PALOVERDE
PAIN SPECIALISTS

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk if you have any questions or are unsure how to complete any section of this form.

Patient Information

Today's Date: _____

Patient's Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Street Address: _____

City/State/Zip: _____

Email: _____

Physical Address Same as Mailing? Yes ☐ No ☐

If not, please list mailing address: _____

_____

Occupation: _____ City: _____

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Work

Email: _____ Driver's License # _____ State: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

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

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

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Primary Insurance Plan

Payer (e.g. 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)

Insurance (e.g. 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: _____

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 job-related accident, which occurred within the last two years, and was caused by the fault or negligence of another? ☐ yes ☐ no

Have you hired an attorney for purposes of making any claims arising from that accident? ☐ yes ☐ no
If yes to either question, you will be asked to complete two additional forms.
I certify that the above information is accurate, complete and true.

Patient Signature:_____ Date:_____

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Your Name: _____ Today's Date: _____

Height: _____ Weight: _____ Lbs: _____

Referral

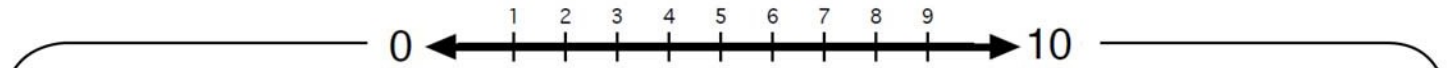
Were you referred to our clinic by another physician? If so, whom? _____

If not, how did you hear about us? ☐ TV ☐ Radio ☐ Insurance ☐ Company ☐ Family ☐ Friend ☐ PCP

☐ Facebook ☐ Twitter ☐ YouTube ☐ Other Website: _____

☐ If Family/Friend/Current Patient, then whom? _____

Pain Description



Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

_____ What number on the pain scale (0-10) best describes your pain **right now**?

_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

_____ What number on the pain scale (0-10) best describes your **average** pain over the **last month**?

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

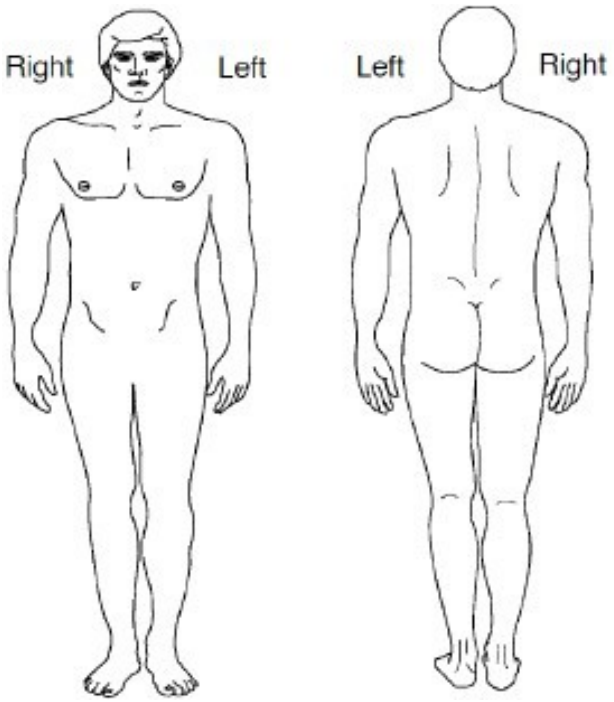
"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A" = aching



Pain Description - Check all of the following that describe of your pain:

☐ Aching
☐ Cramping
☐ Dull
☐ Hot/Burning
☐ Numbness
☐ Shock-like
☐ Shooting
☐ Spasming
☐ Squeezing
☐ Stabbing/Sharp
☐ Throbbing
☐ Tingling/Pins & Needles
☐ Tiring/Exhausting

Pain Frequency

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

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life ☐ Normal Work ☐ Sleep

☐ General Activity ☐ Recreational Activities ☐ Walking

☐ Mood ☐ Relationship with people ☐ Other: _____

☐ My goal is to resume normal activities

In the past three months have you developed any new:

☐ Balance Problems ☐ Fevers ☐ Nausea ☐ Vomiting

☐ Difficulty Walking ☐ Sleep ☐ Chills

☐ Numbness/Tingling-Where? ☐ Bowel incontinence ☐ Others: _____

☐ Progressive Weakness ☐ I Have Not Recently Developed Any of the Above Conditions

Diagnostic Tests and Imaging

☐ MRI of the_____Date:_____Facility: _____

☐ X-ray of the_____Date:_____Facility: _____

☐ CT scan of the_____Date:_____Facility: _____

☐ EMG/NCV study of the_____Date:_____Facility: _____

☐ Ultrasound of the_____Date:_____Facility: _____

☐ Other diagnostic testing: _____

☐ **I Have Not Had Any Diagnostic Tests Performed for My Current Pain Complaints**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

	Beneficial	
☐ Chiropractic	Yes	No
☐ Physical Therapy	Yes	No
☐ Psychological Therapy	Yes	No
☐ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Joint Injection – Joint(s)_____	Yes	No
☐ Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Nerve Blocks – Area/Nerve(s)_____		
☐ Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant	Yes	No
☐ Spine Surgery	Yes	No
☐ Trigger Point Injection – Where?_____	Yes	No
☐ Vertebroplasty / Kyphoplasty – Level(s)_____	Yes	No
☐ Other:_____	Yes	No

☐ **I Have Not Had Any Prior Treatments for My Current Pain Complaints**

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Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐ No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐ No

Which type of anesthesia did you react adversely to? Please check all that apply.

