Board Certified Pain & Rehabilitation Physicians

COMPREHENSIVE PAIN MANAGEMENT

www.schurgin.com

Last Name________________________________First_________________________________DOB__________M/F______

Address____City________________State____Zip________

Home Phone___________________________Cell Phone________________________Work Phone__________________

Social Security#_____________________ E-Mail Address________________________________Marital Status ________

Referring Doctor_________________________________Primary Care Doctor___________________________________

Employment Status________________Employer______________________________Employer Phone_______________

Race: American Indian Asian African American White Hispanic Other Prefer to Not Answer

Ethnicity: Hispanic Not Hispanic Prefer to Not Answer Preferred Language ___________________________

Is this a work related accident______ Is this related to a motor vehicle accident___________Date of Injury___________

Responsible Party if Different From Above (Patient is under 18 or Power of Attorney)___________________________________

Relationship to Patient________________________________DOB______________Phone_________________________

Address____

Emergency Contact__________________________________Phone___________________Relation_________________

Ok to release your protected health information to this person ____ yes / ____ no

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Primary Health Insurance________________________________ID/Subscriber #_____________Group #_____________

Policy Holder___________________________________DOB________________Relation to patient_________________

Secondary Health Insurance______________________________ID/Subscriber #_____________Group#_____________

Policy Hoder____________________________________DOB________________Relation to patient________________

CONSENT FOR TREATMENT AND INSURANCE AUTHORIZATION AND ASSIGNMENT: I give consent for treatment by Comprehensive Pain Management (CPM). I authorize and release all of my medical information necessary to process my insurance claims. I authorize payment of medical benefits directly to CPM. I understand that this office may bill my inurance carrier as a courtesy to me, but that I am financially responsible for all fees incured and I agree to pay them in full. I allow a photocopy of my signature to be used to process my insurance claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my healthcare policy and what I am required to do to secure those benefits. I further agree to pay all collection costs(33%), attorney fees, interest and other collections costs that may be incurred to enforce the collection of any outstanding amounts I owe. I understad that CPM may utilize a facility (North Valley and Biltmore Surgery Center) in which one of our providers has a financial interest; I am not obligated to use that facility and may choose to seek treatment elsewhere.

Signature of Patient (or Responsible Party):____Date:________________

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3811 E. Bell Road, Suite 207 Phoenix, AZ 85032 Phone (602) 971-8200 Fax (602) 971-8201

Initial Pain Management Consultation Patient Acknowledgement

I understand that I will be seen for a *consultation* with Comprehensive Pain Management (CPM) to *evaluate* my pain problem. This means that CPM will obtain a medical history and perform a physical examination. I understand that the purposes of this *evaluation* are to try to identify the *causes* of my pain problem, to possibly make diagnostic or treatment recommendations, and to forward this information to my primary care (or other referring) physician. I understand that this appointment does not, in any way, guarantee that CPM will provide medical treatment for me after this consultation. **The decision to go forward with future medical treatment must be mutually agreed upon by *both* me and the physician**. I understand that CPM will not provide narcotic medications to me at the end of this initial evaluation, ***regardless*** of whether (1) I have run out of medication, (2) I have just moved to Arizona and need my medication, (3) my primary doctor told me that CPM would be prescribing my medicine from now on, or (4) for any other reason. The determination to prescribe medication may take place at the *second visit*, should a doctor-patient relationship be mutually established *after this consultation*.

I also understand that CPM, in trying to reduce my pain and improve my quality of life, may prescribe medications for *off-label uses.* This means that some medications may be prescribed for uses that are not specifically sanctioned or approved by the United States Food and Drug Administration (FDA). These medications *may, or may not,* have been thoroughly studied in controlled investigational drug trials for the off-label uses for which they are being prescribed. Although drugs prescribed for such uses may not have proven efficacy (effectiveness) in clinical trials for off-label use, the general *safety* of such medications has been established; such drugs have already been approved for *other* uses by the FDA. I understand that no drug prescribed by CPM can be considered absolutely safe, regardless of whether the drug is being prescribed for off-label uses or FDA-approved uses. *I understand that all drugs have inherent risk, inherent potential toxicity, and potentially lethal side effects.* I also understand that it is ultimately my decision to take the medications prescribed by CPM. Although I understand that it would be unreasonable to expect CPM to explain *every* risk of *every* medication being prescribed, I am aware that I can ask my physician questions about any of the medications that he prescribes. I further understand that the medications that are *currently* being prescribed and are *currently* considered generally safe, may in the future be determined to be unsafe; new risks or toxicities of any prescribed medication may be identified *in the future*. I accept that CPM cannot be held responsible for such future discoveries.

