Patient Registration Form:

Last Name: ______________________________ **First:** _______________________________ **MI:** ______________

DOB: _________________ Gender _______________ SS #: _________--______--____________

HANDED: RIGHT **OR** LEFT AGE: ___________ Height: _____________ Weight: _____________

Cell #: ________________________ Home #: ________________________ Work #: _________________________

Street Address: ____

City: _____________________________________ State: _______________________ Zip: ____________________

****

Occupation: ____ Employer: _________________________________

Employers address: ____ Phone #: _______________________

PRIMARY INSURANCE: ____ **ID#**: ______________________________

Responsible Party: ____________________________________ Employer: _________________________________

Home #: _______________________________ Work #: ____________________ Relationship: ________________

Subscriber DOB: ____________________________ Subscriber SS#: _________--______--____________

SECONDARY INSURANCE: _____________________________________ **ID#**: _______________________________

Responsible Party: ____________________________________ Employer: _________________________________

Home #: _________________________ Work #: _________________________ Relationship: _________________

Subscriber DOB: ____________________________ Subscriber SS#: _________--______--____________

In case of an emergency please notify:

Name / Relationship: ____ Phone #: _________________________

Name / Relationship: ____ Phone #: _________________________

SIGNATURE OF PATIENT: ____ Date: ___________________

(If Patient is a minor)

PARENT OR GUARDIAN SIGNATURE: _______________________________________ Date: ___________________

INITAL VISIT LOCATION: ___________________________________

NAME: ____ **DOB:** _______________ **DATE:** ____________

BACKGROUND:

When did your pain originally start _____________ Is this workman's comp or motor vehicle? _________________

Where is the pain located? ____

What treatments have you had for your pain? (Please circle)

Acupuncture Chiropractor Physical Therapy Biofeedback TENS Unit Nerve Block

Epidural Injections Triggers Pain Medication Pain Management Surgery

Any additional treatments?

____

Have you had X-ray, MRI or CT scan or EMG? ____

Where were they taken? ____

DESCRIPTION OF PAIN: (please circle)

Sharp Throbbing Shooting Aching Dull Burning Tingling Stabbing

Please rate your pain: 0 = no pain 10 = severe pain ____

Is your pain Constant or Intermittent (with flare ups)? ____

What makes your pain worse? ____

What makes the pain better? ____

How does the pain affect your daily function? 0 = no effect 10 = unable to function ________________________

MEDICATION LIST: (Please list ALL current medication Name and Dosage)

__________________________________ ________ __________________________________ ________

__________________________________ ________ __________________________________ ________

__________________________________ ________ __________________________________ ________

__________________________________ ________ __________________________________ ________

ALLERGIES:

____

Revive
Spine And Pain Center

NAME: ______________________________ **DOB:** __________ **DATE:** ______________

PAST MEDICAL HISTORY: (Please list all conditions you have been diagnosed with by your doctors)

- **Heart** □ Coronary Artery Disease □ Hypertension □ Murmurs □ Valvular Disease □ Aneurysm □ High Cholesterol □ Pacemaker □ Deliberator □ Heart Failure □ Angina □ Other ______________
- **Lungs** □ Asthma □ COPD □ Emphysema □ Bronchitis □ TB □ Pneumonia □ Lung Cancer □ Other________________
- **Gastrointestinal** □ Ulcer □ Reflux □ Gastritis □ Hepatitis □ Cancer □ Bleeding □ Diverticulosis □ Other________________
- **Kidney** □ Failure □ Stones □ Dialysis (When) __________ □ Other ____________________
- **Endocrine** □ Diabetes □ Hypothyroidism □ Hyperthyroidism □ Other ____________________
- **Neuro** □ Stroke □ Aneurysm □ Brain Cancer □ Nerve Injury □ Spinal Cord Injury □ Alzheimer's □ Dementia □ Seizures □ Parkinson's □ Other ______________________________
- **Psychiatric** □ Depression □ Bipolar □ Anxiety □ Panic Disorder □ Psychosis □ Schizophrenia □ **Other** ________________
- **Bone/Muscular** □ Arthritis □ Rheumatoid Arthritis □ Osteoarthritis □ Gout □ Osteoporosis □ Scoliosis □Other______________________
- **Cancer** □ ____
- **Other** □ ____

FAMILY HISTORY:

____

____

SOCIAL HISTORY: Occupation: ____________________ Married, Single, OR Divorced: ____________
Do you smoke Yes or No? Do you drink alcohol Yes or No? Do you use recreational drugs Yes or No?

Do you or have you ever used or been treated for substance abuse Yes or No? Explain:
____

Are you or is there a possibility that you may be pregnant or breast feeding Yes or No?

