

PATIENT REGISTRATION FORM

IF FORM IS NOT COMPLETE WE CANNOT BILL YOUR INSURANCE

ACCOUNT # _____

Billing Code: _____ Resp Dr. # _____ New Pt. Update

PATIENT NAME: _____ RESPONSIBLE PARTY FOR MINOR: _____

ADDRESS: _____ APT # _____ CITY, ST, ZIP: _____

PRIMARY PH: _____ CELL / ALT PH: _____ EMAIL: _____ SEX: Male Female

PT. SS # _____ RESP PARTY SS #: _____ RELATIONSHIP TO PT: Self Spouse Parent Other

BIRTHDATE: _____ AGE: _____ REFERRED BY: _____

PRIMARY CARE PHYSICIAN & ADDRESS: _____

IF INJURY IS RELATED TO AN ACCIDENT, Was it an: Auto Accident Job Related Injury DATE OF INJURY: _____

IS PATIENT: SINGLE MARRIED OTHER IS PATIENT: EMPLOYED STUDENT RETIRED

PT. EMPLOYER NAME AND ADDRESS: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

PHONE / ADDRESS OF PERSON ABOVE: _____

WHAT ARE YOU BEING SEEN FOR: _____ FIRST DATE OF SYMPTOMS: _____

ALLERGIES: _____ ARE YOU PREGNANT? Yes No

INSURANCE INFORMATION:

INDUSTRIAL / WORKMAN'S COMPENSATION

PRIMARY INSURANCE
INSURANCE CO. NAME: _____

SECONDARY INSURANCE:
INSURANCE CO. NAME: _____

INS CO. ADDRESS: _____

INS CO. ADDRESS: _____

POLICY HOLDER NAME: _____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PT: _____

RELATIONSHIP TO PT: _____

EMPLOYER: _____

EMPLOYER: _____

POLICY NO. _____ GROUP/CLAIM NO.: _____

POLICY NO. _____ GROUP/CLAIM NO.: _____

POLICY HOLDER SEX: F M BIRTHDATE: _____

POLICY HOLDER SEX: F M BIRTHDATE: _____

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS: I hereby authorize this physician/clinic to release and/or obtain any information required in the course of my examination or treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I also authorize records to be mailed to me upon my verbal request.

SIGNED (patient or parent, if minor): _____ **DATE:** _____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

SIGNED: _____ **DATE:** _____

AUTHORIZATION TO TREAT MINOR: I hereby authorize the physician (s), physician assistants, technicians or other authorized medical personnel of Spine Institute of Arizona to treat the above patient.

SIGNED Patient (or Legal Guardian): _____ **DATE:** _____



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: _____



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**

9735 North 90th Place
Scottsdale, Arizona 85258
TEL 602/953.9500
FAX 602/953.1782

**Authorization for Disclosure of My Health Information to
My Spouse / Significant Other / Parent / Family Member**

I, _____, hereby authorize that my Spouse / Significant Other / Parent / Family Member(s) may obtain or receive copies of my Protected Health Information to include, but is not limited to; office notes, prescriptions, imaging films.

Unless I revoke this authorization earlier, this authorization will expire six years from the date signed.

Name(s) of Spouse/Significant Other/Parent/Family Member(s)

Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE NOTE: *Your Spouse/Significant Other/Parent/Family Member(s) will be required to show legal I.D. prior to being able to obtain your Protected Health Information.*

Signature of Patient or Legal Guardian

Date

Patient or Legal Guardian's Printed Name

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.

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 will bill secondary insurance as a courtesy.

Our providers are not contracted with any AHCCCS / Medicaid insurance programs. 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 \$25.00 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. The collection agency will assess a 25% collection fee due in addition to your original balance.

