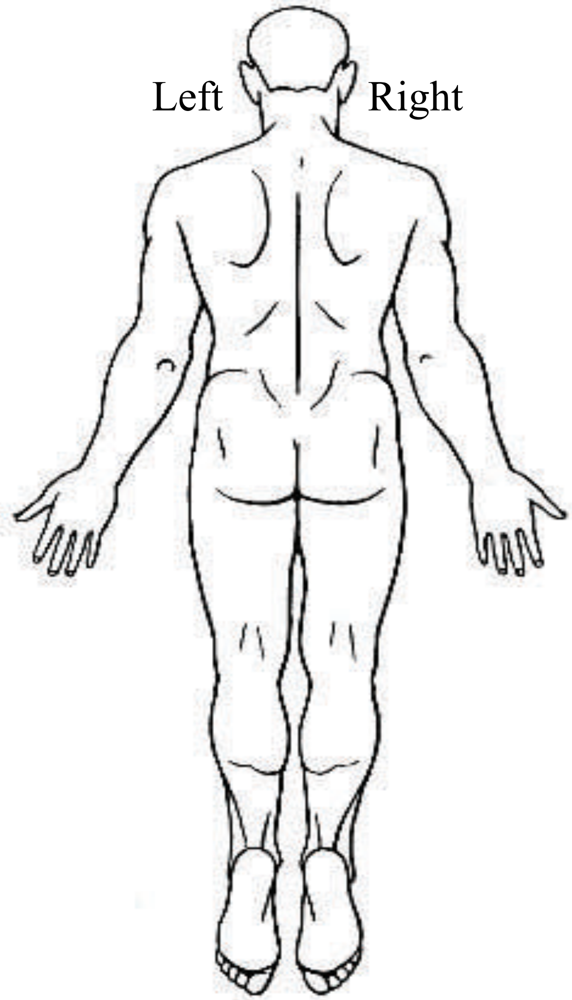
SPINE INSTITUTE *of Arizona*

Patient Name: ______________________________

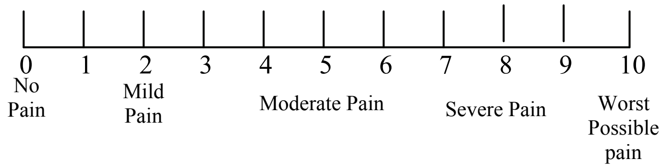
Date: ______________________________________

Please mark an "X" on the body part(s) where you have pain.
Mark a "0" on the body parts where you have numbness.

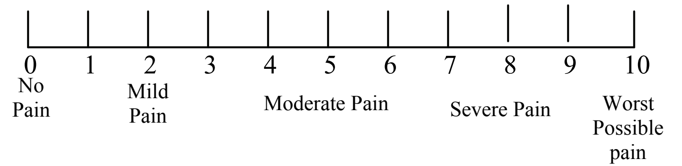




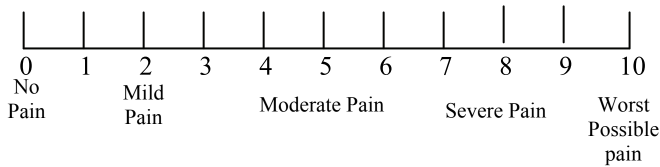
NECK



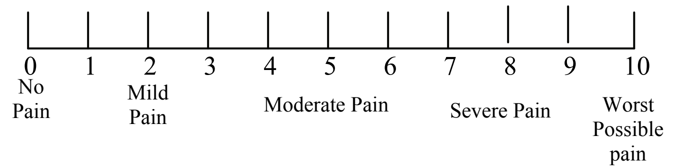
BACK



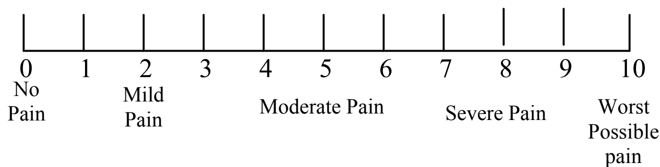
RIGHT ARM



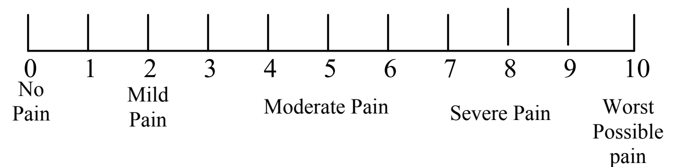
RIGHT LEG



LEFT ARM



LEFT LEG



REVIEW OF SYMPTOMS

In the past month, have you experienced any of the following?
Please put a check mark in front of any/all of the following that you have experienced.
If you have experienced any of the symptoms, please be sure to notify your family doctor.

H.E.E.N.T.

- ☐ Blurred vision
- ☐ Dry Eyes
- ☐ Hard of hearing
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Cough
- ☐ Other_______________

PULMONARY

- ☐ Shortness of breath
- ☐ Other________

ABDOMINAL

- ☐ Abdominal Pain
- ☐ Other_______________

INTEGUMENTARY

- ☐ Moles
- ☐ Skin Rash
- ☐ Other:______________

NEUROLOGIC

- ☐ Tremors
- ☐ Other:________________

GASTROINTESTNAL

- ☐ Abdominal Pain
- ☐ Other______________________

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Other__________________

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Stress
- ☐ Poor sleep
- ☐ Swelling of feet
- ☐ Swollen glands
- ☐ Problems with blood clots
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other_________________

PAST MEDICAL HISTORY: (Please circle any/all of the following that you have experienced.)

AIDS
Anemia
Anxiety Problem
Arthritis
Asthma
Bipolar Disease
Cancer
Colon Polyp
Congestive Heart Failure
COPD/Emphysema
Deep Venous Thrombosis
Depression
Diabetes
Diverticulosis
Ear Trouble
Endometriosis
Enlarged Prostate
Fibromyalgia
Gastritis
Glaucoma
Gout
Head Injury
Heart Attack/Angina
Hepatitis C
High Blood Pressure
HIV
Irregular Heart Beat
Irritable Bowel Syndrome
Jaundice
Kidney Disease
Kidney Stones
Liver Disease
Lupus

Other Medical Problems: ____