



Patient Name: _____ **Chief Complaint:** _____

Pain Description

What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin?

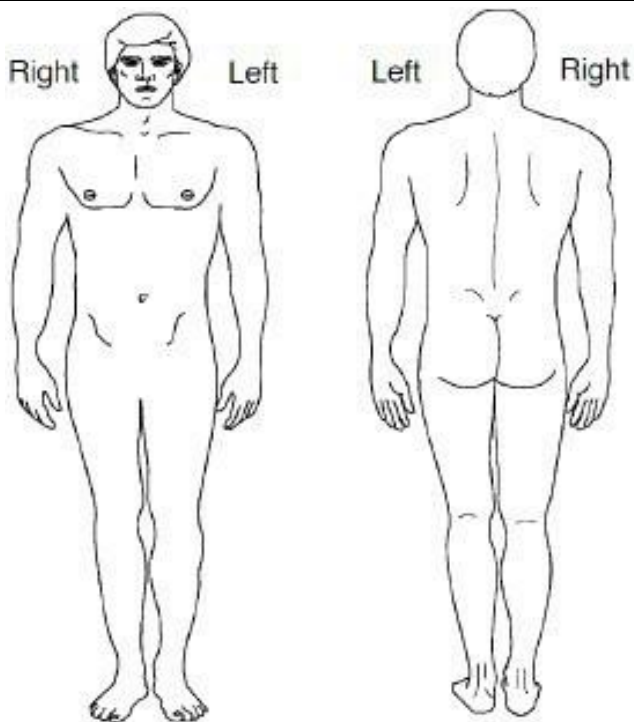
- Gradually Suddenly

Since your pain began, how has it changed?

- Decreased Increased Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

- “N” = numbness
- “S” = stabbing
- “B” = burning
- “P” = pins and needles
- “A” = aching



Pain Description - Check all of the following that describe of your pain:

- Aching Numbness Spasming Throbbing
- Cramping Shock-like Squeezing Tingling/Pins & Needles
- Dull Shooting Stabbing/Sharp Tiring/Exhausting
- Hot/Burning

Pain Frequency

What word best describes the frequency of your pain? Constant Intermittent

When is your pain at its worst? Mornings During the day Evenings Middle of the night



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Patient Name:

Mark all of the following activities that are adversely/negatively affected by your pain

- Enjoyment of Life
- Normal Work
- Sleep
- General Activity
- Recreational Activities
- Walking
- Mood
- Relationship with people
- Other:

Diagnostic Tests and Imaging

- MRI of the Date: Facility:
- X-ray of the Date: Facility:
- CT scan of the Date: Facility:
- EMG/NCV study of the Date: Facility:
- Ultrasound of the Date: Facility:
- Other diagnostic testing:
- I Have Not Had Any Diagnostic Tests Performed for My Current Pain Complaints

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

- Chiropractic
- Physical Therapy
- Psychological Therapy
- Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Joint Injection – Joint(s)
- Medial Branch Blocks or Facet Injections (circle all levels that apply) Cervical/Thoracic/Lumbar
- Nerve Blocks – Area/Nerve(s)
- Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant
- Spine Surgery
- Trigger Point Injection – Where?
- Vertebroplasty / Kyphoplasty – Level(s)
- Other:

Beneficial

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

I Have Not Had Any Prior Treatments for My Current Pain Complaints

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? Yes No

If so, have you ever had any adverse reaction to anesthesia? Yes No

If yes, please explain:



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Patient Name:

Current Medications

Are you taking a prescribed **blood-thinner** medication? Yes No If yes, please check which one:

Prescribing Physician:

- Aggrenox Coumadin Effient Eliquis Lovenox Plavix Pleta Pradaxa
 Ticlid / Warfarin
 Heparin Xarelto Arixta Aspirin Advil, Aleve other NSAIDS

Herbal Supplements:

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? Yes No

If so, please list all medications you are allergic to:

Medication Name:

Allergic Reaction Type:

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Please check if you are allergic to Iodine or Tape

Are you allergic to shellfish? Yes No

Are you allergic to latex? Yes No



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Patient Name:

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- Cancer
- Diabetes
- Thyroid Disease
- Liver Disease
- HIV / AIDS
- Kidney Disease

Head/Eyes/Ears/Nose/Throat

- Glaucoma
- Headaches
- Head Injury
- Migraines
- Sinusitis
- Hearing Loss
- Snoring

Gastrointestinal

- Bowel Incontinence
- Acid Reflux (GERD)
- Gastrointestinal Bleeding
- Constipation
- Opioid Induced Constipation