Examples of families of drugs that may be prescribed for off-label uses include, but are not limited to, antiepileptic drugs (drugs for epilepsy), cardiac drugs, drugs for control of blood pressure, antidepressant

medication, medications for Alzheimer's disease, sedatives, muscle relaxants, steroids, and medications for psychiatric disorders.

I understand that any of the medications prescribed by CPM may negatively affect my judgment, my coordination, my ability to operate heavy equipment or automobiles, and my ability to make critical decisions. I understand that it is ultimately my responsibility to identify such impairment and report it to CPM so that medication adjustments or changes can be made.

I understand and accept all of the explanations given above. I am aware that I may ask any questions about medications prescribed by my physician and CPM *now and in the future*.

___________________________________ _____/_____/_____

Print name Date

____

Signature

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Arthur H. Schurgin, D.O. Steven Giacoppo, D.C., FNP

John Porter, M.D. James KellerShabrokh, D.O.

PATIENT CONSENT FORM

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

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it its appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, as some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy policy notice.

Date:____________________________________

I____ have received a copy of this notice.

Print Name

____

Sign Name

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FINANCIAL POLICY

PAYMENTS: All co-payments, insurance deductible and fees for services not covered by your insurance policy are due at the time service is rendered The co-pay cannot be waived, as it is a requirement placed on you by your insurance company. We accept VISA, Master Card and Discover cards, along with cash or check. Returned checks are subject to a $40 charge.

INSURANCE: As a courtesy, our office will bill your insurance for services you receive. It is *YOUR RESPONSIBILITY* to know your particular insurance plan benefits. You are ultimately responsible for all unpaid balances.

MISSED APPOINTMENTS: If you are unable to keep your scheduled appointment, please call our office at least 24 hours before your appointment to cancel or to reschedule. It is our policy to charge $125 for a late cancellation or no show appointment for an office visit. If you cancel less than 24 hours prior to or no-show for any injection procedure then the charge is $500. This will apply for procedures scheduled in the office or at an out-patient surgery center. Patients who no-show or late cancel more than once will be discharged from our practice.

FORMS: There is a charge to fill out FMLA forms, Disability and other forms. The fee is $25 for the first page, $50 for 2-4 pages. This fee will be collected at the time of your visit. We will not complete this type of paperwork without your presence at an appoitment.

WORK STATUS: If you are injured and require a work status/work restrictions for your employer, you must ask for these during your appointment with our provider. We will not honor requests for work status/work restrictions without an appointment and will not write them after the fact.

WORK EXCUSE: If your employer requires a work excuse for your appointment, please ask for this note before you leave. It will be provided free of charge.

______________________________ ____________________

Patient Signature Date

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Arthur H. Schurgin, D.O. John Porter, M.D Steven Giacoppo ,FNP
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CUSTOMARY AND USUAL CHARGES

You have requested that we treat you for personal injuries arising from an incident where a third party is apparently liable for your injuries. We have agreed to provide treatment to you under these circumstances; without limitation, based upon the following:

All services for treatment will be billed to you based upon our customary charges. A list of the most common types of treatment, and their respective customary charges, are available for you preview at our front desk. **By signing below, you agree that our charges are customary and usual for our office and this geographical community.** Our agreement to treat you is contingent upon this agreement by you, and we are relying upon your agreeing not to later challenge the validity of our charges as being customary as stated herein. You agree you have had a fair opportunity to make any inquiry you desire, including consulting with an attorney, and are fully satisfied with our charges as being customary before signing below. Further, you direct any attorney who may represent you, either now or in the future, to accept our charges as being customary and specifically not to challenge our charges in any way.

YOU AGREE TO PAY, IN FULL, OUR USUAL AND CUSTOMARY TOTAL CHARGES. YOU AGREE THAT THE CHARGES LISTED AT OUR FRONT DESK, FOR YOUR REVIEW, ARE USUAL AND CUSTOMARY. YOU UNDERSTAND THAT WE ARE RELYING UPON THIS AGREEMENT IN AGREEING TO PROVIDE TREATMENT TO YOU FOR THIS ACCIDENT CASE.

