VALLEY PAIN CONSULTANTS
An Envision Physician Services Provider

HEALTH HISTORY AND PAIN QUESTIONNAIRE

Patient Name: _____ **DOB**:_____

Pharmacy:_____**Cross Streets**:_____

☐ Male ☐ Female ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

History of Problem (for which you are being seen):

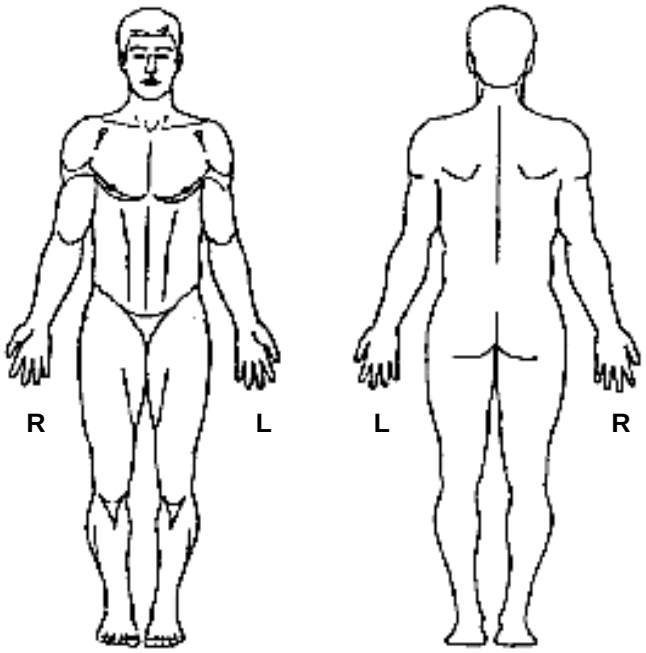
Reason for visit: _____
By whom were you referred to our practice?_____
Expectations from treatment:_____
Type of injury: ☐ Job Accident ☐ Sports Injury ☐ Other: _____
Car accident: ☐ Driver ☐ Passenger Seatbelt: ☐Yes ☐No Airbag: ☐Yes ☐No
Date injury/symptoms started: _____
Do you have cancer? ☐ Yes ☐ No If Yes, Cancer Type: _____
Stage of cancer: _____

How would you describe your mood in a word or two?_____

On the diagram below, shade the areas where you feel pain. **Put an "x" where it hurts the most**;

Check all terms that apply:

☐ Aching ☐ Mild
☐ Burning ☐ Moderate
☐ Stabbing ☐ Severe
☐ Shooting ☐ Unbearable
☐ Constant ☐ Numbness
☐ Transient ☐ Tingling
☐ Sharp
☐ Dull



1. What number best describes your **pain on average** in the past week**?**

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

2. What number best describes your **pain at its least**?

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

3. What number best describes your **pain at its worst**?

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

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What makes pain **worse**: _____

What makes pain **better**: _____

Time of the day when pain is worse:_____

Do you have the following:

Weakness in your:	☐ Arms	☐ right	☐ left	☐ Legs	☐ right	☐ left
Numbness in your:	☐ Arms	☐ right	☐ left	☐ Legs	☐ right	☐ left

New or recurrent problems with bowel or bladder control? ☐ Yes ☐ No

Change in pain with cough/sneeze/bowel movements? ☐ Yes ☐ No

Medication History Indicate what you have used ***for your current pain condition:***

Do you have a history of the following with regards to Opiates/Narcotics:

Side-effect? ☐ Yes ☐ No explain:_____

Adverse reaction? ☐ Yes ☐ No explain:_____

Overdose? ☐ Yes ☐ No explain:_____

If you have tried any of the listed medications, please indicate whether it helped with your pain or not by checking the appropriate box. If you have not tried an agent, check "never tried"

Narcotics/Opiates Did it help?	Yes/No	Never tried
Butrans Patch	☐☐	☐
Codeine (Tylenol #3)	☐☐	☐
Fentanyl Patch (Duragesic)	☐☐	☐
Hydrocodone (Vicodin)	☐☐	☐
Hydromorphone (Dilaudid)	☐☐	☐
Methadone	☐☐	☐
Morphine (Kadian, MS Contin)	☐☐	☐
Nucynta	☐☐	☐
Oxycodone (Percocet)	☐☐	☐
Oxycontin (Xtampza)	☐☐	☐
Oxymorphone (Opana)	☐☐	☐
Tramadol (Ultram)	☐☐	☐