Respiratory

- Asthma
- Emphysema / COPD
- Pneumonia
- Tuberculosis
- Valley Fever
- PE
- Obstructive Sleep Apnea

Musculoskeletal

- Amputation
- Carpal Tunnel Syndrome
- Chronic Low Back Pain
- Chronic Neck Pain
- Chronic Joint Pain
- Fibromyalgia
- Arthritis
- Osteoporosis
- Phantom Limb Pain
- Rheumatoid arthritis
- Vertebral
Compression Fracture
- Reflex Sympathetic
Dystrophy/CRPS

Cardiovascular / Hematologic

- Anemia
- Bleeding Disorders
- Coronary Artery Disease
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Murmur
- Pacemaker/Defibrillator
- Poor Circulation
- Stroke

Neuropsychological

- Alcohol Abuse
- Alzheimer Disease
- Bipolar Disorder
- Depression
- Epilepsy
- Prescription Drug Abuse
- Multiple Sclerosis
- Paralysis
- Peripheral Neuropathy
- Schizophrenia
- Seizures

Past Surgical History

Please indicate any surgical procedures you have done in the past, including the date, type, and any pertinent details.

I Have Never Had Any Surgical Procedures Done



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Patient Name:

Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other medical problems:

I Have No Significant Family Medical History I Am Adopted (No Medical History Available)

Social History

Are you capable of becoming pregnant? Yes No If so, are you currently pregnant? Yes No

Highest level of education obtained: Grammar School High School College Post-graduate

Alcohol Use: Current Alcoholism Daily Limited Alcohol Use History of Alcoholism

Never Drink Alcohol Social Alcohol Use

Tobacco Use: Current Tobacco User If yes, how many per day Former Tobacco Never Used Tobacco

User Prescribed Medical Marijuana: Yes No

Drug Use: Denies Any illegal Drug Use Currently Using Illegal Drugs (Which)

Currently Using Someone Else's Prescription Medications

Formerly Used Illegal Drugs (not currently using) (Which:)

Have you ever abused narcotics or prescription medications? Yes No (Which:)

Have you ever been discharged (fired) from a pain management practice in the past? Yes No

If so, please explain here:

Fall Risk Assessment for patients 65 and older:

1. Have you had any falls or near falls in past year? Yes No
2. If yes, how many? 1 without injury 1 with injury 2 or more (w/o injury)
3. Are you unsteady walking or request assistances? Yes No
4. Do you use any assistive device (i.e., cane, walker)? Yes No
5. Are you often confused or disoriented? Yes No

For staff use: ** If the answer to number 2 is anything but "1 fall without injury", or there is a "yes" for questions 3-5, the patient is at risk for falls and needs a plan of care implemented. **



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Patient Name:

Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, on previous page.

Constitutional:	<input type="checkbox"/> Chills	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Fevers	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Low Sex Drive
	<input type="checkbox"/> Unexplained Weight Gain	<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> Weakness

Eyes:	<input type="checkbox"/> Blurry/Double Vision	<input type="checkbox"/> Eye Redness	<input type="checkbox"/> Glasses or Contacts
	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Vision Changes	

Ears/Nose/Throat/Neck:	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Earaches	<input type="checkbox"/> Hoarseness
	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Recurrent Sore Throat
	<input type="checkbox"/> Snoring	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Ringing in the Ears	

Respiratory:	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Shortness of Breath at Rest	<input type="checkbox"/> Shortness of Breath upon Exertion
	<input type="checkbox"/> Sputum Production	<input type="checkbox"/> Wheezing	

Cardiovascular:	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Palpitations
	<input type="checkbox"/> Shortness of Breath while Sleeping	<input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Murmur

Gastrointestinal:	<input type="checkbox"/> Changes in Appetite	<input type="checkbox"/> Changes in Bowel Habits	<input type="checkbox"/> Constipation
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Swallowing problem	<input type="checkbox"/> Laxative use
			<input type="checkbox"/> Antacid Use

Musculoskeletal:	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling
	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Stiffness
	<input type="checkbox"/> Trauma		<input type="checkbox"/> Joint stiffness
			<input type="checkbox"/> Muscle Stiffness

Psychiatric:	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Feeling Anxious	<input type="checkbox"/> Stress Problems
	<input type="checkbox"/> Disturbing thoughts	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Hallucinations

Skin:	<input type="checkbox"/> Dryness	<input type="checkbox"/> Hair Texture Change	<input type="checkbox"/> Itching
	<input type="checkbox"/> Lumps	<input type="checkbox"/> Nail Texture Change	<input type="checkbox"/> Rashes

Neurological:	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Instability when walking	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Numbness
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tingling	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Weakness	<input type="checkbox"/> Stroke	<input type="checkbox"/> Loss of Consciousness

Endocrine:	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Excessive Urination
	<input type="checkbox"/> Heat intolerance		<input type="checkbox"/> Excessive Thirst

Heme:	<input type="checkbox"/> Bleeding Easily		
	<input type="checkbox"/> Blood Clots		

Genitourinary:	<input type="checkbox"/> Blood in Urine		
	<input type="checkbox"/> Painful Urination		

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

+ +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

<p>10. If you checked off <i>any</i> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk if you have any questions or are unsure how to complete any section of this form.

