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**: _____

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

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 you chose to pay by credit card your payment will be subject to a 3% processing fee.

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 onlyaccepted 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 $50.00 charge for each form. By signing this agreement, you understand that you will need to prepay the $50.00 charge for this form to be completed and subsequently released.

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

_____ _____

Patient Signature Date

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Fellowship Trained Spine Surgeon

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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

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:

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 dat. 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 90th 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

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: _____

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: _____

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 ____ Former Smoker____ packs/day __ # of yrs.

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

Do you use Marijuana/THC ❒ 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:

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

REVIEW OF SYSTEMS

Please circle of any of the below conditions if you have experienced them in the last month. (*If you have experienced any of these symptoms, please consult with your family doctor.)*

HEENT

Visual changes

Hearing loss

Sore throat

Cough

Other: _____

PULMONARY

Shortness of breath

Other:

_____

ABDOMINAL

Abdominal pain

Other: _____

INTEGUMENTARY

Moles

Skin rash

Other:_____

NEUROLOGIC

Tremors

Other:

_____

GASTROINTESTINAL

Abdominal pain

Abdominal pain

Other:

_____

CARDIOVASCULAR

Chest pain

Other:

_____

GENERAL

Fevers

Chills

Night sweats

Swelling of feet/hands

Swollen glands

Weight loss

Weight gain

Other:

_____

SPINE INSTITUTE of Arizona

PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

JOB DESCRIPTION

Are you currently working? Yes / No Occupation: _____

Regular duty _____ Modified Duty _____ Hours per week _____

What are your restrictions, if any? _____

Does your job require you to (circle all that apply) :

Lift/carry greater than 15 pounds — Bend/twist repetitively

Work overhead — Repetitive motion of the arms or legs

HISTORY OF CURRENT CONDITION

Date of onset of symptoms: _____ Description of injury: _____

Frequency of symptoms (circle one): Constant / Intermittent / Rare

Since the onset of symptoms, has the problem (circle one) Improved / Worsened / Unchanged

Have you seen a physician for the current condition in the past? Yes / No

Do any of the following activities exacerbate your symptoms (circle all that apply)?

Walking	Lying	Bending/Twisting	Working Overhead
Sitting	Kneeling	Lifting/carrying	Other: _____
Standing	Computer work	Pushing/pulling	

List any activities, positions or treatments that improve your pain. _____

_____

Do you have any weakness? Where? _____

Do you have any new or recurrent problems with bowel/bladder? Please specify. _____

Are you represented by an attorney for this injury? Yes / No Atty's name: _____

HISTORY OF TREATMENT FOR CURRENT CONDITION

DIAGNOSTIC STUDIES (please list date and facility)

Xrays _____ MRIs _____

CT scan _____ Bone Scan _____

EMG _____ Other _____

MEDICATIONS (Please list all prior medications for current condition and whether they helped or not)

Anti-inflammatories or Cox-2 inhibitors (i.e. Naprosyn, ibuprofen, Vioxx, Voltaren, Celebrex, Bextra) _____

Muscle Relaxers (i.e. soma, Flexeril, Skelaxin, Zanaflex) _____

Pain Meds (i.e., Tylenol w/codeine, Vicodin, Darvocet, Percocet) _____

Oral Steroids (i.e., prednisone, Medrol Dosepak) _____

MAOI/SSOI (i.e., Zonegran, Neurontin, Amitriptyline, Nortriptyline) _____

Other _____

TREATMENTS (circle all that apply and indication if it was helpful):

