4838 E Baseline Rd Ste 108
Mesa, AZ 85206
Phone: 480-924-7091
Fax: 480-854-1445

37100 N. Gantzel Rd
Ste. 113
San Tan Valley, AZ 85140

Patient Policies and Procedures

This is a general notice to explain our policies and procedures in treatment of pain management. Dr. Matthew Ranson specializes in Interventional Pain Management, he does not provide long term opioid medication management except in rare cases such as chronic cancer pain. It is up to the Doctor and his best discretion of whether or not he will take over any medication that you are currently taking. If in the event he decided to take over, they will not be prescribed at your initial consultation.

Before treatment we will explore all options within the scope of our practice to help you regain function and lead an active and healthy lifestyle. We will do so by using a variety of treatment methods to accomplish treatment goals that include physical therapy, basic injection procedures, heat/cold therapy, non- controlled substances and in some cases controlled substances.

If your Doctor decides to prescribe controlled substance to you as part of your treatment plan, He /She will and must follow all federal and state law regulations regarding controlled substance prescribing. Below you will find a list of some things we may ask you to bring to your initial consultation that are in coordination with our patient selection and treatment procedures.

- Gather all information you may have and from your doctors about your medical history and past pain treatments. This should include a list of all current medications.
- We may ask you if you, or anyone in your family has had a problem with alcohol, drugs, perception drug use, or tobacco.
- In addition, we ask patients submit a urine drug screen as part of our initial patient selection. (**we do not guarantee coverage of payment for this service**) If we accept you into our pain management program, we also may ask you to submit additional urine samples as part of your ongoing treatment. All urine samples are requested at the discretion of your doctor and if you choose not to cooperate with us we may find a way to treat you without controlled substances.

Your medical condition and use of medications will be monitored using various tools, in addition to urine drug testing, which may include medication counts, family conferences, physiological evaluations, and more. These policies are not intended to offend anyone, these are just policies and tools that are used in our practice.

On behalf of Gateway Anesthesia and Pain Associates, PLLC, we are committed to treating your pain in an acceptable and appropriate manner. We look forward to helping you, as it is our goal to control your pain.

Confidentiality Statement

Here at Gateway Anesthesia and Pain Associates, PLLC, we value your rights to privacy. All interactions and medical information/records are completely confidential. As a patient, you have rights to your privacy and we

have listed some of your rights below regarding Health Insurance Portability and Accountability Act (HIPPA) You can learn more about HIPAA at www.hhs.gov/ocr/hipaa or by calling 1-866-627-7748.

You have the right to:

- Request any and all medical records
- Have corrections made to your health information
- Receive a notice of how your health information may be used or shared
- You can give authorization for release of your records
- Indicate where you would like to be contacted
- Request your information not be shared with anyone or any other doctor
- File a report if you believe your healthcare information isn't being protected

Disclosure: Your Doctor is obligated to disclose any relevant information to reduce or prevent serious threat to your healthcare or safety.

Protected Health Information Authorization

I hereby authorize the use and/or disclosure of my protected health information for whatever Dr. Matthew Ranson deems necessary for my medical care. This includes but is not limited to: Pharmacies, Hospitals, Physicians referred to/by, diagnostic facilities, nursing home, insurance companies work comp, health facilities and family members.

Should you wish to exclude a person(s) from obtaining your health information, please list them below:

____
____
____
____

I understand I have the right to revoke this authorization at any time. My revocation must be in writing and I am aware that my renovation is not effective to the extent that the person I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I have the right to inspect and copy my own protected health information to be used or disclosed. In alliance with federal privacy protection regulations found under 45 C.F.R (164.524)

I understand that I am not obligated to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Matthew Ranson, nor will it affect my eligibility for benefits.

I have read and understood all policies and procedures at this practice

Patient Name:____

Patient Signature:___________________________________ Date: _____________

Do you have problems with anesthesia? YES or NO

Do you have diabetes? YES or NO

Any heart problems? YES or NO If YES, Please indicate year__________

High blood pressure? YES or NO

Breathing problems? YES or NO On oxygen Asthma COPD Emphysema Chronic Cough Sleep Apnea Bronchitis Other____

Do you smoke? YES or NO Packs Per Day _________ Former Smoker? YES Or NO Years Smoked________

Any stomach or digestion problems? YES or NO

Have you ever had a stroke? YES or NO Year__________

Have you had seizures? YES or NO Frequency____________

Any kidney or urinary problems? YES or NO If YES, please Describe:________________________________

Any liver/thyroid problems? YES or NO Describe: ____

Are you currently taking any blood thinners? YES or NO Describe:__________________________________

Have you ever been diagnosed with cancer? YES or NO Describe:__________________________________

Do you have arthritis? YES or NO Describe:____

Any psychiatric problems? YES or NO

Any substance abuse? YES or NO

Do you drink alcohol? YES or NO Frequency:____

Please indicate the number that best describes your answers to the following: Pain Scale:

(0 -no pain)(1-2 mild)(3-5-discomforting)(6-7 distressing)(8-9 horrible)(10 excruciating)

When your pain is at its worst, what is your pain level? __________

When your pain is at its least, what is your pain level? ___________

When your pain is at its average, what is your pain level? _________

What makes your pain worse? (walking, standing, lifting)____

____

What makes the pain better?____

____

What is the reason for your visit today?____

____

What treatments or medications have you tried to relieve your pain?____________________________________

____

Any medical issues or surgeries? If yes, please list: (include year)____

____

Allergies?:____

Family History of Illness?(Immediate family only) ____

____

Medication:	Dosage:	Directions

If additional medications, please provide attached medication list.

