



NEW PATIENT INTAKE FORM

Patient Name _____ Age _____ DOB _____
 Email _____ Height _____ Weight _____
 Name of Referring Physician: _____ Name of Primary Care Physician: _____

Reason for visit today: _____

PAIN DESCRIPTION

AVERAGE pain level: **No Pain-** 0 1 2 3 4 5 6 7 8 9 10 - **Worst**

My Pain is: Constant but changes in severity Intermittent (Comes and goes) Improving Worsening

How long have you had this pain? _____ Have you had this pain before? No Yes How long ago? _____

Was there any injury or accident? No Yes Explain: _____

Which body parts are involved?

- Neck Arm: Left Right
 Back Leg: Left Right
 Face/Head Hip: Left Right
 Overall Body Knee: Left Right

Other: _____

Check all that describe your pain today:

- Dull/Aching Sharp/Stabbing
 Cramping Pins/Needles/Tingling
 Throbbing Hot/Burning
 Squeezing Shooting/Radiating

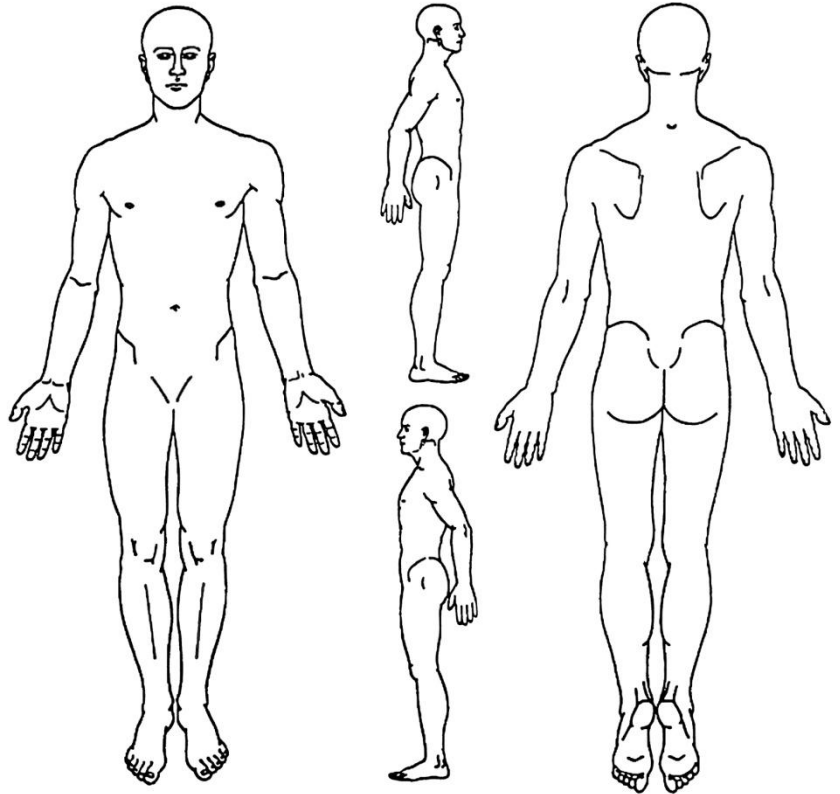
What activities make your pain WORSE?

What activities make your pain BETTER?

Mark any activities that are AFFECTED by your pain

- Enjoyment of Life Work
 Sleep Activities Daily Living
 Mood / Emotions Recreational Activity
 Other: _____

Using "X" marks, mark the diagram below to indicate the location of all of your painful areas



ASSOCIATED SYMPTOMS

Mark all of the following symptoms or conditions that you are CURRENTLY experiencing

- Numbness or tingling, Location: _____
 Weakness, Location: _____
 Joint swelling or Stiffness Aching calf or leg pain Anxiety or Depression
 Fever or Chills SWELLING of the legs Sleep apnea
 Balance problems or difficulty walking Nonhealing wounds Bladder incontinence (loss of control)
 Fatigue Varicose Veins Bowel Incontinence