PRINT NAME:_______________________________________DATE:__________

SIGNATURE: ____

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INJURY INFORMATION

What was the date of the accident?____

In what city did the accident happen?____

How were you injured?

____ In a motor vehicle accident, I was the driver.

____ In a motor vehicle accident, I was a passenger.

____ A vehicle struck me while I was a bicyclist, pedestrian, etc.

____ I had a slip and fall or other injury on a commercial property (ie: grocery store, apartment complex, etc)

____ Other____

If you were in a motor vehicle please prove information regarding the insurance covering the car you were in. Your auto insurance if the accident occurred in your car.

Carrier Name_______________________________ Policy #______________________

Claim #____________________________________

Is there medical payments (med pay) coverage on the policy _____ yes _____ no

Is there Uninsured Motorist (hit and run) ____ yes ____no

Is there Under Insured Motorist (UIM) coverage ____yes ____no

Please provide information regarding the at fault party insurance claim.

Carrier Name_______________________________ Policy #______________________

Claim #________________________Name of at fault driver_____________________________

Adjuster name and phone #____

Do you have an attorney assisting you with your claim? _____ yes _____ no

Attorney name ____Phone #_________________

Paralegal/Assistant____

This information is correct and completed to the best of my knowledge/ability. In order to ensure that the parties responsible for payment of your claim (insurance companies) are fully aware of the fact that CPM is extending credit to you for your care in our office, we will be filing a county medical lien. Responsible parties will receive notification that the lien has been filed via certified mail or fax. The filing and releasing fees (once payment is received) of this lien involves administrative costs of approximately $100.

Signature____**Date**_______________

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Patient Name____**DOB**__________________________

Pharmacy Name____ **Phone** _____________________

Address / Location____

Other Treating Physicians

Chiropractor______________________________________ **Phone**_________________________

Neurologist_______________________________________ **Phone**__________________________

Neurosurgeon_____________________________________ **Phone**__________________________

Orthopedist_______________________________________ **Phone**__________________________

Rheumatologist___________________________________ **Phone**__________________________

Other Pain Mgmt__________________________________ **Phone**__________________________

Cardiologist_______________________________________ **Phone**__________________________

Endocrinologist____________________________________ **Phone**__________________________

Nephrologist______________________________________ **Phone**__________________________

Oncologist____ **Phone**__________________________

Physical Therapist__________________________________ **Phone**__________________________

Other____ **Phone**__________________________

PAST MEDICAL HISTORY

	Yes	No	History
Heart disease	yes	no	________________________________
Breathing Problems	yes	no	________________________________
Kidney Disease	yes	no	________________________________
Stroke	yes	no	________________________________
Seizures	yes	no	________________________________
Ulcers	yes	no	________________________________
Esophageal Reflux	yes	no	________________________________
Dental Infection	yes	no	________________________________
Sinus Infection	yes	no	________________________________
Urinary Problems	yes	no	________________________________
Hepatitis	yes	no	Type____________________________
HIV/AIDS	yes	no	________________________________
High Blood Pressure	yes	no	________________________________
Elevated Cholesterol	yes	no	________________________________
Diabetes	yes	no	Insulin Dependent yes no
Thyroid Disease	yes	no	________________________________
Bleeding Disorders	yes	no	________________________________
Migraine Headaches	yes	no	________________________________
Cancer	yes	no	Type____________________________
Arthritis	yes	no	Type____________________________

Please list any other medical conditions:

____

____

____

DRUG ALLERGIES

DRUG	Reaction
________________________	____________________
________________________	____________________
________________________	____________________
________________________	____________________

Do you have any sensitivity or allergy to latex? YES NO

Do you have any sensitivity or allergy to iodine and/or contrast dye? YES N

MEDICATION

Name **Dose(mg)** **Frequency**

________________________________ ______________ ______________________

________________________________ ______________ ______________________

________________________________ ______________ ______________________

________________________________ ______________ ______________________

________________________________ ______________ ______________________

Past Surgeries: **Year**

____ ____________________

____ ____________________

____ ____________________

____ ____________________

Prior Hospitalizations: **Year**

____ ____________________

____ ____________________

____ ____________________

____ ____________________

FAMILY HISTORY

Is Father alive? Yes No Age (____)
Is Mother alive? Yes No Age (____)
How many siblings? boys_____girls___
How many children? boys____ girls____

