INTEGRATED PAIN Consultants
Comprehensive Approach to Spine & Joint Pain

Patient Registration Form

9500 E Ironwood Sq Dr Suite 125
Scottsdale, AZ 85258

Phone: 480-626-2552 Fax: 480-626-2551

Patient Information (confidential):

Name: _____ Date: _____
(First) (Middle) (Last)

Address: _____ City _____ State ____ Zip _____

Phone: Home (___) _____ Work (___) _____ Cell (____) _____

Birth Date: _____ SS# ____-____-_____ E-Mail: _____

Employer (if Minor, Parent's Employer) _____

Employer Address: _____ City _____ State ____ Zip _____

Spouse Name (if Minor, Parent's Name) _____ Phone: (____) _____

Primary Care Physician: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____

Relationship to patient: _____

Who should we thank for referring you? _____ Phone: (___) _____

Responsible person if different from above.

Do you have medical insurance coverage: □ Yes □ No

Name of Person on account : _____ Phone : _____

Relationship to Patient: _____ SS# _____-_____-_____ Birth Date: _____

Insurance Company: _____ Policy No: _____ Group Number: _____

Phone Number of insurance company: _____

Do you have additional insurance? □ Yes □ No If yes, please complete the following:

Name of Insured: _____ Relationship to patient: _____

SSN: _____ DOB: _____

Insurance Company: _____ Policy No: _____ Group Number: _____

If you are covered under worker's compensation or motor vehicle insurance, enter info below:

Name of Worker's Comp or Motor Vehicle Accident Insurance Carrier: _____

Employer: _____ Claim No.: _____

Date of Injury: _____ Adjuster/Case Manager: _____

Adjuster/Case Manager Phone No.: _____

Carrier Address: _____

Patient Initial: _____

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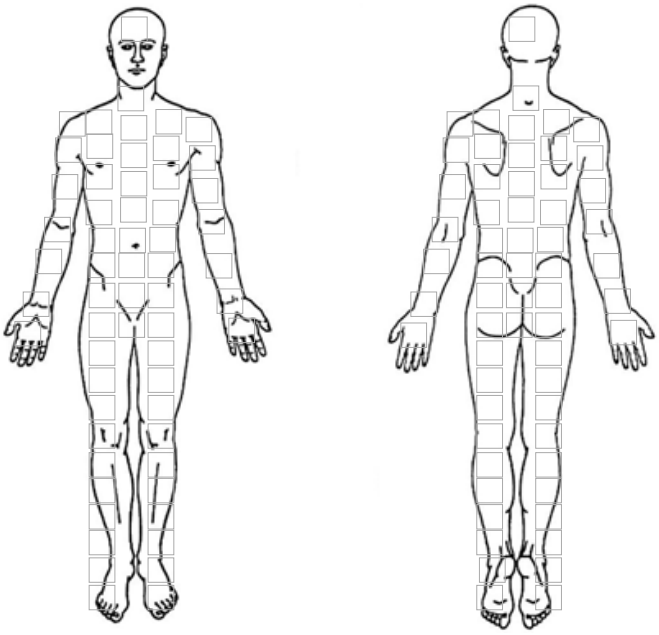
NEW PATIENT FORM

Patient Name :		**DOB:**	**Age :**		☐ **M** ☐ **F**
Name of Referring Physician :			**Name of PCP :**		
Reason for Visit:					
How long have you had this pain?		**Average Pain Level** (1 (no pain) to 10 (worst)) **:**			

Height:_____ Weight:_____

On the diagram below, mark the area where you have pain.



Describe the pain

☐ **Aching**	☐ **Mild**	☐ **Moderate**
☐ **Burning**	☐ **Throbbing**	☐ **Severe**
☐ **Pins/needles**	☐ **Constant**	☐ **Sharp/stabbing**
☐ **Numbess**	☐ **Intermittent**	

What makes your pain Worse:

What makes your pain Better:

Do you have WEAKNESS in your : ☐ **Arms** ☐ **R** ☐ **L**
☐ **Legs** ☐ **R** ☐ **L**

Do you have NUMBNESS in your : ☐ **Arms** ☐ **R** ☐ **L**
☐ **Legs** ☐ **R** ☐ **L**

TREATMENT HISTORY

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

Where was this imaging/study done?