NEW PATIENT INTAKE FORM



PRIOR TREATMENTS

For your current symptoms, please mark the boxes for the following imaging/studies that have been performed

X-Ray MRI CT scan Discogram EMG/NCV (nerve test) CT myelogram

Please mark the type of treatment(s) that you have had in the past and how well they worked, **OTHERWISE LEAVE BLANK:**

Injections: Better Worse No Change Type: _____

Physical Therapy: Better Worse No Change How recently? _____

Spine Surgery: Better Worse No Change Type of surgery and year? _____

Bracing: Better Worse No Change Type: _____

TENS unit: Better Worse No Change **Heat / Ice:** Better Worse No Change

Chiropractor: Better Worse No Change **Acupuncture:** Better Worse No Change

Massage: Better Worse No Change **Psychology:** Better Worse No Change

PRIOR MEDICATIONS

Please indicate which medications you have used in the past for your current pain condition (**OTHERWISE DO NOT CHECK**):

<u>ANTI-INFLAMMATORY</u>	<u>Helped?</u>	<u>NARCOTICS / OPIOIDS</u>	<u>Helped?</u>	<u>NERVE MEDICATIONS</u>	<u>Helped?</u>
Naproxen (aleve)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tramadol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gabapentin (neurontin)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ibuprofen (advil, motrin)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tylenol with codeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lyrica	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diclofenac (voltaren)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hydrocodone (Vicodin)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amitriptyline (elavil)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tylenol (acetaminophen)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Oxycodone (Percocet)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nortriptyline	<input type="checkbox"/> No <input type="checkbox"/> Yes
Celebrex	<input type="checkbox"/> No <input type="checkbox"/> Yes	Morphine, MS Contin	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cymbalta	<input type="checkbox"/> No <input type="checkbox"/> Yes
Flector patch	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hydromorphone (dilauid)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Effexor	<input type="checkbox"/> No <input type="checkbox"/> Yes
<u>MUSCLE RELAXANTS</u>	<u>Helped?</u>	Nucynta (tapentadol)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Savella	<input type="checkbox"/> No <input type="checkbox"/> Yes
Carisoprodol (soma)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Fentanyl patch	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lidoderm patch	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cyclobenzaprine (flexeril)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Methadone	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Skelaxin (Metaxolone)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Opana	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Methocarbamol (robaxin)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Suboxone	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Tizanidine (zanaflex)	<input type="checkbox"/> No <input type="checkbox"/> Yes				

ALLERGIES

Have you ever had an allergic reaction to: Iodine? Contrast? Latex? Dental Numbing Medications?

No known allergies Yes, specify: _____

PRESENT MEDICATIONS

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

Coumadin/Warfarin Plavix Xarelto Pradaxa Eliquis Brilinta

NAME OF MEDICATION	DOSE and number of pills/day	NAME OF MEDICATION	DOSE and number of pills/day
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

PAST MEDICAL HISTORY

Please document all medical history below, including any of the following medical conditions:

High Blood Pressure Kidney/Liver disease Osteoporosis Depression Anxiety disorder
 Diabetes Rheumatoid arthritis Cancer Attention deficit d/o Bipolar Disorder
 Heart attack/disease Gout HIV or AIDs Obsessive Compulsive d/o Abuse during childhood
 Stroke Peptic Ulcer Disease Hepatitis (A, B, C) Schizophrenia

NEW PATIENT INTAKE FORM



Other past medical history:

PAST SURGERIES

Please list any surgeries you have had, and any complications.

Have you ever had a bad reaction to anesthesia? No Yes If yes, describe: _____

SOCIAL HISTORY

Occupation: _____ When was the last time you worked? _____

Restricted or Light-duty Temporary disability Permanent disability Retired Unemployed/Seeking job

Are you currently under worker's compensation? No Yes Is there a lawsuit related to your visit today? No Yes

Tobacco: No Yes How many packs per day? _____ How many years? _____ Quit _____ years ago

Alcohol: No Yes How much do you drink daily? _____ Quit _____ years ago

Have you ever drank heavily or abused alcohol? No Yes

Illicit Drugs: Have you ever used any illicit substances? No Yes Type: _____

Have you ever been addicted to or misused prescription drugs? No Yes, Type: _____

