ARIZONA PAIN INSTITUTE

Dear Patient,

Thank you for choosing our office for your pain management needs. We welcome the opportunity to serve you. Your initial appointment is scheduled on: _____
at the following location:

5750 W. Thunderbird Road #E580
Glendale, AZ 85304
PH: (623) 428-0001
Fax: (602) 548-8161

Please carefully read the following office guidelines to help facilitate smooth running appointments.

Please complete the enclosed forms completely and accurately and ***bring them to your first appointment.*** Some questions may not apply to your case specifically, but please do not withhold information, even if it seems unnecessary to you. All questions asked are necessary for our records, and all records are kept confidential.

Be sure to bring any and all insurance payer information.

Please bring a complete list of all medications you are currently taking along with the dosage and name of who writes these for you. In preparation for your first visit—take all current medications as prescribed.

FOR ALL APPOINTMENTS

We greatly appreciate your cooperation in arriving on time, and understanding if we cannot see you immediately-sometimes we need a little more time than planned in order to serve our patient's needs. Please remember if the time comes that you need additional time at an appointment, we will take the time for you as well.

Please refrain from wearing perfumes or other scented products as these often lead to increased pain and headaches in sensitive patients.

FINANCIAL RESPONSIBILITY

Although we cannot quote you what your out of pocket cost will be, we do anticipate you to have a "specialist" co-payment. This amount is usually located on your insurance card. We recommend contacting your insurance company with any questions. Our office accepts Cash, Check, Visa and MasterCard. We do require payment in full at the time of service so please be prepared to make payment on the day of your appointment. Please do not hesitate to contact our office with any questions. We look forward to meeting you!

Sincerely,

Arizona Pain Institute

PATIENT FINANACIAL RESPONSIBILITY

YOU ARE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE COMPANY DOES NOT PAY.

Copays. Copays are due at the time of service. If payment is not received, you **WILL** be re-scheduled regardless of your medication status.

Deductible. We will attempt to verify any deductible that you need to satisfy for any procedures you elect to have done (injections, biopsy, etc.) Any payment due must be made prior to receiving the service. If the information we receive from the insurance company is incorrect, you will be personally responsible for the fee.

Self Pay Patients. All fees are due upon arrival. The fees are as follows: Initial office visit-$335, Medication visits-$125, Urine Drug Screens-$100. Procedures and other items will be discussed as they arise with the fees being explained prior to providing the service.

Cancelation/No Show. The fee for a no-show or cancellation of a medication visit within 24 hours of the appointment time is $25. The fee for a no-show or cancellation of a procedure visit within 24 hours of the appointment time is $50.

Excessive Calls. I acknowledge that fees may be charged to me for excessive services (e.g. excessive phone calls).

Medication Coverage Exception. There is fee of $25 fee ***per medication*** when you ask us to apply for a medication coverage exception by your insurance company. The fee needs to be paid prior to the Policy Exception being started.

Returned Checks. A $35 fee will be assessed for returned checks. Once a check has been returned, you will be required to pay via cash or credit card for future visits.

Records. The fee for a copy of your medical records is $35 for records stored on site and $50 for records stored off site.

Collections. Once an account is placed in collections status, all prior balances must be paid in full before an appointment will be scheduled.

Forms. Forms (FMLA, etc.) need to be filled out at separate visits (not your regular medication refill visit). There will be two fees assessed for forms: A Form fee based on the time required for the Provider to complete the form, and a $50 office visit fee.

I have read, understand, and agree to the above. _____ _____

(Signature) (Date)

ARIZONA PAIN INSTITUTE

Some Points of Emphasis

- I understand that non-opioid medication refills may take up to 5-7 business days to process. I will not wait until the last minute to ask for refills.

- Opioid medications are only filled at a face-to-face visit with the provider. Medications will NOT be filled or changed via the phone. You will always be given enough medication to last until your next visit. Be sure you understand how, why and when you are to take your medications before you leave the office. Calling to and tell us you changed how you took your medication is not acceptable. If you alter how you take your medication, you risk the possibility of adverse reactions, withdrawal, or overdose. Please be sure to review your prescriptions before leaving the office to be sure they are written correctly: time, date, quantity, name, etc. If you are being seen for an industrial injury, "ICA" must be on each one. All prescriptions for pain medications must be obtained from Arizona Pain Institute providers only. If you receive a pain prescription from anyone else ***FOR ANY REASON***, you must contact our office first and discuss this ***BEFORE*** you fill the prescription.

