New Patient Information Record

All Information Must be Completed Before the Doctor Will See You

PATIENT INFORMATION

Last Name: First: MI:

Social Security #: Date of Birth: Gender: ☐ Male ☐ Female

Home Phone: ( ) Cell Phone: ( )

Address:

City: State: Zip:

E-Mail:

Race: ☐ African American ☐ American Indian/Alaska Native ☐ White ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language:_____

Referring Physician: Telephone: ( )

Primary Care Physician: Telephone: ( )

EMERGENCY CONTACT

Name: Relationship: Telephone: ( )

Advance Directive: Telephone: ( )

PRIMARY INSURANCE

Please check all that apply: ☐ Insurance ☐ Worker's Compensation ☐ Attorney

Insurance Company: Cardholder's Name:

SS#: DOB: Relationship to Patient:

Member #: Group #: Customer Service p#::

Cardholder's Employer:

SECONDARY INSURANCE

(We ***ONLY*** bill secondary if Primary or Secondary is **Medicare)**

Insurance Company: Cardholder's Name:

SS#: DOB: Relationship to Patient:

Member #: Group #: Customer Service p#::

Cardholder's Employer:

Acknowledgement of Policies and Privacy Practices

Communication Authorization

I hereby authorize Arizona Center for Pain Relief to communicate with the following individual(s) regarding all aspects of my medical care and financial obligations:

Name: Relationship: Telephone: ( )

Name: Relationship: Telephone: ( )

Treatment Authorization

I hereby authorize Arizona Center for Pain Relief to render health care to me during my visit.

Privacy Notice

I have been given the option to review Arizona Center for Pain Relief's "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of that "Notice of Privacy Practices" at any time.

Medical Records

I am aware that I may request a copy of my medical records at any time. In addition, I understand that there may be a fee associated with my request and that without a release on file stating otherwise, my records can only be picked up by me or mailed to the address on file. Please note third party request are also the patient's financial responsibility after 60 days of non-payment.

Insurance Benefits

Arizona State Law requires that medical claims be paid by my insurance carrier within 30 days. As a courtesy, Arizona Center for Pain Relief will bill my insurance for all covered services. If my insurance carrier has not appropriately paid the submitted claim within 30 days, all outstanding balances will become my responsibility. I understand that **co-payments, deductibles, and co-insurances are due at time of service**.

Secondary Insurance

I understand that Arizona Center for Pain Relief **does not file claims with secondary insurance** carriers, **unless** I have **Medicare**, and I am fully responsible for secondary insurance amounts.

Insurance Authorization

I hereby authorize Arizona Center for Pain Relief to furnish information to my insurance carriers and/or worker's compensation company concerning my illness and treatment.

Assignment of Benefits

I hereby assign Arizona Center for Pain Relief all payments for medical services rendered to my dependents of myself. I understand that I am responsible for any amount not covered by insurance.

Pre-/Prior Authorizations

If your insurance requires this office to obtain a “pre-/prior authorization” for medical care, there is a **$10.00 fee** to cover the cost. This must be paid in advance prior to the authorization’s submission and there is no guarantee that your insurance will approve the authorization.

Letter of Medical Necessity

If your insurance requires this office to generate a “letter of medical necessity” for medical care, there is a **$35.00 fee** to cover this cost. This must be paid in advance prior to a letter of medical necessity being generated and there is no guarantee that your insurance will make an approval based on this letter of medical necessity.

Appeals

If your insurance requires this office to make an “appeal” for medical care, there is a **$50.00 fee** to cover this cost. This must be paid in advance prior to an appeal being generated by this office. There is no guarantee that your insurance will make an approval based on this appeal.

Peer to Peer

If your insurance requires that our physician make a “peer to peer” phone call for medical care, there is a **$50.00 fee** to cover this cost. This must be paid in advance prior to a “peer to peer” phone call being made. There is no guarantee that your insurance will make an approval based on this “peer to peer” phone call.