FAMILY HISTORY:

Is there a family history of any of the following? check here if unknown

Alcohol Abuse <input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes
Illegal Drug Use <input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes, type: _____
Prescription Drug Abuse <input type="checkbox"/> No <input type="checkbox"/> Yes	Hypertension <input type="checkbox"/> No <input type="checkbox"/> Yes	Other _____

REVIEW OF SYSTEMS:

Are you CURRENTLY experiencing any of the following symptoms? If so, check mark Yes. Otherwise, check no (blank also implies no)

GENERAL:	ENDOCRINE:	EARS/NOSE/THROAT:	GASTROINTEST
Loss of appetite <input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid disease..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Hoarseness..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Nausea/vomiting <input type="checkbox"/> No <input type="checkbox"/> Yes
Recent weight loss <input type="checkbox"/> No <input type="checkbox"/> Yes	Heat/Cold intolerance <input type="checkbox"/> No <input type="checkbox"/> Yes	Trouble swallowing..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Blood in stool..... <input type="checkbox"/> No <input type="checkbox"/> Yes
Fever or chills <input type="checkbox"/> No <input type="checkbox"/> Yes		Hearing loss..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Heartburn..... <input type="checkbox"/> No <input type="checkbox"/> Yes
			Constipation..... <input type="checkbox"/> No <input type="checkbox"/> Yes
RESPIRATORY:	CARDIOVASCULAR:	PSYCHIATRIC:	HEMATOLOGIC:
Shortness of breath <input type="checkbox"/> No <input type="checkbox"/> Yes	Chest pain..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Depression..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Easy bruising..... <input type="checkbox"/> No <input type="checkbox"/> Yes
Chronic cough <input type="checkbox"/> No <input type="checkbox"/> Yes	Palpitations..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Drug/Alcohol addiction <input type="checkbox"/> No <input type="checkbox"/> Yes	Easy bleeding..... <input type="checkbox"/> No <input type="checkbox"/> Yes
		Suicidal Thoughts..... <input type="checkbox"/> No <input type="checkbox"/> Yes	
KIDNEY/BLADDER:	EYES:	NEUROLOGICAL	SKIN:
Painful urination..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Blurred vision..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Headaches..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent Rashes <input type="checkbox"/> No <input type="checkbox"/> Yes
Blood in urine..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Double vision..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Seizures..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Skin ulcers..... <input type="checkbox"/> No <input type="checkbox"/> Yes
Kidney problems <input type="checkbox"/> No <input type="checkbox"/> Yes	Loss of vision..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Dizziness..... <input type="checkbox"/> No <input type="checkbox"/> Yes	Lumps..... <input type="checkbox"/> No <input type="checkbox"/> Yes

Patient Name (print): _____ Signature: _____ Date: _____

FOR OFFICE USE ONLY						
Height: _____	Weight: _____	BP: _____	HR: _____	RR: _____	Temp: _____	
Reviewed by _____		Date: same date of service				

