

**Arizona Pain Specialists
Patient Intake Sheet**

Patient information

Name: _____ Home Phone: () _____

Street: _____ Work Phone: () _____

City: _____ Emergency Phone: () _____

State: _____ Date of Birth: _____ Age: _____

Zip: _____ Weight: _____ Height: _____

Soc. Sec. No. _____ Employer: _____

Email: _____ Today's Date: _____

Who referred you?: _____ Your Occupation: _____

How did you hear about us? Internet TV Radio Insurance Co. Family Friend PCP

Who is your primary care physician?: _____ Who is your Surgeon?: _____

Where is your worst area of pain? Does your Pain Radiate? Please List your other areas of pain?

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Details of your pain:

How did your current episode begin?: Suddenly _____ Gradually _____

When did your current pain episode begin? _____

What caused your current pain episode? _____

Has the pain lessened, worsened or stayed the same? _____

Is this a work-related injury? _____ If yes, date of injury: _____

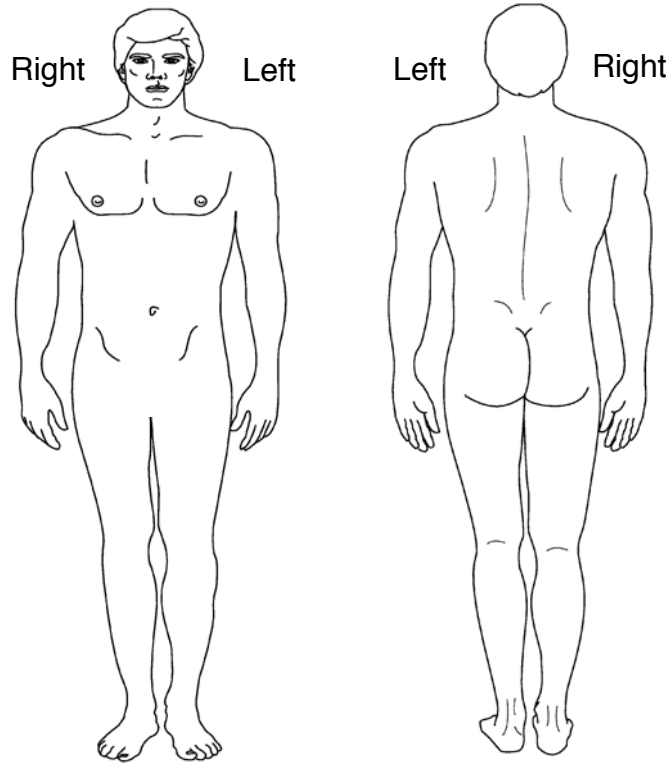
Is this a motor vehicle injury? _____ If yes, date of injury: _____ (Put details on page 7)

Patient Name/DOB:

Location of pain

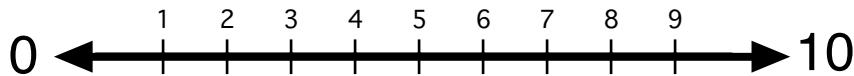
Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms.

- “N” = numbness.
- “S” = stabbing pain.
- “B” = burning pain.
- “P” = pins and needles.
- “A” = aching pain.



What is your pain level today?

Mark on the line where your pain is **today**



- _____ Which number (0-10) describes your pain **right now**?
- _____ Which number (0-10) is your worst pain?
- _____ Which number (0-10) is your least pain?
- _____ Which number (0-10) describes your average pain over the past week

Please use the following scale to give us an estimate of your pain:

- 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, but still distracting
- 5: Can't be ignored for more than 30 minutes
- 6: Can't 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, you can still function with effort
- 8: Physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors of pain
- 9: Unable to speak, crying out or moaning uncontrollably, near delirium
- 10: Unconscious, pain makes you pass out

Patient Name/DOB:

What does the pain feel like?

Check all the following that apply to the quality of your pain.

- Throbbing
- Cramping
- Shooting
- Hot-Burning
- Stabbing
- Aching
- Sharp
- Tiring-Exhausting

How does your pain change over time?

Check the word or words which best describe the pattern of your pain.

- Continuous
- Intermittent
- Other details: _____

Mark the effect of each of the following on your pain:

	Increases my pain	Decreases my pain	No change in my pain
Sitting	_____	_____	_____
Standing	_____	_____	_____
Rising from sitting	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Walking	_____	_____	_____
Climbing stairs	_____	_____	_____
Lying on your back	_____	_____	_____
Lying on your stomach	_____	_____	_____
Driving	_____	_____	_____
Coughing/sneezing	_____	_____	_____
Lifting objects	_____	_____	_____
Other factors	_____	_____	_____

Are there other details of your pain or medical conditions we should know about?

Do you have:

- Weakness if yes, where _____
- Bladder Incontinence
- Bowel Incontinence
- Fever/Chills
- Nausea/Vomitting
- Other

Patient Name/DOB:

Please mark all of the following treatments you have used for pain relief:

	Helped pain	Worsened pain	No change
Massage therapy	_____	_____	_____
Hot or cold packs	_____	_____	_____
Biofeedback	_____	_____	_____
Physical therapy	_____	_____	_____
Chiropractic	_____	_____	_____
Acupuncture	_____	_____	_____
Traction	_____	_____	_____
Brace support	_____	_____	_____
TENS unit	_____	_____	_____
Injection therapy	_____	_____	_____
Medications	_____	_____	_____

Treatment for your pain:

Please mark all of the following physicians or specialists you have consulted

ONLY FOR PAIN RELIEF FOR THE CURRENT PROBLEM, NOT FOR OTHER PROBLEMS.

- | | | |
|---|---|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> General Physician | <input type="checkbox"/> Pain Clinic |
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Hypnotist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Internist | <input type="checkbox"/> Plastic Surgeon |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> ENT Physician | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Endocrinologist | <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Faith Healer | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> Other: _____ |

Medications: (Dosages/ Frequency Per Day) | Allergies:

Patient Name/DOB:

Review of medical history (please mark all appropriate boxes):

General

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low sex drive |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Alcohol (Quantify _____) | <input type="checkbox"/> Weakness | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Tremors | <input type="checkbox"/> Other: _____ |

Head, Eyes, Ears, Nose and Throat

- | | | |
|---|---|---|
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Earaches | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Other: _____ |

Cardiovascular

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Swelling in feet | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> MVP | <input type="checkbox"/> Valve replacement |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other: _____ |

Respiratory

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Valley Fever | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Smoking (packs/day _____) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Other: _____ |

Gastrointestinal

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Abd. cramps | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> GI bleeding from medications | <input type="checkbox"/> Other: _____ |

Musculoskeletal

- | | | |
|---|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Tennis elbow |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Bursitis |
| | <input type="checkbox"/> Joint injury | <input type="checkbox"/> Other: _____ |

Renal

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Kidney problems |
| | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Other: _____ |

Hepatic

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Hepatitis (Active? _____) | <input type="checkbox"/> Other: _____ |
|--|---------------------------------------|

Neuropsychological

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Stress problems | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Other: _____ |

Patient Name/DOB:

Osteoporosis screening

- | | | |
|--|---|---|
| <input type="checkbox"/> Cushing syndrome | <input type="checkbox"/> Post-menopausal * | <input type="checkbox"/> Fractures after minor mishaps |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cigarette smoking | <input type="checkbox"/> Long term use of steroids * |
| <input type="checkbox"/> Low calcium diet | <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Use of thyroid medications |
| <input type="checkbox"/> Heavy alcohol use | <input type="checkbox"/> Family history of osteoporosis | <input type="checkbox"/> Known osteoporosis |
| <input type="checkbox"/> Hyperparathyroidism * | <input type="checkbox"/> Thin or small frame | <input type="checkbox"/> Vertebral abnormalities * |
| <input type="checkbox"/> Caucasian or Asian | <input type="checkbox"/> Never had DEXA scan | <input type="checkbox"/> Hysterectomy/oophorectomy |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Hormone replacement therapy | <input type="checkbox"/> Prostate cancer with hormone therapy |
| <input type="checkbox"/> Over 2 years since last DEXA scan | <input type="checkbox"/> Previous abnormal DEXA scan | |

Date of last DEXA scan: _____

Past surgical history (please list all surgeries and dates):

Have you had a recent MRI/ CT of a Painful area? Date?

Social history:

Married/living with significant other _____ Divorced _____ Widowed _____ Single _____

Do you have children? _____ If yes, what are their ages? _____

Do any children live at home? _____

Alcohol use? _____ How much? _____

Tobacco use? _____ How much? _____

Illegal drug use? _____ How much and when? _____

Patient Name/DOB:

Have you ever abused narcotics or prescription medications? _____

Family history: Please indicate which family members have the following medical problems

Disease:	Which family member(s)?
Headaches	_____
Heart disease	_____
Stroke	_____
Diabetes	_____
High blood pressure	_____
Increased cholesterol	_____
Arthritis	_____
Rheumatoid arthritis	_____
Kidney problems	_____
Liver problems	_____
Seizures	_____
Osteoporosis	_____
Cancer	_____
Other medical problems:	_____

Accident information:

If your injury/pain is the result of an accident or some other incident, please provide the following details:
- Date of injury, location of injury and treatment at time of injury
- Describe how the injury occurred

Patient Name/DOB:

Please tell us whether you are on or you are planning to apply for these programs?:

	I am on this program	I am applying for this program	I am planning to apply for this program
Social Security	_____	_____	_____
State Disability	_____	_____	_____
Private Disability	_____	_____	_____
Worker's Compensation	_____	_____	_____

Have you hired an attorney for your accident or pain condition?

- No, I have not hired a lawyer _____
- No, but I plan to hire an attorney _____
- Yes, I have and the case is in litigation _____
- Yes, I have and the case is settled _____

If there is potential or ongoing litigation, please provide the following information:

- Your attorney's name and address: _____

- Your attorney's telephone number: _____
- Name of defendant: _____
- Defendant's address: _____
- Defendant's attorney: _____
- Court case number: _____

Sources of health care coverage for this patient include the following:

- Private insurance _____
- Medicare _____
- State medicaid _____
- HMO plan _____
- PPO plan _____
- POS plan _____
- Worker's Compensation _____
- Self-pay _____
- Automobile insurance _____
- Other _____

Patient Name/DOB:

Arizona Pain Specialists/Valley MRI & Radiology
9787 N. 91st Street, Suite 101
Scottsdale, Az. 85258

Insurance Information

Patient Information

Name of Patient

Date of Birth

Address

Social Security No.

Telephone

Policy Holder Information

Name of Policy Holder

Date of Birth

Address

Employer

Social Security No.

Telephone

Primary Insurance Information

Primary Insurance

Address

Group No.

Policy/I.D. No.

Treatment Auth. No.

Secondary Insurance Information

Secondary Insurance

Address

Group No.

Policy/I.D. No.

Treatment Auth. No.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and also authorize the physician/facility to release any information required in the processing of the insurance claim. I authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents and any physician he/she may refer me to.

Signed: _____ (Patient) Date: _____

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to AZ Pain Specialists/Valley MRI for any services furnished me by its physician(s) and/or practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

Arizona Pain Specialists/Valley MRI & Radiology

Financial Policy & Notice of Privacy Practices

Insurance Benefits

Arizona State Law (HB2600) requires that medical claims be paid by insurance carriers within 30 days. If your insurance carrier has not appropriately paid the submitted claim within 30 days, I understand that outstanding balances will become the responsibility of the policy holder.

Insurance Co-Payments

In accordance with my insurance contract, I understand that co-payments are due at time of service.

Deductible

If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service and at the time interventional procedures are scheduled.

Co-insurance

I understand that co-insurance amounts may be collected at time of service, and at the time interventional procedures are scheduled.

Private Pay

If I have no insurance coverage, or insurance with which Arizona Pain Specialists/Valley MRI does not participate, or Arizona Pain Specialists/Valley MRI is unable to verify current insurance coverage, I understand full payment is expected at time of service and at the time interventional procedures/studies are scheduled. A full fee schedule will be provided upon request.

Secondary Insurance

I understand that Arizona Pain Specialists/Valley MRI does not file claims with secondary insurance carriers and that I am fully responsible for secondary insurance amounts. **Notice to Medicare Patients:** If we are unable to verify from Medicare that there is automatic submission of claims to the secondary insurance carrier, you may be responsible for secondary insurance balances at the time of service and at the time interventional procedures are scheduled.

Refund Policy

I understand that amounts collected from me (including co-payments, co-insurance and deductibles) are based on information received by Arizona Pain Specialists/Valley MRI from my insurance carrier. Refunds are made only after a written request is submitted, and there has been full insurance reimbursement for all medical services on the account, regardless of the date of service. Please allow 4-6 weeks for the request to be processed.

Verification of Benefits and Non-Covered Services

Insurance policies are individualized per patient plan. Arizona Pain Specialists/Valley MRI may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage benefits and exclusions. I understand that all non-covered services are my responsibility.

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 (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

No Show or Late Cancellations/Returned Checks

Cancellations made less than 24 hours in advance or any "no show" appointments are subject to a \$48.00 charge for office visits and \$228.00 charge for procedures and MRI appointments. These charges are my responsibility and will not be billed to my insurance carrier. Additionally, I acknowledge that if I have 3 or more "no show" or "late cancellations" for any service, I may be referred for treatment to another clinic. Returned checks will be subject to a \$38.00 returned check fee. Detailed patient ledgers are available for \$12.00.

Notice of Privacy Practices

I understand that the Notice of Privacy Practices for Arizona Pain Specialists/Valley MRI is displayed for public inspection at the facility and on the website. This Notice describes how medical information about you may be used and discloses how you can get access to this information. Please review it carefully. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of Arizona Pain Specialists/Valley MRI.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES

Signature

Date