Phoenician Pain & Rehabilitation Center

Shimul Sahai, M.D. Trevor Patience, PA-C

PATIENT INFORMATION FORM

DATE _____ { } MARRIED { } SINGLE { } SEPARATED { } DIVORCED { } PARTNERED

PATIENT LAST NAME _____ **FIRST NAME** _____ **MI** _____ SEX (PLEASE CIRCLE) M / F

AGE _____ DATE OF BIRTH _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____ PHONE _____ OCCUPATION _____

SPOUSE LAST NAME _____ **FIRST NAME** _____ **MI** _____

DATE OF BIRTH _____ PHONE _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____ WORK PHONE _____

PRIMARY INSURANCE _____ PHONE _____

INSURED _____ ID# _____ GROUP# _____

SECONDARY INSURANCE _____ PHONE _____

INSURED _____ ID# _____ GROUP# _____

PRIMARY CARE PHYSICIAN _____ **PHONE** _____

REFFERING PHYSICIAN _____ **PHONE** _____

IN CASE OF EMERGENCY

NAME _____ PHONE _____

AUTHORIZATIONS AND RELEASE (PLEASE INITIAL BELOW)

_____ I am aware that I am responsible to pay co-pays and deductibles set forth by Medicare or Commercial Insurance Plans at the time of service.
_____ I hereby authorize by signing below to release any MEDICAL information which might be needed in connection with payment for medical services rendered. I request that all amounts payable under Medicare or Commercial Insurance Plans be made payable directly to Phoenician Pain and Rehabilitation Center or Shimul B. Sahai, M.D. When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any services deemed non-covered by my insurance company.
_____ I am aware that if I fail to pay my account and if it is deemed necessary to turn any past due balance over to collections, I understand that there will be additional costs accessed in addition to my account balance. This additional amount could be as high as 33%.
_____ I am aware that if I request my medical records, I understand to allow 7-10 days for the process of the release of medical records.
_____ I am aware of a $25.00 fee for FMLA or Disability Paperwork. I understand this is to be paid at the time of retrieving my FMLA or Disability Paperwork.

By signing below, I acknowledge that I have read and understand the above statements.

PATIENT SIGNATURE _____ **DATE** _____

PARENT OR GUARDIAN (IF MINOR) _____ **DATE** _____

INDUSTRIAL INFORMATION

INDUSTRIAL INJURY __ YES __ NO TYPE OF INJURY _____ DATE OF INJURY _____
INDUSTRIAL INSURANCE NAME _____ CLAIM# _____ PHONE# _____
NAME OF CASE MANAGER _____

Phoenician Pain & Rehabilitation Center

Date _____

Name _____ Age _____

Current Problem _____

_____

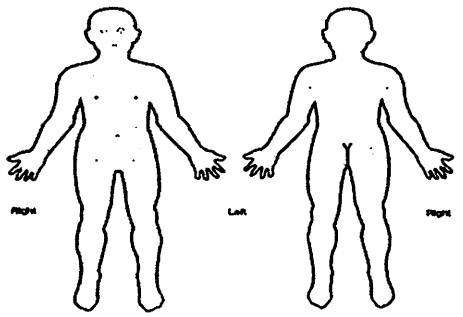
Date of Injury (If Applicable) _____

Date When First Symptoms Occurred _____

How Occurred _____

1.) Shade the area of your pain

2.) Place an "X" at the worst area(s) of pain



Describe your pain _____

_____

On a scale of 0-10

What is the level of the worst pain you have?