Other:_____

Anti-Inflammatory Did it help?	Yes/No	Never tried
Acetaminophen (Tylenol)	☐☐	☐
Aspirin	☐☐	☐
Celecoxib (Celebrex)	☐☐	☐
Diclofenac (Voltaren)	☐☐	☐
Etodolac (Lodine)	☐☐	☐
Ibuprofen (Advil, Motrin)	☐☐	☐
Indomethacin	☐☐	☐
Meloxicam (Mobic)	☐☐	☐
Nabumetone (Relafin)	☐☐	☐
Naproxen (Aleve)	☐☐	☐

Other:_____

Muscle Relaxants Did it help?	Yes/No	Never tried
Baclofen	☐☐	☐
Carisoprodol (Soma)	☐☐	☐
Chlorzoxazone (Lorzone)	☐☐	☐
Cyclobenzaprine (Flexeril)	☐☐	☐
Metaxalone (Skelaxin)	☐☐	☐
Methocarbamol (Robaxin)	☐☐	☐
Tizanidine (Zanaflex)	☐☐	☐

Other:_____

Antineuropathics: Did it help?	Yes/No	Never tried
Amitriptyline	☐☐	☐
Duloxetine (Cymbalta)	☐☐	☐
Gabapentin (Neurontin)	☐☐	☐
Milnacipran (Savella)	☐☐	☐
Nortriptyline	☐☐	☐
Pregabalin (Lyrica)	☐☐	☐
Topiramate (Topamax)	☐☐	☐

Other:_____

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Treatment History (for your current pain condition):

If you have tried any of the listed treatments, please indicate whether it helped with your pain or not by checking the appropriate box. If you have not tried an agent, check "never tried"

Treatment

Did it help?	Yes/No	Never tried		Yes/No	Never tried
Physical Therapy	☐☐	☐	Facet Block/ Medial Branch Block	☐☐	☐
Chiropractic	☐☐	☐	Epidural Steriod Injection	☐☐	☐
TENS Unit	☐☐	☐	Radiofrequency Ablation	☐☐	☐
Acupuncture	☐☐	☐	Spinal Cord Stimulator	☐☐	☐
Trigger Point Injection	☐☐	☐	Psychiatric/Psychological Care	☐☐	☐
Joint injections	☐☐	☐	Other:_____		

Name of prior Pain Physican(s):_____ ***Phone:***_____

Do you currently have a Pacemaker or an AICD? **Yes** ☐ **No** ☐

Are you currently taking Anticoagulants/Blood Thinners? **Yes** ☐ **No** ☐

If yes, what type?

☐ Warfarin/Comadin	☐ Aspirin	☐ Lovenox	☐ Pacemaker/AICD
☐ Plavix	☐ Eliquis	☐ Heparin	☐ Other_____
☐ Pradaxa	☐ Arixta	☐ Herbals (Garlic, Ginko, Ginseng, Vitamin E)	

What doctor manages the blood thinner?_____

Why are you taking a blood thinner?_____

Current Medications (Include vitamins, antacids, birth control, etc. – **attach list if necessary**):

	Name:	Dose:	How often:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

Diagnostic Studies:

X-Ray	☐Yes ☐No	MRI Scan	☐Yes ☐ No
CT Scans	☐Yes ☐No	Bone Scan	☐Yes ☐ No
EMG	☐Yes ☐No	Other _____	

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Past Medical History (check all that apply):

Cardiac

- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Angina
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Vascular Disease
- ☐ Pacemaker
- ☐ Blood Thinners
- ☐ Valvular Disease

Pulmonary

- ☐ Pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Bronchial Disease
- ☐ Tobacco

Renal

- ☐ Dialysis
- ☐ Renal Insufficiency
- ☐ Kidney Stone
- ☐ Prostate Problems

Neurological

- ☐ Stroke
- ☐ Transient Ischemic Attack
- ☐ Seizures
- ☐ Nerve Damage

Infectious

- ☐ Valley Fever
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Polio

Hepatic

- ☐ Jaundice
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Gall Bladder

Gastrointestinal

- ☐ Hiatal Hernia
- ☐ GERD
- ☐ Gastric Ulcers
- ☐ Colitis

Endocrine

- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Diabetes Mellitus

Psychological

- ☐ Depression
- ☐ Bipolar
- ☐ Addiction
- ☐ Schizophrenia

General

- ☐ Anemia/Bleeding
- ☐ Arthritis
- ☐ Obesity
- ☐ Alcoholism

Allergies to Medications: ☐ **Yes** ☐ **No (if yes, indicate below drug and reaction)**

Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History (be as specific as possible, including surgery type and year of surgery)**:**

	Date	Surgery		Date	Surgery
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

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Serious Injury (list injuries you have sustained): ☐ Yes ☐ No

Date	**Injury**
_____	_____
_____	_____
_____	_____

Family History (Mark all appropriate diagnosis as they pertain to your family members only)**:**

	Diabetes	Hypertension	Heart Disease	Neurological	Psychiatric	Cancer
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐	☐	☐
Son(s)	☐	☐	☐	☐	☐	☐
Daughter(s)	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐

☐ I Have No Significant Family Medical History

☐ I Am Adopted (No Medical History Available)

Social History:

Are you currently working? ☐ Yes ☐ No ☐ Part-time ☐ Full-time

Occupation: _____

Education: ☐ Elementary ☐ High school ☐ College ☐ Graduate school

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Children: ☐ Yes ☐ No If yes, how many? _____

Do you have any lawsuits pending? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No

Workmen's Comp? ☐ Yes ☐ No

Do you use illicit substances? ☐ Yes ☐ No

*If yes, please describe: _____

Do you use tobacco? ☐ Yes ☐ No

# of packs/ day _____ How many years?_____

Do you use alcohol? ☐ Yes ☐ No

# of drinks/ day _____ How many years?_____

Do you have a history of drug/alcohol abuse/addiction? ☐ Yes ☐ No

Have You ever been treated with Buprenorphine (Suboxone) or Methadone for opioid abuse/addiction? ☐ Yes ☐ No

Is there any history of drug/alcohol abuse/addiction in your family? ☐ Yes ☐ No

Do you currently use Medical Marijuana? ☐ Yes ☐ No

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Review of Systems (List Only Current or Very Recent Symptoms):

General:	☐ Weight Change ☐ Fever ☐ No Problems	☐ Fatigue ☐ Loss of Appetite	☐ Weakness ☐ Chills
Cardiac:	☐ Chest pain/Angina ☐ Peripheral Edema	☐ Shortness of Breath ☐ No problems	☐ Palpitations
Endocrine:	☐ Heat intolerance ☐ Cold intolerance	☐ Excessive sweating ☐ Excessive thirst	☐ Excessive urination ☐ No problems
Gastrointestinal:	☐ Diarrhea ☐ Change in appetite ☐ Loss of bowel control ☐ No Problems	☐ Reflux ☐ Abdominal pain ☐ Blood or Black Stool	☐ Constipation ☐ Nausea ☐ Vomiting
Genitourinary:	☐ Difficulty Urinating ☐ Loss of Bladder Control	☐ Painful Urination ☐ No Problems	☐ Blood in urine
HEENT:	☐ Sinus Problems ☐ Jaw Problems ☐ Mouth Problems	☐ Difficulty Swallowing ☐ Dry Mouth ☐ No Problems	☐ Headache ☐ Migraines
Hematology/ Oncology:	☐ Chemotherapy History ☐ Radiation History	☐ Bleeding Disorder ☐ Anticoagulation Therapy	☐ No Problems
Musculoskeletal:	☐ Muscle Cramps ☐ Joint Redness ☐ Joint Heat	☐ Joint Stiffness ☐ Joint Swelling	☐ Muscle atrophy ☐ No Problems
Neurological:	☐ Blackouts ☐ Fainting ☐ Hallucinations ☐ Tremors	☐ Weakness ☐ Paralysis ☐ Dizziness ☐ Confusion	☐ Numbness ☐ Gait Difficulties ☐ No Problems
Opthalmology:	☐ Blurrred Vision ☐ Double Vision	☐ Eye Pain ☐ Photophobia (light is painful)	☐ No Problems
Psychiatric:	☐ Depression ☐ Drug Abuse	☐ Suicidal Ideation ☐ Homicidal Ideation	☐ Anxiety ☐ No Problems
Respiratory:	☐ Cough ☐ Hemoptysis	☐ Shortness of Breath ☐ No Problems	☐ Wheezing
Skin:	☐ Dry Skin ☐ Changes in Skin Color ☐ Itching	☐ Changes in Hair or Nail ☐ Recurrent Rashes	☐ Eczema ☐ No Problems
Toxins:	☐ Asbestos ☐ Pesticides	☐ Industrial Chemicals ☐ Drug Use	☐ Lead ☐ No Problems

X_____ _____/_____/_____
Patient Signature *Date*

Reviewed by: _____ _____/_____/_____
Provider Signature *Date*

VALLEY PAIN CONSULTANTS
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Annual PQRS Questionaire (Pain)

Patient Name: _____ **DOB**:_____

1. Do you have little or no interest in doing things? Yes ☐ No ☐

If yes, please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

2. Are you feeling down, depressed or hopeless? Yes ☐ No ☐

If yes, please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

*If you answered **YES*** to question 1 or 2, then complete the following table.