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: _____

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

TENS unit: ☐ Better ☐ Worse ☐ No Change

Chiropractor: ☐ Better ☐ Worse ☐ No Change

Massage: ☐ Better ☐ Worse ☐ No Change

Physical Therapy: ☐ Better ☐ Worse ☐ No Change
How recently? _____

Bracing: ☐ Better ☐ Worse ☐ No Change
Type:

Heat / Ice: ☐ Better ☐ Worse ☐ No Change

Acupuncture: ☐ Better ☐ Worse ☐ No Change

Psychology: ☐ Better ☐ Worse ☐ No Change

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PAST MEDICATIONS

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

ANTI-INFLAMMATORY	Helped? Yes	No
Naproxen (aleve)	☐	☐
Ibuprofen (advil, motrin)	☐	☐
Diclofenac (voltaren)	☐	☐
Tylenol (acetaminophen)	☐	☐
Flector patch	☐	☐

MUSCLE RELAXANTS	Helped? Yes	No
Carisoprodol (soma)	☐	☐
Cyclobenzaprine (flexeril)	☐	☐
Skelaxin (Metaxolone)	☐	☐
Methocarbamol (robaxin)	☐	☐
Tizanidine (zanaflex)	☐	☐

NARCOTICS / OPIOIDS	Helped? Yes	No
Tramadol	☐	☐
Tylenol with codeine	☐	☐
Hydrocodone (Vicodin)	☐	☐
Oxycodone (Percocet)	☐	☐
Morphine, MS Contin	☐	☐
Hydromorphone	☐	☐
Nucynta (tapentadol)	☐	☐
Fentanyl patch	☐	☐
Methadone	☐	☐
Opana	☐	☐
Suboxone	☐	☐

NERVE MEDICATIONS	Helped? Yes	No
Gabapentin (neurontin)	☐	☐
Lyrica	☐	☐
Amitriptyline (elavil)	☐	☐
Nortriptyline	☐	☐
Cymbalta	☐	☐
Effexor	☐	☐
Savella	☐	☐
Lidoderm patch	☐	☐

PAST MEDICAL HISTORY

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

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

Other past medical history:

ALLERGIES TO MEDICATIONS

Iodine Allergy	☐ **Yes** ☐ **No**
Shellfish Allergy	☐ **Yes** ☐ **No**

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PAST SURGERIES

FAMILY HISTORY

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

Other Blood Thinners

NAME OF MEDICATION	DOSE and # of pills/day

SOCIAL HISTORY

Occupation :

Are you currently working? ☐ Yes ☐ No ☐ Part-time ☐ Full-time

Education : ☐ Elementary ☐ High School ☐ College ☐ Graduate school

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Significant Other

Children : ☐ Yes ☐ No **If Yes, how many?** _____

Do you have any lawsuits pending? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No **Worker's Comp?** ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No **# of packs / day** _____ **How many years?** _____

Do you use alcohol? ☐ Yes ☐ No **# of drinks / day** _____ **How many years?** _____

Do you use illicit substances? ☐ Yes ☐ No

If Yes, describe _____

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

Patient/Representative Name (print) _____

Signature_____

Date _____

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Authorization to Disclose PHI including HIV Related information

I understand that Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulation.

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.

By signing below, I authorize INTEGRATED PAIN CONSULTANTS, 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 allow my 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.

Organized Health Care Arrangement/Data Exchange:

Integrated Pain Consultants participates in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals, as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment, or the health care operations of this organized health care arrangement.

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

Patient or Legal Representative Signature: _____ Date: _____

INTEGRATED PAIN Consultants
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Financial Policy and Consent to Proceed

BY PROVIDING US WITH ACCURATE INFORMATION, WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY.

