CANYON PAIN AND SPINE

New Patient Intake Paperwork

Patient Name: ____ **DOB**:___________________________

Pharmacy:____**Cross Streets**:____________________

Have you seen Dr. Bowden, Dr. Gibb, or Dr. Syed before? ☐YES ☐NO

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

History of Problem:

Reason for visit: ____

Who referred you to our practice?____

Expectations from treatment:____

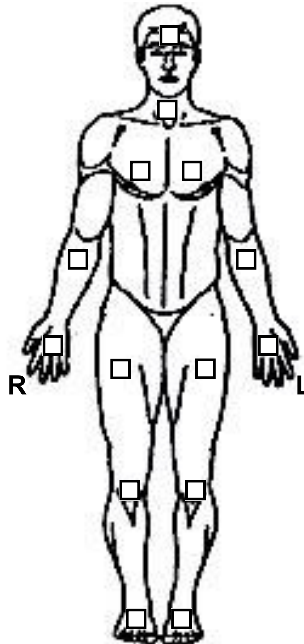
When did your pain symptoms start? ____

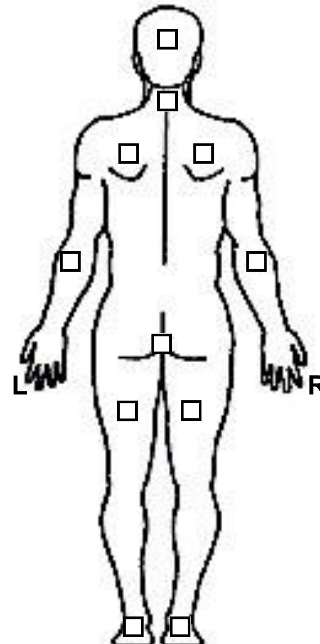
Do you have cancer? ________ If yes, Cancer Type: ______________________________ Stage: ______________

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

Check all terms that apply:

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





0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

Please use 0-10 number scale (above) to describe your pain:

pain on average _______ **pain at its least** _______ **pain at its worst** _______

What makes pain **worse**: ____

What makes pain **better**: ____

Time of the day when pain is worse: ☐ MORNING ☐ AFTERNOON ☐ EVENING ☐ BEDTIME ☐ NIGHT

Do you have the following?

Weakness in your: ☐Right Arm ☐Left Arm ☐Right Leg ☐Left Leg
Numbness in your: ☐Right Arm ☐Left Arm ☐Right Leg ☐Left Leg
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 (Tapentadol)		
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 (Relafen)		
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:____________________		

Diagnostic Studies:

X-Ray ☐Yes ☐No   MRI Scan ☐ Yes ☐ No
CT Scans ☐Yes ☐No   Bone Scan ☐ Yes ☐ No
EMG ☐Yes ☐No   IF YES, where did you have done? ____________________

Treatment History Indicate the treatment you have received ***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?

Physical Therapy	Facet Block/ Medial Branch Block
Chiropractic TENS Unit	Epidural Steroid Injection
Spinal Cord Stimulator	Radiofrequency Ablation
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)	

Name of Doctor prescribing blood thinner____ Phone ____________________

Why are you taking a blood thinner?____

Current Medications – INCLUDE NAME OF MEDICATION / DOSE / FREQUENCY

1. ____	8. ____
2. ____	9. ____
3. ____	10.____
4. ____	11.____
5. ____	12.____
6. ____	13. ____
7. ____	14.____

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.	___________	________________________	8.	___________	________________________

2.	___________	________________________	9.	___________	________________________
3.	___________	________________________	10.	___________	________________________
4.	___________	________________________	11.	___________	________________________
5.	___________	________________________	12.	___________	________________________
6.	___________	________________________	13.	___________	________________________
7.	___________	________________________	14.	___________	________________________

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/TIA ☐ Seizures ☐ Nerve Damage

Infectious

☐ Valley Fever ☐ Tuberculosis ☐ HIV/AIDS

Hepatic

☐ Jaundice ☐ Cirrhosis ☐ Hepatitis ☐ Gall Bladder

Gastrointestinal

☐ Hiatal Hernia ☐ GERD ☐ Gastric Ulcers ☐ Colitis

Endocrine

☐ Thyroid Disease ☐ Parathyroid Disease ☐ Diabetes Mellitus

Psychological

☐ Depression ☐ Bipolar ☐ Addiction

General

☐ Anemia/Bleeding ☐ Arthritis ☐ Obesity ☐ Alcoholism

Social History:

Are you currently working? ☐ No ☐ Yes ☐ Full time / Part time ☐ Occupation: ______________________________

Do you have any lawsuits pending? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No

Do you have a FAMILY history of: (circle all that apply)

Alcohol Abuse / Drug Abuse / Rx Abuse

Do you use alcohol? ☐Yes ☐No
How often? ______________________________

Do you use tobacco/smoke? ☐Yes ☐No
How often? ______________________________

Do you use Marijuna ☐Yes ☐No
How often?______________________________

Do you have a PERSONAL hx of:
Alcohol Abuse ☐Yes ☐No
Illegal Drug Abuse ☐Yes ☐No

Do you have a of preadolescent sexual abuse?
☐Yes☐No☐I do not wish to answer. (This question is part of a recommend screening tool for patients in pain management and remains confidential.)

