

# 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: \_\_\_\_\_

## INSURANCE INFORMATION:

ARE YOU PREGNANT?  Yes  No

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:** \_\_\_\_\_

## **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 \$40.00 charge for each form. By signing this agreement, you understand that you will need to prepay the \$40.00 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

## CONTROLLED SUBSTANCES

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 require 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:

**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*

**Ryan J. Godinsky, M.D.**  
*Board Certified Orthopaedic Surgeon*  
*Fellowship Trained Spine Surgeon*

**Keven S. Burns, 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*

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

**Jennifer R. Watry, PA-C**  
*Certified Physician Assistant*

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

1. I am responsible for my controlled substance medications. If the medication is lost, misplaced, or stolen, or used up sooner than prescribed, I understand it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or 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. Refills requested on Friday will be filled the following week.
4. 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.
5. 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. If confusion, mental changes or excessive sleepiness occur, report this to your physician or present to the nearest emergency room immediately.
  - B. Constipation. Notify your physician if you are experiencing constipation. People over the age of 60 are especially at risk for this complication. You should aim towards consuming eight 8-oz glasses of water per day. In addition, you make take daily doses of Senokot-S or Dulcolax. Alternatively, Milk of Magnesia may be used once every three days (follow package instructions). Continue in the manner until bowel movement is achieved.
  - C. Urinary retention. 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.

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 and I understand the above cautions and 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



**SPINE INSTITUTE OF ARIZONA**

I acknowledge that I have received a copy of SpineInstitute 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 healthcareinformation, and rights I may have regarding my 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 any time. 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 90<sup>th</sup> Place, Scottsdale, Arizona 85258.

With my consent, Spine Institute of Arizona may call, mail or email 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. 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.

I hereby authorize that my Spouse / Significant Other / Parent / Family Member(s) listed below 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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

# Pain Diagram

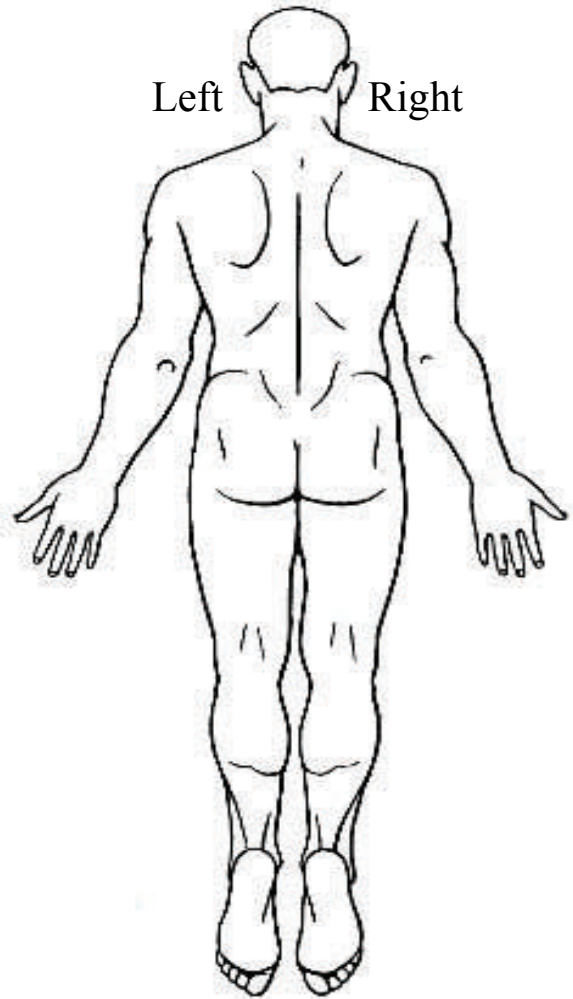
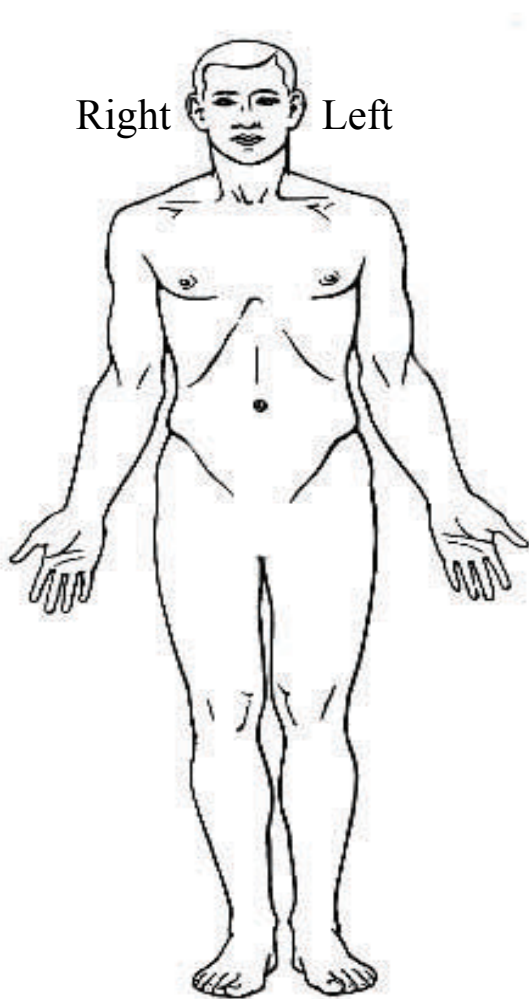