Signature: _____ Date: _____

Witness (office use): _____ Date: _____

Financial Policy & Waiver

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Insurance Co-Payments/Deductibles/Co-Insurance

In accordance with my insurance contract, I understand that **co-payments, deductibles, and co-insurances are due at time of service**. This contractual obligation requires that payments be made at time of service, so it may be necessary to reschedule my appointment if my co-payment, co-insurance, and/or deductible cannot be satisfied. **All outstanding patient balances over 30 days will be subject to a 10% per annum interest rate.**

Verification of Benefits and Non-Covered Services

Insurance policies may differ per patient plan. The Arizona Center for Pain Relief may provide services that my insurance plan excludes. Although the Arizona Center for Pain Relief makes every attempt to notify me of my benefits, it is ultimately **my responsibility to verify and understand my coverage benefits and exclusions. All non-covered services are my responsibility and may be due at time of services.**

Change of Insurance

I must notify Arizona Center for Pain Relief within 30days of new insurance so that all claims can be re-submitted as appropriate. In the event that my insurance changes and I **fail to notify the office within 30 days there will be a $75 administrative fee** assessed upon the re-working of my account. The above fee must be paid in full at the time of notification of all outstanding balances and will become my responsibility.

Private Pay

If I have no insurance coverage, or insurance with which the Arizona Center for Pain Relief does not participate, full payment is expected at the time of service.

Collections

I understand that once an account is placed in a collection status, all future services must be paid in full at time of service. If my account is placed into collections, I will be responsible for all collection costs equal to 50% of my outstanding balances, but no less than $25.

Cancellations/No-Show

Office Visit cancellations made less than 24 hours in advance or if I "No Show" will be subject to a **$30.00** fee. **New Patient cancellations made less than 48 hours** in advance or "No Show" will be subject to a **$75.00** fee**. Procedure cancellations made less than 48 hours** in advance or "No Show" will be subject to a **$150.00** fee. These charges are my responsibility, will not be billed to my insurance carrier, and will be due at my next appointment.

Checks

Due to large quantities of returned checks the **Arizona Center for Pain Relief no longer accepts checks for payment at time of services**. However, I can still submit payment by check for any statement received via mail. Returned checks will be subject to a **$50.00** returned check fee.

Signature: Date:

ARIZONA cpr CENTER for PAIN RELIEF

Urine Drug Screening Program

This notice is presented to explain the policy of the Arizona Center for Pain Relief regarding Narcotic Prescriptions and our Urine Drug Screening (UDS) program.

The possible treatments available for pain include various modalities, one of which is the use of narcotic and/or non-narcotic prescription medications. While these medications may be extremely beneficial, as with any other treatment, there are certain risk associated with their use or in order to illegally sell medication to others.

This is a major concern to us, as physicians. Additional, this unsafe and concerning practice has reached national prominence, earning the attention of multiple government and law enforcement agencies, including the United States Drug Enforcement Agency. At the Arizona Center for Pain Relief, we take this matter very seriously.

As part of our desire to ensure proper medication utilization, we employ a urine drug screen program. This program allows us to confirm the medications are being taken as prescribed. It also allows us to ensure the absence of other harmful agents, including recreational or street drugs.

Please understand a request to submit a sample is not an accusation. The vast majority of test preformed confirm proper medication usage. Additionally, we randomly test patients monthly, thus eliminating any bias we as providers, may have.

Patient's Financial Responsibilities

Regretfully, this may or may not be covered by your insurance. While a majority of insurance companies do, in fact, pay for this service some do not. For this reason, we have an advance beneficiary notice that you will need to sign if you are screened at our facility. This notice simply states that you understand this screen may not be covered by your insurance, and in the event that it is not, you will be financially responsible for the fees incurred. We will do our best to work with you if your insurance does not pay for this service, but please remember it is ultimately up to you to be aware of your benefits.

Additionally, please be aware that we use a third party lab for final confirmation of the screen. This means that you will receive an EOB (Explanation of benefits from your insurance regarding our initial screen and another from the third party that confirms our results. If you have any questions regarding the billing from our third party lab, please contact them directly.

Please remember that you may or may not receive medications from our facility and thus may or may not be tested. This notification is given to prevent any confusion or misunderstanding in the future, and to ensure that all patients understand our commitment to providing the best care and service.

Forms Completion Policy

All Information Must be Completed Before the Doctor Will See You

Patients may require forms to be completed by one of the providers (disability, FMLA, life insurance, MVA, etc.) Completion of forms requires administrative time to gather data, physician time to review, and time to complete the form. To expedite processing these forms, we have developed the following policy.

Disability, FMLA, Motor Vehicle Accident, Insurance Policy, etc. Forms cannot be completed on the day presented to the office. If you have seen the doctor within the past 30 days, then you may choose to leave the forms and the doctor will complete them within 10 business days. **There will be a $50 charge to the patient, payable upon submission of the forms**. If you have not seen the doctor in the last 30 days, you may need an appointment before the forms can be completed.