- I understand that I need to be prepared to provide a urine sample at every visit.

- If I am late to an appointment I understand that I may have to be re-scheduled for a different day regardless of how much medication I have.

I have read the above and understand the policies of Arizona Pain Institute.

Patient Signature **Date**

Clarification Regarding The Use of Marijuana

Any patient testing positive for THC (the active ingredient in marijuana) should expect to be discharged from the practice.

This notice is to make clear that Arizona Pain Institute will follow Federal guidelines that continue to designate marijuana as a Schedule I Controlled Substance. The law considers drugs or substances in this schedule to "have a high potential for abuse" and "have no currently accepted medical use in treatment in the United States". In addition, "There is a lack of accepted safety for use of the drug or other substance under medical supervision."

Since the Federal Government does not recognize marijuana as a legitimate medication, the FDA has issued no guidelines with respect to dosage or interactions with other medications. In addition, there are no standards regarding the amount of effective ingredients in any given quantity of marijuana. This makes it difficult for medical providers to advise you with respect to these matters. We cannot advise you on safety concerns as we typically do with drugs that have been studied and approved by the FDA. We know that marijuana can impair judgement and motor skills and therefore create some of the same dangerous situtations that alchohol does; beyond this we simply do not know what the risks are.

Be advised:

- Marijuana will be treated the same as any other illict substance.
- Possession of a Medical Marijuana Card (MMC) makes no difference.
- Prior discussions you may have had with your provider (either API or otherwise) are not relevant.

Please sign below to acknowledge your receipt and understanding of this notice.

Print Name	**Date of Birth**
Signature	**Date**

Consent for Care Form

I,_____agree to be evaluated and treated at ARIZONA PAIN INSTITUTE. The evaluation will consist of a personal interview, review of records and a hands-on physical examination, which could increase your pain for a short period (hopefully not). Laboratory and radiographic testing may be ordered. It is your responsibility to be sure that such testing is done in a timely manner—in most cases this is prior to your next visit.

As part of your care, you may receive injections. Usually these are trigger point injections into identified muscles to lessen the pain. On occasion, a joint injection or nerve block may be done. A separate consent form is contained in this packet for you to initial and sign. Please do so.

If any procedure is going to be done, a further discussion will occur. You are encouraged to ask questions. We wish to empower you to seek a level of health by getting involved in your care. Help us to get to know you and your history.

If pharmacotherapy (medication) is going to be prescribed, a reasonable discussion of expected benefits/side effects will occur, but such talk is frequently brief and at times difficult for you to understand. We will frequently provide written information along with verbal. We expect you to read the information we provide, ask questions, and even seek further information from your pharmacist and various web sites, such as: painconnection.org and drugs.com.

In pain management, various medications are prescribed for "off label" indications or may contain "black box" warnings. Such usage is common and expected. A drug company obtains marketing rights for limited conditions, but because the drug's pharmacology is generally well-known, clinical conditions are treated over and above the restricted limitations. This is particularly true for anti-seizure medication's, which reduce pain by decreasing excitability in the nervous system. It is equally true for anti-depressants, which raise the neurotransmitter levels and decrease reception of pain signals. If concerned, please ask.

Thank you,

Signature **Date**

ARIZONA PAIN INSTITUTE

Name Date

Address Suite/Unit City State Zipcode

Home Phone Cell Phone Work Phone

Which number would you like as your primary? ☐ Home ☐ Cell ☐ Work

Birthdate Age Sex Social Security #

Marital Status: (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation Employer

Name of Spouse Cell Phone

Spouse's Employer Work Phone

In case of Emergency, please list (2) people we may contact:

Name Relationship Phone Number

Name Relationship Phone Number

ALL patients MUST have a (and agree to have) primary care provider (PCP).