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



Spine Institute of Arizona

CAUTIONS REGARDING THE USE OF LONG-TERM NARCOTICS

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.
*Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon*

John H. Faryna, M.D.
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Interventional Pain Management*

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

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

Bill Balogh, P.A.
Physician Assistant

Jennifer R. Watry, PA-C
Certified Physician Assistant

Donna M. Lahey, R.N.F.A.
*CEO
Registered Nurse First Assist*

Megan E. Ashby, CMPE
Business Development

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

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 _____

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

Prescott Office
3655 Crossings Drive
Prescott, Arizona



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 9 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 for all prescription refill requests. Refill calls made on Friday will be filled the following week.
 - 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.

Effective April 26, 2018 all medical prescribers must comply with the 2018 Arizona Opioid Epidemic Act. This means that any medication that you are prescribed must meet the requirements of this new law. If you have been receiving medication from the Spine Institute of Arizona the quantity, dosage, or frequency of your prescription may be adjusted to meet these new requirements.

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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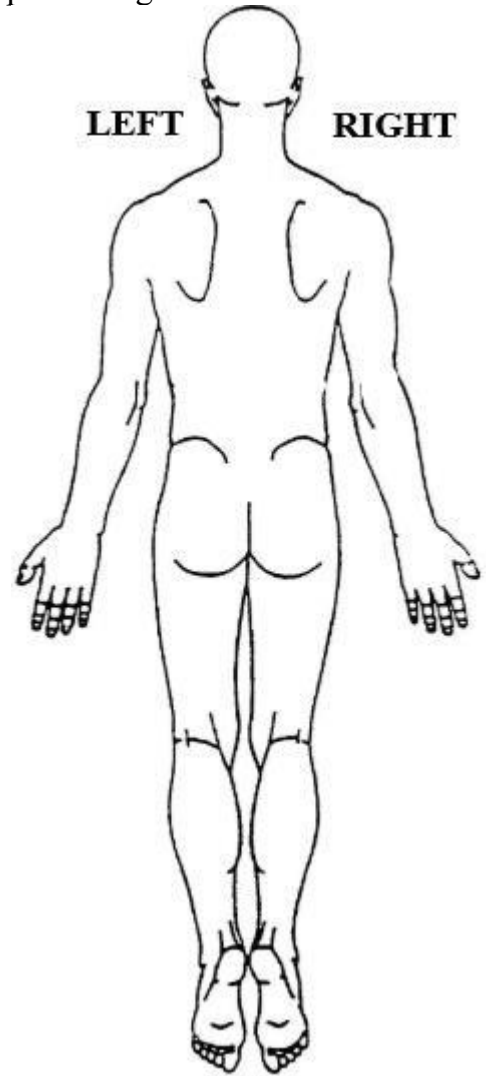
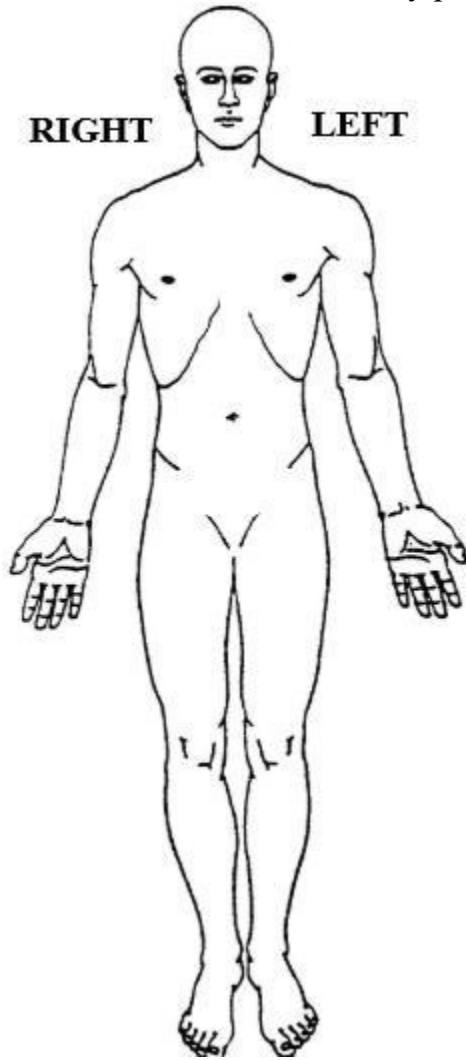
Main Office
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Scottsdale, Arizona 85258