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (SEVERE PAIN)

PAST MEDICAL HISTORY-MAJOR ILLNESSES

	NO	YES	ACTIVE?
Diabetes			
Cancer			
Stomach Ulcer			
High Blood Pressure			
Emphysema			
Bronchitis			
Neurologic			
Disease/Injury			
Stroke			
Bleeding Disorder			
Thyroid Disorder			
Infections-TB			

PLEASE LIST OTHER CHRONIC ILLNESSES

_____

_____

OPERATIONS/HOSPITALIZATIONS	DATE

CURRENT MEDICATIONS	DOSAGE

DRUG ALLERGIES	REACTION

SOCIAL / PERSONAL HISTORY

Occupation _____

Are you currently working? _____

Marital Status _____ Children _____

Do you smoke Y __ N __ Date Quit _____

Do you drink alcohol Y __ N__ Date Quit _____

Are you pregnant? Y __ N __

Last menstrual period-date _____

FAMILY MEDICAL HX—LIST MAJOR ILLNESSES

Father / Living Y __N __ _____

Mother / Living Y__N __ _____

Siblings / # of Brothers _____

Siblings / # of Sisters _____

SYSTEM REVIEW - please check any of the following you may have had over the past year

	N	Y		N	Y
Fever			Joint Pain		
Chills			Morning Stiffness		
Night Sweats			Swelling		
Weight Loss			Skin Disorder		
Double Vision			Weakness		
Blurry Vision			Numbness/ Tingling		
Hearing Loss			Dizziness		
Short of Breath			Depression		
Cough			Anxiety		
Coughing Blood			Alcoholism		
Stomach Ulcers			Illegal Drug Use		
Blood In Stool			Thyroid Disease		
Diarrhea			Anemia		
Constipation			Abnormal Bleeding		
Liver Disease			Allergies		
Kidney/Bladder Infection			Baladder/Bowel Incontinence		

Reviewed by _____, M.D.

Date _____

PAST TREATMENT (Please check all that Apply)

Treatment	N	Y	Did This Help?
Medication (List)			
Physical Therapy			
Brace			
Injections			
Home Exercise			
Tens Unit			
Chiropratic			
Surgery			

PAST TREATING PHYSICIANS

_____

_____

_____

PAST TESTS

X-Rays? _____

CT Scan? _____

MRI? _____

EMG? _____

Bone Scan? _____

Blood Tests? _____

Other _____

Phoenician Pain & Rehabilitation Center

SHIMUL SAHAI, M.D.
CAROLYN WAGNER VON HOFF, P.A.C.

FINANCIAL POLICIES AND ARRANGEMENTS

Phoenician Pain & Rehabilitation Center, PLC recognizes the need for understanding the areas of payment arrangements and insurance filings. Below will explain the protocols of our office.

1. INSURANCE, FILING/BENEFITS/PAYMENTS

There are numerous insurance plans with which Phoenician Pain & Rehabilitation Center have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make a co-payment. If you are covered by one of these plans, please show us your card. Be prepared to make your co-payment, or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, Visa and Mastercard. With plans that we are not contracted with, you will be asked to pay at the time service is rendered.

If we are billing your insurance for you, it is extremely important that you furnish us with accurate and updated information so your claim can be files. It is your responsibility as a patient to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Services provided that are not a covered benefit are your responsibility and payment is due at the time services are rendered. It you have questions as to what services are covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for 45 days. If your carrier does not remit payment with 45 days, you will be responsible for the full balance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim, you will continue to receive statements until the account is paid in full.

2. PAYMENT ARRANGEMENTS

Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit may be rescheduled. Also, Phoenician Pain & Rehabilitation Center recognize the need to set up payment plans for patients who require extensive treatment. Our Office Manager will be happy to make these arrangements.

3. DELIQUENT ACCOUNTS

Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency with additional fees assessed, unless prior arrangements have been made with our Office Manager. If you have questions or feel an error has been made, please request to speak to our Office Manager.

4. RETURNED CHECKS

There is a $40.00 service fee for checks returned for insufficient funds. Phoenician Pain & Rehabilitation Center belong to the Maricopa County Attorney's Check Enforcement Bureau. Phoenician Pain & Rehabilitation Center will request a copy of your Driver's License or State ID card at your initial appointment for identification.