Name of PCP Phone Number

Address Suite/Unit City State Zipcode

Who referred you to our Practice? Phone Number

Ethnicity: Do you consider yourself Hispanic or Latino? (check one) ☐ Yes ☐ No

Race: (check one) ☐ American Indian or Alaska Native ☐ Native American ☐ Asian ☐ Black or African American

☐ Hawaiian or Other Pacific Islander ☐ White ☐ Other

Smoking Status: (check one)

☐ Current every day smoker Start Date:_____

☐ Current some day smoker Start Date:_____

☐ Former smoker Start Date:_____ End Date:_____

☐ Never smoked

Signature **Date**

Privacy and Consent

It is the strict policy of API never to provide any information (except in case of emergency) to any person other than a patient unless that patient first provides consent. If you wish to permit disclosure of your protected medical information to one or more people, please list their names below. ***Note: This list is different than the emergency contact list—if your spouse, children, parents, sibilings, or emergency contacts are not listed below, we will not discuss any of your protected medical information with them, (unless, of course, it is an emergency). Also, you have previously consented to allow for communication between medical providers; this is for everyone else.***

Name	Relationship

ARIZONA PAIN INSTITUTE

Insurance Information

Please note: You must complete and provide a copy of your insurance card(s)

Patient's Name:_____

Primary Insurance Carrier:_____

ID#_____Group#_____

Name of Insured:_____

Employer_____
SS#_____
Insurance company Phone#_____

Secondary Insurance Carrier:_____

ID#_____Group#_____

Name of Insured:_____

Employer_____
SS#_____
Insurance company Phone#_____

Attorney Information (if applicable)

Attorney Name_____

Law Firm:_____

Address:_____

Phone:_____Fax:_____

I acknowledge that the above is true and correct to the best of my knowledge.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for full payment. Necessary forms will be completed to help expedite insurance carrier payments, however, I am responsible for all fees regardless of insurance coverage.
I request that payment of authorized Medicare or other insurance company benefits be paid on my behalf to this office for any services provided by this office. I understand that my signature requests payment to be made and authorized release of medical information necessary to pay the claim. If item 9 on the HCFA-1500 is completed, my signature authorizes releasing information to the insurer or agency shown.
In the event that payment is not made on this account and it is placed with a licensed collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account was placed with the agency. Interest of 10% per year will be accrued on the principal balance. I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection, there is no termination date to this financial agreement.

_____ _____

Signature **Date**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
- is not part of your medical or billing records;
- is not available for inspection as set forth above; or
- is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.

6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:

- to carry out treatment, payment and health care operations as provided above;
- to persons involved in your care or for other notification purposes as provided by law;
- to correctional institutions or law enforcement officials as provided by law;
- for national security or intelligence purposes;
- that occurred prior to the date of compliance with privacy standards (April 14, 2003);
- incidental to other permissible uses or disclosures;
- that are part of a limited data set which does not contain protected health information that directly identifies individuals;
- made to patient or their personal representatives;
- for which a written authorization form from the patient has been received

7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

ARIZONA PAIN INSTITUTE

How medical information about you may be used and disclosed

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Arizona Pain Institute or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Arizona Pain institute
Privacy Officer
5750 W. Thunderbird Rd., Suite E-580
Glendale, AZ 85306
(623) 428-0001
(602) 548-8161

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on our Web site for downloading.

EFFECTIVE DATE: June 2009
CURRENT VERSION: April 2013

ARIZONA PAIN INSTITUTE

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ Patient ID#:_____

I hearby acknowledge that I have received or reviewed a copy of Arizona Pain Institute's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name of Pateints's Representative (if applicable)

FOR OFFICE USE ONLY

We attempted to obatain written acknowledgement of receipt fo our Notice of Privacy Practices on the following date, _____ but acknowledgment could be obtained because:

☐ Patient/representative refused to sign

☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)

☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

☐ Other (Specify)

_____

_____

_____

By:_____ Date:_____

ARIZONA PAIN INSTITUTE

Medical Information

Describe your Chief complaint:_____

_____

_____

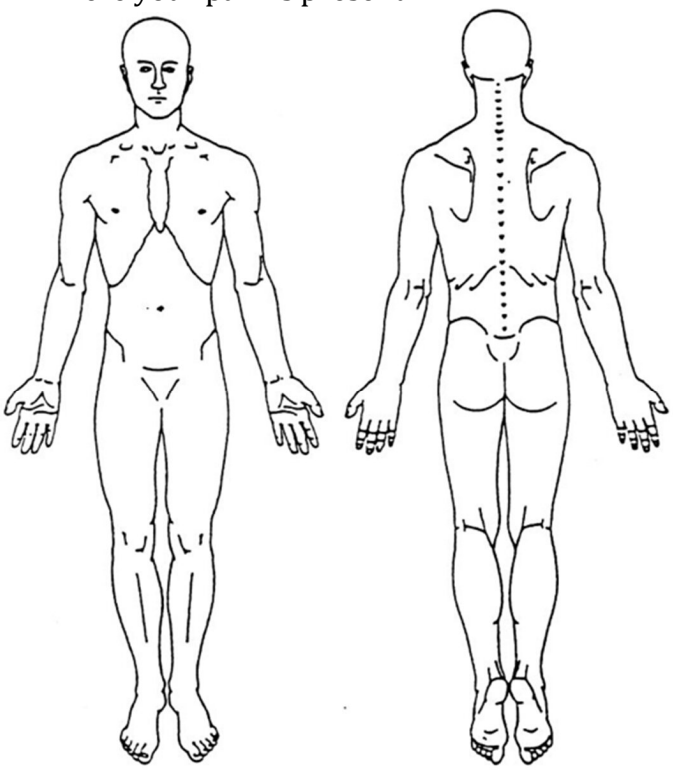
History of Present Illness: Please Circle if it is on your Left or Right Side or Middle

Low Back	L / R / Middle	Calf	L / R / Middle
Chest	L / R / Middle	Ankle	L / R / Middle
Mid Back	L / R / Middle	Foot	L / R / Middle
Neck	L / R / Middle	Head	L / R / Middle
Abdomen	L / R / Middle	Hand	L / R / Middle
Upper Back	L / R / Middle	Face	L / R / Middle
Buttock	L / R / Middle	Shoulder	L / R / Middle
Thigh	L / R / Middle	Knee	L / R / Middle

Please rate your pain level: 1-10. A pain level of 10 is close to death, in the hospital pain.

Indicate your pain at it's **worst** during the last month:_____
Indicate your pain at it's **least** during the last month:_____
Indicate your pain on average during the last month:_____
Indicate your pain as it is right now:_____

Please mark on the diagram where your pain is present:



Since your pain began, overall has it: ☐ Increased ☐ Decreased ☐ Stayed the Same

When did you first notice your pain?_____

Date of injury or accident if different?_____

When did you first see a doctor for this pain?_____

Check the words that best describe your pain: (Check up to four)

☐ Aching	☐ Sharp	☐ Penetrating	☐ Throbbing	☐ Tender	☐ Nagging
☐ Shooting	☐ Burning	☐ Numb	☐ Stabbing	☐ Exhausting	☐ Miserable
☐ Gnawing	☐ Tiring	☐ Unbearable			

Does your pain travel anywhere? ☐ YES ☐ NO

If yes, where?_____

Which Statement best describes your pain frequency? (Check one)

☐ always present, always the same intensity
☐ always present, intensity varies
☐ usually present, but have short period without pain
☐ often present, but have pain free periods lasting for one to several hours
☐ often present, but am pain free for most of the day
☐ occasionally present, have pain once to several times per day, lasting minutes to an hour
☐ occasionally present for brief periods, a few seconds to a few minutes
☐ rarely present, have pain every few days or weeks

What time of day is your worst? (Check all that apply)

☐ Morning upon arising
☐ Later in the morning
☐ Afternoon ☐ Evening ☐ Bedtime ☐ Night
☐ Pain is always the same
☐ Pain varies, but is not worse at any particular time

Do you have associated? (Check all that apply)

☐ Numbness	☐ Muscle Spasms, tightness
☐ Tingling, Pins & Needles	☐ Skin Discoloration
☐ Increased Sweating	☐ Weakness
☐ Coldness	☐ Bladder Problems
☐ Bowel Problems	

What makes your pain worse? (Check all that apply)

☐ Sitting	☐ Standing
☐ Walking	☐ Lying Down
☐ Heat	☐ Relaxation
☐ Cold	☐ Alcoholic Beverage
☐ Medication	☐ Other:_____

What makes your pain feel better? (Check all that apply)

- ☐ Sitting
- ☐ Walking
- ☐ Heat
- ☐ Cold
- ☐ Medication
- ☐ Standing
- ☐ Lying Down
- ☐ Relaxation
- ☐ Alcoholic Beverage
- ☐ Other:_____

Have you seen other physicians for your pain? ☐ YES ☐ NO

DATE	PHYSICIAN	SPECIALTY	Diagnosis/Treatment

What tests have you had done to diagnose your pain? (Check all that apply)

☐ X-Ray ☐ CT Scan ☐ MRI Scan ☐ Bone Scan ☐ Myelogram ☐ EMG
☐ Other: _____

Under what circumstances did your pain begin? (Check all that apply)

- ☐ Accident at Work
- ☐ Accident at Home
- ☐ Motor Vehicle Accident
- ☐ At work, not an accident
- ☐ Pain just began, no reason
- ☐ Other: _____
- ☐ Following Surgery
- ☐ Following an Illness

Describe the accident, injury or circumstance: _____

_____

_____

Have you had any of the following for relief of pain? If yes, did it relieve your pain? And comment on how it decreased or increased your pain.

Hypnosis	Y / N	_____
Biofeedback	Y / N	_____
Tens Unit	Y / N	_____
Chiropratic	Y / N	_____
Physical Therapy	Y / N	_____
Psychotherapy	Y / N	_____
Acupuncture	Y / N	_____

Have you had nerve blocks (injections) for pain relief? ☐ YES ☐ NO
If yes, how long of relief? ☐ None ☐ Hour(s) ☐ Day(s) ☐ Week(s) ☐ Month or More

Indicate the number that best describes how your pain interferes with your daily functioning, use a 0-10 scale with 10 being completely interferes.

General Activity _____	Mood _____	Walking Ability _____
Normal Work Routine _____	Social Activity _____	Sleep _____
Enjoyment of Life _____	Ability to Concentrate _____	Appetite _____

Health History Please check any condition you have or have had in the past.

☐ Seizures	☐ Irritable Bowel Syndrome	☐ Nerve injuries	☐ High Cholesterol
☐ Emphysema	☐ High Blood Pressure	☐ Prostate Problems	☐ Kidney Disease
☐ Heart Attack	☐ Stroke	☐ Thyroid Problems	☐ Hepatitis
☐ Headaches	☐ Gout	☐ Liver Disease	☐ Diverticulitis
☐ Bronchitis	☐ Congestive Heart Failure	☐ Shingles	☐ Multiple Sclerosis
☐ Heart Disease	☐ Angina	☐ Anemia	☐ Bleeding Disorders
☐ Muscle Disease	☐ Cataracts	☐ Glaucoma	☐ Asthma
☐ Dental Concerns	☐ Joint Disease	☐ Tuberculosis	☐ Jaw Pain
☐ Palpitations	☐ Ulcers	☐ Arthritis	☐ Diabetes
☐ Sleep Apnea			

☐ Other:_____

Surgical History Have you had any surgeries? ☐ YES ☐ NO
If so, please list with date:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Mental Health History

Have you ever had a psychological or psychiatric treatment? ☐ YES ☐ NO
Diagnosis: _____

☐ Outpatient ☐ Inpatient Please Explain:_____

Have you previously taken any medications for anxiety or depression? ☐ YES ☐ NO
Please list:_____
Any side effects from these?_____

Do you have substance abuse problems now? ☐ YES ☐ NO
Please explain:_____

Have you had a substance abuse problem in the past? ☐ YES ☐ NO
Please explain:_____

Have you lived with someone with alcohol or substance abuse problems? ☐ YES ☐ NO
Please explain relationship and substance:_____

Do you have any history of being abused? (physical, sexual, emotional) ☐ YES ☐ NO
Please explain:_____

Current Medication List

Patient Name: _____ Date: _____

Medication Name	Dosage	Direction for Use	Prescribing Provider	Condition used for
DRUG ALLERGIES AND REACTIONS:				

Family History

☐ No known significant family history of heart disease, cancer or other serious illnesses

Family Member	Alive/Deceased	Health Status or Cause of Death			
Father	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Mother	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Brother	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Sister	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Children	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Grandmother	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Grandfather	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Aunt	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____
Uncle	_____	☐ Heart Disease	☐ Cancer	☐ HTN Diabetes	☐ Other:_____

☐ Any family member(s) with Chronic Pain? Y / N Who?_____
☐ Any family member(s) with Psychiatric Illness? Y / N Who?_____
☐ Any family member(s) with a drug or alcohol problem? Y / N Who?_____

Social History

Alcohol Consumption Y / N If Yes, how much?_____

Recreational Drugs Y / N If Yes, which ones?_____

Tobacco Consumption: ☐ Current ☐ Quit ☐ Never smoked

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Homosexual

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Living Situation: ☐ Alone ☐ w/Spouse ☐ w/Relatives (Who):_____ ☐ w/Friends ☐ w/Roommate ☐ w/Partner

☐ I have a Living Will or Advanced Directive ☐ I have a medical POA on file

Occupation: ☐ Full Time ☐ Part Time ☐ No Employment

Position:_____

Specific Duties:_____

_____

Did you stop working because of pain? ☐ YES ☐ NO

Are you bringing lawsuit due to pain? ☐ YES ☐ NO

Attorney's Name:_____ Phone:_____

Symptom History Please check if you *CURRENTLY* have any of the following:

Constitutional

- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Loss of Sleep
- ☐ Night Sweats
- ☐ Chills
- ☐ Fever

Cardiovascular

- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ Ankle Swelling
- ☐ Varicose Veins

Women Only

- ☐ Abnormal Pap
- ☐ Vaginal Bleeding
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Hot Flashes
- ☐ Menstrual Pain
- ☐ LMP:_____

Neurological

- ☐ Seizures
- ☐ Paralysis
- ☐ Tremors
- ☐ Memory Problems
- ☐ Dizzyness

Eyes

- ☐ Double Vision
- ☐ Flashes or Halos
- ☐ Poor Vision
- ☐ Eye Pain

Respiratory

- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Men Only

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge

Psychiatric

- ☐ Feeling Depressed/Sad
- ☐ Nervousness
- ☐ Suicidal Ideas

Ear, Nose, & Throat

- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Nose Bleeds
- ☐ Sinus Concerns
- ☐ Trouble Swallowing

GI

- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Hemorrhoids
- ☐ Vomiting

Musculoskeletal

- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Stiffness

Endocrine

- ☐ Increased Sweating
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Genitourinary

- ☐ Poor Bladder Control
- ☐ Painful Urination
- ☐ Blood in Urine

Skin

- ☐ Hives
- ☐ Excessive Itching
- ☐ Rash
- ☐ Moles that Change

Hematologic

- ☐ Swollen Glands
- ☐ Easy Bleeding or Bruising

Other medical concerns not included above:_____

_____

Thank you for taking the time to complete this paperwork! -API Staff

ARIZONA PAIN INSTITUTE

Opioid Agreement

The dual purposes of this document are to give you information about the medications you may be taking for pain management, and to make clear the rules that must be followed in order to receive treatment for opioid medications from Arizona Pain Institute.

Our providers' goal is for you to have the best quality of life possible, given the reality of your clinical condition. To the extent a provider believes that a medication such as an opioid (narcotic analgesic) may be beneficial in that regard, a trial may be initiated. Complete elimination of your pain is not a realistic goal, reduction to a tolerable level is.

THESE MEDICATIONS COME WITH RISKS SUCH AS: DEPENDENCY, LIVER DAMAGE, RESPIRATORY DEPRESSION, MENTAL IMPAIRMENT, ACCIDENTAL OVERDOSE, ADDICTION, AND/OR DEATH.

In addition, many of these medications have a high street value. Because they have such a significant potential for abuse and/or diversion, the Federal Government has designated them "Schedule II Controlled Substances" and strict accountability is necessary when they are used. For this reason, the following items must be agreed to prior to any of our providers initiating a trial of, or continuing to prescribe, opioids or other controlled substances to treat your chronic pain.

I, _____, as a patient of Arizona Pain Institute (API) have received a copy of this agreement and consent to the following: PLEASE INITIAL THE SPACES TO THE LEFT

_____ I will only receive prescriptions for medications related to my pain from my assigned provider or, during his or her absence, by the covering provider, unless specific authorization is obtained for an exception.

_____ I will only fill my prescriptions for medications related to my pain at a single pharmacy when possible. Should the need arise to change pharmacies, I will notify API. The primary pharmacy I have selected is:

_____ Phone: _____.

_____ I will notify API of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take. For Women: In the event I become pregnant or even *suspect* pregnancy, I will notify my provider immediately.

_____ The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other medical professionals who provide my health care for purposes of continuity of care.

_____ I understand that my provider, in his or her sole discretion, may discontinue my opioid therapy and/or discharge me from the practice if: I do not abide by the rules listed in this document; I fail to follow any reasonable instructions given by my provider; Or, I am hostile or aggressive toward the API staff or others.

_____ I will not share, sell, or otherwise permit others to have access to these medications and I will take my medications only at the dose and frequency prescribed.

_____ It is my responsibility to ensure that I do not run short of my medications for any reason. I will not expect my provider to provide an early refill or schedule an early visit if: I lose my medication, it is stolen, I "run out early", etc.

_____ I will arrive at each and every appointment prepared to provide a sample for a urine drug screen. I will submit to a random urine, saliva, blood, or other test whenever my provider requests.

_____ I agree to have a primary care provider or other specialist manage my medical condition(s).

_____ I will store my medications in a secure and locked location, and dispose of them in a manner that makes it impossible for someone else to recover them.

_____ I will bring my medications to the office in their original containers when requested to do so by the staff.

_____ If the responsible legal authorities (DEA, Board of Pharmacy, etc.) have questions concerning my treatment, all confidentiality is waived and these authorities may be given full access to my records as necessary.

_____I understand that only medications prescribed within the past SIX MONTHS will be used. Any medication prescribed outside of SIX MONTHS is considered inactive and must NOT be used.

_____I agree to refrain from the use of **ANY** alcohol while on prescription medication due to the strong potential of respiratory depression.

_____ I understand that failure to adhere to these policies may result in discharge from the practice.

_____ I have read and understand the following about the mental effects of opioids:

A. Alcohol, sleeping aids, sedatives, some anti-anxiety medications, anti-depressants, antihistamines, anti-seizure medications, and muscle relaxants can increase the mental side effects of opioids. I must be extra careful to watch for mental impairment if I take any of these substances along with opioids. I will ask my provider and/or the pharmacist if I am unsure if it is safe to combine medications.

B. I agree not to drive, carry or use a firearm, operate dangerous machinery, or serve in any capacity related to public safety, **if I feel impaired by my medication.**

C. I understand that it is possible to be cited for DUI if a law enforcement officer determines that I am impaired while operating a motor vehicle—merely having a prescription is no defense.

_____ I understand that I will develop the capacity to experience physical withdrawal symptoms (headache, nausea, vomiting, chills, muscle aches, etc.) if I take opioid medications for more than a few weeks. This is NOT addiction. I understand that I can always stop opioids with minimal withdrawal symptoms if I taper the medication slowly under a provider's care. I understand that serious dehydration and chemical imbalance can occur if I go through withdrawal and cannot eat or drink for a prolonged period, and that I should seek help in an emergency room or urgent care center for re-hydration if this should occur.

I AFFIRM THAT I HAVE READ, UNDERSTAND, AND ACCEPT ALL OF THE TERMS OF THIS DOCUMENT.

_____ _____

Patient Signature **Date**

ARIZONA PAIN INSTITUTE

Injection Consent

Please read each segment carefully and initial when you are done. Below write any questions you may have for review.

Overview
Local anesthetic and Kenalog are often used during the injection process at Arizona Pain Institute. to treat many conditions such as (but not limited to) Bursitis, Arthritis, Nerve Pain, Headache and other miscellaneous conditions where inflammation is a contributor to the pain, such as frozen shoulder/adhesive capsulitis, Morton's neuroma, ganglion cyst injections and Dupuytren's contracture). WhileKenalog is a steroid is NOT an illegal steroid medication such as those steroids used by some athletes. Kenalog intra-articular/intramuscular injection contains the active ingredient triamcinolone, which is a type of medicine known as a corticosteroid and has an anti-inflammatory effect.

_____Initials

Procedure
The skin is prepared using an antiseptic agent. A small needle is inserted into the relevant body part (joint/nerve/muscle) or area of discomfort. The injection is completed, needle withdrawn and you will be able to leave within 10 minutes of the injection.

_____Initials

Consent
I give my consent to receive anesthesia and/or medications that I may need. I know that all procedures and anesthetics have risks like stroke, heart attack, respiratory failure and death, but that these are exceedingly rare. The risks of steroid are: allergic reaction to the anesthetic/steroid, scar, changes in pigmentation of skin (either the skin may get darker in color or lighter in color). I may require further injections after this procedure. I understand that this consent will be in effect until I request, in writing, that it be updated or withdrawn.

_____Initials

After the Injection(s)
Numbness from the anesthetic may last a few hours, or longer in some cases. Bruising at the site is common. I understand that each person reacts in a different way to treatments and procedures; therefore the results cannot be certain.

_____Initials

I have read the injection consent, have been given the opportunity to ask questions and due to the nature of the procedure and medications I am acknowledging that there may be side effects to the injections that I may be unaware of.

Questions:

Patient Signature _____ Date _____

ARIZONA PAIN INSTITUTE

SOAPP-R

Patient Name:_____ Date:_____

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you had worries about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐

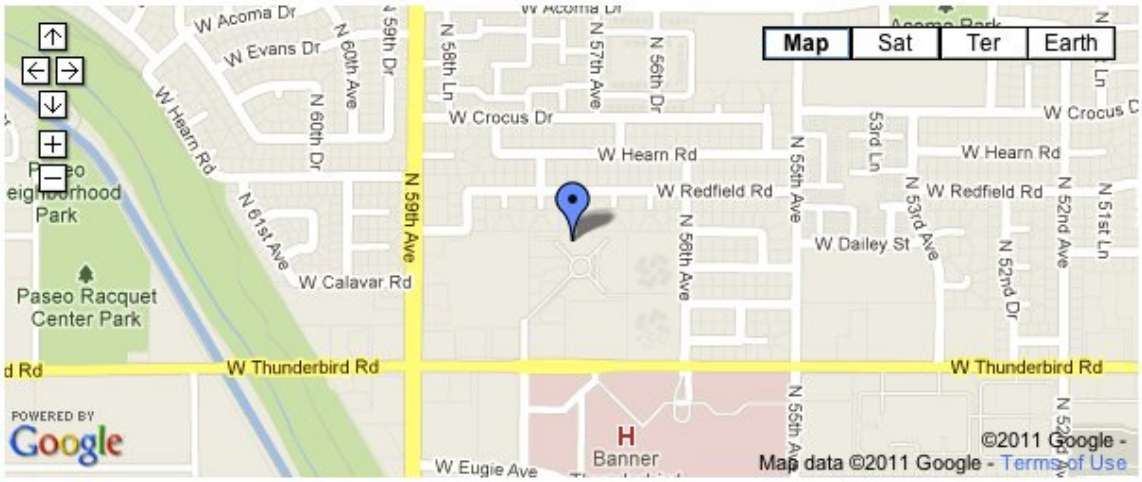
ARIZONA PAIN INSTITUTE
SOAPP-R (Cont.)

Patient Name:_____ Date:_____

	Never	Seldom	Sometimes	Often	Very Often
13. How often have any of your close friends had a problem with alchohol or drugs?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alchohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family and friends?	☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

Please include any additional information you wish about the above answers. Thank you.

Glendale/Thunderbird Office
5750 West Thunderbird Road
Suite E-580
Glendale, Arizona 85306
PH: (623) 428-0001



North on 57th Drive
Veer to the Right into the Thunderbird Palms Medical Campus
We are to the NORTH of the fountain
Please do not park under the covered parking as Tenants will tow