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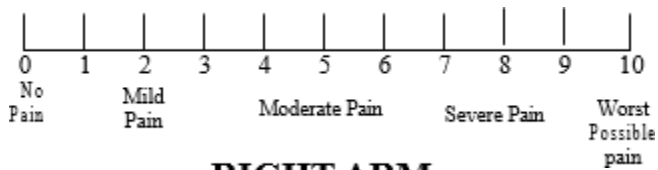
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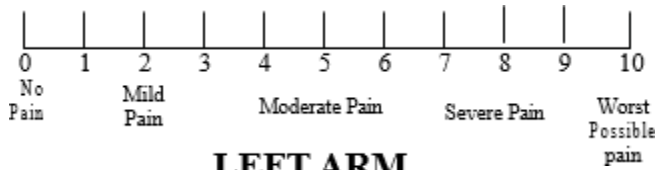
Place an "X" on the body part(s) where you are experiencing pain.
Place a "0" on the body part(s) where you are experiencing numbness.



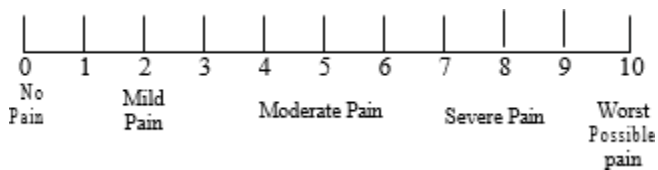
NECK



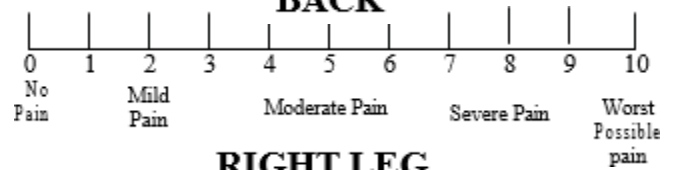
RIGHT ARM



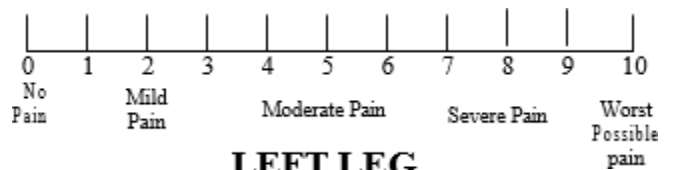
LEFT ARM



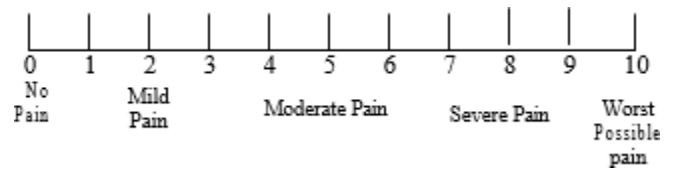
BACK



RIGHT LEG



LEFT LEG



SYMPTOM REVIEW

Have you experienced any of the following conditions in the past month?
If so, please place a check mark in front of any/all of the following you have experienced.
If you have experienced any of these symptoms, please consult with 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: _____

GASTROINTESTINAL

- Abdominal pain
- Other: _____

CARDIOVASCULAR

- Chest pain
- Other: _____

GENERAL

- Fevers
- Chills
- Night sweats
- Stress
- Poor sleep
- Swelling of feet
- Swollen glands
- Problem with blood clots
- Weight loss
- Weight gain
- Other: _____

CURRENT WORK STATUS

- Full Time
- Regular Duty
- Other: _____
- Restrictions: _____

Patient Name: _____

Date: _____

**This form must be fully completed at each office visit.
We are required to have documentation of medications and allergies for each office visit.
Due to those requirements, we are unable to accept forms with “no change” or “same”
answers on this form.**