Family History; Example: Cancer, Stroke, Heart Attack, High blood pressure, High cholesterol, Diabetes, Etc.
Father: ____
Mother:____
Siblings____

SOCIAL HISTORY

Smoker current smoker (___ cigarettes/day) former smoker (quit date: _____) never smoker
Alcohol YES: 1-2 drinks per week 3-5 drinks per week 5+ drinks per week NO
Drug abuse history____
Marital status: single married divorced/separated widowed
Children YES: how many? NO
Educational Level <high school high school some college completed college graduate school
Employed yes no
Occupation ____

REVIEW OF SYSTEMS

Constitutional **If yes please explain**

- **Fevers** **yes** **no** ________________________________
- **Insomnia** **yes** **no** ________________________________
- **Loss of appetite** **yes** **no** ________________________________
- **Unexplained weight gain** **yes** **no** ________________________________
- **Unexplained weight loss** **yes** **no** ________________________________

Musculoskeletal

- **Joint Arthritis** **yes** **no** ________________________________
- **Disc Herniation** **yes** **no** ________________________________
- **Joint Surgery** **yes** **no** ________________________________
- **Joint Swelling** **yes** **no** ________________________________

Neurology

- **Headache** **yes** **no** ________________________________
- **Seizure** **yes** **no** ________________________________
- **Memory Loss** **yes** **no** ________________________________
- **Tremors** **yes** **no** ________________________________
- **Vertigo** **yes** **no** ________________________________
- **Loss of Smell** **yes** **no** ________________________________

General

- **Easily Fatigued** **yes** **no** ________________________________
- **Swollen Glands** **yes** **no** ________________________________
- **Skin Rash** **yes** **no** ________________________________

Allergy

- **Itchy eyes** **yes** **no** ________________________________
- **Runny nose** **yes** **no** ________________________________
- **Stuffy nose** **yes** **no** ________________________________
- **Sinus problems** **yes** **no** ________________________________

Cardiology

- **Chest Pain** **yes** **no** ________________________________
- **Irregular Heartbeat** **yes** **no** ________________________________
- **Leg Swelling** **yes** **no** ________________________________
- **Shortness of breath laying down** **yes** **no** ________________________________
- **Shortness of breath with normal activity** **yes** **no** ____________________________

Dermatology

- **Hives** **yes** **no** ____
- **Lumps/bumps** **yes** **no** ____
- **Moles** **yes** **no** ____
- **Rash** **yes** **no** ____

Endocrine

- **Extreme cold intolerance** **yes** **no** ____
- **Excessive sweating** **yes** **no** ____
- **Excessive thirst** **yes** **no** ____
- **Excessive urination** **yes** **no** ____
- **Extreme heat intolerance** **yes** **no** ____

ENT

- **Ear pain** **yes** **no** ____
- **Ringing in ears** **yes** **no** ____

Female Reproductive

• Are you pregnant?	yes	no		
• Date of last menstrual period	______________________________			None
• Sexually active	yes	no		
• Pregnancies	yes	no	how many________________________________	

Gastrointestinal

• Abdominal pain	yes	no	____
• Blood in stool	yes	no	____
• Change in bowel habits	yes	no	____
• Constipation	yes	no	____
• Diarrhea	yes	no	____
• Difficulty swallowing	yes	no	____
• Heartburn	yes	no	____
• Nausea	yes	no	____

Hematology

• Abnormal bleeding/bruising	yes	no	____
• Anemia	yes	no	____

Male Reproductive

• Difficulty urinating	yes	no	____

Ophthalmology

• Blurred vision	yes	no	____
• Eye pain	yes	no	____
• Photophobia (light sensitive)	yes	no	____

Psychology

• Serious depression	now	previous	never
• Sleep disturbance	now	previous	never
• Suicidal thoughts	now	previous	never
• Eating disorder	now	previous	never
• Psychiatric hospitalization	now	previous	never
• Counseling	now	previous	never

Respiratory

• Shortness of breath	yes	no	____
• Chest pain	yes	no	____
• Excessive sputum	yes	no	____
• Wheezing	yes	no	____
• Coughing	yes	no	____

NOTES

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