PAIN DOCTOR
WE CHANGE LIVES HERE ®

New Patient Intake Form

Your Name: _____ Today's Date: _____

Height: _____ Weight: _____lbs Date of Birth: _____

Pharmacy Name: _____ Phone Number: _____

Other Physicians you have seen specifically for this pain problem: _____

_____

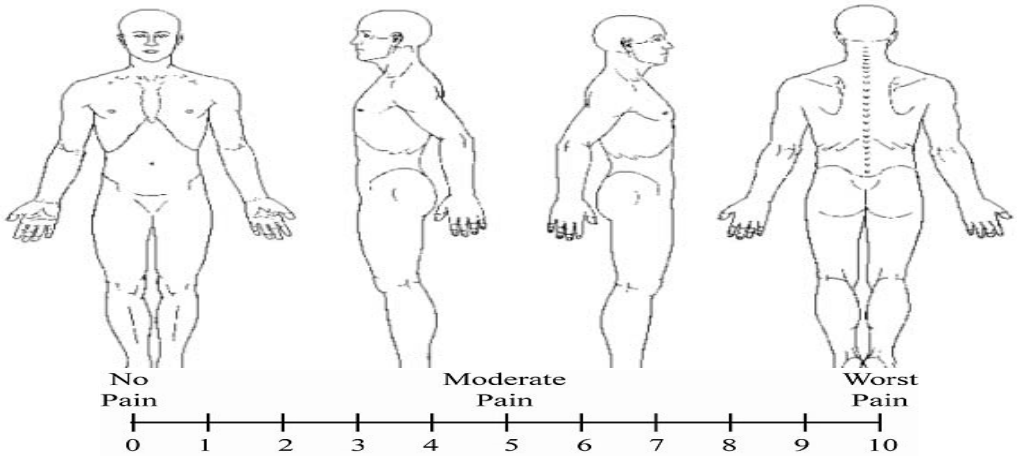
Onset of Symptoms and Reason for Visit Today

When did this pain begin? _____

What caused your current pain or injury? _____

Was the pain or injury due to a motor vehicle accident or personal injury? ❑ No ❑ Yes

Use the diagram below to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: **"N"**umbness **"P"**ins and Needles **"A"**ching **"S"**tabbing **"B"**urning



What is your current pain level **right now**? _____ What is your **worst** level of pain level? _____

Where is your worst area of pain located? _____

Does the pain radiate? If yes, where? _____

Please list additional areas of pain _____

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

Since your pain began, has your pain ❑ Increased ❑ Decreased ❑ Stayed the Same

When is your pain at its worst? ❑ Mornings ❑ During the Day ❑ Evenings ❑ Middle of Night

Check all that describe your pain **today**:

❑ Aching	❑ Hot/Burning	❑ Spasms	❑ Throbbing
❑ Cold	❑ Numb	❑ Squeezing	❑ Tingling/Pins and Needles
❑ Cramping	❑ Shock-like	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Dull	❑ Shooting		

Factors that Affect your Pain

Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down? ❑ No ❑ Yes

If yes to the above question, is your pain also alleviated with bending forward (using a shopping card, leaning on kitchen counter, etc.? ❑ No ❑ Yes

Please indicate any factors that affect your pain in the list below:

	Increases Pain	Decreases Pain	No Change
Bending Backward	❑	❑	❑
Bending Forward	❑	❑	❑
Changes in Weather	❑	❑	❑
Climbing Stairs	❑	❑	❑
Cold	❑	❑	❑
Coughing/Sneezing	❑	❑	❑
Heat	❑	❑	❑
Lifting Objects	❑	❑	❑
Looking Forward	❑	❑	❑
Looking Downward	❑	❑	❑
Looking Side to Side	❑	❑	❑
Lying Down	❑	❑	❑
Rising from a Seated Position	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑

What other factors worsen or affect your pain that is not listed above? _____

_____

Activity

How many days a week do you exercise? _____ Type of Exercise ❑ Bicycle ❑ Cardio ❑ Strength