PATIENT INFORMATION



PATIENT INFORMATION			
PATIENT NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS Street	City	State Zip	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male
HOME PHONE NO.	CELL PHONE NO.	WORK PHONE NO.	
E-MAIL		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
RACE <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander			ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
2 ND /SEASONAL ADDRESS Street		City	State Zip
EMPLOYER		PATIENTS OCCUPATION	
EMPLOYER ADDRESS Street		City	State Zip
PHARMACY NAME		PHARMACY PHONE NO.	
How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Newspaper <input type="checkbox"/> Magazine <input type="checkbox"/> Online <input type="checkbox"/> Flier/Brochure <input type="checkbox"/> Lecture <input type="checkbox"/> Friend			
PERSON RESPONSIBLE FOR CHARGES			
If person responsible for payment is different from patient, then complete below.			
NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS		RELATIONSHIP TO PATIENT	
City	State	Zip	
EMPLOYER		EMPLOYER PHONE NO.	
EMPLOYER ADDRESS:		City	State Zip
If this is a job related injury, is this the employer you were working for at the time of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If due to an injury, date of injury: ____/____/____			
Will an attorney or Liability Carrier be involved in payment of charges? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is injury related to: <input type="checkbox"/> Accident <input type="checkbox"/> Auto Accident <input type="checkbox"/> Job Related <input type="checkbox"/> Other: _____			
If job related: Claim Number _____ Case Manager: _____ Phone No.: _____			
REFERRAL INFORMATION			
PRIMARY CARE PHYSICIAN		NAME OF REFERRING PHYSICIAN	
EMERGENCY CONTACT INFORMATION			
IN CASE OF EMERGENCY NOTIFY NAME		RELATIONSHIP	PHONE
ADDRESS Street	City	State	Zip
INSURANCE INFORMATION			
PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name	Policy ID Number	Insurance Name	Policy ID Number
Policy Holder's Name	DOB	Policy Holder's Name	DOB
Social Security Number	Relationship to Patient	Social Security Number	Relationship to Patient
I hereby certify the above information is true and correct to the best of my knowledge.			
Patient Signature: _____		Date: _____	

Notice of Privacy Practices



This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Novaspine Pain Institute (Novaspine) is committed to protecting your medical information. Further, we are required by law to maintain the privacy of your protected health information (PHI) and to give you this notice, explaining our legal duties and privacy practices with regards to your protected health information. We are required to must abide by the terms set forth in this notice. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. Any revisions will be posted in a prominent location in our office and, upon request, a copy will be provided to you of the revised notice. .

Uses and Disclosures of Your Protected Health Information:

- 1) **Treatment:** Your PHI may be used provide, coordinate, or manage your health care and any related services. We may also disclose your PHI to other health care providers who may be treating you or involved in your health care to ensure they have the necessary information to diagnose, treat or provide a service.
- 2) **Payment:** Your PHI may be used and disclosed to obtain payment for health care services provided by us or to determine whether we may obtain payment for services recommended for you. Your PHI may be disclosed to obtain payment or for payment activities from you, a health plan, healthcare clearinghouse, or a third party). As an example, we may need to include information that identifies you, your diagnosis, procedures performed, with a bill to a third-party payer or your health plan to agree to payment for that treatment.
- 3) **Health Care Operations:** We may use and disclose your PHI to support the business activities of our office. The activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for education and learning purposes. As an example, we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.
- 4) **Appointment Reminders/Treatment Alternatives/ Health-Related Services:** We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.
- 5) **Facility Directory:** Unless you object, we may use and disclose in our facility directory your name, location in the facility, general condition and religious affiliation. All of this information, except for your religious affiliation, will be disclosed to persons who ask for you by name. Information in the facility directory may be shared with clergy.
- 6) **Persons Involved in Your Care:** We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.
- 7) **Notification:** We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.
- 8) **As required by Law:** We will disclose your PHI when required to do so by international, federal, state or local law. Examples include:
 - Public health activities including reporting of certain communicable diseases,
 - Workers' compensation or similar programs as required by law,
 - Authorities when we suspect abuse, neglect, or domestic violence,
 - Health oversight agencies, including the Food and Drug Administration and Department of Health and Human Services
 - For certain judicial and administrative proceedings pursuant to an administrative order,
 - Law enforcement purposes, legal proceedings
 - Medical examiner, coroner, or funeral director,
 - The facilitation of organ, eye, or tissue donation if you are an organ donor,
 - To avert a serious threat to your health and safety or that of others,
 - For governmental purposes such as military service or for national security; and
 - In the event of an emergency or for disaster relief
 - Inmates, during the course of providing care
- 9) **Business Associates:** We may share your PHI with other individuals or companies that perform various activities on behalf of, our office such as after-hours telephone answering, quality assurance, or clinic research. Our Business Associates agree to protect the privacy of your information.
- 10) **Marketing & any purposes which require the sale of your information:** These disclosures require your written authorization.
- 11) **Any other uses and Disclosures not recorded in this Notice** will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Notice of Privacy Practices



YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF NOVASPINE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU.

BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

- 1) **Copy of this notice:** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
- 2) **Inspect and Copy:** You have the right to inspect and copy your PHI that we maintain about you for as long as we maintain that information. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or PHI that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer at the address listed below. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. Novaspine has up to 30 days to make your PHI available to you (fee may apply), or 60 days if stored off-site, but must inform you of this delay.
- 3) **Request an Electronic Copy:** You have the right to request that an electronic copy of your PHI be given to you or transmitted to your designated officer. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fee may apply).
- 4) **Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. You may ask us not to use or disclose any part of your PHI and by laws we must comply when the PHI pertains solely to health care items or services for which the health care provider involved has been paid out of pocket in full. Request must be made in writing to our Privacy Officer with instructions. If we agree to the restriction, we may only be in violation of the restriction for emergency treatment purposes. By law, you may not request we restrict the disclosure of your PHI for treatment purposes.
- 5) **Right to receive Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.
- 6) **Request Amendments:** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be in writing to the Privacy Officer as listed below. In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy.
- 7) **Request Accounting of Disclosures:** You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12- month period will be free. If you request an additional list within 12- months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.
- 8) **Request Restrictions:** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.
- 9) **Request a Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.
- 10) **File a Complaint.** You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our Privacy Officer must be in writing. We will not retaliate against you for filing a complaint.
- 11) If you have questions about this notice or would like additional information, please contact our Privacy Officer at:

NovaSpine Pain Institute, Attn Privacy Officer, 13203 N 103rd Ave Ste H4 Sun City, AZ 85351 or 623.777.4747

By signing below, I acknowledge that I have received the Notice of Privacy Practices of this office, which outlines how patient confidential information will be used, disclosed, and protected. I understand that I may refuse to sign this Acknowledgement.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

*****FOR OFFICE USE ONLY*****

We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided Was Emergent
_____ Other: _____ Employee Initials: _____ Date: _____

NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/we) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services as follows:

Durable Medical Equipment - Orthosis/Bracing
Dynamic Managed Services AZ LLC
Genetic Technological Innovations-toxicology and phlebotomy
Insight Management Group LLC - toxicology and phlebotomy
Simple Ventures, LLC
Chiropractic and or Therapy services
Avon Surgery Centers, LLC

Further, as indicated below, goods or services (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

Sonora Quest Laboratories
LabCorp Laboratories
Practical Medical
Hanger Clinic Orthotics and Prosthetics
Summa
Rx Medics Equipment & Supplies
Foothills Physical Therapy
Van Metre Chiropractic
Heid Chiropractic
Aris Physical Therapy
Banner Physical Therapy

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file.

ACKNOWLEDGEMENT: I/We have read this "Notice to Patients" form and understand the disclosures that it contains.

Signature of Patient or Guardian

Date

Thank you for choosing NovaSpine Pain Institute as your pain management specialist. Please review and sign the following financial policy to indicate your agreement to these terms. Our financial policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients.

APPOINTMENTS

- 1) **No insurance card, referral, co-payment or outstanding balance.** Copayments and/or outstanding balances are due at the time of service. In addition, we may not be authorized to see you until referral authorization and insurance benefits have been obtained and/or verified. Your appointment may be rescheduled until such time that these document and/or payments are provided.
- 2) **Procedure Prepayment.** NovaSpine Pain Institute collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy (see below). We reserve the right to reschedule your procedure until prepayment has been made.
- 3) **Missed Appointments and Late Arrivals.** If you are more than 15 minutes late, we reserve the right to reschedule your appointment. If you are more than 60 minutes late, no show for an appoint, or do not give cancellation notice at least 24 hours in advance, you will be responsible for a missed appointment fee. The first 'missed appointment' occurrence will not be charged a fee. Any additional missed appointments will result in a missed appointment fee as follows:
 - Missed office visit appointments are subject to a \$50 charge.
 - Missed procedure, or EMG appointments are subject to a \$75 charge.These charges are your responsibility and will not be billed to any insurance carrier. It is at the provider's discretion to determine whether or not you will be dismissed from the practice due to missed appointments.