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

General:	☐ Weight Gain ☐ Sleep disturbace ☐ Chills	☐ Fever ☐ Change in Appetite ☐ No Problems	☐Night Sweats
Cardiac/ Respiratory:	☐ Chest pain/Angina ☐ Peripheral Edema ☐ No problems	☐ Shortness of Breath ☐ Hemoptysis	☐ Palpitations ☐ Cough
Gastrointestinal:	☐ Diarrhea ☐ Nausea/Vomiting	☐ Blood or Black Stool ☐ No problems	☐Constipation
Genitourinary:	☐ Difficulty Urinating ☐ Loss of Bladder Control	☐ Painful Urination ☐ No Problems	☐Blood in urine
HEENT:	☐ Sinus Problems ☐ Jaw Problems ☐ No Problems	☐ Difficulty Swallowing ☐ Dry Mouth	☐Headache ☐Migraines
Hematology/ Oncology:	☐ Chemotherapy History ☐ Radiation History	☐ Bleeding Disorder ☐ Anticoagulation Therapy	☐Active Cancer ☐No Problems
Musculoskeletal:	☐ Muscle Cramps ☐ Joint Redness ☐ Muscle fatigue	☐ Joint Stiffness ☐ Joint Swelling	☐Muscle atrophy ☐No Problems
Neurological:	☐ Balance difficulty ☐ Difficulty speaking ☐ Confusion	☐ New weakness ☐ Fainting ☐ No Problems	☐Numbness/Tingling ☐Recent Visual Changes
Psychiatric:	☐ Depression ☐ Anxiety/Stress	☐ Suicidal Thoughts ☐ Homicidal Thoughts	☐Suicidal Plans ☐No Problems

X *Patient Signature*:______________________________ ___________ *Date*

Provider Signature: ______________________________ ___________ *Date*

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Print Name of Patient:____ Date of Birth:________________________

My Authorization:

I authorize Canyon Pain and Spine, PLLC, its agents and employees to use or disclose the following health information. Please check one of the boxes below:

- o All of my health information
- o My health information for the following condition(s): ____
- o I do not authorize disclosure of my health information

The above party may disclose this health information to the following recipient(s), please include medical providers, family, and friends:

Name, relationship and/or organization:

____

My Rights

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient:____ Date:______________________________

If the patient is a minor or unable to sign please complete the following:

Patient is a minor: _______ years of age

Patient is unable to sign because: ______________________________

Signature of Authorized Representative:________________________________ Date: ___________________________

Print Name of Authorized Representative: _____________________________________

Authority of representative to sign on behalf of the patient: ❑ Parent ❑ Legal Guardian ❑ Court ❑ Other: __________

Additional Consent for Certain Conditions: This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released

❑ I consent to have the above information released ❑ I do not consent to have the above information released

Signature of Patient or Authorized Representative: ______________________________Date: __________________

Financial Policy

Canyon Pain and Spine is committed to the success of your medical treatment and a mutual financial understanding is part of our relationship. Please review this policy, initial, and sign to accept its terms.

Payment is due at the time of service: All co-payments, deductibles, coinsurance, and fees for non-covered services are due at the time of service unless you have made payment arrangements prior to your appointment. If you arrive without payment, you may be asked to reschedule your appointment. We accept cash, check, debit, and credit cards.

Prepayment is due at the time a procedure is scheduled or by phone prior to the procedure date. We will provide an estimate of your insurance required deductible/co-insurance amounts for all procedures. We reserve the right to reschedule your procedure until prepayment has been completed. You are responsible for any unpaid balance after your insurance has processed your claim.

We designate accounts "Self-Pay" under the following circumstances:

1. patient does not have health insurance
2. patient is covered by an insurance plan that our providers do not participate in
3. patient does not have a current, valid insurance card on file, or
4. patient does not have a valid insurance referral on file

We request 24-hour notice if you are unable to keep your appointment. You may be charged for each incident where notice is not provided. These charges are your responsibility and will not be billed to your insurance. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Initials __________

Proof of Insurance: Please bring your insurance card(s) and a valid photo ID with you to your visit.
It is your responsibility to notify the Practice of changes to your health insurance coverage. If the Practice is unable to process your claim within your insurance carrier's filing limits you will be responsible for all charges. If we are not part of your insurance carrier's network (out of network) or your insurance carrier pays you directly, you are obligated to forward the payment immediately to the Practice.

