NOVASPINE
PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts ™

IMPORTANT: PLEASE READ BEFORE FILLING OUT FORMS

This is the electronic fillable PDF version of our New Patient Intake Forms. You may simply PRINT the forms and hand write in the information and bring to your clinic visit if you wish to do so.

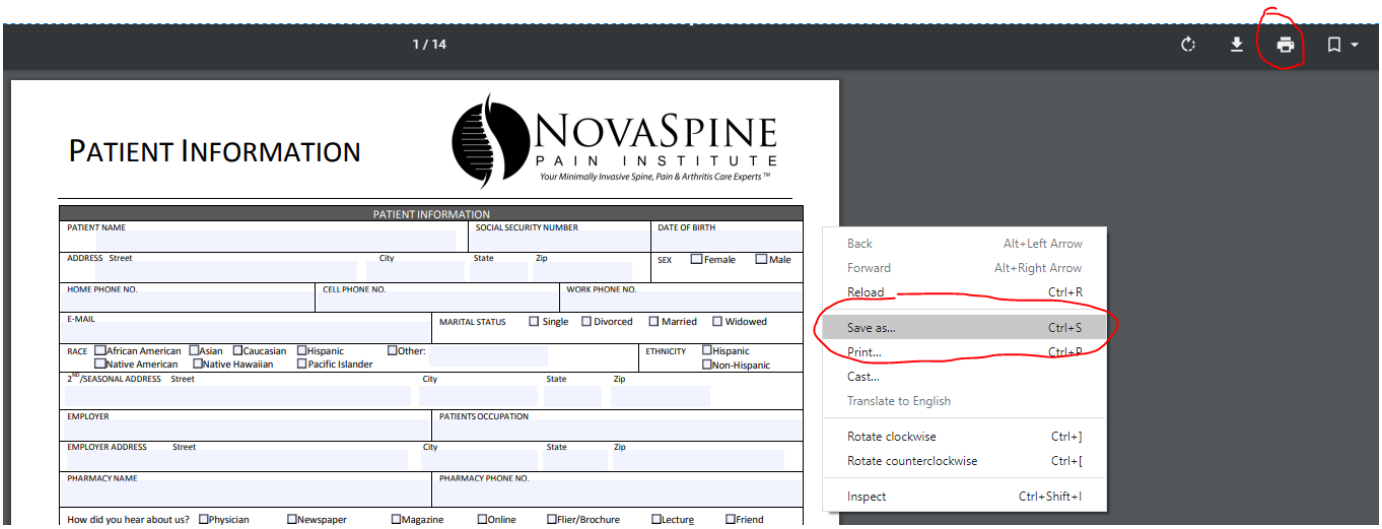
Alternatively, and for your convenience, you may also **DOWNLOAD** the PDF file and TYPE in your information on your computer/device and send to us electronically.

However, it is IMPORTANT to **FIRST DOWNLOAD AND SAVE** the file to your computer/device **BEFORE** you have filled in the information. Otherwise, all of the information you typed may be lost!

To properly SAVE your information, we recommend the following:

1) First, **DOWNLOAD** the file to your computer/device. You can do this by clicking on the link to open it. Then, RIGHT-CLICK on it and choose **'SAVE-AS'** and save the forms to a location on your desktop
2) AFTER you have filled the forms out, AGAIN SAVE the file to your desktop.
3) You may then EMAIL the forms to us at: contact@novaspine.net
    a. If you are UNABLE to email the forms, you will be REQUIRED to bring them to any office in order to be seen by a provider

In addition, we do REQUIRE a copy, front and back, of any insurance cards, in addition to your DRIVER'S license. You may bring this by our office or, at your discretion, you may email this to us as well.



TIME: APPT:_____ ARRIVAL:_____ CHART UP:_____

INSURANCE: _____

PROVIDER:_____

NEW PATIENT INTAKE FORM

Patient Name _____ Age _____ DOB _____

Email _____ Height _____ Weight _____

Name of Referring Physician: _____ Name of Primary Care Physician: _____

Reason for visit today:_____

PAIN DESCRIPTION

AVERAGE pain level: ***No Pain-*** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ***- Worst***

My Pain is: ☐Constant but changes in severity ☐ Intermittent (Comes and goes) ☐Improving ☐Worsening

How long have you had this pain? _____ Have you had this pain before? ☐No ☐Yes How long ago? _____

Was there any injury or accident? ☐ No ☐ Yes Explain:

Which body parts are involved?

☐ Neck ☐ **Arm:** ☐Left ☐ Right

☐ Back ☐ **Leg:** ☐Left ☐ Right

☐ Face/Head ☐ **Hip:** ☐Left ☐ Right

☐ Overall Body ☐ **Knee:** ☐Left ☐ Right

Other: _____

Check all that describe your pain today:

☐ Dull/Aching ☐ Sharp/Stabbing

☐ Cramping ☐ Pins/Needles/Tingling

☐ Throbbing ☐ Hot/Burning

☐ Squeezing ☐ Shooting/Radiating

What activities make your pain WORSE?

_____

_____

What activities make your pain BETTER?