INSURANCE PAYMENTS

- 4) **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
- 5) **Coverage Changes and Timely Submission.** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Novaspine Pain Institute must submit a claim on your behalf to your insurer. If NovaSpine is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
- 6) **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by NovaSpine Pain Institute, then you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

- 7) **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.
- 8) **Prior Authorization and Non-Covered Services.** NovaSpine Pain Institute may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. As a courtesy to our patients, NovaSpine makes a good faith effort to determine if services are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
- 9) **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to NovaSpine, immediately.

ACCOUNT BALANCES AND PAYMENTS

- 10) **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.
- 11) **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Novaspine reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay NovaSpine for any expenses incurred to collect your account, including reasonable attorneys' fees and collection costs.
- 12) **Returned Checks.** Returned checks will be subject to a \$38 returned check fee.
- 13) **Refunds.** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed.
Requests may be sent to: NovaSpine Pain Institute, Attn: Billing Department, 13203 N 103rd Ave Ste H4, Sun City AZ 85351
- 14) **Forms and Records Requests.** I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.
- 15) **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

I have read and understand the financial policy of NovaSpine Pain Institute, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to NovaSpine Pain Institute. I understand that I am financially responsible for all services I receive from NovaSpine Pain Institute. I understand that this financial policy is binding upon me, my estate, executors and/or administrators, if applicable.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

PATIENT FINANCIAL
RESPONSIBILITY/AGREEMENT



NOVASPINE
PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts™

Patient Initials

PROVIDER FEES: Patient is aware that NovaSpine Pain Institute healthcare providers including Clifford Baker MD, John Paul Malayil, MD, Jae H. Park, MD, Kristin Oarde, MSN, FNP-C, Victoria Tweedy, FNP, NP-C, Mynon Mitton, MSN, FNP-C, Samantha Gonzalez, PA-C, Michelle Hitchcock, PA-C, Alexandra Gral, MSN, FNP-C, Brittany Anderson, MSN, FNP-C, Peter D. Cummings, MD, Aaron Rodarte, PA-C and Laina Koryakos, PA-C are in network with majority of insurance carriers and when appropriate will accept assignment according to the terms of the contract. The patient understands they will be responsible for only the fees as determined by the plan. This will include any previously unmet portion of the in-network deductible and co-insurance based on their benefit

Patient Initials

ANESTHESIA FEES: Because most pain injection procedures can be performed without the administration of anesthesia, in most cases it is the patient's decision whether-or-not to have conscious sedation administered. Patient is aware the sedation is administered by a certified registered nurse anesthetist (CRNA) or anesthesiologist and that provider may be out-of-network with his/her insurance. Patient understands their insurance will be billed for this service. In the event insurance does not pay for administration of the sedation, the patient will be billed a MAXIMUM of \$150 per procedure. Patients are aware providers are in network with Medicare and BCBS.

Patient Initials

PAYMENTS TO PATIENTS: In some instances, the insurance carrier will pay the patient directly for out-of-network services. The patient understands and agrees to relinquish payment to our office upon receipt.

By signing below, I accept the terms as outlined above. I acknowledge that I have read or had explained to me and fully understand all of the above information. I have had the opportunity to ask questions. I understand I have the right to cancel the procedure if I do not agree. I wish to proceed with the procedure with full understanding of the above information. Should questions arise prior to the procedure, I understand that I may speak to a financial representative at 623-777-4747.

Patient Signature

Patient Name

Date

PAIN MANAGEMENT AGREEMENT



Patient Name: _____ Date of Birth: _____

This agreement relates to my use of any medications for pain, including controlled substances and opioids, for pain as prescribed by my provider. The purpose of this Agreement is to set forth specific guidelines and help both myself and my provider comply with the law and guidelines regarding controlled substances and optimize my pain treatment in a safe and collaborative manner.