❑ Swimming ❑ Walking ❑ Other _____

Sleep

Do you snore? ❑ No ❑ Yes Do you have a history of sleep apnea? ❑ No ❑ Yes

Diagnostic Tests & Imaging - Mark all of the following tests you have had related to your current pain:

MRI of the _____ Date: _____ Facility: _____

X-ray of the _____ Date: _____ Facility: _____

CT scan of the _____ Date: _____ Facility: _____

EMG/NCV study _____ Date: _____ Facility: _____

Other _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History - Mark the following pain treatments you have undergone **PRIOR** to today's visit:

Treatment ❑ **NO PREVIOUS TREATMENTS**	**No Relief**	**Moderate Relief**	**Excellent Relief**
Chiropractic Therapy, # of sessions _____ Date range _____	❑	❑	❑
Decompression Therapy, # of sessions _____ Date range _____	❑	❑	❑
Home Exercise Program, # of sessions _____ Date range_____	❑	❑	❑
Physical Therapy, # of sessions _____ Date range_____	❑	❑	❑
Spinal Column Stimulator ❑ Trial ❑ Permanent Implant	❑	❑	❑
Biofeedback	❑	❑	❑
Bracing	❑	❑	❑
Rest	❑	❑	❑
Spine Surgery	❑	❑	❑
TENS Unit	❑	❑	❑
Medications ❑ **NO PREVIOUS MEDICATIONS**			
Topical Cream, type _____ Date range _____	❑	❑	❑
Anti-inflammatories, type _____ Date range _____	❑	❑	❑
Muscle Relaxants, type _____ Date range _____	❑	❑	❑
Nerve Pain Medications, type _____ Date range _____	❑	❑	❑
Opioids, type _____ Date range _____	❑	❑	❑
Injections ❑ **NO PREVIOUS INJECTIONS**			
Trigger Point Injections, Date completed _____	❑	❑	❑
Joint Injection, type _____ Date completed _____	❑	❑	❑
Joint Injection, type _____ Date completed _____	❑	❑	❑
Epidural Steroid Injection, Date completed _____	❑	❑	❑
Medial Branch Blocks/Facet Injections , Date completed _____	❑	❑	❑
SI Joint Injections , Date completed _____	❑	❑	❑
Radiofrequency Ablation , Date completed _____	❑	❑	❑

Other Treatments _____

_____

Current Medications

Are you taking a **prescribed blood-thinner or aspirin**, if so, which one? _____

Name/phone of the doctor that prescribes your blood thinner: _____

Are you taking any NSAID's or OTC pain medication, if so, which one(s)? _____

Please list **ALL** medications you are currently taking. Attach an additional sheet if required.

Medication Name	**Dose**	**Frequency**	**Medication Name**	**Dose**	**Frequency**
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Allergies - Please list all allergies that you have, **DO NOT LIST SIDE EFFECTS**

Medication Name that I'm Allergic to:	The Allergic Reaction I have is:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Are you allergic to any of the following?

Iodine ❑ No ❑ Yes

Tape ❑ No ❑ Yes

Latex ❑ No ❑ Yes Do you require special rescue measures for your latex allergy? ❑ No ❑ Yes

❑ **I HAVE NO KNOWN ALLERGIES**

Past Medical History /Problem List

Are you currently pregnant? ❑ No ❑ Yes Are you post-menopausal? ❑ No ❑ Yes

Do you plan on becoming pregnant? ❑ No ❑ Yes

Have you had two or more falls in the last year? ❑ No ❑ Yes

Have you received a pneumonia vaccination? ❑ No ❑ Yes

Have you been diagnosed with hypertension? ❑ No ❑ Yes Date _____

Mark any other conditions/diseases that you have been **DIAGNOSED** with:

❑ Asthma	❑ Heart Disease	❑ Migraines
❑ Cancer, type _____	❑ Hepatitis, type _____	❑ Osteoarthritis/Osteoporosis
❑ Diabetes, type _____	❑ HIV/AIDS	❑ Peripheral Vascular Disease
❑ Emphysema/COPD	❑ High Blood Pressure	❑ Shingles
❑ Epilepsy	❑ Kidney Disease	❑ Sleep Apnea
❑ Fibromyalgia	❑ Lupus	❑ Stroke

❑ Other _____

❑ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

Past Surgical History

Do you currently have an implanted ICD, pacemaker, or defibrillator? ❑ No ❑ Yes

Please list prior surgeries or procedures in the table below. Attach an additional sheet if required.