*If you answered **NO*** to both question 1 and 2 then you **DO NOT** have to complete the table below.

Please answer the following questions (please place a check mark in the box) ✓	Not at All (0)	Several days (1)	More than half the days (2)	Everyday (3)
3. Do you have trouble falling or staying asleep or sleeping too much?				
4. Do you feel tired or having little energy?				
5. Do you have poor appetite or overeating?				
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?				
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
8. Do you move or speak so slowly that other people could have noticed? Or the opposite? Are you fidgety or restless and move around more than usual?				
9. Do you have thoughts that you would be better off dead and/ or have thoughts of hurting yourself in some way?				

Have you fallen in the past year? (Answer ony if 65 years and older.)

☐ **No**

☐ **Yes** ☐ 1 fall with injury ☐ 2 or more falls with injury

☐ 1 fall without injury ☐ 2 or more falls without injury

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Date:_____/_____/_____

Patient Registration Form

Patient's Full Name:_____ **Date of Birth:**_____

Address:_____ SSN:_____

Primary Contact Phone Number: _____ (please check ✓)

Home Phone: _____ ☐

Mobile Phone: _____ ☐

Work Phone: _____ ☐

Email: _____

Do you want access to the patient portal? ☐ Yes ☐ No

Please Circle One:

Sex: Male Female

Martial Status: Single
Married
Divorced
Widowed

Primary Care Physician / Facility:_____ Phone: _____

Referring Physician / Facility:_____ Phone: _____

In Case of Emergency Contact: Name: _____

Phone Number:_____ Relationship to Patient:_____

Power of Attorney Information/ Caregiver Information (Note: Can only be listed if legal forms are available)

Do you have Legal Forms Available? ☐ Yes ☐ No Scanned ☐

Would you like to list the individual as the Primary Contact? ☐ Yes ☐ No

Name: _____ Phone Number:_____

Financial Responsible Party Information: (please check) ☐ Self (same as above) ☐ Spouse ☐ Parent ☐ Other

Guarantor's Name: _____ Date of Birth: _____
Address: _____City: _____ State: _____ Zip Code: _____
Home Phone: _____ Mobile: _____ Work Phone: _____
Relationship to Patient: _____ Social Security #_____
Guarantor's Employer: _____ Work Phone: _____
Employer Address: _____

Insurance Information: Scanned ☐

Primary Carrier: Insurance Name: _____ Policy #_____
Claims Address:_____
Policy Holder's Name: _____ Relationship to Patient:_____
Policy Holder's Date of Birth: _____ Social Security #_____

Secondary Carrier: Insurance Name: _____ Policy #_____
Claims Address:_____
Policy Holder's Name: _____ Relationship to Patient:_____
Policy Holder's Date of Birth: _____ Social Security #_____

Workmen's Comp: Carrier:_____ Claim #_____
Address:_____Date of Injury: _____
Claim Representative _____Phone _____
Employer_____

VALLEY PAIN CONSULTANTS
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Patient Demographics

In order to participate in federal and state healthcare programs, our practice requests the demographic information below. The terms below are the federal government's standards for classification of race and ethnicity.

Race (please check one box)

☐ **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Black or African American.** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

☐ **More than one race**

☐ **I prefer to not provide this information**

Ethnicity (please check one box)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Undefined

☐ **I prefer to not provide this information**

Preferred Language (please check one box)

☐ Spanish
☐ English
Other (please list) _____

☐ **I prefer to not provide this information**

VALLEY PAIN CONSULTANTS
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AUTHORIZATION AND RELEASE OF INFORMATION TO INSURANCE

I authorize the release of any Protected Health Information information including the diagnosis and the records of any treatment rendered to my child or me during the period of such care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to Valley Pain Consultants insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf or my dependents.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

CONSENT TO RELEASE INFORMATION TO FAMILY AND OTHERS

I hereby give my consent to release Protected Health Information information from my medical and/ or financial records from Valley Pain Consultants to anyone specifically listed below.

