Phoenician Pain & Rehabilitation Center

Patient Information

****Please write your name EXACTLY how it is shown on your insurance card****

Last Name_____ First Name_____ MI____ Date of Birth _____

Gender_____ Marital Status (Married, Single, Divorced, Separated, Domestic Partnership) _____

Address_____ City_____ State_____ Zip_____

Primary Phone_____ **Circle Type** (Home, Mobile, Work, Alternate)

Secondary Phone_____**Circle Type** (Home, Mobile, Work, Alternate)

Email Address_____

Do you have a living will? Yes / No

Occupation_____ Employer_____ Phone_____

Associated Providers & Pharmacy Information

Primary Care Provider_____ Referring Physician_____

Pharmacy Name_____ Crossroads_____

Insurance Information

Primary Insurance_____ Phone_____

ID #_____ Group #_____

Guarantor(Policy Holder) _____ Relationship to Patient_____ Date of Birth_____

Secondary Insurance_____ Phone_____

ID #_____ Group #_____

Guarantor(Policy Holder) _____ Relationship to Patient_____ Date of Birth_____

Emergency Contact

Name _____ Phone_____

Relationship to Patient_____

Phoenician Pain & Rehabilitation Center

Name_____

Date_____

Chief Complaint_____

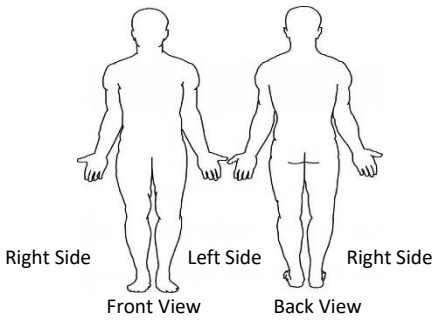
_____

Date of Injury (If Applicable) _____

Date When First Symptoms Occurred _____

How Did Symptoms Occur _____

1) Shade the area of your pain
2) Place an "X" at the worst area(s) of pain



Describe your pain _____

_____

On a scale from 0-10, what is the level of the worst pain you currently have?

No Pain Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

Past Medical History-Major Illnesses

	No	Yes	Active?
Diabetes			
Cancer			
Stomach Ulcer			
High Blood Pressure			
Emphysema			
Neurologic			
Disease/ Injury			
Stroke			
Bleeding Disorder			
Thyroid Disorder			
Infections-TB			

Please List Other Chronic Illnesses

_____

_____

Operations/Hospitalizations	Date

Current Medications	Date

Drug Allergies	Date

Social/ Personal History

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 History

Father- Living Y __ N __ _____

Mother- Living Y __ N __ _____

Siblings/ # of Brothers Y __ N __ _____

Siblings/ # of Sisters Y __ N __ _____

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System Review

Please check any of the following that you may have had over the past year:

	Y	N		Y	N
Fever			Join 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			Bladder/ Bowel Incontinence		

Past Treatment

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

Past Treating Physicians

_____

_____

_____

Past Test

X-Rays? _____

CT Scan? _____

MRI? _____

EMG? _____

Bone Scan? _____

Blood Test? _____

Other? _____

Phoenician Pain & Rehabilitation Center

Patient Consent Form

_____
Initial

Insurance

Our office and providers are contracted with most insurance carriers. Upon scheduling we will request for insurance information to determine the likely hood of being contacted with your carrier. Due to the constant change and updates on carrier plans and networks, we may not be able to determine that every individual plan is contracted. Ultimately, it is the patient's responsibility to know their health plan benefits and network before seeking any services.

_____
Initial

Co-Payments, Deductibles and Account Balances

We accept cash, personal checks, Visa, Master Card, Discover and American Express. Co-payments will be collected at the time of service at each appointment. For any deductible balances or applicable account balances we can provide payment plans if needed. We also offer the option for payments to be called in or made on our website.

_____
Initial

No-Shows, Cancellations and Reschedules

Our office requires a **24-hour notice** for cancelations and reschedules for **office appointments**. Failure to provide proper notice can be subject to a **$50 fee.** Our office requires a **72-hour notice** for cancelations and reschedules for **procedure appointments**. Failure to provide proper notice can be subjected up to a **$75 fee**, per the providers distraction, Our office allows a maximum of 3 no-shows, cancelations and/or reschedules within a 60-day period, failure to comply can be subject to a practice discharge.

I acknowledge that I have read and agree to the office policy.

I hereby assign my medical benefits to be utilized by the provider services are rendered under.

I hereby authorize the release of my medical information to the insurance companies to process claims, to my referring physician and to any physician involved in my care.

_____ _____

Patient/Guardian (Please Print) Date

_____ _____ _____

Patient/Guardian Signature Relationship to Patient Patient Date of Birth

Phoenician Pain & Rehabilitation Center

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it has been cancelled.

If there are any changes to your payment card preference, please notify us to fill out a new form.

Credit Card Information
Card Type: ☐VISA ☐Mastercard ☐Discover ☐AMEX ☐Other _____
Card Holder Name (as shown on card): _____
Card Number: _____
Expiration Date: _____ /_____
Billing ZIP Code: _____
CVC: _____

I, _____ authorize **Phoenician Pain and Rehabilitation Center** to charge my credit card above for agreed upon amount towards my account balance. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date

Phoenician Pain & Rehabilitation Center

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? ☐ YES or ☐ NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(Please Print Name)

Signature: _____ Date: _____

Phoenician Pain & Rehabilitation Center

Shimul Sahai. M.D. Jessica Kappes, 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