_____

_____

Mark any activities that are AFFECTED by your pain

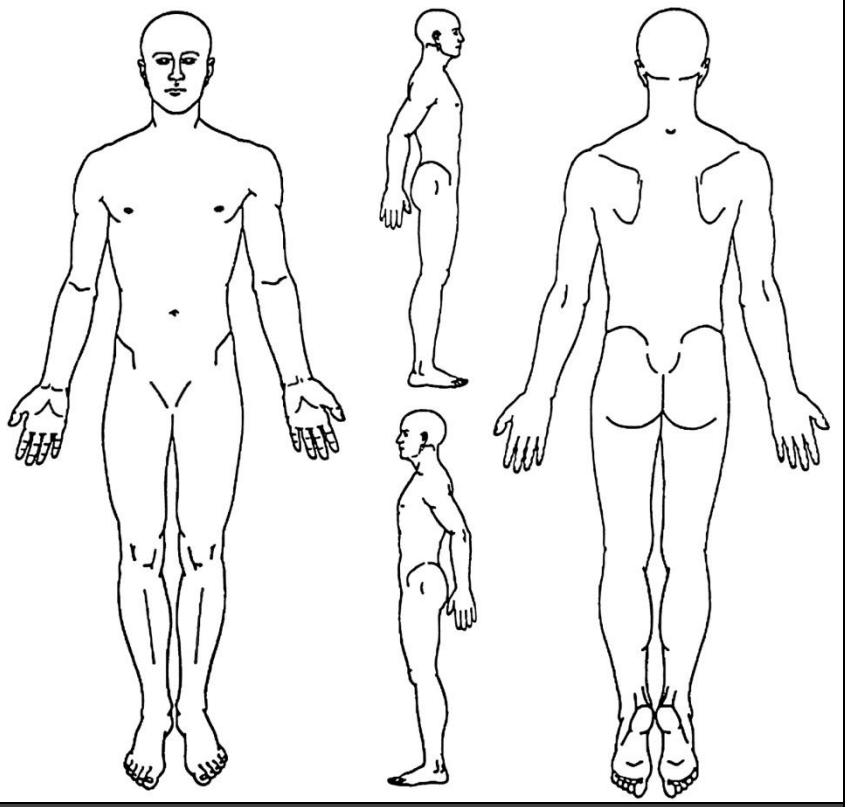
☐Enjoyment of Life ☐Work

☐Sleep ☐Activities Daily Living

☐Mood / Emotions ☐Recreational Activity

☐Other:_____

Using "X" marks, mark the diagram below to indicate the location of all of your painful areas



ASSOCIATED SYMPTOMS

Mark all of the following symptoms or conditions that you are CURRENTLY experiencing

☐ Numbness or tingling, Location: _____

☐ Weakness, Location: _____

☐ Joint swelling or Stiffness ☐ Aching calf or leg pain ☐ Anxiety or Depression

☐ Fever or Chills ☐ SWELLING of the legs ☐ Sleep apnea

☐ Balance problems or difficulty walking ☐ Nonhealing wounds ☐ Bladder incontinence (loss of control)

☐ Fatigue ☐ Varicose Veins ☐ Bowel Incontinence

INSURANCE: _____ IMAGING: _____ PHARMACY: _____

Intake done by: _____

NEW PATIENT INTAKE FORM

PRIOR TREATMENTS

For your current symptoms, please mark the boxes for the following imaging/studies that have been performed

☐ X-Ray ☐ MRI ☐ CT scan ☐ Discogram ☐ EMG/NCV (nerve test) ☐ CT myelogram

Please mark the type of treatment(s) that you have had in the past and how well they worked, **OTHERWISE LEAVE BLANK:**

Injections: ☐ Better ☐ Worse ☐ No Change Type: _____

_____

Physical Therapy: ☐ Better ☐ Worse ☐ No Change How recently? _____

Spine Surgery: ☐ Better ☐ Worse ☐ No Change Type of surgery and year? _____

_____

Bracing: ☐ Better ☐ Worse ☐ No Change Type: _____

TENS unit: ☐ Better ☐ Worse ☐ No Change **Heat / Ice:** ☐ Better ☐ Worse ☐ No Change

Chiropractor: ☐ Better ☐ Worse ☐ No Change **Acupuncture:** ☐ Better ☐ Worse ☐ No Change

Massage: ☐ Better ☐ Worse ☐ No Change **Psychology:** ☐ Better ☐ Worse ☐ No Change

PRIOR MEDICATIONS

Please indicate which medications you have used in the past for your current pain condition **(OTHERWISE DO NOT CHECK):**