CURRENT MEDICATIONS

DOSAGE

FREQUENCY

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

ALLERGIES

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

PHARMACY

Pharmacy Name:
Address:
Phone:

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Birthplace: _____

Reason for your visit: Pain Disability Medication Other: _____

Have you been seen here within the past 3 years? YES NO

Hand Dominance: Left Right

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

- | | | | |
|--------------------------|-------------------|--------------------------|-----------------------------------|
| AIDS | Depression | Heart Attack/Angina | Pacemaker |
| Anemia | Diabetes | Hepatitis C | Peripheral Vascular Disease |
| Anxiety Problem | Diverticulosis | High Blood Pressure | Polio |
| Arthritis | Ear Trouble | HIV | Psychological/Psychiatric Problem |
| Asthma | Endometriosis | Irregular Heartbeat | Rheumatic Fever |
| Bipolar Disease | Enlarged Prostate | Irritable Bowel Syndrome | Scoliosis |
| Cancer Type: _____ | Fibromyalgia | Jaundice | Seizures |
| Colon Polyp | Gastritis | Kidney Disease | Sexually Transmitted Disease |
| Congestive Heart Failure | Glaucoma | Kidney Stones | Stroke |
| COPD/Emphysema | Gout | Liver Disease | Thyroid Disease |
| Deep Venous Thrombosis | Head Injury | Lupus | Tuberculosis |
| | | Osteoporosis | Ulcers |

Other Medical Problems: _____

Allergies: _____

Injuries: Please list all fractures, injuries, and motor vehicles accidents.

Year Injured	Nature of Injury	Year Injured	Nature of Injury
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations/Surgeries:

Year	Reason for Hospitalization/Surgery	Year	Reason for Hospitalization/Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please continue the other side

Have you ever had a blood transfusion? YES NO

SOCIAL HISTORY:

Do you smoke now? NO YES _____ packs/day _____ # of yrs.

Did you smoke in the past? NO YES _____ packs/day _____ # of yrs.

Do you drink alcohol? NO YES _____ number of drinks/wk.

Do you have a history of drug/ alcohol abuse? NO YES

Your level of education: Grade School Associates degree Graduate School
 High School Bachelor’s degree

FAMILY HISTORY:

Please check the box of any/all the following problems that your blood relatives (e.g., parents, brothers, sisters, grandparents, aunts, uncles, children), have had:

<u>Illness</u>	<u>Relative/Family Member (i.e., Mom, Grandfather)</u>
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Back or Neck Surgery	_____
<input type="checkbox"/> Back Pain/Sciatica	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Attack/Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Muscle Disease	_____
<input type="checkbox"/> Neck Pain	_____
<input type="checkbox"/> Nerve Disease	_____
<input type="checkbox"/> Stroke	_____

Relation	Age	State of Health/ Medical Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				



PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

JOB DESCRIPTION

Occupation: _____ Number of years at this job: _____

Are you currently working? YES NO If yes: Part-time Full-time

Regular Duty Modified Duty Hours per week: _____

What are your restrictions, if any? _____

Does your job require you to: (please check all that apply)?

- lift or carry greater than 15 lbs.?
- bend or twist repetitively?
- work overhead?
- use repetitive motion of the arms or legs?

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date problem/symptoms began: _____

Location of symptoms/pain when the problem began: _____

HOW DID THE PROBLEM START?

Home/Leisure At Work Motor Vehicle Accident Fall Other: _____

Please briefly describe: _____

Location of symptoms/pain now: _____

Frequency of symptoms/pain: (please check one)

CONSTANT INTERMITTENT RARE

Since the onset of symptoms, has the problem: (please check one)

IMPROVED WORSENERD NO CHANGE

Does coughing or sneezing cause any pain? YES NO

If so, where? _____

Do any of the following activities make your symptoms worse? (please check all that apply)

- WALKING LYING BENDING/TWISTING WORKING OVERHEAD
- SITTING KNEELING LIFTING/CARRYING OTHER: _____
- STANDING TYPING PUSHING/PULLING

List anything (i.e. activities, positions, or treatments) that make the pain better:

Do you have any weakness, if so, which arm, leg or muscle? _____

Have you had any new or recurrent problems with: Control of urination? YES NO
Bowel movements? YES NO

Have you experienced recent weight loss or fevers? YES NO

Please continue the other side ♡

HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

<u>TEST</u>	<u>RECEIVED</u>	<u>DATE OF TEST/LOCATION</u>
X-ray	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
MRI	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
CT Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Bone Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
EMG	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

MEDICATIONS

(If yes, please circle the medication below.)