1. We need copies of your insurance card or cards for our files. Proper group numbers and Social Security numbers of any and all insurances are required with the name of the person who carries the insurance. If retired, please list under employer "Retired From" (List name of company). Without the information completed you will be considered a personal pay account. RESPONSIBLE PARTY IS THE PERSON SIGNING THIS FORM.
2. We expect you to know and understand your insurance policy. Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer). FOR UN-INSURED PATIENTS, WE REQUEST PAYMENT ARRANGEMENTS BE MADE *BEFORE YOUR* VISIT. Special arrangements can be made for large accounts.
3. As a courtesy we will file your insurance. (If you do file your own insurance, you need to pay for your services today.) We do not accept what your insurance pays as payment in full. It is your responsibility to ensure that the services provided are covered and authorized by your insurance plan. If authorization is required, Integrated Pain Consultants will attempt to get authorization on your behalf.
4. If your insurance company does not pay Integrated Pain Consultants the balance may become your responsibility. Balances are due within 30 days of receiving a statement
5. It is your responsibility to inform us of any insurance changes and/or cancellation of your policy.
6. If your insurance requires a special claim form, we must have it within two working days or the insurance billing will be processed and sent without it.
7. If your visit is related to an injurv at work, vou must report it to the receptionist. A special form needs to be completed. If the patient does not file on his work related injury; it must be done by this office. Patients will continue to receive statements for their record until we are satisfied by the insurance.
8. In accordance with the FEDERAL TRUTH-IN-LENDING ACT, all doctors are required to give to their patient's complete information in connection with the extension of credit. BASIC POLICY: The patient is responsible for all medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you, without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims.
9. WORKMAN'S COMPENSATION: In the event it is determined by the Workman's Compensation board that the illness or injury is not a result of a compensated Workman's Compensation case, I hereby agree to pay usual and customary fees for services rendered.
10. REJECTED CLAIMS: If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our Business Office.
11. DELINQUENT ACCOUNTS: Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the doctor to decide appropriate legal action. We reserve the right to add late charges for delinquent accounts requiring collection action and to add attorneys' fees and court costs. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees and costs of collection
12. RETURNED CHECKS: A $25.00 handling charge is applied to all returned checks.
13. YOU MAY BE CHARGED A FEE OF $50.00 IF A CLINIC APPOINTMENT IS MISSED (AND $100 FOR PROCEDURE VISIT) OR NOT CANCELLED 24 HOURS PRIOR TO SCHEDULED APPOINTMENT OR BEING 15 MINUTES LATE AND THE APPOINTMENT MAY BE RESCHDULED. A PATIENT MAY BE DISMISSED FROM OUR PRACTICE FOR TWO MISSED APPOINTMENTS IN A YEAR. U
14. Co-Payments and outstanding balances must be made before your appointment. Otherwise your appointment may be rescheduled. We may not be authorized to see you until referral authorization and insurance benefits have been obtained.
15. MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payments on your account and have a record of services. Once your insurance has paid, you are responsible for the unpaid balance. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50¢ per month.

I have read and agree with the Financial Policy of this office.

Patient._____ Date_____

Insured_____ Witness._____

INTEGRATED PAIN Consultants
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Financial Disclosure Statement

Notice to Patients

In order to be compliant with the requirements of AZ and federal law, a physician must notify a patient that the physician has a direct financial interest in a separate treatment or diagnostic agency to which a physician is referring the patient. A physician must also notify the patient of any financial interest in non routine good or services being prescribed by the physician and whether these are available on a competitive basis. By informing you of this law we are allowing our patients to make reasonable financial decisions. To maintain compliance, you are being informed of possible financial interests in the agencies and non routine good or services named below.