Date	Surgery/Procedure	Physician

❑ **I HAVE NO SIGNIFICANT SURGICAL HISTORY**

Family History - Mark all appropriate diagnoses as they pertain to your BIOLOGICAL family members only.

- ❑ Anxiety/Depression
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Headaches
- ❑ Heart Disease/Stroke
- ❑ High Blood Pressure
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ Substance Abuse

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

Social History

Smoking: ❑ Current every day ❑ Current some days ❑ Former smoker ❑ Never smoker

Alcohol: ❑ Current alcoholism ❑ History of alcoholism ❑ Social alcohol use ❑ No alcohol use

Marijuana: ❑ Current use ❑ Former use ❑ Medical Marijuana Card Holder ❑ Never used

Illegal Drugs: ❑ Current use, list which ones _____

❑ Former use, list which ones _____

❑ Never used

Narcotic and Prescription Medications:

I am currently using someone else's prescription medications ❑ No ❑ Yes

If yes, please list which ones _____

I have abused narcotic and/or prescription medications ❑ No ❑ Yes

If yes, please list which ones _____

Review of Systems - Mark all of the following symptoms that you **CURRENTLY** suffer from:

Constitutional:
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Fatigue
- ❑ Fevers
- ❑ Night Sweats

Cardiovascular/Respiratory:
- ❑ Chest Pain
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Swelling in the Feet

Gastrointestinal:
- ❑ Constipation
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Nausea/Vomiting

Genitourinary/Nephrology:
- ❑ Blood in Urine
- ❑ Involuntary Urination
- ❑ Loss of Bowel Control
- ❑ Painful Urination
- ❑ Pelvic Pressure

Ears/Nose/Throat/Neck:
- ❑ Difficulty Hearing
- ❑ Earaches
- ❑ Hay fever/Allergies
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

Eyes:
- ❑ Recent Visual Changes

Neurological:
- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling
- ❑ Weakness

Psychiatric:
- ❑ Anxiety/Stress
- ❑ Depressed Mood
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

Musculoskeletal:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Neck Pain

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I certify that my Medical History is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Arizona Pain Specialists provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

PHOTOGRAPHS I consent to taking and reproducing pictures of me in any form (e.g., photograph, film, tape, etc.) in connection with my diagnosis, care and treatment (including surgical procedures). These pictures will be used for purposes related to treatment, scientific and educational purposes, billing, coordination of care, and healthcare operations, such as quality assurance, patient safety and identification.

RELEASE OF INFORMATION I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Arizona Pain Specialists physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____ _____

Signature of Patient or Representative Date

_____

Relationship to Patient

Patient Demographic Information

Patient Name: _____ Date of Birth: _____

Social Security Number _____ - _____ - _____ Gender: ❑ Male ❑ Female

Street Address: _____

City/State/Zip: _____

Email: _____

Physical Address Same as Mailing? ❑ Yes ❑ No If not, please list mailing address:

_____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Patient Primary Insurance Plan

Payer (example BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are ***not*** the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are ***not*** the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: _____

Agent Name: _____ State of Injury: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

Injury Claim

Is your pain the result of a Motor Vehicle Accident or Personal Injury? (legal term describing injury sustained to your person by negligence of another) ❑ Yes ❑No If yes, you will be asked to complete a separate form

Certification

I certify that the above information is accurate, complete and true. I understand that this will become part of my medical record.

Signed:_____ Date: _____

Patient or Guardian or Patient Representative

Printed Name: _____

Financial Policy

ARIZONA PAIN
WE CHANGE LIVES HERE
a Pain Doctor Company

Thank you for choosing Arizona Pain Specialists! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. Please carefully review this Financial Policy, initial each section and sign the agreement to indicate your acceptance of its terms.