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

☐ Gallbladder removal _____

☐ Appendectomy _____

☐ Other _____

Female Surgeries

☐ Caesarean section _____

☐ Hysterectomy _____

☐ Laparoscopy _____

☐ Ovarian _____

☐ Other _____

Heart Surgery

☐ Valve replacement _____

☐ Aneurysm repair _____

☐ Pace Maker _____

☐ Other _____

Joint Surgery

☐ Shoulder _____

☐ Hip _____

☐ Knee _____

Spine/ Back Surgery

☐ Discectomy (levels) _____

☐ Laminectomy _____

☐ Spinal fusion (levels) _____

Other Common Surgeries

☐ Hemorrhoid surgery _____

☐ Hernia repair _____

☐ Thyroidectomy _____

☐ Tonsillectomy _____

☐ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary): _____

_____

☐ **I Have Never Had Any Surgical Procedures Done**

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Current Medications

Are you taking a prescribed **blood-thinner** medication? ☐ Yes ☐ No If yes, please check which one:
Prescribing Physician:_____

☐ Aggrenox ☐ Coumadin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pleta ☐ Pradaxa

☐ Ticlid ☐ Warfarin ☐ Xarelto ☐ Other _____

☐ Aspirin ☐ Advil, Aleve, other NSAIDS

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

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name: **Allergic Reaction Type:**

_____

_____

_____

_____

_____

Please check if you are allergic to ☐ Iodine or ☐ Tape Are you allergic to shellfish? ☐ Yes ☐ No

***Are you allergic to latex?** ☐ Yes ☐ No *If yes, you will be asked to complete a separate questionnaire

Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

☐ **I Have No Significant Family Medical History** ☐ **I Am Adopted (No Medical History Available)**

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No If so, are you currently pregnant? ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar school ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Current Alcoholism ☐ Daily Limited Alcohol Use ☐ History of Alcoholism
☐ Never Drinks Alcohol ☐ Social Alcohol Use

Tobacco Use: ☐ Current Tobacco ☐ Former Tobacco User ☐ Never Used Tobacco

Prescribed Medical Marjuana ☐ Yes ☐ No

Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs (Which:_____)

☐ Currently Using Someone Else's Prescription Medications

☐ Formerly Used Illegal Drugs (not currently using) (Which:_____)

☐ History of any addiction: ☐ Personal ☐ Family

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No (Which:_____)

Have you ever been discharged (fired) from a pain management practice in the past?

If so, please explain here:_____

_____

_____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type _____
- ☐ Diabetes – Type _____
- ☐ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraines
- ☐ Sinusitis
- ☐ Hearing Loss
- ☐ Snoring

Cardiovascular / Hematologic
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Pacemaker/Defibrillator
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Stroke

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema / COPD ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ PE
- ☐ Obstructive Sleep Apnea

Musculoskeletal
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid arthritis
- ☐ Tennis Elbow
- ☐ Vertebral Compression Fracture
- ☐ Reflex Sympathetic Dystrophy/CRPS

Gastrointestinal
- ☐ Bowel Incontinence
- ☐ Acid Reflux (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation

Genitourinary/Nephrology
- ☐ Bladder Infection(s)
- ☐ Dialysis
- ☐ Kidney Infection(s)
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Hepatic
- ☐ Hepatitis A (active / inactive / unsure)
- ☐ Hepatitis B (active / inactive / unsure)
- ☐ Hepatitis C (active / inactive / unsure)

Neuropsychological
- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Prescription Drug Abuse
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Other Diagnosed Conditions

Who and (approximately when) was the last provider to prescribe you pain medications or other controlled substances?

_____

_____

Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, on previous page.

Constitutional:
☐ Chills
☐ Difficulty Sleeping
☐ Easy Bruising
☐ Excessive Sweating
☐ Excessive Thirst
☐ Fatigue
☐ Fevers
☐ Insomnia
☐ Low Sex Drive
☐ Night Sweats
☐ Unexplained Weight Gain
☐ Unexplained Weight Loss
☐ Weakness

Eyes:
☐ Recent Visual Changes

Ears/Nose/Throat/Neck:
☐ Dental Problems
☐ Earaches
☐ Hearing Problems
☐ Nosebleeds
☐ Recurrent Sore Throats
☐ Ringing in the Ears
☐ Sinus Problems
☐ Snoring

Cardiovascular:
☐ High Blood Pressure
☐ Chest Pain
☐ Deep Vein Thrombosis
☐ Fainting
☐ Cough
☐ Irregular Heartbeat
☐ Lightheadedness
☐ Shortness of Breath During Sleep
☐ Swelling in the Feet