5. CANCELLATION OF APPOINTMENTS/NO SHOW APPOINTMENTS

If you cancel an appointment, Phoenician Pain & Rehabilitation Center request you give a 24 hour notice for consultations and 48 hours for any type of office procedure or surgery. If you fail to cancel your appointment, you may be charged a $25.00 fee as a no-show. If there is a consecutive repeat of 3 no-shows, then this could possibly be grounds for dismissal from Phoenician Pain & Rehabilitation Center.

6. ADVANCED BENEFICIARY AGREEMENT

Medicare and other insurance plans will only pay for services that they may determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If payment is denied for services or tests, (i.E. routine exam/lab work, procedures and non-related diagnoses for the services provided), then the patient is personally and fully responsible for payment.

ADDITIONAL HELP

Please feel free to discuss any concerns you may have with our Office Manager or Staff. Phoenician Pain & Rehabilitation Center are dedicated to making your visits with us a pleasant as possible. **It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.**

I have read and agree to the above policy of Phoenician Pain & Rehabilitation Center. I understand the contents and by signing below accept the aforementioned financial responsibilities.

Patient/Guardian Signature: _____ Date: _____

Phoenician Pain & Rehabilitation Center

PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Phoenician Pain & Rehabilitation Center of their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Phoenician Pain & Rehabilitation Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this Phoenician Pain & Rehabilitation Center at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand the information will be used/disclosed for the following purposes:

1. To inform me of my medical condition(s) by phone, mail, email or in person
2. To give information/referrals/medical records/samples/prescription/test results to you or the person(s) named on this form by phone, mail, email or in person
3. For treatment, payment and health care operations

I understand that I may request in writing how Phoenician Pain & Rehabilitation Center restricts my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Phoenician Pain & Rehabilitation Center are not required to agree to my requested restrictions, but if Phoenician Pain & Rehabilitation Center does agree, then the practice is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Phoenician Pain & Rehabilitation Center have taken action relying on this consent.

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO PERSON(S) BELOW:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____

Patient Name: _____ Date: _____
Please print

Relationship to Patient: _____

PHOENICIAN PAIN & REHABILITATION CENTER
SHIMUL B. SAHAI, M.D.
CAROLYN WAGNER VON HOFF, P.A.C.
963 N McQueen Road
Chandler, Arizona 85225

Phoenician Pain & Rehabilitation Center

PATIENT'S BILL OF RIGHTS

- You have a right to seek consultation with the physician(s) of your choice
- You have a right to contract with your physician(s) on mutually agreeable terms
- You have a right to talk privately with your physician(s) and to have your health care information protected
- You have a right to use your own resources to choose the care of your choice
- You have a right to refuse medical treatment even if it is recommended by your physician(s)
- You have a right to be informed about your medical condition/treatment and take part in decisions about your care. To be informed about the risks and benefits of treatment and appropriate alternatives
- You have a right to refuse third-party interference in your medical care, and to be confident that your actions in seeking or declining medical care will not result in third-party-imposed penalties for patients or physicians
- You have a right to receive full disclosure of your insurance plan explaining the coverage and benefits

Patient Name: _____ DOB: _____ DATE: _____

PHOENICIAN PAIN & REHABILITATION CENTER
Shimul B. Sahai, M.D.
Carolyn Wagner von Hoff, P.A.C.
963 N McQueen Road
Chandler, Arizona 85225

Phoenician Pain & Rehabilitation Center

SHIMUL B. SAHAI, M.D.
TREVOR PATIENCE, PA-C
963 N McQueen Road
Chandler, Arizona 85225
Office: 480-398-1940 Fax: 480-782-1453

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that Phoenician Pain & Rehabilitation Center release my medical records to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I hereby authorize and request my medical records to be released to Phoenician Pain & Rehabilitation Center:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I authorize to release the following information:

☐ History & Physical ☐ Lab Reports ☐ XR/MRI/CT Scan/EMG ☐ Discharge Summaries
☐ Consultations ☐ Pharmacy/Medication Profile ☐ All Available Records

Patient Name: _____ DOB: _____
Print Name Please

Patient Signature: _____ Date: _____

When requesting release of records, please allow us 7-10 days for processing – Thank you