ANTI-INFLAMMATORY	Helped?	NARCOTICS / OPIOIDS	Helped?	NERVE MEDICATIONS	Helped?
Naproxen (aleve)	☐ No ☐ Yes	Tramadol	☐ No ☐ Yes	Gabapentin (neurontin)	☐ No ☐ Yes
Ibuprofen (advil, motrin)	☐ No ☐ Yes	Tylenol with codeine	☐ No ☐ Yes	Lyrica	☐ No ☐ Yes
Diclofenac (voltaren)	☐ No ☐ Yes	Hydrocodone (Vicodin)	☐ No ☐ Yes	Amitriptyline (elavil)	☐ No ☐ Yes
Tylenol (acetaminophen)	☐ No ☐ Yes	Oxycodone (Percocet)	☐ No ☐ Yes	Nortriptyline	☐ No ☐ Yes
Celebrex	☐ No ☐ Yes	Morphine, MS Contin	☐ No ☐ Yes	Cymbalta	☐ No ☐ Yes
Flector patch	☐ No ☐ Yes	Hydromorphone (dilaudid)	☐ No ☐ Yes	Effexor	☐ No ☐ Yes
MUSCLE RELAXANTS	Helped?	Nucynta (tapentadol)	☐ No ☐ Yes	Savella	☐ No ☐ Yes
Carisoprodol (soma)	☐ No ☐ Yes	Fentanyl patch	☐ No ☐ Yes	Lidoderm patch	☐ No ☐ Yes
Cyclobenzaprine (flexeril)	☐ No ☐ Yes	Methadone	☐ No ☐ Yes		
Skelaxin (Metaxolone)	☐ No ☐ Yes	Opana	☐ No ☐ Yes		
Methocarbamol (robaxin)	☐ No ☐ Yes	Suboxone	☐ No ☐ Yes		
Tizanidine (zanaflex)	☐ No ☐ Yes				

ALLERGIES

Have you ever had an allergic reaction to: ☐ Iodine? ☐ Contrast? ☐ Latex? ☐ Dental Numbing Medications?

☐ No known allergies ☐ Yes, specify: _____

PRESENT MEDICATIONS

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

☐ Coumadin/Warfarin ☐ Plavix ☐ Xarelto ☐ Pradaxa ☐ Eliquis ☐ Brilinta

NAME OF MEDICATION	DOSE and number of pills/day	NAME OF MEDICATION	DOSE and number of pills/day
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

PAST MEDICAL HISTORY

Please document all medical history below, including any of the following medical conditions:

☐ High Blood Pressure	☐ Kidney/Liver disease	☐ Osteoporosis	☐ Depression	☐ Anxiety disorder
☐ Diabetes	☐ Rheumatoid arthritis	☐ Cancer	☐ Attention deficit d/o	☐ Bipolar Disorder
☐ Heart attack/disease	☐ Gout	☐ HIV or AIDs	☐ Obsessive Compulsive d/o	☐ Abuse during childhood
☐ Stroke	☐ Peptic Ulcer Disease	☐ Hepatitis (A, B, C)	☐ Schizophrenia	

NEW PATIENT INTAKE FORM

Other past medical history:

PAST SURGERIES

Please list any surgeries you have had, and any complications.

Have you ever had a bad reaction to anesthesia? ☐ No ☐ Yes If yes, describe:

SOCIAL HISTORY

Occupation: _____ When was the last time you worked? _____

☐ Restricted or Light-duty ☐ Temporary disability ☐ Permanent disability ☐ Retired ☐ Unemployed/Seeking job

Are you currently under worker's compensation? ☐ No ☐ Yes Is there a lawsuit related to your visit today? ☐ No ☐ Yes

Tobacco: ☐ No ☐ Yes How many packs per day? _____ How many years? _____ ☐ Quit _____ years ago

Alcohol: ☐ No ☐ Yes How much do you drink daily? _____ ☐ Quit _____ years ago

Have you ever drank heavily or abused alcohol? ☐ No ☐ Yes

Illicit Drugs: Have you ever used any illicit substances? ☐ No ☐ Yes Type: _____

Have you ever been addicted to or misused prescription drugs? ☐ No ☐ Yes, Type: _____

FAMILY HISTORY:

Is there a family history of any of the following? ☐ check here if unknown

Alcohol Abuse	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Illegal Drug Use	☐ No ☐ Yes	Heart Disease	☐ No ☐ Yes	Cancer	☐ No ☐ Yes, type: _____
Prescription Drug Abuse	☐ No ☐ Yes	Hypertension	☐ No ☐ Yes	Other	_____

REVIEW OF SYSTEMS:

Are you CURRENTLY experiencing any of the following symptoms? If so, check mark Yes. Otherwise, check no (blank also implies no)