**SPINE INSTITUTE**  
*of Arizona*

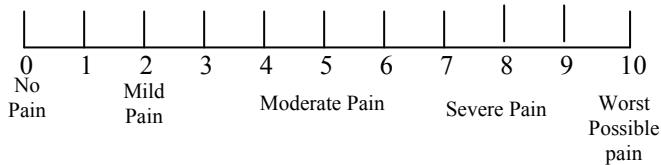
**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

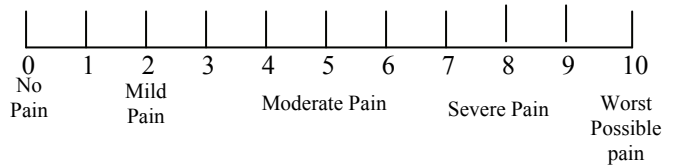
Please mark an "X" on the body part(s) where you have pain.  
Mark a "0" on the body parts where you have numbness.



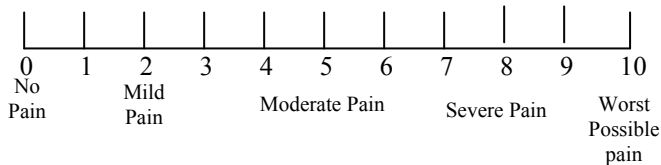
## NECK



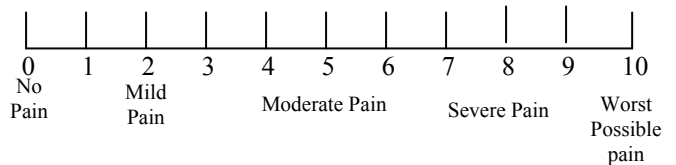
## BACK



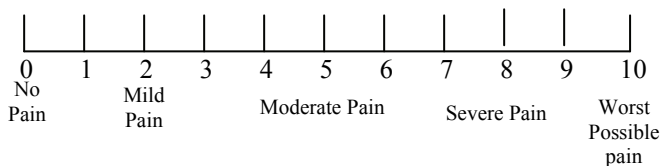
## RIGHT ARM



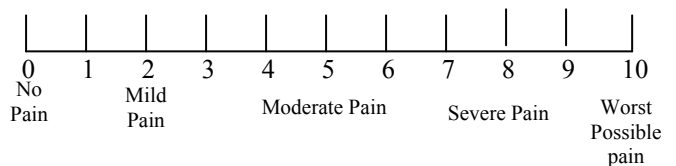
## RIGHT LEG



## 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: \_\_\_\_\_

## GASTROINTESTINAL

- 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 \_\_\_\_\_

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### **PAST MEDICAL HISTORY:**

(Please circle any/all of the following that you have experienced.)

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

Other Medical Problems: \_\_\_\_\_

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: