Patient Demographics

Purpose of this form: To have your information on file to: identify you in our office, to have an emergency contact on record, to contact your doctors and insurance companies for information used in your treatment and billing, and to identify your preferred pharmacy.

Patient Information

Last Name __________________________ First Name __________________________ MI ______

Social Security#__________________________ Birth Date ____________ Age________ Sex ______

Home Address __________________________ City __________________________

State __________________________ Zip Code __________________________

Home Phone# __________________________ Cell Phone# __________________________

Work Phone# __________________________ Email __________________________

Marital Status __________________________

Emergency Contact Information Person Name and relationship: ____________________________

Phone number: ______________________________________

If you have a resuscitation limitation, please provide us with documentation. Otherwise, all patients are considered for resuscitation in an emergency.

Race ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian/ Pacific Islander
☐ Asian ☐ Black/African American ☐ Choose not to answer
☐ Other _________________________

Ethnicity/culture/heritage ☐ _______________________________ ☐ Decline to answer

Primary Language ☐ English ☐ Spanish ☐ Other_____________

Primary Care Physician

Name __________________________ Phone number: __________________________

Referring Provider Information

Name __________________________ Phone number: __________________________

How did you hear about us? ____

Claims

Do you have an open Workers Compensation claim related to this visit? ☐ Yes ☐ No

Pharmacy

Name: __________________________

Phone number: __________________________

Financial Policies

Purpose of this document: To inform you of our policies regarding billing and payment.

Assignment of Benefits

I permit Arizona Back Pain Institute to receive payment for medical services rendered in my care. Understand that I am responsible for all charges whether or not covered by insurance.

For Patients With Insurance Accepted by Arizona Back Pain Institute

I authorize Arizona Back Pain Institute to directly bill and receive payments from my primary or secondary insurance company. If my insurance company has not paid within 30 days of a submitted claim, I am responsible for the balance. I understand that services will not be rendered unless copayments and deductibles are collected before the visit including the allowed amount for the visit, lab tests, and procedures.

For Patients Without Insurance, Insurances Not Accepted, or Who Decline To Have Their Insurance Billed

If I do not have insurance or my insurance is not accepted by Arizona Back Pain Institute, I understand that I am responsible for payment before services are rendered. If I do not want Arizona Back Pain Institute to bill my insurance, I understand that the physicians and Arizona Back Pain Institute are not liable for pre-authorization penalty, usual and customary quote, or provider discounts and that I am responsible for payment before services are rendered.

Non-covered Services

I understand that my insurance company might designate a service not “reasonable and necessary” and, although that service would otherwise be covered, may deny payment for that service. If my insurance denies payment, I agree to be personally and fully responsible for payment before services are rendered.

No Show and Cancellation Fees / Unpaid Balances

Arizona Back Pain Institute requires a 24 hour notice for all appointments that need to be cancelled or rescheduled. If a 24 hour notice is not provided a fee equal to my insurance allowable amount will be charged for injections. As for follow ups, there will be a $50.00 charge. I understand I am responsible for paying all fees and all unpaid balances in full before any future appointments and services are rendered.

By signing below, I attest that I have read the Financial Policies document of Arizona Back Pain Institute and agree to its terms.

Print Name ____________________________________ Date ________________

Sign Name ____________________________________

Privacy Practices and Policies

Purpose of this document: To allow us permission to treat you. To make patients aware of their legal right to access and use of their protected health information and how this information may be shared with others. At Arizona Back Pain Institute, your protected health information is not released without your permission unless required by law.

Treatment Authorization

I authorize Arizona Back Pain Institute, physicians, and staff to render care to me.

Availability of Privacy Practices and HIPAA Rules

I acknowledge that I have access to and been given the option of reviewing the document "Privacy Practices and Policies" of Arizona Back Pain Institute through their website and/or available for review in the office and that a copy will be furnished to me upon request.

Patient Acknowledgement for Use of Protected Health Information

I, the patient, acknowledge that my protected health information may be used as described below:
Entity authorized to accept and share my health information:
I authorize my physician to release any information regarding my medical care, including disability or employment related information concerning my claims to insurance carriers, authorized agents, or attorneys for the purpose of validating and delineating benefits payable in connection with my incurred medical expenses. Arizona Back Pain Institute, 5505 W Chandler Blvd, Ste 11, Chandler, AZ 85226.

For Use In

○ Consulting, assessing, and planning my medical treatment.
○ Other ______________________________

Description of health information to be authorized for release

○ Complete chart
○ Complete chart except ______________________________
○ Only the following items ______________________________

Print Name ____________________ Date ____________
Sign Name ____________________

Controlled Substances Agreement

The following is an agreement between you, the patient, and our clinic Arizona Back Pain Institute and its providers regarding terms as they relate to the prescription of controlled substances including narcotics and sedatives.

1. You may not receive narcotics or sedatives from other providers unless our staff is not available and you have first received consent from our office to do so.
2. You must inform us of any controlled substances prescribed by other providers.
3. Refill requests will only be honored during business hours Monday – Friday 9am-5pm and messages left will be returned the next business day.
4. Participation in urine drug screens is required and collection will be observed by our staff. If the observed results are non-compliant with your prescribed regimen, the urine sample is subject to be sent to a laboratory for further testing. Prescriptions will not be provided until a urine sample is given. We recommend drinking water before each visit. Should the occasion arise that you are unable to provide a urine drug screen, we are able to obtain a screening through a blood draw.
5. Participation in random prescription pills counts may be required if you are called. Should you be called for a pill count, you are required to bring your remaining pills with you to our office within the same day.
6. An office visit is required for refills. Certain medications cannot be refilled and require a new prescription each month.
7. Marijuana, even for state legal medicinal purposes, is not allowed by our facility.
8. Reasons for immediate cessation of prescription of medications by our clinic include: tampering with prescriptions, giving prescribed medications to others, taking the medications of others, losing medications for any reason (including theft), presence of illegal drugs, and taking more medications than the prescribed amount. You may continue care with us, however, you will be required to seek prescription of controlled substances elsewhere.

By signing below, I agree to follow the terms of this agreement. I understand that if I violate any of these terms, I may be discharged from the care of Arizona Back Pain Institute.

Patient	**Provider**
Print Name: ____________________________	Print Name: ____Wladislaw Fedoriw MD_____
Sign Name: ____________________________	Sign Name: ____________________________
Date: ____________________________________	Date: ___________________________________

• 5505 W Chandler Blvd Ste. 11 Chandler, AZ 85226 • Phone 480.659.2571 • Fax 480.207.2713 • azbpi.com •

Patient Medical History

Purpose of this form: To gather personal and medical information that will help us understand and plan for your visit. Please check the appropriate boxes. Thank you.

Last Name________________ First Name______________ Birth Date__________ Date____________

Reason for Visit

	Right	Left	Middle
☐ Back Pain	☐	☐	☐
☐ Neck Pain	☐	☐	☐
☐ Leg Pain	☐	☐	
☐ Arm Pain	☐	☐	
☐ Stroke	☐	☐	
☐ Other	____________________		

When did the problem start? ________________________________

How did the problem start? ________________________________

Has the problem recently gotten worse? ________________________________

Did this injury occur as a result of an accident or at work? ________________________________

What treatments have you had for this problem? (Please explain)

☐ Physical Therapy ________________________________

☐ Chiropractic ________________________________

☐ Medications that have helped ________________________________

☐ Medications that have NOT helped ________________________________

☐ Injections ________________________________

☐ Surgery ________________________________

☐ Other ________________________________

Allergies: Please list any allergies you may have

____

☐ No Known Drug Allergy

Last Name________________ First Name______________ Birth Date__________ Date____________

Past Medical History: Do you or have you ever had any of the following medical problems?

☐ High Blood Pressure ☐Diabetes ☐ Cancer
☐ Heart Disease ☐ Kidney Disease ☐ Osteoporosis
☐ Heart Attack ☐ Liver Disease ☐ Bleeding Disorder
☐ Depression ☐ Stroke
☐ Asthma ☐ Restless leg syndrome

Other: Please List:

____

____

Past Surgical History:

☐ Back Surgery What: ____
When: ____

☐Neck Surgery What: ____
When: ____

Other: ____

Social History:

What is/was your occupation: ____________________________________ ☐ Retired
☐ On Disability

Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Widowed

Do you smoke? ☐Yes: How many packs per day/How many years:_________________
☐No ☐Past Smoker

Do you drink Alcohol? ☐Yes ☐No
Do you use recreational drugs? ☐Yes ☐No

☐History of Alcoholism ____________________ ☐History of Addiction_____________________

Who do you live with? ____

How many levels is your home? ____

How many stairs to enter your home? ____

How many stairs inside your home? ____

Do you require any assistive devices for getting around? (cane, walker etc.) _________________

Do you have any physical limitations or restrictions at work? ______________________________

Last Name________________ First Name______________ Birth Date__________ Date____________

Medications: Please list your current medications

___________________________ ________________________________
___________________________ ________________________________
___________________________ ________________________________
___________________________ ________________________________

Pharmacy

Name: ___________________ Phone number: ___________________

Family History: Please list any medical problems of your parents or siblings.

____

☐Cancer
☐Heart Disease
☐Poor Immunity
☐Back Pain

Your General Health: Please check if you have any of the following:

☐ Loss of appetite
☐ Fever
☐ Active cancer
☐ Night sweats
☐ Anal numbness
☐ Buttocks numbness
☐ Always feeling hot
☐ Always feeling cold
☐ Bladder accidents
☐ Blood in the urine
☐ Current pregnancy
☐ Easy Bruising/Bleeding

☐ Loss of balance
☐ Numbness
☐ Tingling
☐ Weakness
☐ Shooting pain
☐ Burning pain
☐ Headaches
☐ History of blindness
☐ Painful deep breath
☐ Change in erections
☐ Testicle pain
☐ Constipation

☐ Seasonal allergies
☐ Itchy eyes
☐ Pain in calves while walking
☐ Cold arms or legs
☐ Rash
☐ Painful lumps
☐ Depression
☐ Suicidal thoughts
☐ Bipolar
☐ Anxiety
☐ Pain with coughing

Have you ever:

☐Been in the ICU?
☐Had to be resuscitated?
☐Had to have a breathing tube inserted into your throat for an emergency?
☐Had a life threatening allergic reaction?
☐Do you get faint around needles?
☐Have you ever passed out?

☐ Had an allergic reaction to:
☐ IODINE ☐ LATEX
☐ CONTRAST DYE ☐ ANTIBIOTICS ☐DENTAL NUMBING MEDICINES