Please Circle All that apply:

General: Recent fever, weight loss

Cardiovascular: Chest pain, palpitations

Eyes: Vision changes, irritation

ENT: Difficulty hearing, sore throat, hoarseness

Respiratory: Cough, shortness of breath, wheezing, sleep apnea

Gastrointestinal: Abdominal pain, change in appetite, reflux, constipation, diarrhea, nausea, vomiting, loss of bowels

Genitourinary: Difficulty urinating, painful urination, incontinence, loss of urine

Musculoskeletal: Back pain, muscle aches, muscle weakness, neck pain and joint pain/ swelling in the extremities

Psychiatric: Depression, anxiety, PTSD, hallucinations

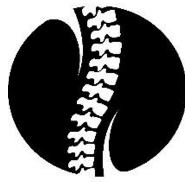
Addiction: alcohol abuse, drug abuse, history of inpatient or outpatient substance abuse treatment

Endocrine: Fatigue, increased thirst, heat and cold intolerance, hair loss

Hematological: Excessive bleeding, easy bruising, swollen glands

Allergies/immunologic: Runny nose, sinus pressure, hives, HIV/AIDS, hepatitis

Gynecologic: Pregnancy



Patient Demographic Form

Patient Name:______________________________ **Sex:** M or F **Age:**______________ **Date:** ________________

SSN:____________________ **Date of Birth:**__________________ **Marital Status:**___________________________

Address:____

Home phone:_________________ **Cell Phone:**_____________________ **Work:**_____________________________

Email Addess:____

Do you have a living will on file? YES or NO

Primary Care Doctor:____

Referring Doctor:____

Are you currently: EMPLOYED RETIRED DISABLED UNEMPLOYED

Occupation:____

Emergency Contact Name:____

Phone #:_______________________ **Relationship:**____

Pharmacy Name:___________________________________**Location:**______________________________________

Phone:____ **Fax:**____

Primary Insurance:_________________________________**Policy Number:**_______________________________

Group number:_____________________________________**Phone#:**______________________________________

Secondary Insurance:_________________________ **Policy Number:**____________________________________

Group number:_____________________________________**Phone#:**______________________________________

X____--________________

Patient Signature Date

If workers comp or auto please fill out below

Name of Insurance:_________________________ **Adjuster name:**______________________________________

Phone#:__________________________ **Claim number:**_____________________ **Date of Accident:**__________

Insurance Claim Address:____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Last Name: ______________________________ **First Name:**____

Date of Birth:_____________________________ **Phone Number:**_______________________________________

Address:____

Date(s) of Service requesting:________________ **Purpose of Disclosure:**_________________________________

Please Send:____

I understand the infromation in my health records may include information relating to sexually transmitted disease Acquired Immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization is valid only for the realease of medical information dated prior to and including the on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

Release to: Mathew Ranson, MD

Address: 4838 E. Baseline Rd #108 Mesa, AZ 85206

Phone: 480-924-7091 Fax: 480-854-1445

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under policy. Unless otherwise revoked this authorization will expire on the following date: __________, if I fail to specify an expiration date this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.521. I understand that any disclosure of information carried with it the potential for an for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have question about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above forgoing Authorization for Release for information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature:______________________________________ **Date:**_________________________________

Name of Authorized Representative:____

Signature of Authorized Representative:____

GATEWAY ANESTHESIA AND PAIN ASSOCIATES PLLC

FINANCIAL POLICY GUIDELINES

WELCOME
Thank you for choosing us as your health care provider. We are committed to providing quality medical care. In order to reduce potential confusion, we have adopted the following Financial Policy Guidelines. Please read and sign it prior to the commencement of any treatment.

APPOINTMENTS
To schedule an appointment, please call our office at (480) 924-7091. We strive to provide the best possible service available to all of our patients. If you are unable to keep an appointment, please call at least 24 hours in advance so that we can schedule another patient who is waiting for a sooner time slot. Many of our patients have urgent needs, so we use appointment cancellations to accommodate their special needs. Patients with recurrent missed appointments or short notice cancellations will be charged a $25.00 fee for each missed appointment. This fee is not billed to your insurance company; it is solely your responsibility. If you call for an urgent appointment, we will make our best effort to accommodate your needs.

INSURANCE
Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. All health plans are not the same and they do not always cover the same services. In the event your health plan determines a service is "not covered", you will be responsible for the complete charge. <u>This office is not responsible for disputing your insurance company's decision regarding coverage.</u> We will do our best to prior authorize any and all tests and procedures prior to them being done. ***We expect that you are responsible in knowing your insurance benefits, including but not limited to: deductible, co-insurance and co-payment amounts as well as labs, radiology facilities and hospitals contracted with your plan.*** If you have insurance coverage with a plan in which we do not participate or you have no health insurance plan, our charges for your care are due at the time of service. You may, however, bill your insurance company, even if we are not a contracted provider. Our office will provide you with the necessary paperwork to do so.

ADMINISTRATIVE
Your insurance is your responsibility! It is a courtesy to our patients, we will file claims for these plans which we have an agreement. ***It is your responsibility to notify our office with current and valid insurance information.*** If your insurance does not pay within a reasonable amount of time, we will look to you for payment. Any costs incurred by this office because of incorrect information provided to us will be your responsibility. Payment is due upon receipt of a statement from our office.

All monies owed including co-pays, co-insurance, deductibles or outstanding balances are collected at the time of service. Administrative Fees:

$25.00 fee for NSF returned checks
$25.00 fee for repetitive no show or late cancellations
$25.00 fee for Disability/FMLA paperwork

If this account should go into default, you understand that you will be held liable for all collection fees and attorney fees incurred to collect this debt.

I have read and understand the financial policy guidelines:

Patient: ____ Date: ____________________________