GENERAL:		ENDOCRINE:		EARS/NOSE/THROAT:		GASTROINTEST	
Loss of appetite	☐ No ☐ Yes	Thyroid disease.....	☐ No ☐ Yes	Hoarseness.....	☐ No ☐ Yes	Nausea/vomiting	☐ No ☐ Yes
Recent weight loss	☐ No ☐ Yes	Heat/Cold intolerance	☐ No ☐ Yes	Trouble swallowing.....	☐ No ☐ Yes	Blood in stool.....	☐ No ☐ Yes
Fever or chills	☐ No ☐ Yes			Hearing loss.....	☐ No ☐ Yes	Heartburn.....	☐ No ☐ Yes
						Constipation.....	☐ No ☐ Yes
RESPIRATORY:	☐ No ☐ Yes	**CARDIOVASCULAR:**		**PSYCHIATRIC:**		**HEMATOLOGIC:**	
Shortness of breath	☐ No ☐ Yes	Chest pain.....	☐ No ☐ Yes	Depression.....	☐ No ☐ Yes	Easy bruising.....	☐ No ☐ Yes
Chronic cough	☐ No ☐ Yes	Palpitations.....	☐ No ☐ Yes	Drug/Alcohol addiction	☐ No ☐ Yes	Easy bleeding.....	☐ No ☐ Yes
				Suicidal Thoughts.....	☐ No ☐ Yes		
KIDNEY/BLADDER:		**EYES:**		**NEUROLOGICAL**		**SKIN:**	
Painful urination.....	☐ No ☐ Yes	Blurred vision.....	☐ No ☐ Yes	Headaches.....	☐ No ☐ Yes	Frequent Rashes	☐ No ☐ Yes
Blood in urine.....	☐ No ☐ Yes	Double vision.....	☐ No ☐ Yes	Seizures.....	☐ No ☐ Yes	Skin ulcers.....	☐ No ☐ Yes
Kidney problems	☐ No ☐ Yes	Loss of vision.....	☐ No ☐ Yes	Dizziness.....	☐ No ☐ Yes	Lumps.....	☐ No ☐ Yes

Patient Name (print): _____ Signature: *Type name here fully to qualify as a valid signa* Date: _____

FOR OFFICE USE ONLY

Height: _____ Weight: _____ BP: _____ HR: _____ RR: _____ Temp: _____

Reviewed by _____ Date: same date of service

PATIENT INFORMATION

PATIENT INFORMATION

PATIENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS Street City State Zip		SEX ☐ Female ☐ Male
HOME PHONE NO.	CELL PHONE NO.	WORK PHONE NO.
E-MAIL	MARITAL STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed	
RACE ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Other: ☐Native American ☐Native Hawaiian ☐Pacific Islander		ETHNICITY ☐Hispanic ☐Non-Hispanic
2ND/SEASONAL ADDRESS Street City State Zip		
EMPLOYER	PATIENTS OCCUPATION	
EMPLOYER ADDRESS Street City State Zip		
PHARMACY NAME	PHARMACY PHONE NO.	

How did you hear about us? ☐Physician ☐Newspaper ☐Magazine ☐Online ☐Flier/Brochure ☐Lecture ☐Friend

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS	RELATIONSHIP TO PATIENT	
City State Zip	PRIMARY PHONE NO.	
EMPLOYER	EMPLOYER PHONE NO.	
EMPLOYER ADDRESS: City State Zip		

If this is a job related injury, is this the employer you were working for at the time of injury? ☐Yes ☐No If due to an injury, date of injury: _____/_____/_____

Will an attorney or Liability Carrier be involved in payment of charges? ☐Yes ☐No

Is injury related to: ☐Accident ☐Auto Accident ☐Job Related ☐Other: _____

If job related: Claim Number_____Case Manager: _____Phone No.: _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE
ADDRESS Street City State Zip		

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Name	Policy ID Number	Insurance Name	Policy ID Number
Policy Holder's Name	DOB	Policy Holder's Name	DOB
Social Security Number	Relationship to Patient	Social Security Number	Relationship to Patient

I hereby certify the above information is true and correct to the best of my knowledge.

Patient Signature: *Type name here fully to qualify as a valid signature* Date: _____

Notice of Privacy Practices

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.

Novaspine Pain Institute (Novaspine) is committed to protecting your medical information. Further, we are required by law to maintain the privacy of your protected health information (PHI) and to give you this notice, explaining our legal duties and privacy practices with regards to your protected health information. We are required to must abide by the terms set forth in this notice. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. Any revisions will be posted in a prominent location in our office and, upon request, a copy will be provided to you of the revised notice. .

Uses and Disclosures of Your Protected Health Information:

1) **Treatment:** Your PHI may be used provide, coordinate, or manage your health care and any related services. We may also disclose your PHI to other health care providers who may be treating you or involved in your health care to ensure they have the necessary information to diagnose, treat or provide a service.
2) **Payment:** Your PHI may be used and disclosed to obtain payment for health care services provided by us or to determine whether we may obtain payment for services recommended for you. Your PHI may be disclosed to obtain payment or for payment activities from you, a health plan, healthcare clearinghouse, or a third party). As an example, we may need to include information that identifies you, your diagnosis, procedures performed, with a bill to a third-party payer or your health plan to agree to payment for that treatment.
3) **Health Care Operations:** We may use and disclose your PHI to support the business activities of our office. The activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for education and learning purposes. As an example, we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.
4) **Appointment Reminders/Treatment Alternatives/ Health-Related Services:** We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.
5) **Facility Directory:** Unless you object, we may use and disclose in our facility directory your name, location in the facility, general condition and religious affiliation. All of this information, except for your religious affiliation, will be disclosed to persons who ask for you by name. Information in the facility directory may be shared with clergy.
6) **Persons Involved in Your Care:** We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.
7) **Notification:** We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.
8) **As required by Law:** We will disclose your PHI when required to do so by international, federal, state or local law. Examples include:
    - Public health activities including reporting of certain communicable diseases,
    - Workers' compensation or similar programs as required by law,
    - Authorities when we suspect abuse, neglect, or domestic violence,
    - Health oversight agencies, including the Food and Drug Administration and Department of Health and Human Services
    - For certain judicial and administrative proceedings pursuant to an administrative order,
    - Law enforcement purposes, legal proceedings
    - Medical examiner, coroner, or funeral director,
    - The facilitation of organ, eye, or tissue donation if you are an organ donor,
    - To avert a serious threat to your health and safety or that of others,
    - For governmental purposes such as military service or for national security; and
    - In the event of an emergency or for disaster relief
    - Inmates, during the course of providing care
9) **Business Associates:** We may share your PHI with other individuals or companies that perform various activities on behalf of, our office such as after-hours telephone answering, quality assurance, or clinic research. Our Business Associates agree to protect the privacy of your information.
10) **Marketing & any purposes which require the sale of your information**: These disclosures require your written authorization.
11) **Any other uses and Disclosures not recorded in this Notice** will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Notice of Privacy Practices

