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

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:_____

COMPREHENSIVE PAIN MANAGEMENT
ARTHUR H. SCHURGIN, D.O., P.C.
BOARD CERTIFIED PAIN MANAGEMENT - CERTIFIED INDEPENDENT MEDICAL EXAMINER
www.schurgin.com
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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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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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 ☐NO

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

_____

_____