Anti-Inflammatories or
Cox-2 Inhibitors

EXAMPLES

Naprosyn, Ibuprofen, Vioxx
Voltaren, Celebrex, Bextra

RECEIVED

YES NO

DID THIS HELP?

YES NO

Muscle Relaxers

Soma, Flexeril, Skelaxin, Zanaflex

YES NO

YES NO

Pain Medication

Tylenol w/ Codeine, Vicodin,
Darvocet, Percocet

YES NO

YES NO

Oral Steroid

Prednisone, Medrol Dose Pak,

YES NO

YES NO

MAOI/SSOI

Zonegram, Nerutonin,
Amitriptyline, Nortriptyline

YES NO

YES NO

Other

Please list: _____

YES NO

YES NO

TREATMENTS

Physical Therapy/ Exercise

RECEIVED

YES NO

DID THIS HELP?

YES NO

Chiropractic Care

YES NO

YES NO

Injections in Muscle or other injections in office

YES NO

YES NO

Epidural Steroid Injections

YES NO

YES NO

Facet Blocks

YES NO

YES NO

Braces/Corsets

YES NO

YES NO

Back Surgery: Cervical Thoracic Lumbar

When: _____

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine? YES NO *If yes, please list...*

PHYSICIANNNAME

MONTH/YEAR OF TREATMENT

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? YES NO

If yes, please list your attorney's name: _____

Name: _____ Age: _____ Date: _____

IMPORTANT – PLEASE READ ENTIRELY: This questionnaire is designed to allow us to understand how much your low back has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just circle the one which most closely describes your problem *right now*.**

SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any washing and dressing without help.
- F. Because of pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very little weights, at the most.

SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
- B. I have some pain with walking, but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevent me from walking more than ½ mile.
- E. I can only walk while using a cane or crutches.
- F. I am in bed most of the time and must crawl to the toilet.

SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevent me from sitting more than one hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

SECTION 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away.

SECTION 7 – Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- C. Because of pain, my normal night’s sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night’s sleep is reduced by less than one-half.
- E. Because of pain, my normal night’s sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal but increases the degree of my pain.
- C. Pain has no significant effect on my social life aside from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from a social life at all.

SECTION 9 – Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
- D. I get extra pain while traveling which compels me to seek alternate forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

LUMBAR INDEX SCORE: _____

PATIENT SIGNATURE: _____



AUTHORIZATION FOR SPINE INSTITUTE OF ARIZONA TO USE OR DISCLOSE MY MEDICAL INFORMATION

Entity Releasing Information		Entity Receiving Information	
Facility: _____		Entity/Individual: _____	
Address: _____		Address: _____	
City, State	Zip Code	City, State	Zip Code
Fax: _____	Phone: _____	Fax: _____	Phone: _____

Patient Information:	Patient Name: _____ Date of Birth: _____
	Address: _____ Phone Number: _____
	SSN: _____
Dates Requested:	FROM: _____ TO: _____

There May be a FEE Associated with your Request for Records

Records Being Requested:	<input type="checkbox"/> My Authorization- You may use or disclose the following health care information (check all that apply): <input type="checkbox"/> All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care / Psychiatric Care / Psychotherapy Notes, Alcohol and/or Drug Abuse Treatment <input type="checkbox"/> All radiologic studies in Spine Institute of Arizona's possession. (I understand and agree that I am financially responsible for the following Fees associated with my request: I understand that there is a copying charge of \$7.00 per x-ray for my Spine Institute of Arizona x-rays films.) <input type="checkbox"/> All of my health information except the following: _____ <input type="checkbox"/> Other Records: <input type="checkbox"/> Billing Record
	THIS AUTHORIZATION EXPIRES ON DATE: _____ <i>Per HIPAA Regulation an authorization for disclosure of Protected Health Information MUST have an expiration date. Your expiration date may not exceed six years from the initial date of authorization.</i>