Name Relationship

_____

_____

_____

☐ I specifically **DENY** permission to release information to anyone.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

CONSENT TO RELEASE INFORMATION TO PHYSICIAN

I hereby give consent to release Protected Health Information information regarding my treatment and/or copies of my medical record to my referring physician and/or primary care physician as listed on the Patient Registration Sheet.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

CONSENT TO TREAT

I further authorize and consent to the Practice's physicians and their assistants and other Practice professional staff providing outpatient medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

****I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Valley's Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, this *Consent for Release of Protected Health Information* will remain in effect until terminated by me in writing.**

VALLEY PAIN CONSULTANTS

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Insurance Acknowledgement

Dear Patient,

Due to all of the various HMO and PPO insurance plans now available in the marketplace, it has become a very complicated process to become familiar with each plan. All of the various companies and plans have their individual requirements for various procedures.

It has therefore become necessary to request that all patients provide all information needed from their insurance company, and that they assume responsibility for providiing this information to our office, and to any other health facility involved in their particular treatment or illness, including hospitals. Patients must also notify their insurance company of any changes in their care or treatment so that proper handling and payment will be made by their insurance company.

You may receive a pre-certification or authorization number from your insurance company. Please remember that this does not guarantee that your insurance company will pay for the procedure. It is your responsibility to call your insurance benefits department to see if you have any pre-existing or routine testing clauses in your contract which would prevent your insurance company from paying the bill.

We have always filed and will continue to file claims for patients, but you must share equal responsibility for obtaining and giving the doctor or insurance company the necessary information needed to get your claim processed and paid within a reasonable time period.

We realize that patients are not always given all the information required by their insurance company or agent, but it is still your responsibility to call and obtain this information before receiving treatment and before filing claims for treatment. We cannot emphasize enough how important this is, in order for you to receive the proper benefit you are entitled to under your insurance plan or contract.

We are requesting your cooperation so that we may better serve you and give you the health care you deserve, without having to spend an exorbitant amount of time dealing with your insurance company. You should have and know all the information required by your individual plan(s) of insurance to avoid any confusion on your behalf of what services are covered by your insurance policie(s).

Thank you for your cooperation.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

VALLEY PAIN CONSULTANTS

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Agreement of Financial Responsibility

Thank you for choosing Valley Pain Consultants as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.
- In addition, if you're insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

VALLEY PAIN CONSULTANTS
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CONSENT FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT PAYMENT OF HEALTHCARE OPERATIONS

As set forth more fully in our Notice of Privacy Practices, we are permitted to obtain your consent for any use or disclosure of your health information to carry out treatment, payment, or health care operations. In our Notice of Privacy Practices, we provide you information about how this office can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Consent. The Notice is available on our website or a brochure can be obtained at the front desk.

We reserve the right to change the terms of our Notice of Privacy Practices at any time. If you have any questions related to the notice, you may contact Valley's Privacy Officer, Dean F. Smith III, MD, or Patricia Durlam, RN, MAOM, Practice Administrator at 1850 N. Central Avenue, Suite 1600, Phoenix, AZ 85004 (telephone: 602.262.8903).

By signing this form below, you consent to our use and disclosure of your health information for treatment, payment or health care operations. You have the right to request that we restrict how your health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree with your requested restrictions; however, if we do agree to your restrictions, we are bound to follow them.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Valley's Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, this ***Consent for Release of Protected Health Information*** will remain in effect until terminated by me in writing.

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse. My signature authorizes release of information as it pertains to authorization or billing needs.

X_____ _____/_____/_____

Signature of Patient or Legal Representative *Date*

*If signed by Legal Representative, please describe the authority of Legal Representative to sign for patient:_____

☐ I have **received** a copy of the Notice of Privacy Practices Initials _____

☐ I have **declined** a copy of the Notice of Privacy Practices Initials _____

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Billing Questions
Valley Pain Consultants
Phone: 602.774.4760
Fax: 602.744.4799 I 602.528.6998

Mailing Address/General Questions
645 E. Missouri Avenue, Suite 300
Phoenix, AZ 85012

Patient Rights and Responsibilities

This notice describes your rights and responsibilities concerning your medical care. Please review it carefully and let us know if you have questions. Except where medically contraindicated, these rights apply to all adults, children, and adolescents treated by Valley Pain Consultants and their parents and/or guardians.