I understand that if I am prescribed any controlled substances or opioids, I will adhere to the following guidelines:

- I understand that my provider and I will work together to find the most appropriate treatment for my pain symptoms. I understand the goals of treatment are not to completely eliminate pain, but to improve my pain and function. Chronic opioid therapy is only one part of my overall pain management plan.
- I understand that my provider and I will continually evaluate the effectiveness of opioids in achieving the treatment goals and changes will be made as needed. I agree to take the medication ONLY at the dosage and frequency as prescribed by my provider and I will NOT increase the dosage or frequency of medications without the consent of the provider.
- I agree to take ONLY those pain medication(s) that are actively being prescribed by my provider and I will NOT take 'old' pain medications that are not actively being prescribed. I agree to properly discard of any 'old' pain medications that are not actively being prescribed to treat my pain. I understand that I will NOT 'stockpile' medications. If I am taking less medication than is prescribed, I will report this to my provider so my dose can be adjusted. I agree to bring in all unused pain medicine if requested for verification and compliance purposes.
- I agree I will not attempt to obtain (or fill) any opioid medicines from another medical provider without informing NovaSpine Pain Institute provider. I agree to have any controlled substances filled at only one pharmacy.
- I will attend all appointments, treatments and consultations as requested by my provider. I will follow all recommendations as determined by the provider(s). I understand that failure to keep appointments or follow recommendations may lead to discontinuation of treatment and discharge from NovaSpine Pain Institute.
- I will tell my provider about the level of my pain, the effect of the pain on my daily life, how well the medication is helping to relieve my pain, and potential adverse effects from any prescribed medication.
- I recognize that my pain represents a complex problem and may benefit from physical therapy, psychotherapy, behavioral medicine and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize function and improve coping with my condition. If treatment for my condition is available, I agree that I will not refuse the treatment just so that opioids will be continued. I understand that I have the right to refuse any procedure, but that does not mean that my provider must continue to prescribe opioid medications.
- The risks and benefits of taking opioid medications have been explained to me and I understand them. Opioids can impair my judgment, affect reflexes and motor skills. If I am impaired in any fashion, I will refrain from or not participate in activities that would endanger myself or others while using these medications.
- I agree I will not use any illegal substances of any kind, including marijuana, amphetamines, cocaine, heroin, or other. I agree I will not use any prescription medications obtained illegally or obtain them from friends or relatives. I understand that doing so is extremely dangerous and illegal, with potential legal ramifications
- I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.
- I agree I will not share, sell or trade my medication with anyone. I understand that it is dangerous and potentially criminal to share controlled substances in any fashion with another person.
- I agree to protect my pain medicine from loss or theft. I understand lost or stolen medicines will NOT be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event to my provider if requested.

PAIN MANAGEMENT AGREEMENT



- I agree to obtain Narcan (Naloxone) per State of Arizona requirements and at the request of my provider. I agree to be educated on its use and to have it readily available in the case of accidental overdose.
- I agree that medication changes, dosage and/or frequency changes, and refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available after 4:00pm, weekends, holidays or through the emergency room. Medications will not be mailed or refilled without being seen at monthly pain clinic appointments.
- I understand that it is my responsibility to keep track of the amount of medications I have remaining and to plan ahead of time for refills. I will notify NovaSpine Pain Institute **a minimum of 72 hours** before my prescription runs out to allow my refill request to be processed.
- I agree to submit urine for drug testing and random pill counts, even without prior notice, if requested by my provider to determine my compliance and safety with the treatment regimen.
- I authorize NovaSpine Pain Institute to cooperate fully with any official including the state board of pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
- I understand that I may become dependent, tolerant, or addicted to opioids, or may develop complications related to their use. If this occurs, the medication may be changed, tapered, discontinued and other methods of pain control may be used. If necessary, I will permit a referral to an addiction specialist.
- If it appears to the provider that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I agree to taper my medication as directed by the prescribing provider.
- I agree to exercise caution when operating heavy equipment including automobiles if I am on opioid medication. These medications can decrease reaction times, cause drowsiness and cloud judgement. I agree to monitor for these conditions and WILL NOT drive if impaired in any way.
- I understand that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate by the institution.
- I understand that suddenly stopping some pain medications can cause severe medical problems including, but not limited to: withdrawal symptoms, shakiness, irregular heartbeat, heart attack, stroke, seizures, mental state changes, permanent brain damage, disability or death.
- I understand that if I violate any of the above conditions, my provider may choose to stop writing opioids prescribed for me and may discharge me from his/her care. Discontinuation of the medications and discharge from care will be coordinated by the provider and may require referrals to other specialists.
- I agree to follow ALL of the above guidelines. By signing below, I attest that I have read and understand this agreement in its entirety and any questions and concerns regarding treatment have been adequately answered. If requested, a copy of this document has been given to me for my own records.

