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: _____

INS CO. ADDRESS: _____

_____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PT: _____

EMPLOYER: _____

POLICY NO. _____ GROUP/CLAIM NO.: _____

POLICY HOLDER SEX: ☐ F ☐ M BIRTHDATE: _____

SECONDARY INSURANCE:
INSURANCE CO. NAME: _____

INS CO. ADDRESS: _____

_____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PT: _____

EMPLOYER: _____

POLICY NO. _____ GROUP/CLAIM NO.: _____

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: _____

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

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

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.

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

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.
Board Eligible Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

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)

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

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 overdose 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_____

Edward J. Dohring, M.D.
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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. prescription. 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_____

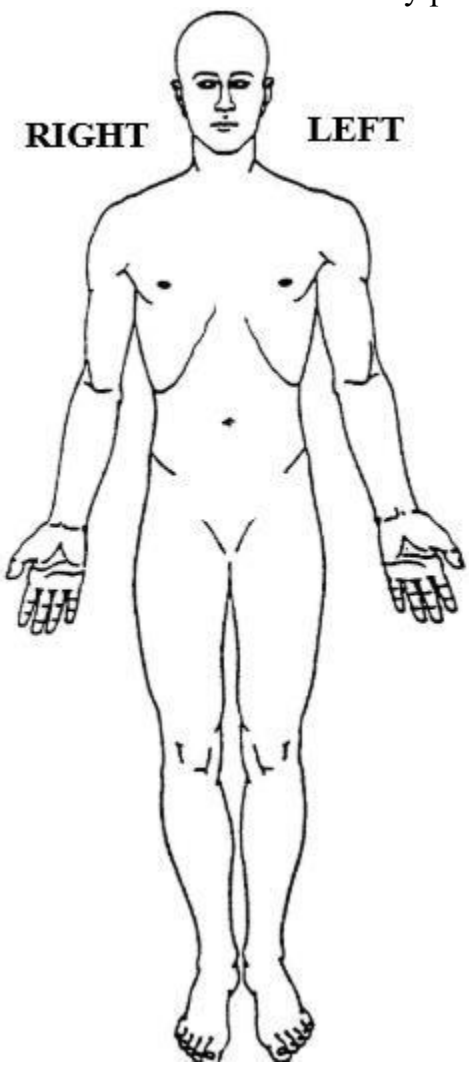
Witness_____ Date_____

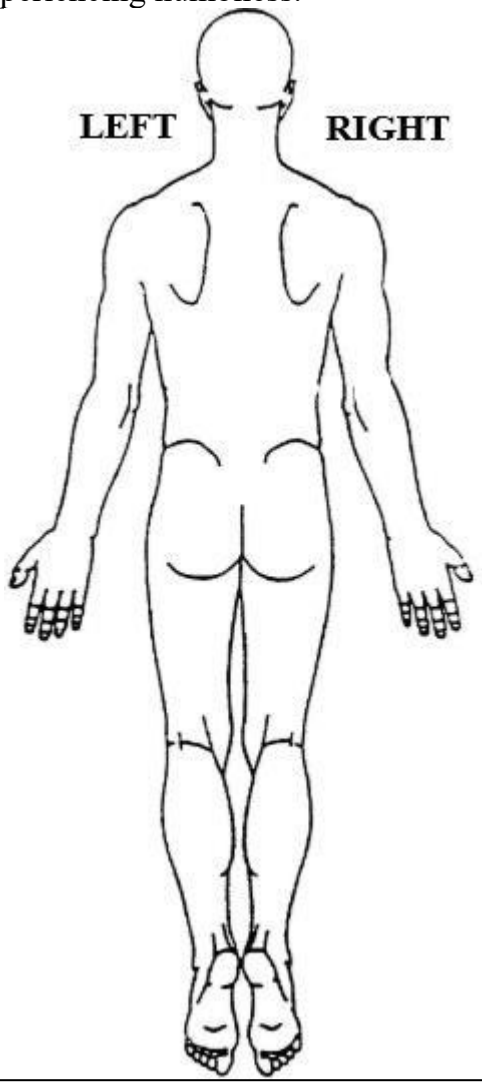
SPINE INSTITUTE *of Arizona*

Patient Name: _____

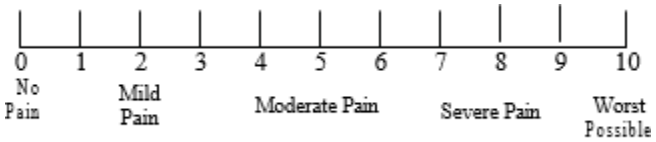
Date: _____

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.