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF NOVASPINE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU.

BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1) **Copy of this notice:** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
2) **Inspect and Copy:** You have the right to inspect and copy your PHI that we maintain about you for as long as we maintain that information. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or PHI that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer at the address listed below. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. Novaspine has up to 30 days to make your PHI available to you (fee may apply), or 60 days if stored off-site, but must inform you of this delay.
3) **Request an Electronic Copy:** You have the right to request that an electronic copy of your PHI be given to you or transmitted to your designated officer. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fee may apply).
4) **Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. You may ask us not to use or disclose any part of your PHI and by laws we must comply when the PHI pertains solely to health care items or services for which the health care provider involved has been paid out of pocket in full. Request must be made in writing to our Privacy Officer with instructions. If we agree to the restriction, we may only be in violation of the restriction for emergency treatment purposes. By law, you may not request we restrict the disclosure of your PHI for treatment purposes.
5) **Right to receive Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.
6) **Request Amendments:** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be in writing to the Privacy Officer as listed below. In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy.
7) **Request Accounting of Disclosures**: You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12- month period will be free. If you request an additional list within 12- months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.
8) **Request Restrictions:** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.
9) **Request a Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.
10) **File a Complaint**. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our Privacy Officer must be in writing. We will not retaliate against you for filing a complaint.
11) If you have questions about this notice or would like additional information, please contact our Privacy Officer at:

NovaSpine Pain Institute, Attn Privacy Officer, 13203 N 103rd Ave Ste H4 Sun City West AZ 85351 or 623.777.4747

By signing below, I acknowledge that I have received the Notice of Privacy Practices of this office, which outlines how patient confidential information will be used, disclosed, and protected. I understand that I may refuse to sign this Acknowledgement.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: *Type name here fully to qualify as a valid signature* Date: _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided Was Emergent

_____ Other: _____ Employee Initials: _____ Date: _____

FINANCIAL DISCLOSURE STATEMENT

NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/we) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services as follows:

Durable Medical Equipment - Orthosis/Bracing
Dynamic Managed Services AZ LLC
Genetic Technological Innovations-toxicology and phlebotomy
Insight Management Group LLC - toxicology and phlebotomy
Integrated Anesthesia Consultants PLC - office-based anesthesiology services
Integrated Pain and Spine Outpatient Treatment Center LLC - outpatient treatment center
Ocotillo Treatment Center LLC - outpatient treatment center
Silverleaf Surgical Centers LLC - surgery center
Premiere Diagnostics, LLC
Simple Ventures, LLC

Further, as indicated below, goods or services (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

LabCorp Laboratories

SonoraQuest Laboratories

Practical Medical

Hanger Clinic Orthotics and Prosthetics

Summa

Rx Medics Equipment & Supplies

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file.

ACKNOWLEDGEMENT: I/We have read this "Notice to Patients" form and understand the disclosures that it contains.

Type name here fully to qualify as a valid signature

Signature of Patient or Guardian

Date

NovaSpine Pain Institute PLC

TEL: 623.777.4747
FAX: 623.777.4748

FINANCIAL POLICY

Thank you for choosing NovaSpine Pain Institute as your pain management specialist. Please review and sign the following financial policy to indicate your agreement to these terms. Our financial policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients.

APPOINTMENTS

1) **No insurance card, referral, co-payment or outstanding balance.** Copayments and/or outstanding balances are due at the time of service. In addition, we may not be authorized to see you until referral authorization and insurance benefits have been obtained and/or verified. Your appointment may be rescheduled until such time that these document and/or payments are provided.
2) **Procedure Prepayment.** NovaSpine Pain Institute collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy (see below). We reserve the right to reschedule your procedure until prepayment has been made.
3) **Missed Appointments and Late Arrivals.** If you are more than 15 minutes late, we reserve the right to reschedule your appointment. If you are more than 60 minutes late, no show for an appoint, or do not give cancellation notice at least 24 hours in advance, you will be responsible for a missed appointment fee. The first 'missed appointment' occurrence will not be charged a fee. Any additional missed appointments will result in a missed appointment fee as follows:
   - Missed office visit appointments are subject to a $25 charge.
   - Missed procedure, or EMG appointments are subject to a $50 charge.