Integrated Pain Consultants and Dr Nikesh Seth may have a direct financial interest in, but not solely limited to, the following goods and services: DME services, Competitive Medical Solutions, Mission Lab, OmniWest, Atlantis, Physicians Surgery Center, Phoenix Anesthesiology Consultants, Integrated Surgical Associates, etc,

Below are only some of the alternative sources of similar services to the best of our knowledge

Surgery Center/Outpatient treatment Facilities

North Valley Surgery Center – 8901 E Raintree Dr #100, Scottsdale, AZ 85260

Honor Health Shea – 9003 E Shea Blvd Scottsdale, AZ 85260

DME –

Hanger - 9023 E Desert Cove Ave, Suite 102 Scottsdale AZ 85260

Amazon.com

LAB SERVICS

Sonora Quest – 9445 e Ironwood sq dr suite 110 Scottsdale, AZ 85258

Sonora Quest – 10900 n Scottsdale rd #204 Scottsdale, AZ 85254

By signing below I acknowledge having read and understood these disclosures.

Patient Signature _____ Date _____

INTEGRATED PAIN Consultants
Comprehensive Approach to Spine & Joint Pain

HIPPA NOTICE OF PRIVACY PRACTICES

IN THIS FORM YOU WILL LEARN HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION AND HOW YOU MAY OBTAIN ACCESS TO IT.

Integrated Pain Consultants (IPC) is dedicated to protecting your medical information. We are required by law to maintain the privacy of your protected health information (PHI) and to give you notice explaining our legal duties and privacy practices with regards to your PHI. We do reserve the right to change the terms of this notice and to make the new notice effective for all PHI we maintain. Any revisions will be posted in our office, and upon request, a copy will be provided to you for your records.

Treatment: Your PHI may be used to 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 involved in your health care to ensure they have the proper information to diagnose, treat, as well as provide a service to you.

Health Care Options: Integrated Pain Consultants may use and disclose your PHI to support the business activities of this office. Business activities include the following:

- **Evaluation of our staff directly or indirectly involved in your care**
- **Quality Assessment and Quality Improvement**
- **Information disclosed to physicians, nurse practitioners, physician assistants, nurses, paramedics, medical technicians, medical students, and any other authorized personnel for educational purpose.**

We may disclose your PHI to a third party service, i.e. billing and transcription services, to perform certain activities. Furthermore, we may disclose a limited data set of your PHI to a third party for certain business services.

Payment: Payments obtained by us for health care services or to determine whether we may obtain payment for services recommended for you may require your PHI be used and disclosed. Your PHI may be disclosed to obtain payment or for payment activities from you, a health insurance plan, a healthcare clearinghouse, or a third party service.

- **Example:** Information may need to be provided that identifies you, your diagnosis, as well as procedures performed, with a bill to your health plan to agree to payment for a treatment.

Appointment reminders/Treatment Alternative/Health Related Services:

Your PHI may be disclosed by us to contact you, either by a staff member or automated system, to remind you of a scheduled medical appointment, treatment procedure, or with treatment alternatives, treatment options, or health related benefits and services which may be beneficial or of interest to you.

Facility Directory:

Unless objected by you, 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 denomination or affiliation, will be disclosed to persons who ask for you by name.

Persons Involved in Your Care:

Unless you object, we may use and disclose to a family member, relative, close friend, or individual you identify your PHI with, that is directly relevant to the person/s involvement in your care or payment related to your care. 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.

Notificaton:

Your PHI may be used or disclosed, by us, to notify or assist in notifying a family member, personal representative, or any person deemed responsible for your care of your location, your general condition, or death.

Business Associates:

Your PHI may be shared with other individuals or companies that perform various activities on behalf of our office. This activities may include, but are not limited to, after-hours telephone answering, quality assurance/quality improvement, or clinic research. Our business associates agree to protect the privacy of your information.

As required by law:

- Your PHI will be disclosed when required to do so by international, federal, state and/or local law. These may include public health activities which include reporting certain communicable diseases, workers compensation or similar programs 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 officer, law enforcement purposes and legal proceedings, medical examiner, coroner, or funeral director, the facilitation or organ, eye, or tissue donation if you are a registered organ donor, to avert a serious threat to your health and safety of that or others, For governmental purposes such as military service or for national security, in the event of an emergency for disaster relief, and inmates during the course of providing care.