Payment is Due at the Time of Service

1. All co-payments, deductibles, coinsurance and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment. If you arrive without your co-payment, we may ask you to reschedule your appointment. We accept cash, checks, debit and credit cards.

2. In the event you need a procedure, we will provide an estimate of your insurance required deductible and co-insurance amounts. Prepayment of this estimate is due at the time the procedure is scheduled or by phone prior to the procedure date. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim.

3. Patient-responsible balances are due when you check in for your appointment.

4. We designate accounts **Self-Pay** under the following circumstances: (1) patient does not have health insurance coverage, (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, or (4) patient does not have a valid insurance referral on file**.**

5. We request at least **24-hours** advanced notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Initial: _____

Proof of Insurance

1. Please bring your insurance card(s) and a valid photo ID with you to each appointment.

2. It is your responsibility to notify the Practice in a timely manner of changes in your health insurance coverage. If the Practice is unable to process your claim within your health insurance carrier's filing limits, or lack of your response to insurance carrier inquiries due to untimely notice, you will be responsible for all charges.

3. If we are not part of your insurance carrier's network (out of network) or your insurance carrier pays you directly, you are obligated to forward the payment immediately to the Practice.

Initial: _____

Referrals and Authorization

1. The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and co-payments, which are your responsibility.

2. If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance. As a matter of course, the Practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission or by an employee of the practice.

3. The Practice may provide services that your insurance carrier's plan excludes or requires prior authorization. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

Initial: _____

Billing and Refunds

1. If we must send you a statement, the balance is due in full within 30 days of the statement date.

2. 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 for collection. This may result in adverse reporting to credit bureaus and additional legal action. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order to service your account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide.

3. You will be charged a fee for returned checks according to the Public Fee Schedule.

4. Our Practice treats patients regardless of financial status. We offer financial assistance in the form of a sliding scale discount based on verifiable household income.

5. If you make an overpayment on your account, we will issue a refund only if there are no other outstanding balances for medical services on your account or any other account(s) with the same financial responsible party. **Initial: _____**

Additional Information

1. The Privacy Rule allows you to receive a copy of your personal medical and billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. **Initial: _____**

2. The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. All requests require an office visit. **Initial: _____**

3. By initialing this section, I acknowledge that I have received and reviewed, or have been given opportunity to receive and review, a copy of the Practice's Notice of Privacy Practice. **Initial: _____**

4. By initialing this section, I acknowledge that I have received a copy of the Practice's Public Fee Schedule. **Initial: _____**

5. By initialing this section, I acknowledge that I have received a copy of the Practice's Statement of Patient's Rights. **Initial: _____**

6. By initialing this section, I acknowledge that I have received a copy of the Practice's Advanced Directive Statement. **Initial: _____**

Practice Code of Conduct

We are pleased to serve you and glad that you chose Arizona Pain as your new pain management provider. We will always strive to provide exceptional care for you.

Reasons that Arizona Pain may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing.

Initial: _____

Public Fee Schedule

ITEM	**FEE CHARGED**
Failure to Cancel your Appointment within 24 hours of the schedule time	$50.00 per Clinic incident $100.00 per Procedure or EMG
No Show for your appointment	$50.00 per Clinic incident $100.00 per Procedure or EMG
Late Arrivals – if you arrive 15 minutes past your arrival time, and we must reschedule your	$50.00 per Clinic incident $100.00 per Procedure or EMG appointment
Return Check Fee	$30.00 per incident
Completion of Disability Forms	Costs below are per each occurrence: **FMLA** - $50.00 each completion **Temporary Disabled Parking Permit** - $5.00 **Short Term Disability Form** - $25.00

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of Arizona Pain Specialists, PLLC, 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 the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: _____

Signed:_____ Date: _____

HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE
OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient:_____**Date of Birth:** _____

I. My Authorization

I authorize Arizona Pain Specialists, PLLC, its agents and employees to use or disclose the following health information.

All of my health information

My health information for the following condition(s):_____

I do not authorize disclosure of my health information

The above party may disclose this health information to the following recipient(s), please include medical providers, family, and friends:

Name, relationship and/or organization _____

_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient:_____Date: _____

If the patient is a minor or unable to sign please complete the following:

Patient is a minor:_____years of age
Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

Parent Legal Guardian Court Order Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

I consent to have the above information released.
I do not consent to have the above information released.

Signature of Patient or Authorized Representative:_____Date: _____

PAIN DOCTOR
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Notice of Privacy Practice

Effective Date September, 2015

This Notice Describes How Medical Information About You May Be Used, Disclosed and How You Can Get Access to This Information. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer at 480.563.6400.

Our Pledge Regarding Medical Information.

We understand that medical information about you and your health is personal. We are committed to protecting medical information in a reasonable and appropriate manner. We create a record of the care and the services you receive at Pain Doctor, Inc. and its affiliates (PDI). We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you, your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and practices concerning medical information about you; and
- follow the terms of this notice that is currently in effect.

How We May Use and Disclose Medical Information About You. The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

- For Treatment. We can use your health information and share it with other professionals who are treating you.
- For Payment. We can use and share your health information to bill and get payment from health plans or other entities.
- For Health Care Operations. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We can share and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
- Individuals Involved In Your Care or Payment for Your Care. When appropriate, we can share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.
- Research. Under certain circumstances, we can share and disclose Health Information for research. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
- As Required By Law. We can share and disclose Health Information about you when required to do so by federal, state or local laws.
- To Advert a Serious Threat to Health or Safety. We can share and disclose Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- For All Other Uses and Disclosures. All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization.
- Organ and Tissue Donation. We can share health information about you with organ procurement organizations.
- Workers' Compensation, Law Enforcement and Other Government Agencies. We can share health information about you for workers' compensation, for law enforcement purpose and healthcare oversight agencies for activities authorized by the law, or special government functions such as military, national security and presidential protection.
- Public Health Risks. We can share Health Information about you for certain situations:
    - to prevent or control disease;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products that they may be using;
    - notify a person who may have been exposed to a disease or may be at risk.
- Lawsuits and Legal Disputes. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

- Comply with the Law. We will share information about you if state or federal laws require it, including with Health and Human Services should it want to see we are complying with federal privacy law.
- Coroners, Medical Examiners and Funeral Directors. We can share Health Information to a coroner, medical examiner or funeral director when an individual die.

Uses and Disclosures That Require Us To Give You An Opportunity To Object and Opt Out.
In these cases, you can tell us what we can share:

1. Share information with your family, close friends, or others involved in your care.
2. Share information in a disaster relief situation
3. Include your information in a hospital directory
4. Contact you for fundraising efforts. We may contact you, but you can tell us not to contact you again.

Your Written Authorization Is Required For Other Uses And Disclosures.
In these cases, we never share your information unless you have given us written permission:

1. Marketing Purposes
2. Sale of your information
3. Sharing of psychotherapy notes

*If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But any disclosure that we made in reliance on your authorization **before** you revoked it will not be affected by the revocation.*

Your Rights.
You have the following rights regarding Health Information we have about you:

- Right to Inspect and Obtain a Copy of Your Medical Records. You can ask to see or get an electronic copy of your medical record or other health information we have about you. If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your records be given to you or transmitted to another individual or entity. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- Right to Correct Your Medical Records. You can ask us to correct health information about you that you think is incorrect or incomplete. We may also say "no" to your request, but we will tell you why in writing within 60 days. To request an amendment, you must make your request, in writing, to our Privacy Officer.

- Right to an Account of Disclosures. You can ask us for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures. We will provide one accounting per year for free. There will be a reasonable, cost-based fee if you ask for another accounting within the 12 month period. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

- Right to Limit Information We Share. You have the right to ask us not to use or share certain Health Information for treatment, payment, or health care operations. We are required to agree to your request, unless it would affect your care. If you pay for services out-of-pocket in full, for a specific item or service, you can ask that your Protected Health Information is not shared with your health insurer for the purposes of payment. We will say yes unless a law requires us to share that information.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing to our Privacy Officer. We will say yes to all reasonable requests.