SURGICAL HISTORY: (Please list all surgeries you have had)

____

____

____

NAME: ____ **DOB:** ______________ **DATE:** ______________

REVIEW OF SYSTEMS: (Please check any of the following symptoms you are experiencing currently)

- **Gen** □Weight loss □Weight gain □Fever □Fatigue □Loss of appetite □Nausea □Vomiting
- **Skin** □Skin problem □Rash □Psoriasis □Slow healing □Easy bruising □Itching
- **Neuro** □Numbness □Tingling □Light headed/dizziness □Fainting □Weakness □Tremor □Seizure □Memory loss
- **Eyes** □Vision changes □Blurred vision □Double vision □Seeing spots
- **ENT** □Ear pain □Hearing loss □Ringing in ears □Nose bleed □Sore throat □Hoarseness □Dental problems
- **Cardiovascular** □Chest pain □Chest pressure □Shortness of breath □Irregular heart beat □Murmurs
- **Respiratory** □Coughing □ Difficulty breathing □ Asthma/Wheezing □Coughing up blood
- **Gastrointestinal** □Constipation □Diarrhea □Heartburn □Bloody stool □Pain in stomach □Ulcers □Hepatitis
- **Genitourinary** □Painful urination □Frequent urination □Bloody urine □Kidney stone □Incontinence □Loss of libido □Sexual difficulty □Infection
- **Endocrine** □ Heat sensitivity □Cold sensitivity □Abnormal sweating □Morning fatigue
- **Hematology** □Anemia □Bleeding disorder □Easy bleeding □Lymphoma/Leukemia □Sickle cell disease □History of blood transfusion
- **Immunologic** □Recurring infection □HIV/AIDS □Fever □Hay fever □Frequent sinus infections □Allergies
- **Musculoskeletal** □Loss of muscle size □Muscle tenderness or pain □Painful joints □Joint stiffness □Neck pain □Lower back pain
- **Psychiatric** □Depression □Anxiety □Panic attacks □OCD □Manic episodes □Bipolar □Homicidal thoughts □Suicidal thoughts □Hallucinations □Other Psychoses

- **Women only** □Irregular periods □Premenstrual depression □Hot flashes □Menstrual cramps □Vaginal discharge □Breast surgery □Nipple discharge □Breast lumps □Last mammogram___

- **Men only** □Burning on urination □Dripping after urination □Prostate problems □Difficulty starting urination □Loss of Libido or Sex drive □Loss of frequency/firmness of erections

This is an agreement between: ____ and Revive

. (Please Print)

Spine and Pain Center regarding the diagnosis of: ____.

. **Chronic Pain**

For which the following medication(s) have been prescribed (narcotics): _______________________

. **All prescribed scheduled or controlled substances**

I understand that there are alternative treatments, which have been explained to me.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a narcotic increases certain risks, which include, but not limited to:

• Addiction

• Allergic reactions, overdose, and/or fatal complications

• Breathing Problems

• Drowsiness, dizziness and/or confusion

• Impaired judgment and inability to operate machines or drive motor vehicles

• Nausea, vomiting and/or constipation

• Development of tolerance

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount of frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed. (see #2)
2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will not be allowed to obtain early refills or receive replacement for lost or stolen medications. Refills will only be provided during office hours on your regular scheduled appointment date.
3. I will obtain ALL of my prescriptions through: Revive spine and Pain Center. And will fill ALL my prescriptions at (pharmacy name) ____ In an acute emergency, another provider may prescribe medications for me, if this occurs, I will notify my primary care physician or nurse practitioner as soon as possible.
4. I will submit to random urine or blood tests if requested by provider to access my compliance.
5. I agree to see: Revive Spine and Pain Center for my pain management needs.
6. If I do not follow these guidelines, I understand that my treatment may be terminated. I have discussed these risks, benefits, and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to my satisfaction.

Patient Signature: ____ Date: ______________

Provider Signature: ____ Date: ______________

1001 Lincoln Drive West ▫ Suite E ▫ Marlton, New Jersey 08053 ▫ (856) 983-9001 ▫ Fax (856) 983-9011
1225 Whitehorse-Mercerville Road ▫ Suite 202 ▫ Hamilton New Jersey 08619 ▫ (609) 581-2400 ▫ Fax (609) 581-2500

NAME: ____ DOB: _______________ DATE: ____________

I, __________________________ have decided to use Revive Spine and Pain Center for all of my chronic pain needs. This, I decided, of my own free will.

I was not solicited or coerced to switch physician groups. I understand that it is my own decision to choose a physician in any specialty to treat my personal health needs.

I also understand that at any time I may choose to leave Revive Spine and Pain Center and seek health care for my chronic pain needs at any facility I so choose.