Letters on Arizona Center for Pain Relief letterhead for medical needs including but not limited to:

-Excuse for Jury Duty due to a medical condition	-Special consideration for needs	-Other specialized letter requests

There will be a $25 fee charged to the patient upon patient's receipt of the requested letter.

Handicapped Tags/Parking Permits
There will be a $15 fee charged to the patient, payable upon submission of the form(s).

We are not obligated to complete these forms. We reserve the right to refuse to complete any form. If records are requested, in addition to a completed form, then the form will be sent from our office once payment has been received from the company requesting the records. No forms or records will be sent to a third party without a signed release from the patient.

Signature: _____ Date: _____

Witness (office use): _____ Date: _____

Comprehensive Pain Questionnaire
All information must be completed prior to seeing the Doctor.

Complete this form prior to your first appointment at Arizona Center for Pain Relief. Your careful answers will help us understand your pain problem and design the best treatment program for you.

Name: Date:

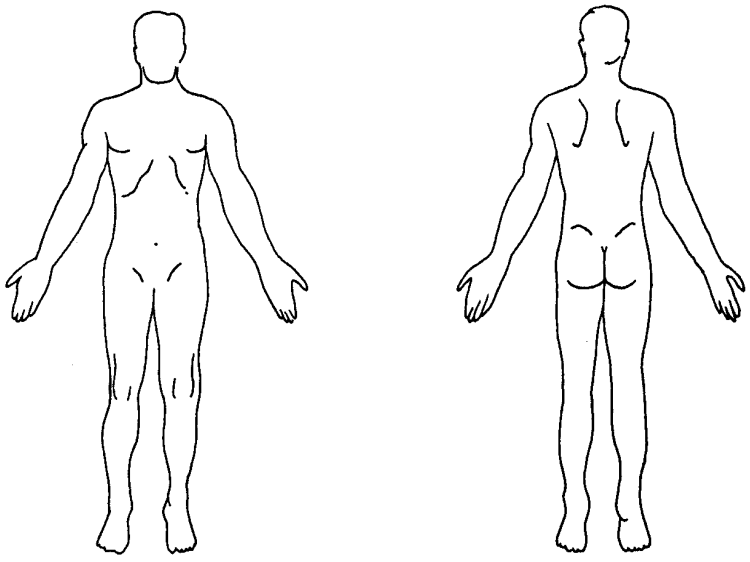
Date of Birth: Height: Weight:

CHARACTERISTICS OF PAIN (Chief Complaint):
What is the main problem for which you are seeking treatment at Arizona Center for Pain Relief?

HISTORY OF PRESENT ILLNESS

PAIN LOCATION
Please describe the location(s) of your pain:

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.



Front *Back*

ONSET OF PAIN / CAUSE OF PAIN
How did your current pain start?

☐ Injury at work ☐ Injury, not at work ☐ Treatment caused (e.g. surgery, etc.)

☐ Motor vehicle accident ☐ Illness ☐ Undetermined

PROGRESSION OF PAIN

☐ Acute (quick/severe) ☐ Gradual (slow) ☐ Sudden (unexpected) ☐ Variable (intermittent)

PAIN RATING VAS – Visual Analog Scale

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10
☺ ☹

Minimum Pain Level 0 1 2 3 4 5 6 7 8 9 10
☺ ☹

Maximum Pain Level 0 1 2 3 4 5 6 7 8 9 10
☺ ☹

PAIN DURATION

How long have you had your current pain problem(s)?

_____weeks _____months _____ years

PAIN FREQUENCY / TIMING OF PAIN

How often do you have your pain? (Please check one)

☐ Constantly (100% of the time) ☐ Nearly constantly (60%-95% of the time)
☐ Intermittently (30% to 60% of the time) ☐ Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst? (Please check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No typical pattern

ACTIVITIES & YOUR PAIN

Which activities have you avoided or limited during the past month because of pain"

☐ Going to work ☐ Performing household chores ☐ Doing yard work or shopping
☐ Socializing with friends ☐ Participating in recreation ☐ Having Sexual relations
☐ Exercise ☐ Sitting/Standing ☐ Walking

ASSOCIATED SYMPTOMS

☐ "Pins and Needles" ☐ Numbness ☐ Tingling ☐ Weakness

PAIN QUALITY

How would you describe the pain?