An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Sexual abuse;
    g. Sexual assault;
    h. Except as allowed in R9-10-1012(B), restraint or seclusion;
    i. Retaliation for submitting a complaint to the Department or another entity; or
    j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
    a. Except in an emergency, either consents to or refuses treatment;
    b. May refuse or withdraw consent for treatment before treatment is initiated;
    c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
    d. Is informed of the following:
        i. The outpatient treatment center's policy on health care directives, and
        ii. The patient complaint process;
    e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
    f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
        i. Medical record, or
        ii. Financial records.

A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

X_____ _____/_____/_____
Signature of Patient or Legal Representative Date

*If signed by Legal Representative, please describe the authority of Legal Representative to sign for patient:_____

☐ I have **received** a copy of the Patients Rights and Responsibilties Initials _____

☐ I have **declined** a copy of the Patients Rights and Responsibilties Initials _____

VALLEY PAIN CONSULTANTS
An Envision Physician Services Provider

EXPECTATIONS OF PATIENT / CAREGIVER

The following statements are expectations that we as a practice would like you to be informed. Once signed, you as a patient/caregiver acknowledge understanding of these policies and are aware that any violation of these policies may result in discharge from our practice.

a. I understand that opiates are not generally prescribed on the initial consultation.

initials_____

b. I understand that the medications I may receive from this practice are provided for their therapeutic value; however, they may have serious side effects. These side effects may be accentuated by the concurrent use of other medications and/or alcohol. It is unsafe to combine any medications and/or alcohol without first consulting with my physician. I also understand that I will need to take steps to prevent any pregnancy while on these medications due to the potential impact on the fetus.

initials_____

c. I understand that any medication that I receive from this practice may affect my ability to operate a motor vehicle, boat, or heavy machinery. I am accountable for determining whether my ability to do these things is impaired. I will be solely accountable for my decision regarding this as outlined under Arizona State Law, Title 28, Chapter 4, Article 3: “It is unlawful for a person to drive or be in actual physical control of a vehicle in this state under the influence of intoxicating liquor, and drug, a vapor releasing substance containing a toxin or any combination of liquor, drugs, or vapor releasing substances if the person is impaired to the slightest.” In Arizona, this may be grounds for prosecution of a Driving While Intoxicated (DWI) offense.

initials_____

d. I am expected to be respectful of the physicians and staff, and I understand that inappropriate behavior will not be tolerated and may result in my dismissal from the Valley Pain Consultants practice.

initials_____

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

VALLEY PAIN CONSULTANTS

An Envision Physician Services Provider

Direct Financial Interest Disclosure Statement

State law, A.R.S. δ 32-1401 (25)(ff), requires that a physician 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. (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,please be advised that we have a direct financial interest in the following Surgical Centers:

- Honor Health Pain Center
- Metro Surgery Center
- North Valley Ambulatory Surgery Center (Honor Health)
- North Scottsdale Ambulatory Surgery Center
- Mountain Vista Medical Center

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

VALLEY PAIN CONSULTANTS
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Permission to Pick-Up Prescriptions

I, _____ give permission for the following person(s) to pick up my prescriptions on my behalf:

Name	Relationship
_____	
_____	

Name(s) of authorized person(s)

I understand that no one other than the above listed person(s) will be able to pick up my prescriptions. I understand that if something should happen to the prescriptions while in the possession of the listed person(s), I am still fully responsible. This consent is good for one year from date signed unless you notify the office in writing of a change.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

Cancellation and No-Show Policy

Thank you for choosing our practice to assist you with your care. We appreciate your trust and are committed to providing you with high quality, compassionate care.

We value our patients and tailor their treatment plans according to their unique needs, in doing so, we allocate time for each appointment accordingly. We realize that circumstances may occur beyond your control that may not allow you to provide 24 hour notification. Failure of a patient to notify the office to cancel or change their appointment without 24 hour notice is considered a “No-Show”. To help remind patients of their appointments we have implemented an automated reminder system. Please assure we have your correct and most up to date phone numbers or email addres at all times throughout the course of your treatment to allow us to better serve you.

The “No-Show” appointments will be documented in the patient record.
Charges for appointment no shows are as follows:

- **Office visit $50.00**
- **Procedure or surgical center visit $100.00**

This letter will serve as notice about the office no show policy and fees.

I acknowledge that I have read and understand the policy.

X_____ _____/_____/_____

Signature of Patient or Parent, if a minor *Date*

**Apointment Confirmation Preference: ☐ Text ☐ Call

We do send out ***courtesy*** appointment reminders. However, it is the patients responsibility to keep track of all appointments.