_____________________________________ _____________________________________

Witness Signature/Staff Patient Signature

Assignment of Benefits Form

I ____________________ (Print Name) hereby authorize benefits to be assigned to Revive Spine and Pain Center for healthcare Services to me by Revive Spine and Pain Center. I hereby certify that the insurance company that I have provided Revive Spine and Pain Center is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of networks services. I hereby authorize Revive Spine and Pain Center to submit claims on my behalf, to the insurance company listed on the copy of the current insurance card I have provided Revive Spine and Pain Center, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full. I hereby irrevocably designate, authorize and appoint Revive Spine and Pain Center as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as Revive Spine and Pain Center has received payment in full and remedies under applicable regulatory guideless for all medical care service provided to patient. I hereby confirm and ratify all actions taken by my attorney in fact pursuant granted herein. I hereby authorized my insurer to assign and transfer and all applicable ERISA plan benefits and rights to Revive Spine and Pain Center and any business associates working with them to make sure all rights and benefits are administered accurately, including the right to receive any applicable plan documents/remedies, disclosures, pursue appeals, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state federal laws including the right for administrative review by the appropriate governing body.

I hereby instruct my Insurance Company to pay Revive Spine and Pain Center directly. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service. I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and Revive Spine and Pain Center. Upon proof of non-assign ability documentation, I instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

I agree and understand that any funds I receive by my insurance company due for services rendered by Revive Spine and Pain Center will be immediately signed over and sent directly to Revive Spine and Pain Center.

This is a direct assignment of my rights and benefits under this plan/policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Revive Spine and Pain Center to receive any such checks, endorse them for deposit only, and to deposit and apply all proceeds toward payment on my account.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I authorize Revive Spine and Pain Center to be my personal representative, which allows Revive Spine and Pain Center (1) Submit any and all appeals when my insurance company denies me benefits to which I am entitled. (2) submit any and all requests for benefit information from my insurance company. (3) Initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits based on billed charges, within (90) days of any and all appeals or requests for information. Should the account be referred to an attorney or outside agency for the collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Revive Spine and Pain Center for acting as my personal representative.

I authorize Revive Spine and Pain Center and its associates to provide medical care by today's standards. A photocopy of this agreement shall be considered as effective and valid as the original.

____ ________________________

Signature of Parent/Guarantor Date

____ ________________________

Signature of Policy Holder Date

H 2.6C 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 READ IT CAREFULLY

The following is the privacy policy ("Privacy Policy") of ________________________ ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in0 accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you

are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. . .

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law. .

Right To Receive Confidential Communications .

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information .

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access, but we know where the requested information is maintained, we will inform you of where to direct your request for access. Right To Amend Your Personal Health Information You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services (“DHHS”). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeable rely, on such information to your detriment. All requests for amendment shall be sent to the office at which you were seen. .

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer at the office location at which you were seen. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

I ___________________________ hereby acknowledge receipt of the Notice of privacy practice given to me. .

Patient Signature ____ Date __________________

Witness ____

AUTHORIZATION FOR THE RELEASE OF MEDICAL and PSYCHOLOGICAL INFORMATION

Patients Name: ____Date of Birth: ______________________

Address: ____ City: _______________________ State: ________

I hereby authorize: Revive Spine and Pain Center

1001 Lincoln Drive West Suite E
Marlton, New Jersey 08053
(856) 983-9001
Fax (856) 983-9011

1225 Whitehorse-Mercerville Road Suite 202
Hamilton, New Jersey 08619
(609) 581-2400
Fax (609) 581-2500

*****Please Fax Medical Records For All Locations To: (856) 888-4715*****

To obtain any and all information in my medical records from:

Name: ____

Address: ____City: _____________________ State: _______

Phone Number: ____________________________________ Fax Number: _________________________________

Please specify dates if necessary:

____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing to this office. I understand that this revocation does not apply to information that has already been released in response to this authorization.

I understand that the information in my health records may include information pertaining to the treatment of drug and alcohol abuse, mental health, acquired immunodeficiency (AIDS) or human immunodeficiency (HIV), sexually transmitted diseases, tuberculosis information or genetics.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the office manager at this facility.

I now certify by my signature below that I have read and full understand every part of the form.

Patient Signature: ____Date: __________________

If patient is unable to sign, state reason why and sign below;

____

Empowered representative's signature and relationship:

____ Date______________________

Name: ______________________________ **Date:** ______________

Physicians and Healthcare Providers

Primary Care: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Orthopedic Doctor: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Rheumatologist: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Surgeon: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Psychologist/Psychiatrist: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Neurologist: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Previous Pain Management: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Pharmacy: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________