PATIENT NAME

PATIENT SIGNATURE

DATE

Authorization for Use and Disclosure Of Protected Health Information



By signing below, I authorize NovaSpine Pain Institute, its agents and employees ("Provider"), to use and/or disclose any and all of my protected health information ("Records") on my behalf, of any kind and description, to the following ("Recipient"):

Recipient Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

I also authorize Provider to release my protected health information to my insurance, primary care provider(s), referring provider(s), hospitals, diagnostic centers and/or laboratories that may require this information for continued care and authorize Provider to transmit this information through electronic means.

Authorization to Disclose Protected Health Information including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnoses or treatment for HIV, HIV-related diseases and communicable disease-related information. With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

I understand I have the right to refuse to sign this authorization, writing, at any time and that I do not have to sign this authorization to receive treatment at Novaspine Pain Institute. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is:

NovaSpine Pain Institute, Attn Privacy Officer, 13203 N 103rd Ave Ste H4 Sun City, AZ 85351

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This Authorization will remain effective until one-year following the date set forth below, or, if not date is set forth below, the date Novaspine Pain Institute receives this executed Authorization, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

MEDICAL RECORDS RELEASE
Authorization to Disclose
Health Information



PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

INFORMATION TO BE RELEASED: (check all items to be released)

- | | | |
|--|---|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Period From: _____ | |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Urine Toxicology Results | <input type="checkbox"/> EMG/NCS Results |
| <input type="checkbox"/> Office Visit / Progress Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Imaging Reports (X-rays, CT, MRI) |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Medication List | <input type="checkbox"/> Radiology Images CD / DVD |
| | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> All <input type="checkbox"/> _____ |

REQUESTING RECORDS FROM: _____

Special Records: I understand that protected information related to my diagnosis or treatment for AIDS/HIV, psychiatric care treatment, treatment for drug and alcohol abuse may be released as part of my health information. **Please check appropriate boxes below.**

- | | | |
|--|--|--|
| <u>AIDS/HIV Information</u> | <u>Psychiatric Care/Treatment</u> | <u>Treatment for Drug or Alcohol use/abuse</u> |
| <input type="checkbox"/> YES, Disclose | <input type="checkbox"/> YES, Disclose | <input type="checkbox"/> YES, Disclose |
| <input type="checkbox"/> NO, do not disclose | <input type="checkbox"/> NO, do not disclose | <input type="checkbox"/> NO, do not disclose |

PURPOSE/USE OF REQUESTED INFORMATION:

- Personal Treatment Insurance Disability Legal Other: _____

RELEASE INFORMATION TO:

Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

FORMAT:

- Paper Copy Electronic Copy (Fax) 623.777.4748

AUTHORIZATION:

- **FOR PERSONAL REQUESTS:** There will be a \$0.25 per page fee for all requests on paper (plus the cost of postage and envelope) or there will be a \$0.25 per page fee for all requests on CD (plus the cost of postage and envelope).
- **FOR DOCTOR TO DOCTOR REQUESTS:** There will be no fee. By default the past two (2) years of pertinent information will be sent. •
- I understand that I may revoke this authorization at any time, by notifying NovaSpine Pain Institute in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under the applicable law, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- My refusal to sign this authorization will not affect enrollment, eligibility for benefits, payment, or my ability to receive treatment.
- I understand that I may inspect or copy the information that is used or disclosed

Patient or Legal Representative Signature: _____ Date : _____

(If a personal representative executes this authorization, then the authorization must contain a description of the representatives authority to act for the individual, e.g., "parent" or "guardian ad litem")