Your PHI may be used for marketing and any purposes which require the sale of your information which require written authorization.

Any other uses and disclosures not recorded in this notice will be made only with your written authorization which you may revoke 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.

INTEGRATED PAIN Consultants
Comprehensive Approach to Spine & Joint Pain

HIPPA NOTICE OF PRIVACY PRACTICES

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

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

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, civil, criminal, or administrative action or proceedings; 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 the office. Integrated Pain Consultants has up to 30 days to make your PHI available to you, in which a fee may apply, or 60 days if stored offsite.

Request an Electronic Copy:
You have the right to request an electronic copy of your PHI be transmitted to you or your designated officer. We will make every effort to provide the electronic copy in the format your request, however, if it is not readily producible by us, we will provide it in either our standard format or in hard copy form but a fee may apply.

Right to Receive Notice of a Breech:
You have the right to be notified upon a breach of any of your unsecured PH and will be contacted in a timely manner.

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 law, we must comply when the PHI pertains solely to healthcare 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 at the address below. If we agree to the restriction, we may 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.

Request Amendments:
If you feel 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 at the address 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 with a copy of the denial.

Request Accounting of Disclosures:
You have the right to request a list of our disclosures of you PHI, 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 and 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 your of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

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. You request may 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 or an explanation for your request.

If you have any questions about this notice or would like additional information, please contact our office at:

9500 E Ironwood Square Dr. Suite 125 Scottsdale, Arizona 85258

By signing below, I acknowledge that I have reviewed the HIPPA 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.

Patent Printed Name or Legal Representative _____ Date of Birth _____

Patient or Legal Representative Signature _____ Date: _____

INTEGRATED PAIN
Consultants
Comprehensive Approach to Spine & Joint Pain

MEDICAL RECORD RELEASE

Patient: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

_____

Date of Birth: _____

Please send the medical records at your earliest convenience.

Integrated Pain Consultants is authorized to furnish to / receive from:_____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

o I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth , communications to social workers and/or psychotherapies, psychologists, if any.

o I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

_____

_____

I release Integrated Pain Consultants, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. 1 may withdraw this authorization at any time by giving written notification to Integrated Pain Consultants, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

Release Information to:

Name - Integrated Pain Consultants
Address – 9500 E Ironwood Sq Dr. Suite 125 Scottsdale, AZ 85258
Phone - 480-626-2552 **Fax** - 480-626-2551

_____ _____
Patient Signature (Parent's Representative if minor) Date

I understand that there is a $25 fee for all Personal record requests on paper plus shipping costs. By default, the past one year of records will be sent.

NAME: _____ **DATE**: _____

AGREEMENT FOR CHRONIC PAIN MEDICATION

INTEGRATED PAIN Consultants
Comprehensive Approach to Spine & Joint Pain

PLEASE INITIAL ALL SECTIONS BELOW:

_____I UNDERSTAND THE PURPOSE OF THIS AGREEMENT IS TO PREVENT MISUNDERSTANDINGS ABOUT CERTAIN MEDICATIONS YOU WILL BE TAKING FOR PAIN MANAGEMENT. THIS IS TO HELP YOU AND YOUR DOCTOR TO COMPLY WITH THE LAW REGARDING CONTROLLED MEDICATIONS.

_____I UNDERSTAND THAT IF I BREAK THE AGREEMENT, WE WILL STOP PERSCRIBING PAIN MEDICATIONS TO YOU.

_____I WILL NOT USE ANY ILLEGAL CONTROLLED SUBSTANCES. I WILL NOT INCREASE OR DECREASE THE DOSAGE WITHOUT INFORMING MY DOCTOR. IF I FEEL THAT ADJUSTMENS IN THE MECICATION DOSAGE IS REQUIRED, I AGREE TO CONTACT THE PRESCRIBING DOCTOR.