   These charges are your responsibility and will not be billed to any insurance carrier. It is at the provider's discretion to determine whether or not you will be dismissed from the practice due to missed appointments.

INSURANCE PAYMENTS

4) **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
5) **Coverage Changes and Timely Submissio**n. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Novaspine Pain Institute must submit a claim on your behalf to your insurer. If NovaSpine is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
6) **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by NovaSpine Pain Institute, then you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

7) **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.
8) **Prior Authorization and Non-Covered Services.** NovaSpine Pain Institute may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. As a courtesy to our patients, NovaSpine makes a good faith effort to determine if services are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
9) **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to NovaSpine, immediately.

ACCOUNT BALANCES AND PAYMENTS

10) **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

11) **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Novaspine reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay NovaSpine for any expenses incurred to collect your account, including reasonable attorneys' fees and collection costs.

12) **Returned Checks.** Returned checks will be subject to a $38 returned check fee.

13) **Refunds.** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed.
Requests may be sent to: NovaSpine Pain Institute, Attn: Billing Department, 13203 N 103rd Ave Ste H4, Sun City AZ 85351

14) **Forms and Records Requests.** I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

15) **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

I have read and understand the financial policy of NovaSpine Pain Institute, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to NovaSpine Pain Institute. I understand that I am financially responsible for all services I receive from NovaSpine Pain Institute. I understand that this financial policy is binding upon me, my estate, executors and/or administrators, if applicable.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: *Type name here fully to qualify as a valid signature* _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY/AGREEMENT

_____
Patient Initials

PROVIDER FEES: Patient is aware that Novaspine Pain Institute healthcare providers including Dr. Clifford Baker, Dr. David Morales, Kristian Oarde NP, Victoria Tweedy NP, Terrie Pasch PA, Nathan Franke PA, Derek Mello, Shauna Papa RN are in network with majority of insurance carriers and when appropriate will accept assignment according to the terms of the contract. The patient understands they will be responsible for only the fees as determined by the plan. This will include any previously unmet portion of the in-network deductible and co-insurance based on their benefit.

_____
Patient Initials

ANESTHESIA FEES: Because most pain injection procedures can be performed without the administration of anesthesia, in most cases it is the patient's decision whether-or-not to have conscious sedation administered. Patient is aware the sedation is administered by a certified registered nurse anesthetist (CRNA) or anesthesiologist and that provider may be out-of-network with his/her insurance. Patient understands their insurance will be billed for this service. In the event insurance does not pay for administration of the sedation, the patient will be billed a MAXIMUM of $150 per procedure. Patients are aware providers are in network with Medicare and BCBS.

_____
Patient Initials

PAYMENTS TO PATIENTS: In some instances, the insurance carrier will pay the patient directly for out-of-network services. The patient understands and agrees to relinquish payment to our office upon receipt.

By signing below, I accept the terms as outlined above. I acknowledge that I have read or had explained to me and fully understand all of the above information. I have had the opportunity to ask questions. I understand I have the right to cancel the procedure if I do not agree. I wish to proceed with the procedure with full understanding of the above information. Should questions arise prior to the procedure, I understand that I may speak to a financial representative at 623-777-4747.

Type name here fully to qualify as a valid signature
_____
Patient Signature

_____
Patient Name

_____
Date

NovaSpine Pain Institute PLC

TEL: 623.777.4747
FAX: 623.777.4748

PAIN MANAGEMENT AGREEMENT

Patient Name: _____ Date of Birth:_____

This agreement relates to my use of any medications for pain, including controlled substances and opioids, for pain as prescribed by my provider. The purpose of this Agreement is to set forth specific guidelines and help both myself and my provider comply with the law and guidelines regarding controlled substances and optimize my pain treatment in a safe and collaborative manner.

I understand that if I am prescribed any controlled substances or opioids, I will adhere to the following guidelines:

- I understand that my provider and I will work together to find the most appropriate treatment for my pain symptoms. I understand the goals of treatment are not to completely eliminate pain, but to improve my pain and function. Chronic opioid therapy is only one part of my overall pain management plan.
- I understand that my provider and I will continually evaluate the effectiveness of opioids in achieving the treatment goals and changes will be made as needed. I agree to take the medication ONLY at the dosage and frequency as prescribed by my provider and I will NOT increase the dosage or frequency of medications without the consent of the provider.
- I agree to take ONLY those pain medication(s) that are actively being prescribed by my provider and I will NOT take 'old' pain medications that are not actively being prescribed. I agree to properly discard of any 'old' pain medications that are not actively being prescribed to treat my pain. I understand that I will NOT 'stockpile' medications. If I am taking less medication than is prescribed, I will report this to my provider so my dose can be adjusted. I agree to bring in all unused pain medicine if requested for verification and compliance purposes.
- I agree I will not attempt to obtain (or fill) any opioid medicines from another medical provider without informing NovaSpine Pain Institute provider. I agree to have any controlled substances filled at only one pharmacy.
- I will attend all appointments, treatments and consultations as requested by my provider. I will follow all recommendations as determined by the provider(s). I understand that failure to keep appointments or follow recommendations may lead to discontinuation of treatment and discharge from NovaSpine Pain Institute.
- I will tell my provider about the level of my pain, the effect of the pain on my daily life, how well the medication is helping to relieve my pain, and potential adverse effects from any prescribed medication.
- I recognize that my pain represents a complex problem and may benefit from physical therapy, psychotherapy, behavioral medicine and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize function and improve coping with my condition. If treatment for my condition is available, I agree that I will not refuse the treatment just so that opioids will be continued. I understand that I have the right to refuse any procedure, but that does not mean that my provider must continue to prescribe opioid medications.
- The risks and benefits of taking opioid medications have been explained to me and I understand them. Opioids can impair my judgment, affect reflexes and motor skills. If I am impaired in any fashion, I will refrain from or not participate in activities that would endanger myself or others while using these medications.
- I agree I will not use any illegal substances of any kind, including marijuana, amphetamines, cocaine, heroin, or other. I agree I will not use any prescription medications obtained illegally or obtain them from friends or relatives. I understand that doing so is extremely dangerous and illegal, with potential legal ramifications
- I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.
- I agree I will not share, sell or trade my medication with anyone. I understand that it is dangerous and potentially criminal to share controlled substances in any fashion with another person.
- I agree to protect my pain medicine from loss or theft. I understand lost or stolen medicines will NOT be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event to my provider if requested.

PAIN MANAGEMENT AGREEMENT

- I agree to obtain Narcan (Naloxone) per State of Arizona requirements and at the request of my provider. I agree to be educated on its use and to have it readily available in the case of accidental overdose.
- I agree that medication changes, dosage and/or frequency changes, and refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available after 4:00pm, weekends, holidays or through the emergency room. Medications will not be mailed or refilled without being seen at monthly pain clinic appointments.
- I understand that it is my responsibility to keep track of the amount of medications I have remaining and to plan ahead of time for refills. I will notify NovaSpine Pain Institute **a minimum of 72 hours** before my prescription runs out to allow my refill request to be processed.
- I agree to submit urine for drug testing and random pill counts, even without prior notice, if requested by my provider to determine my compliance and safety with the treatment regimen.
- I authorize NovaSpine Pain Institute to cooperate fully with any official including the state board of pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
- I understand that I may become dependent, tolerant, or addicted to opioids, or may develop complications related to their use. If this occurs, the medication may be changed, tapered, discontinued and other methods of pain control may be used. If necessary, I will permit a referral to an addiction specialist.
- If it appears to the provider that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I agree to taper my medication as directed by the prescribing provider.
- I agree to exercise caution when operating heavy equipment including automobiles if I am on opioid medication. These medications can decrease reaction times, cause drowsiness and cloud judgement. I agree to monitor for these conditions and WILL NOT drive if impaired in any way.
- I understand that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate by the institution.
- I understand that suddenly stopping some pain medications can cause severe medical problems including, but not limited to: withdrawal symptoms, shakiness, irregular heartbeat, heart attack, stroke, seizures, mental state changes, permanent brain damage, disability or death.
- I understand that if I violate any of the above conditions, my provider may choose to stop writing opioids prescribed for me and may discharge me from his/her care. Discontinuation of the medications and discharge from care will be coordinated by the provider and may require referrals to other specialists.
- I agree to follow ALL of the above guidelines. By signing below, I attest that I have read and understand this agreement in its entirety and any questions and concerns regarding treatment have been adequately answered. If requested, a copy of this document has been given to me for my own records.

_____

PATIENT NAME

Type name here fully to qualify as a valid signature

_____

PATIENT SIGNATURE

_____

DATE

Authorization for Use and Disclosure Of Protected Health Information

By signing below, I authorize NovaSpine Pain Institute, its agents and employees ("**Provider**"), to use and/or disclose any and all of my protected health information ("**Records")** on my behalf, of any kind and description, to the following ("**Recipient**"):

Recipient Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

I also authorize Provider to release my protected health information to my insurance, primary care provider(s), referring provider(s), hospitals, diagnostic centers and/or laboratories that may require this information for continued care and authorize Provider to transmit this information through electronic means.

Authorization to Disclose Protected Health Information including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnoses or treatment for HIV, HIV-related diseases and communicable disease-related information. With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

I understand I have the right to refuse to sign this authorization, writing, at any time and that I do not have to sign this authorization to receive treatment at Novaspine Pain Institute. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is:

NovaSpine Pain Institute, Attn Privacy Officer, 13203 N 103rd Ave Ste H4 Sun City West AZ 85351

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This Authorization will remain effective until one-year following the date set forth below, or, if not date is set forth below, the date Novaspine Pain Institute receives this executed Authorization, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: *Type name here fully to qualify as a valid signature* _____ Date: _____

MEDICAL RECORDS RELEASE
Authorization to Disclose Health Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

INFORMATION TO BE RELEASED: (check all items to be released)