Delivery of Records:	Paper Requests <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Fax Electronic Requests: <input type="checkbox"/> Patient Portal <input type="checkbox"/> CD (Complete ONLY if requesting records via Patient Portal)																																								
	<table border="1" style="width:100%; text-align: center; border-collapse: collapse;"> <tr> <td colspan="20">Email Address for Patient Portal</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	Email Address for Patient Portal																																							
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Purpose:	<input type="checkbox"/> Self <input type="checkbox"/> Continuing Care <input type="checkbox"/> Other (please specify): _____																																								

My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a dated letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect it.

I understand that this office has requested this authorization, I have a right to inspect or copy the information to be used or disclosed.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of patient

Relationship (parent, legal guardian, personal representative, etc)



Spine Institute of Arizona

Dear Patient,

Spine Institute of Arizona and its providers participate in an electronic health information exchange with other health care providers, hospitals, labs, and radiology centers. The Health Information Exchange, or HIE, is a way of sharing health information through secure, electronic means. With your permission our participation in the HIE does two things:

- Allows Spine Institute of Arizona to disclose our confidential health information about you to other providers who are treating you and request your information through the HIE.
- It allows other providers to electronically disclose your confidential health information to the Spine Institute of Arizona through the HIE for treatment and care coordination.

This consent is to obtain your permission to share and receive a limited summary of your medical health record from and to healthcare providers and facilities who are involved with your treatment via the HIE. The summary may include (as applicable) the following information:

- Patient Demographics
- Vital Signs
- Medications & Allergies
- Lab Tests & Results
- Procedures
- Immunizations
- Implanted Devices
- Functional Status
- Miscellaneous Orders & Advice
- Referral Information
- Diagnosis
- Care Team Members

This information is sent over the internet in a secure, encrypted and reliable way among health care professionals and it can be compared to sending a secured email. The HIE enables medical professionals to coordinate care, benefitting both providers and patients. Your choice to opt-out of the HIE will not affect your ability to access medical care. Opting out will not prevent Spine Institute of Arizona from sharing your health information with authorized entities when necessary or required by federal and state law. If you chose to opt out of the HIE the Spine Institute of Arizona will still have the authority to use and disclose protected health information to carry out treatment, payment and healthcare operations through other non-HIE mediums to coordinate your treatment.

- Opt-In - The Spine Institute of Arizona may share and receive my health information via the HIE
- Opt-Out – The Spine Institute of Arizona may not share or receive my health information through the HIE

Patient Name

Date

Patient Signature

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Fellowship Trained Spine Surgeon*

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Glendale, Arizona

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Ahwatukee, Arizona

Prescott Office
3655 Crossings Drive
Prescott, Arizona



Spine Institute of Arizona

Dear Patient:

We are pleased to announce that the Spine Institute of Arizona Patient Portal is now available. This online tool gives you the flexibility to access your health information and other resources at your leisure – any time of day and from any location.

As a patient of Spine Institute of Arizona enrolling in the Patient Portal will allow you to:

- Update your personal information
- View medications, allergies and vital signs
- Send and receive direct messages with your provider
- View certain chart documents
- Upload files to your medical record
- Share portal documents to other health providers you select
- We are always working on new enhancements to the portal and new features will be added as they become available.

Also, the Patient Portal is completely secure, so you can be confident that your private information is protected.

Please enroll me in the patient portal. A portal invitation will be sent to my email address that I provide below.

Patient Name Date

Email

Patient Signature

I elect to Opt-out of the patient portal at this time.

Patient Name Date

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