Patient Information

Today's Date: _____

Patient's Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Physical Address Same as Mailing? Yes No

If not, please list mailing address:

Occupation: _____ City: _____

Preferred Phone: _____ Home Mobile Work

Secondary Phone: _____ Home Mobile Work

Email: _____ Driver's License # _____ State: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Marital Status: Married Single Divorced Widowed Other:

Primary Language: English Spanish Other: _____

Referral

Were you referred to our clinic by another physician? If so, whom? _____

If not, how did you hear about us? TV, Radio, Insurance, Family, Friend (if so, whom), Social Media?

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician

Name: _____ Phone Number: _____



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Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Integrated Spine, Pain and Wellness and its providers and staff to treat my condition, and to refer me to other providers if warranted. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Integrated Spine, Pain and Wellness to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Integrated Spine, Pain and Wellness Notice of Privacy Practices and Patient Rights and Responsibility ("NPP"), which is displayed for public inspection at its facility and on its website. That NPP describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Integrated Spine, Pain and Wellness to release my Protected Health Information (medical records) in accordance with its NPP. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Integrated Spine, Pain and Wellness to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Integrated Spine, Pain and Wellness will not release my Protected Health Information to any other party (including family) without my completing an Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** (Please note that Integrated Spine, Pain and Wellness does not have an in-house laboratory and all samples are sent to outside laboratories who generate their own records and billings for their services, separate and apart from Integrated Spine, Pain and Wellness).

I understand that I have the right to refuse specific tests but understand this may impact my pain management treatment. This Consent can be revoked by me at any time with written notification and is valid until revoked.

Signed: Date:



Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Financial Policy

Integrated Spine, Pain and Wellness believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** - is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment Integrated Spine, Pain and Wellness reserve the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). If a prepayment is made for any services and a refund is due after insurance processes, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co- insurance, co- payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. **INSURANCE** - We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our providers are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim is rejected for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Integrated Spine, Pain and Wellness only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case, the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **TOXICOLOGY LAB** - In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.

4. **COLLECTION** - 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. Integrated Spine, Pain and Wellness reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Integrated Spine, Pain and Wellness for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account, including wireless



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telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

5. **RETURNED CHECKS** - will incur a \$35.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the \$40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the \$40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

6. **ACCOUNTING PRINCIPALS** - Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. **FORMS AND CONSULTS FEES** - Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the provider. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

8. **CANCELLATIONS OR MISSED APPOINTMENTS** - If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a \$50.00 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you may be assessed a \$100.00 missed procedure fee. Multiple missed visits may result in discharge from the practice.

9. **RESPONSIBILITY FOR PAYMENT** - I understand that I, personally, am financially responsible to Integrated Spine, Pain and Wellness for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby assign, transfer, and set over directly to Integrated Spine, Pain and Wellness sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Integrated Spine, Pain and Wellness to contact my insurance company or

health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Integrated Spine, Pain and Wellness. I authorize Integrated Spine, Pain and Wellness to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **RELEASE OF INFORMATION** - I hereby authorize the and direct Integrated Spine, Pain and Wellness to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy of Integrated Spine, Pain and Wellness and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Integrated Spine, Pain and Wellness. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Integrated Spine, Pain and Wellness. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

Patient's Printed Name

Patient's Signature

Guarantor's Signature, if applicable

Date: _____



Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

Your Name:

Date of Birth:

Authorized Parties

By signing below, I authorize Integrated Spine, Pain and Wellness, its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party	Relationship
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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 re-disclose 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, diagnosis 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.

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 42C.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.

Signature of Patient or Legal
Guardian

Date



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Authorized Parties

I acknowledge that I have had the opportunity to review Integrated Spine, Pain and Wellness Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Integrated Spine, Pain and Wellness. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure 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 listed below:

Privacy Officer
Integrated Spine, Pain and Wellness
7425 E Shea Blvd. Ste. 102
Scottsdale, AZ 85260

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any):

Signature

Signature of Patient or Legal Guardian

Today's Date

Relationship to Patient