_____I WILL NOT SHARE MY MEDICATIONS WITH ANYONE NOR WILL I TAKE ANOTHER PERSONS MEDICATION.

_____I WILL NOT RECEIVE ANY PAIN MEDICATIONS FROM ANY OTHER DOCTORS, INCLUDING ER DOCTORS. ALL PATIENT'S WILL BE MONITORED FOR THIS VIA THE STATE OF ARIZONA PHARMACY MONITORING PROGRAM AT EACH VISIT AND ANY VIOLATIONS OF THIS RULE MAY LEAD TO DISCHARGE FROM THE PRACTICE

_____I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SAFEGUARD MY MEDICATION. THEY WILL **UNDER NO CIRCUMSTANCE** BE FILLED EARLY IF THEY ARE LOST, STOLEN, DESTROYED OR USED UP EARLY.

_____I UNDERSTAND THAT THERE MAY BE RISKS THAT ASSOCIATE WITH THE USE OF PAIN MEDICATION, INCLUDING RISK OF DEATH, RESPIRATORY DEPRESSION, BOWEL AND BLADDER DYSFUNCTION, SEXUAL DYSFUNCTION, CHANGE OF APPETITE WITH POSSIBLE WEIGHT GAIN OR LOSS, CHANGE OF COORDINATION(WHICH MAY INTERFERE WITH DRIVING, OPERATING MACHINERY AND FINE MOTOR MOVEMENT) AND OTHERS.

_____ADDITIONALLY, THE CONTINUOUS USE OF PAIN MEDICATION MAY RESULT IN DEPENDENCE, ADDICTION, CHANGE IN PERSONALITY AND SLEEP CHANGES. I ALSO UNDERSTAND THAT I WILL NOT MIX ACOHOL WITH PAIN MEDICAITON AND I WILL REPORT ANY CHANGES IN MY MENTAL STATE AS WELL AS POSSIBLE SIDE EFFECTS.

_____I AGREE TO SUBMIT TO FREQUENT URINE TESTING ON AN AS NEEDED BASIS TO MONITOR FOR MEDICATION COMPLICATIONS AND COMPLIANCE WITH RECOMMENDED TREATMENT.

_____I UNDERSTAND THE RISKS AND BENEFITS OF TAKING PAIN MEDICATIONS. I UNDERSTAND THAT OPIOIDS CAN IMPAIR MY JUDGEMENT AND MOTOR SKILLS AND FOR THIS REASON I WILL NOT TAKE PART IN ACTIVITIES THAT WILL ENDANGER MYSELF AND/OR OTHERS WHILE USING THESE MEDICATIONS.

_____I UNDERSTAND THAT SUDDEN STOPPING OF PAIN MEDICATION CAN LEAD TO REBOUND PAIN, WITHDRAWAL SYMPTOMS, SEIZURES AND OTHER SYMPTOMS. I HAVE BEEN INFORMED NOT TO STOP ANY PAIN MEDICATION SUDDENLY UNLESS DECIDED JOINTLY BY MYSELF AND MY PAIN DOCTOR.

_____I AGREE TO ALLOW MY PAIN PHYSICIAN TO REVIEW ANY OF MY PAST MEDICAL OR PSYCHOLOGICAL RECORDS.

_____I AGREE THAT WHEN I HAVE ANY CONTACT WITH THE DOCTORS, NURSES OR ANY OTHER STAFF MEMBER IE: MEDICAL ASSISTANTS, DOCTORS, ASSISTANTS, PHONE ANSWERS, ETC. I WILL NOT BE RUDE, AGGRESSIVE, SWEAR AND OR BE DISRUPTIVE, WITH ANY MEMBER OF THE OFFICE.

_____**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I AGREE AND UNDERSTAND THAT NON-COMPLIANCE WITH THE ABOVE WILL RESULT IN FORMAL DISCHARGE WITH NOTIFICATION TO MY PRIMARY CARE PHYSICIAN AND OTHER TREATING PHYSICIANS.**

PATIENT SIGNATURE _____ **DATE** _____

PHYSICIAN/WITNESS SIGNATURE _____ **DATE** _____