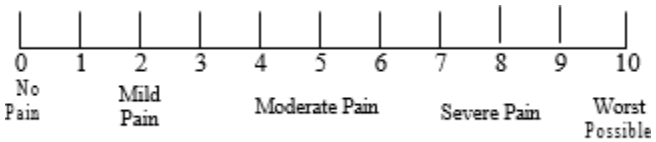




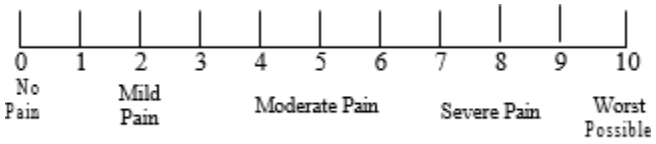
NECK



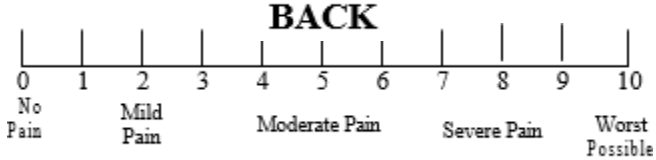
RIGHT ARM



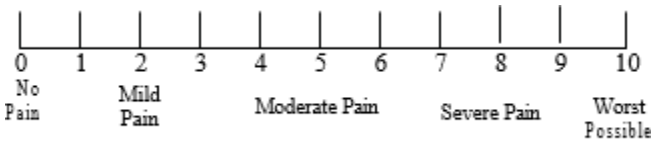
LEFT ARM



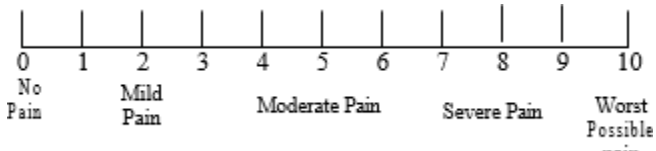
BACK



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: _____

_____

_____

_____

SPINE INSTITUTE of Arizona

Patient Name: _____

Date: _____

This form must be <u>fully completed</u> 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:

SPINE INSTITUTE of Arizona

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
Anemia
Anxiety Problem
Arthritis
Asthma
Bipolar Disease
Cancer Type: _____
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 Heartbeat
Irritable Bowel Syndrome
Jaundice
Kidney Disease
Kidney Stones
Liver Disease
Lupus
Osteoporosis
Pacemaker
Peripheral Vascular Disease
Polio
Psychological/Psychiatric Problem
Rheumatic Fever
Scoliosis
Seizures
Sexually Transmitted Disease
Stroke
Thyroid Disease
Tuberculosis
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 ☛

Patient Signature: _____

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 ❒ High School ❒ Associates degree ❒ Bachelor's degree ❒ Graduate School

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:

Illness	**Relative/Family Member (i.e., Mom, Grandfather)**
❒ Arthritis	
❒ Back or Neck Surgery	
❒ Back Pain/Sciatica	
❒ Cancer	
❒ Diabetes	
❒ Heart Attack/Heart Disease	
❒ High Blood Pressure	
❒ Mental Illness	
❒ Muscle Disease	
❒ Neck Pain	
❒ Nerve Disease	
❒ Stroke	

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

Patient Signature: _____

SPINE INSTITUTE *of Arizona*

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 ❒ WORSENED ❒ 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 ☛

PATIENT SIGNATURE: _____

HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

TEST	RECEIVED	DATE OF TEST/LOCATION
X-ray	❒ YES ❒ NO	
MRI	❒ YES ❒ NO	
CT Scan	❒ YES ❒ NO	
Bone Scan	❒ YES ❒ NO	
EMG	❒ YES ❒ NO	
Other:_____	❒ YES ❒ NO	

MEDICATIONS *(If yes, please circle the medication below.)*	EXAMPLES	RECEIVED	DID THIS HELP?
Anti-Inflammatories or Cox-2 Inhibitors	Naprosyn, Ibuprofen, Vioxx Voltaren, Celebrex, Bextra	❒ YES ❒ NO	❒ 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
	Prozac, Elavil, Paxil, Pamelor		
Other *Please list:* _____		❒ YES ❒ NO	❒ YES ❒ NO

TREATMENTS	RECEIVED	DID THISHELP?
Physical Therapy/ Exercise	❒ YES ❒ NO	❒ 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…*

PHYSICIANNAME	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:_____

PATIENT SIGNATURE: _____

SPINE INSTITUTE of Arizona

C E R V I C A L

Name: _____ Age:_____ Date: _____

Please read: This questionnaire is designed to enable us to understand how much your neck pain 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. I have no pain at the moment.
B. The pain is mild at the moment.
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 (Washing, Dressing, etc.)**
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

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 but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very heavy weights.
F. I cannot lift or carry anything at all.

SECTION 4 – **Reading**
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – **Headache**
A. I have no headaches at all.
B. I have slight headaches which come frequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – **Concentration**
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 – **Work**
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – **Driving**
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my care at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – **Sleeping**
A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 - **Recreation**
A. I am able to engage in all recreational activities with no pain in my neck at all.
B. I am able to engage in all recreational activities with some pain in my neck.
C. I am able to engage in most, but not all recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain In my neck.
F. I cannot do any recreational activities at all.

CERVICAL index score: _____

PATIENT SIGNATURE: _____

SPINE INSTITUTE
of Arizona

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

Entity Releasing Information	
Facility:	
Address:	
City, State	Zip Code
Fax:	Phone:

Entity Receiving Information	
Entity/Individual:	
Address:	
City, State	Zip Code
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:	☐ My Authorization- You may use or disclose the following health care information (check all that apply): ☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavorial Health Care / Psychiatric Care / Psychotherapy Notes, Alcohol and/or Drug Abuse Treatment ☐ 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.) ☐ All of my health information except the following: _____ _____ ☐ **Other Records:** ☐ Billing Record THIS AUTHORIZATION EXPIRES ON DATE:_____ *Per HIPAA Regulation an authorization for disclosure of Protected Health Information MUST have an expiration date. Your expiration date may not exceed six years form the initial date of authorization.*
Delivery of Records:	**Paper Requests** ☐ Mail ☐ Pick Up ☐ Fax **Electronic Requests:** ☐ Patient Portal ☐ CD **(Complete ONLY if requesting records via Patient Portal)** **Email Address for Patient Portal**
Purpose:	☐ Self ☐ Continuing Care ☐ 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 receive s 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)

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

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Interventional Pain Management

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Physician Assistant

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

Jennifer R. Watry, PA-C
Certified Physician Assistant

Megan E. Ashby, CMPE
Business Development

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

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

Spine Institute of Arizona

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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