☐ Burning ☐ Cutting ☐ Sharp ☐ Shooting ☐ Throbbing

☐ Cramping ☐ Dull/Aching ☐ Pressure ☐ Other: _____

RELIEVING & AGGRAVATING FACTORS

How do the following affect your pain? (Please check one box for each item)

	Decrease	No Change	Increase
Laying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise	☐	☐	☐
Medications	☐	☐	☐

Relaxation	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel Movements	☐	☐	☐

PREVIOUS TREATMENT(S)

Please check all of the treatments you have tried for your pain and complete the appropriate column at the right.

Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
☐ Bed rest	_____	☐	☐	☐
☐ Traction	_____	☐	☐	☐
☐ Surgery	_____	☐	☐	☐
☐ Hypnosis	_____	☐	☐	☐
☐ Acupuncture	_____	☐	☐	☐
☐ Nerve block or other injections	_____	☐	☐	☐
☐ TENS	_____	☐	☐	☐
☐ Physical Therapy	_____	☐	☐	☐
☐ Exercise	_____	☐	☐	☐
☐ Heat / Ice	_____	☐	☐	☐
☐ Biofeedback	_____	☐	☐	☐
☐ Psychotherapy	_____	☐	☐	☐
☐ Chiropractic	_____	☐	☐	☐
☐ Other: _____	_____	☐	☐	☐

EFFECTS ON SLEEP

☐ No Effect ☐ Difficult to FALL asleep ☐ Difficult to STAY asleep

EFFECT ON BOWEL & BLADDER CONTROL

☐ No Effect ☐ Loss of bladder control ☐ Loss of bowel control

ASSISTING DEVICE(S)

Devices used to assist ambulation

☐ Cane ☐ Walker ☐ Wheelchair ☐ None

PAST MEDICAL HISTORY

Medical
Have you had any of the following health problems? (Please check all that apply)

☐ Angina or chest pain
☐ Arthritis
☐ Asthma or wheezing
☐ Anemia
☐ Chronic Cough
☐ Diabetes
☐ Heart Attack
☐ High blood pressure
☐ High cholesterol
☐ Kidney disease
☐ Liver disease
☐ Peptic Ulcer
☐ Reflux (GERD)
☐ Seizure or epilepsy
☐ Thyroid disease: please specify: hyper- or hypo-
☐ TIA or stroke
☐ Cancer (please specify what type):
_____
_____
☐ Other (please specify):
_____
_____

SURGERIES

Date (approximate)	Hospital	Type of Operation

ALLERGIES & SIDE EFFECTS

Please indicate the names of any medication to which you are allergic:
_____
_____

☐ Yes, I am allergic to dye put into my body (e.g. "X-ray dye")

MEDICATIONS, VITAMINS & SUPPLEMENTS

Please list any and all ***CURRENT*** medication(s) you are taking:

Medication Name	Dosage (e.g. mg/mcg)	How often? (e.g. once a day, 2x day)

Please list any and all ***PREVIOUS*** medication(s) you have tried in the past:

Medication Name	Dosage (e.g. mg/mcg)	How often? (e.g. once a day, 2x day)

Medical Marijuana Card: ☒ Yes ☐ No ☐ Other: _____

BLOOD THINNERS / ANTIBIOTICS

☐ Yes - If yes, which one(s): _____
☐ No

REVIEW OF SYSTEMS
Please check all items you feel are applicable to you.

General:
☐ Chills
☐ Fatigue
☐ Fever
☐ Night sweats
☐ Tiredness
☐ Weight change: ☐ Gain? ☐ Loss?

Skin:
☐ Itching
☐ Rashes or redness

HEENT:
☐ Vision changes
☐ Ringing in the ears
☐ Vertigo
☐ Seasonal allergies

Respiratory:
☐ Difficulty breathing
☐ Shortness of breath

Cardiovascular:
☐ Chest pain
☐ Palpitations (awareness of fast heart)

GI:
☐ Abdominal pain
☐ Constipation
☐ Diarrhea

Musculoskeletal:
☐ Joint Pain
☐ Joins Stiffness
☐ Swelling in joints

Neurological:
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Stool incontinence
☐ Urine incontinence
☐ Numbness
☐ Trouble walking
☐ Unsteadiness
☐ Weakness

Psychiatric:
☐ Anxiety
☐ Depression
☐ Insomnia
☐ Memory loss
☐ Suicidal ideation

Hematology:
☐ Abnormal bleeding
☐ Blood clots
☐ Bruise easily

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problems, including your pain? ☐Yes ☐No

If *yes*, when: _____

Have you ever considered suicide? ☐ Yes ☐No

GENERAL FAMILY ILLNESS

Please check any health problems that are known to run in your family:

☐ Angina or chest pain
☐ Arthritis
☐ Asthma or wheezing
☐ Anemia
☐ Chronic Cough
☐ Diabetes
☐ Heart Attack
☐ High blood pressure
☐ High cholesterol
☐ Kidney disease
☐ Liver disease
☐ Peptic Ulcer
☐ Reflux (GERD)
☐ Seizure or epilepsy
☐ Thyroid disease: please specify: hyper- or hypo-
☐ TIA or stroke
☐Cancer (please specify what type):
_____
_____
☐Other (please specify):
_____
_____

SOCIAL HISTORY

Marital Status

☐ Divorced
☐ Engaged
☐ Married living w/spouse
☐ Remarried
☐ Separated
☐ Single
☐ Widowed

Living arrangements

☐ Living alone
☐ Living with friends
☐ Living with children
☐ Living with spouse/partner
☐ Living with spouse/partner and children
☐ Living with other

EMPLOYMENT

Your current or former occupation:

_____

Current employment status (please check all that apply):

☐ Employed full-time
☐ Employed part-time
☐ Unemployed
☐ Student
☐ Retired
☐ Unemployed or working P/T due to pain
☐ Homemaker

If you are currently unemployed, indicated how long you have been off work:

☐ 1 - 3 weeks
☐ 1 - 3 months
☐ 4 - 7 months
☐ 8 - 11 months
☐ 12 - 18 months
☐ 19 - 24 months
☐ 25 or more months

Please indicate any of the following claims you have filed related to your pain problem:

☐ Worker's Compensation
☐ Personal injury/liability (unrelated to work)
☐ Social Security Disability Insurance (SSDI)
☐ Other Insurance
☐ None

Substance Abuse
Do you have a history of:

Tobacco use?	☐Yes - currently	☐Yes - in the past	☐ Never
Alcoholism?	☐Yes - currently	☐Yes - in the past	☐ Never
Illicit (illegal) drug use?	☐Yes - currently	☐Yes - in the past	☐ Never

Have you ever been in a detoxification program for drug abuse? ☐Yes ☐No

REGENERATIVE MEDICINE
In addition to the reason for your visit, are you (or any family member) experiencing ongoing pain in any of the following areas, or suffering from any of the following conditions:

Joints:
☐ Shoulders
☐ Hips
☐ Knees
☐ Elbows
☐ Ankle
☐ Other:

Bursitis:
☐ Hips
☐ Shoulders
☐ Other:

Tendonitis:
☐ Tennis Elbow
☐ Golfers Elbow

Muscular:

Specify Area: _____

CLINICAL USE ONLY:

Mark J. Rubin, MD_____ Aaron C. Rodarte, PA-C_____

99202		NP Expand Prob Focus		99212	Est Pt Problem Focused		99242	Office Consult Expanded Prob Focus
99203		NP Detailed HX Low		99213	Est Pt Expanded Problem		99243	Office Consult Detailed HX Low
99204		NP Comprehensive Mod		99214	Est Pt Detailed		99244	Office Consult Comprehensive Mod
99205		NP Comprehensive High		99215	Est Pt Comprehensive		99245	Office Consult Comprehensive High
G0436		Tobacco Cessation dx:305.1						
80104	1	UDS dx: Z79.891 Z51.81		99211	5 Min Nurse Visit		99024	Stim Trial Removal of Global Post-Op
G0434	1	UDS dx: Z79.891 Z51.81		G8553	E-Prescribe		76942	UltraSound Guidance
20550		Injection-Tendon		A4209	Needle			
20552		Trigger Point (1-2)		J3301	Kenalog 10mg=1 unit			
20553		Trigger Point (3+)		J1040	Depo Medrol 80mg= 1 unit			
20600		Small Joint Injection		J3490	Lidocaine 1% 1mg=1 unit			
20605		Intermediate Joint Injection		J3490	Lidocaine 2% 1mg=1 unit			
20610		Major Joint Injection		J3490	Bupivicaine .25% 1mg-1 unit			
64405		Greater Occipital Nerve Blk		J3490	Bupivicaine .50% 1mg=1 unit			
64450		Cluneal Nerve Injection						
64615		Botox Injection				Mod	25	Same Day Procedure
J0585		Botox (200 Units)				Mod	50	Bilateral Procedure
96372		Toradol Injeccion				Mod	59	Separate Distinct Procedure
J1885		Toradol 15mg per unit						