- ☐ Entire Record
- ☐ History and Physical
- ☐ Office Visit / Progress Notes
- ☐ Other:
- ☐ Period From: _____
- ☐ Urine Toxicology Results
- ☐ Operative Reports
- ☐ Medication List
- ☐ Lab Reports
- ☐ EMG/NCS Results
- ☐ Imaging Reports (X-rays, CT, MRI)
- ☐ Radiology Images CD / DVD
- ☐ All ☐ _____

REQUESTING RECORDS FROM: _____ _____

Special Records: I understand that protected information related to my diagnosis or treatment for AIDS/HIV, psychiatric care treatment, treatment for drug and alcohol abuse may be released as part of my health information. **Please check appropriate boxes below.**

AIDS/HIV Information	Psychiatric Care/Treatment	Treatment for Drug or Alcohol use/abuse
☐ YES, Disclose	☐ YES, Disclose	☐ YES, Disclose
☐ NO, do not disclose	☐ NO, do not disclose	☐ NO, do not disclose

PURPOSE/USE OF REQUESTED INFORMATION:

☐ Personal ☐ Treatment ☐ Insurance ☐ Disability ☐ Legal ☐ Other: _____

RELEASE INFORMATION TO:

Name: NovaSpine Pain Institute

Address: 13203 N 103rd Ave Ste H5 Phone: 623.777.4747

City: Sun City State: AZ Zip: 85351 Fax: 623.777.4748

FORMAT:

☑ Paper Copy ☐ Electronic Copy (provided on encrypted disk)

AUTHORIZATION:

- **FOR PERSONAL REQUESTS**: There will be a $0.25 per page fee for all requests on paper (plus the cost of postage and envelope) or there will be a $0.25 per page fee for all requests on CD (plus the cost of postage and envelope).
- **FOR DOCTOR TO DOCTOR REQUESTS**: There will be no fee. By default the past two (2) years of pertinent information will be sent. •
- I understand that I may revoke this authorization at any time, by notifying NovaSpine Pain Institute in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under the applicable law, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- My refusal to sign this authorization will not affect enrollment, eligibility for benefits, payment, or my ability to receive treatment.
- I understand that I may inspect or copy the information that is used or disclosed

Patient or Legal Representative Signature: *Type name here fully to qualify as a valid signature* Date : _____

(If a personal representative executes this authorization, then the authorization must contain a description of the representatives authority to act for the individual, e.g., "parent" or "guardian ad litem")

COVID-19 Notification and Acknowledgement

NOVASPINE
PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts™

NovaSpine Pain Institute prioritizes the health and well-being of our patients and staff. To meet this objective and maintain strict universal precautions, we have implemented several changes to our operations, protocols and procedures in accordance with federal, state and local recommendations. Despite the increased precautions that we are taking to reduce the risk of infection, it is important to recognize the risk of exposure to COVID-19 when you are at our office or procedure center. The CDC has determined that there are patients that are considered "high-risk COVID-19" patients. To be clear, high risk patients are at a higher risk of complications and death in the event they become infected with COVID-19.

Patients who are considered high risk for complications from COVID-19 include the following:

- 65 years of age or older
- Lung disease (asthma, COPD/emphysema/bronchitis, bronchiectasis, pulmonary fibrosis, other interstitial lung diseases, pulmonary hypertension, oxygen dependent)
- Heart disease (history of heart attack, stent, bypass surgery, congestive heart failure)
- Diabetes
- Chronic kidney or liver disease
- Immunosuppressed patients (patients on chronic steroids, HIV, organ transplant recipients, use of immune-suppressing medications, history of cancer, other immunodeficiencies)
- Obesity

It is also important to note that even if you are not a high risk COVID-19 patient, you are still at risk of complications from COVID-19 infection. It was recently reported that 40% of the patients hospitalized for COVID-19 were younger than 55 years old.

Recommendations and considerations:

- The majority of office visits are being switched to telehealth or virtual visits to reduce the risk of exposure to patients and staff. We encourage all patients to participate in telehealth visits.
- High risk COVID-19 patients should isolate themselves to reduce risk of exposure and strongly consider whether or not they should be at our clinic or procedure center.
- For interventional pain procedures, it is highly recommended that you postpone your procedure if you are a high-risk COVID-19 patient until such time that COVID-19 is not considered a significant risk.
- During this time, interventional pain procedures are only recommended for those patients with severe, debilitating pain that is severely impacting quality of life and function, such that the patient would suffer more harm than benefit by postponing a procedure, including increased likelihood of emergency care utilization, and other complications from uncontrolled pain such as debility, autonomic instability, and uncontrolled medication usage.
- Interventional pain procedures will be considered on a case by case basis, taking into account the patient's pain, health and other risk factors. A decision will be made together with the patient.
- Procedures that involve the use of steroids can help to reduce pain and improve function. However, all steroids can temporarily suppress the immune system which could reduce one's ability to fend off or fight an infection from or associated with COVID-19.

I acknowledge that I have read and understand the information above, and all of my questions were answered.

Patient Name: _____ Date of Birth: _____

Patient Signature: *Type name here fully to qualify as a valid signature* Date: _____