Respiratory:
☐ Abdominal Cramps
☐ Wheezing
☐ Pulmonary Embolism
☐ Shortness of Breath on Exertion/Effort
☐ Shortness of Breath at Rest
☐ Snoring

Gastrointestinal:
☐ Acid Reflux
☐ Constipation
☐ Coffee Ground Appearance in Vomit
☐ Dark and Tarry Stools
☐ Diarrhea
☐ Hernia
☐ Vomiting

Musculoskeletal:
☐ Joint Pain
☐ Joint Stiffness
☐ Joint Swelling
☐ Back Pain
☐ Muscle Spasms
☐ Neck Pain

Genitourinary/Nephrology:
☐ Blood in Urine
☐ Decreased Urine Flow/Frequency/Volume
☐ Erectile Dysfunction
☐ Flank Pain
☐ Pelvic Pressure
☐ Painful Urination

Neurological:
☐ Carpal Tunnel Syndrome
☐ Headaches
☐ Instability When Walking
☐ Numbness/Tingling
☐ Dizziness
☐ Seizures

Psychiatric:
☐ Depressed Mood
☐ Stress Problems
☐ Suicidal Thoughts
☐ Suicidal Planning
☐ Feeling Anxious

Skin:
☐ Itching
☐ Rashes
☐ Chronic Skin Infections

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Palo Verde Pain Specialists and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Palo Verde Pain Specialists to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Palo Verde Pain Specialists Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Palo Verde Pain Specialists to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Palo Verde Pain Specialists to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Palo Verde Pain Specialists will not release my Protected Health Information to any other party (including family) without my completing an Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance owed.

Signed:_____ Date: _____

PALOVERDE

PAIN SPECIALISTS

Financial Policy

Palo Verde Pain Specialists believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT -** is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment Palo Verde Pain Specialists reserve the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). If a prepayment is made for any services and a refund is due after insurance processes, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. I**NSURANCE -** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.
If our providers are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim is rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Palo Verde Pain Specialists only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case, the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **TOXICOLOGY LAB -** In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.

4. **COLLECTION -** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Palo Verde Pain Specialists reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Palo Verde Pain Specialists for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account, including wireless telephone numbers, which

could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

5. **RETURNED CHECKS -** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

6. **ACCOUNTING PRINCIPALS -** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. **FORMS AND CONSULTS FEES -** Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the provider. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

8. **CANCELLATIONS OR MISSED APPOINTMENTS -** If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $25 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you may be assessed a $150.00 missed procedure fee. Multiple missed visits may result in discharge from the practice.

9. **RESPONSIBILITY FOR PAYMENT -** I understand that I, personally, am financially responsible to Palo Verde Pain Specialists for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS -** I hereby assign, transfer, and set over directly to Palo Verde Pain Specialists sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Palo Verde Pain Specialists to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Palo Verde Pain Specialists. I authorize Palo Verde Pain Specialists to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **RELEASE OF INFORMATION -** I hereby authorize the and direct Palo Verde Pain Specialists to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy of Palo Verde Pain Specialists and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Palo Verde Pain Specialists. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Palo Verde Pain Specialists. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable)_____ **Date:**_____

Please print the name of the patient _____

Your Name:_____ Date of Birth:_____

Authorized Parties

By signing below, I authorize Palo Verde Pain Specialists, its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party Relationship

_____

_____

_____

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

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

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, diagnosis 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.

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

Signature of Patient or Legal Guardian:_____Date: _____

Authorized Parties

I acknowledge that I have had the opportunity to review Palo Verde Pain Specialists Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

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

Privacy Officer
Palo Verde Pain Specialists
13090 N 94th Drive, Suite 212
Peoria, AZ 85381

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

Signature

Signature of Patient or Legal Guardian_____Today's Date _____

Relationship to Patient _____

Authorization to Disclose Health Information to Palo Verde Pain Specialists

Patients Name:_____ Date of Birth: _____
*I hereby authorize _____

*Phone:_____*Fax: _____
or its agent(s) to disclose my health information as described in this authorization to:

Palo Verde Pain Specialists
Office 833-578-7246
Fax 602-714-7176
13090 N 94th Drive, Suite 212
Peoria, AZ 85381

*The health information is being disclosed for the following purpose: (check appropriate box):
☐Change of Insurance or Physician ☐ Continuation of Care

*I understand I may revoke this Authorization at any time by sending written notice of my revocation to Palo Verde Pain Specialists health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event, or condition. If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.
*I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.
*I understand that Palo Verde Pain Specialists may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

***I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.**

_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative Date
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative and Telephone Number Relationship / Capacity to

PALOVERDE
PAIN SPECIALISTS

Patient Health Questionnaire (PHQ-2)

Patient Name:_____ Date of Visit:_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

If you answered YES to any of the above questions please complete the below questions:

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
2. Feeling tired or having little energy	0	1	2	3
3. Poor appetite or overeating	0	1	2	3
4. Feeling bad about yourself- or that you're a failure or have let yourself or your family down	0	1	2	3
5. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
6. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
7. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____+_____+_____

Add Totals Together _____

8. If you checked off any problems, how difficult have those problems made it for you to do you work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐ Very difficult ☐ Extremely difficult