Initials __________

Referrals and Authorizations: The Practice has specific network agreements with many insurance carriers, but not all insurance carriers.
It is your responsibility to verify that your assigned provider participates in your healthcare plan. If you have an HMO plan we are contracted with, you will need a referral authorization from your primary care physician. If we have not received a referral prior to your appointment it is your responsibility to obtain it. Without an insurance required referral, insurance will deny payment. If you are unable to obtain the referral, your visit will be rescheduled, or you will be asked to pay for the visit in advance. The Practice will inform your referring physician of your patient care plan and progress by using a secure electronic transmission. The Practice may provide services that your insurance plan excludes or require prior authorization. If prior authorization is required, we will attempt to obtain authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided are covered benefits and authorized by your insurance carrier.

Initials __________

Billing and Refunds: If we must send you a statement, the balance is due in full within 30 days of the statement date. If you have an outstanding balance over 120 days 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. This may result in adverse reporting to credit bureaus and additional legal action. The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days. You agree, in order to service your account or to collect any amounts

you may owe, that we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail.

You will be charged a fee for returned checks according to the Public Fee Schedule.
If you make an overpayment, we will issue a refund only if there are no outstanding balances for medical services on your account or any other account(s) with the same financially responsible party.

Initials __________

Additional Information

1. The Privacy Rule allows you to receive a copy of your personal medical and billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form.
2. The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. All requests require an office visit.
3. By initialing this section, I acknowledge that I have, or have been given the opportunity, to receive and review the Practice's Notice of Privacy Practice.
4. By initialing this section, I acknowledge that I have received a copy of the Practice's Statement of Patient's Rights.
5. By initialing this section, I acknowledge that I have received a copy of the Practice's Advanced Directive Statement.

Initials __________

Canyon Pain and Spine strives to provide exceptional care to our patients. We ask that you schedule and keep all follow up appointments and participate in all treatments and diagnostic testing.

Initials __________

Public Fee Schedule:

ITEM	FEE CHARGED
Failure to cancel your appointment within 24 hours	$60.00 per Clinic incident
Appointment "No Show"	$60.00 per Clinic incident $100.00 per Procedure
Late Arrivals – if you arrive 15 minutes past your arrival time, and we must reschedule your appointment	$60.00 per incident $100.00 per Procedure
Return Check Fee	$25.00 per incident
Completion of Disability Forms (per each occurrence)	**FMLA** - $50.00 each completion **Short Term Disability Form** - $25.00 **Temporary Disabled Parking Permit**-$5.00

I have read and understand the Financial Policy of Canyon Pain and Spine and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Print Name_________________________________

Signature__________________________________ Date___________

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent provides Canyon Pain and Spine with your permission to perform reasonable and necessary medical examinations, testing, and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I certify that my Medical History is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Canyon Pain and Spine provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing, and treatment which may include diagnostic, radiology, and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

Release of Information I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Canyon Pain and Spine physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written, or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers, or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

By signing below, I am agreeing to the consents and releases described on this form. I have read this consent and have been able to ask questions.

______________________________	______________________________
Printed Name of Patient or Representative	Signature of Patient of Representative
______________________________	______________________________
Relationship to Patient	Date

Patient Registration Form

Patients Full Name: ________________________________ **Date of Birth**: ______________

Address: ____

City: ________________________________State: ______________ Zip: ____________

Preferred Phone: ______________________ Secondary Phone: ______________________

Email: ____________________________ **Preferred Way to Confirm Appts**: Text Voicemail

Marital Status: Married Single Divorce Widowed **Primary Language**: ______________________

Ethnicity: ________________________ **Race**: _______________________________

Emergency Contact: ________________ Phone: __________________ Relationship: _________

Primary Care Physician / Facility: _______________________ Phone: ____________________

Referring Physician / Facility: _________________________ Phone: ____________________

Primary Insurance: ______________________________ Policy/ID Number: ______________

Claims Address: ____

Group Number: ____________________ Policy Holder: SELF SPOUSE OTHER: _____________

Date of birth: ______________ Social Security # _________________

Secondary Insurance: _____________________________ Policy/ID Number: ______________

Claims Address: ____

Group Number: ____________________ Policy Holder: SELF SPOUSE OTHER: _____________

Date of birth: ______________ Social Security # _________________

Worker's Comp Carrier: _____________________________ Claim # ____________________

Address: ______________________________________ Date of Injury: ________________

Claim Representative ______________________________ Phone: ____________________

Employer: ____

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

Do you have legal forms? ________________________________Scanned ________ (employee initials)

Would you like to list the individual as the primary contact? _______________________________