Prior Back Surgery: Cervical / Thoracic / Lumbar Date: _____

Physical Therapy _____ Chiropractic Care _____ Intramuscular injections _____

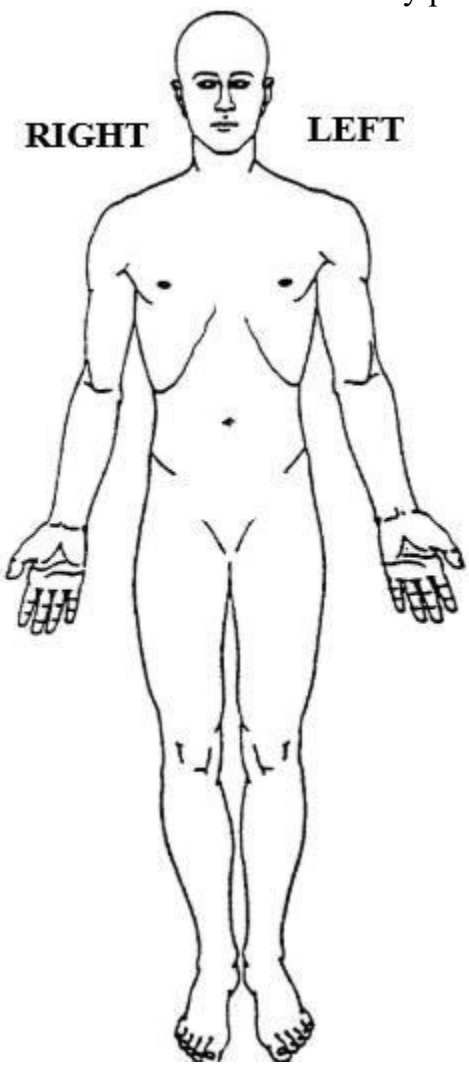
Epidural steroid injections _____ Facet Blocks _____ Braces/Corsets _____

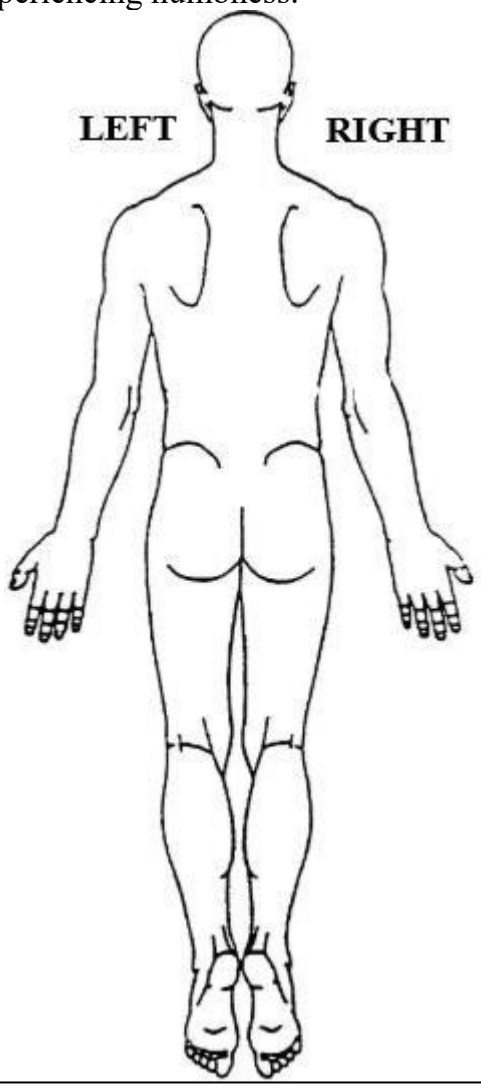
SPINE INSTITUTE *of Arizona*

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

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

BACK

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

RIGHT ARM

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

RIGHT LEG

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

LEFT ARM

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

LEFT LEG

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

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Spine Institute of Arizona

PATIENT NAME:_____ **DATE**_____

All Private Insurance Companies including Medicare now require certain protocols be followed prior to ordering Radiologic studies such as MRI's, Injections, or recommending surgery. In order to help us streamline the authorization process and to make sure we are following those guidelines, please answer the following questions:

1) **When was the last time you went to formal Physical Therapy and for how long? (Please list the month, year, and place)**

Month_____Year_____

Place Therapy Performed_____

Number of Visits_____ Length of Therapy_____

2) **Have you ever taken <u>PRESCRIBED</u> anti-inflammatory medications or muscle relaxers? (Circle your answer) Yes No**

Please provide the names of those medications and when you started and stopped taking those.

Medication Name_____

Start Date_____ End Date_____

Medication Name_____

Start Date_____ End Date_____

Medication Name_____

Start Date_____ End Date_____

3) **Have you ever had any Injections performed in your spine, what type, and where was it performed. List date (month and year) performed?(Epidural, Facet Joint etc.)**
(Circle your answer) Yes No

Type of Injection_____

Place performed_____Date_____

Type of Injection_____

Place performed_____Date_____

Type of Injection_____