- Right to a Paper Copy of This Notice. You have right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer. You may obtain a copy of this notice at our websites at www.arizonapain.com or www.paindoctor.com

- Changes to this Notice. We reserve the right to change this notice and make a new notice that applies to the Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

- Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office by contacting our Privacy Officer at 480.563.6400. The Secretary of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be in writing. You will not be penalized for filing a complaint.

  Our facility is licensed as an Outpatient Treatment Center and we are inspected regularly by AZDHS. The inspection report is available to all patients upon request.

STATEMENT OF PATIENT RIGHTS – Pain Doctor, Inc.

Patients Have the Right To:

- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
- Receive privacy in treatment and care for personal needs;
- Review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- Receive a referral to another health care institution if this facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
- Participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
- Participate or refuse to participate in research or experimental treatment;
- Receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights;
- Be treated with dignity, respect, and consideration;
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault or except as allowed in R9-10-1012(B), restraint or seclusion;
- Not be subjected to retaliation for submitting a complaint to the Department or another entity;
- Not be subjected to misappropriation of personal and private property by any clinic personnel member, employee, volunteer, or student;
- Consent to or refuse treatment, except in an emergency and to refuse or withdraw consent for treatment before treatment is initiated;
- Be informed of alternatives to medications or surgical procedure and associated risks and possible complications of medications or surgical procedure, except in an emergency;
- Be informed of the clinic's policy on health care directives, and the patient complaint process;
- Consent to photographs before a patient is photographed, except that a patient may be photographed for identification and administrative purposes;
- Provide written consent to the release of information in the patient's medical records or financial records, except as otherwise permitted by law.

Patients Have the Responsibility To:

- Be honest about matters that relate to you as a patient.
- Provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertaining to your health.
- Report any perceived risks in your care.
- Report any unexpected changes in your condition to those responsible for your care and welfare.
- Follow the care, service, or treatment plan developed.
- Ask any questions when you do not understand or have concerns about your plan of care.
- Understand the consequences of the treatment alternatives and not following your plan of care.
- Know the staff who are caring for you.
- Be considerate and respectful of the rights of both fellow patients and staff.
- Honor the confidentiality and privacy of other patients.
- Be considerate of the property of Arizona Pain Specialists.
- Assure the financial obligations of your healthcare are fulfilled as promptly as possible.

How to File a Complaint

Patients or patient's representatives that have any concerns about patient rights, safety, or complaints or grievances, please contact the Clinical Manager for that clinic or call 480-563-6400 and ask to speak with the Clinical Manager. Written correspondence will be forwarded to the Clinical Manager for the patient. Any patient or patient's representative may submit a grievance without retaliation.

Patients also have the right to contact the Department of Health at any time at:

Arizona Department of Health Services
Attn: Licensing Medical Facilities
150 N. 18th Ave., Suite 450
Phoenix, Arizona 85007
(602) 364-3030
- or -
www.medicare.gov/ombudsman/resources.asp

Per A.R.S. § 36-436.01(C) - The Practice's schedule of rates is available for review upon request. Per A.R.S. § 36-425(D), State inspection records are maintained in the Administrative office located at 8767 E. Via De Ventura Suite# 226, Scottsdale, AZ 85258. Requests may be made by calling 602-563-6400 and asking to speak with the Program Manager for Clinical Compliance.

PAIN DOCTOR
WE CHANGE LIVES HERE

ADVANCED DIRECTIVE STATEMENT

An “Advance Directive” is a general term that refers to your oral and/or written instructions about your future medical care, in the event that you become unable to speak for yourself.

Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like a copy of the Official AZ State advance directive forms, please visit http://www.azsos.gov/adv_dir/.

If you have a Living Will or Medical Power of Attorney, we encourage you to provide us with a copy to be placed in your chart. This will only be used in the unlikely event that you are unable to make your own decisions.