SONORANSPINE

STATEWIDE LOCATIONS
PHONE: (480) 962-0071 | FAX: (480) 962-0590
www.SonoranSpine.com | www.SpineResearch.org

EXPERTISE IN SPINE • EXCLUSIVELY SPINE

WHAT TO BRING

❑ Sonoran Spine Center Information Sheet

Complete this information sent to you.

❑ Medication List | Drug Allergies

Make a list of any medications you are currently taking including dosages and frequency. Include a list of any drug allergies you may have. Provide us your current pharmacy telephone and fax numbers.

❑ Insurance Company Information

Please have your insurance card and insurance company information, including the group number and address where claims should be sent.

❑ Workers Compensation Information

Bring the claim number, insurance carrier, address, contact person and phone number if you are covered by workers compensation.

❑ Co-pay

If your insurance has a co-pay, you must pay this amount before being seen. We Accept cash, debit or credit cards. Sorry, no checks are accepted.

❑ Insurance Authorization | Doctor Referral

We are on most insurance plans, but be sure your visit with us has been authorized by your insurance company, if this is required. We will not see you if we don't have a required referral and authorization. Any questions you may have should be directed to your primary care provider. This is your responsibility. Please have your authorization number when you make your appointment with us.

❑ X-rays, MRI Scan, CT Scan, Other Studies

Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiologist reports. Bring all studies that have been done.

❑ If You Require Disability Forms –

We will fill out forms required by the government such as those from the State of Arizona or the Social Security Administration free of charge. However, If you require disability forms completed for privately-held policies such as those that protect your car, wages, home or credit cards, we charge $5 per page up to a maximum of $25/form. Your insurance plan will not reimburse you for the preparation of these forms nor will it reimburse Sonoran Spine Center, PC; therefore, we require payment before completing the form. Upon receipt of full payment and your signature which acknowledges your understanding of our policy, we will complete your forms. Ask to sign our Disability Form Acknowledgement if you need disability forms filled out.

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PLEASE PRINT

PATIENT INFORMATION RECORD

Patient Name _____Age_____ Male Female
Last First Middle Initial

Race/Ethnicity: Decline to answer American Indian Asian Black/African American White/Caucasian
Alaskan native Pacific Islander Unknown Hispanic Multi-racial Native Hawaiian Other: _____

Date of Birth: _____/_____/_____Social Security Number _____-_____-_____ Marital Status: S M W D

Mailing Address_____ City_____ State ____ Zip Code _____

Home phone Number (_____) _____ Alternate Daytime Phone Number (_____) _____

Cell phone (_____) _____ Work phone (_____) _____ Primary Language Spoken: _____

EMAIL address: _____ Confirm EMAIL ADDRESS: _____

What is best way to reach you? Home Cell Work EMAIL Other: _____

Can we leave a message on your home or cell phone that contains personal information? Yes No
May we send you updates about our practice to your email? Yes No N/A

Employer _____ Occupation _____ How Long? _____

Street Address _____City _____ State _____ Zip Code _____

Patient's Primary Doctor _____ Phone (____) _____

Your Doctor's Address _____ City _____ State _____ Zip _____

How did you hear about us?

Healthcare Provider: (Name) _____ is an MD DO PA-C NP PT DC

Family/Friend/Co-worker Workers' Comp Referral Spine seminar/class Attorney

Online Search (circle one) Google | Yahoo | Bing | Other:_____ ❑ Sonoran Spine website

Health Insurance Phonebook/DEX TV TV-The Doctors Show Phoenix Magazine Top Docs

Other: _____

Sonoran Spine transmits prescriptions electronically (except those that must be hand written by law) to your pharmacy.

Which pharmacy will you be using for any prescriptions from us? Pharmacy Name:_____

City:_____ Cross-Streets:_____

More on PAGE TWO

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ADDITIONAL INFORMATION

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Spouse (parent, if minor) _____
Last First Middle Initial
Date of Birth: _____/_____/_____ Social Security Number _____-_____-_____ Phone (____) _____
Street Address _____ City _____ State _____ Zip Code _____
Employer _____ Occupation _____ How Long? _____
Street Address _____City _____ State _____ Zip Code _____
Name of Nearest Relative Not Living With You_____ Relationship_____
Address _____City _____ State _____ Zip Code _____ Phone (___) _____

INSURANCE INFORMATION

Primary Insurance Company _____

Is this a work-related injury? Yes No Do you have a health savings account (HSA)? Yes No

Street Address _____City _____ State _____ Zip Code _____

ID# _____ Policy # _____ Group #_____

Policy Holder Name _____ Date of Birth ____/___/____ Relationship to Patient_____

Policy Holder's Address, if not patient_____ City_____ State_____ Zip_____

Policy Holder's Employer Address _____City _____State _____ Zip_____

Secondary Insurance Company _____

ID# _____ Policy # _____ Group #_____

Policy Holder Name _____ Date of Birth ____/___/____ Relationship to Patient_____

Policy Holder's Address, if not patient_____ City_____ State_____ Zip_____

Policy Holder's Employer Address _____City _____State _____ Zip_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that Sonoran Spine Center, PC. bills my insurance carrier as a courtesy, but I am responsible for paying all changes incurred by me and/or my dependents. I understand that if my account is turned over for collections, I will incur a collections fee.

I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize my insurance carrier(s), including Medicare, any private or public insurer and any other insuring party to issue payment directly to Sonoran Spine Center, PC for all medical expenses for me and/or my dependents regardless of insurance benefits, if any.

I authorize Sonoran Spine Center, PC to release any and all information regarding my condition and care to myself, my insurance carriers, or other healthcare providers or referring physician associated with my care. _____
INITIALS

I have read and understand this form.

X_____ Date_____

SONORANSPINE

Farhad Mosallaie, DO, PhD
Physical Medicine & Rehabilitation

MUSCULOSKELETAL MEDICINE • SPINAL & PERIPHERAL INJECTIONS • PAIN MANAGEMENT

Name _____Date of Birth ____/____/_____ Date _____

Primary Doctor _____ Referring Doctor _____

CHIEF COMPLAINT

Chief Complaint (check all that apply): ❑Neck Pain ❑Arm Pain ❑Back Pain ❑Leg Pain ❑Other: _____

How long has the pain (or your problem) been present? _____ Has it worsened recently? ❑No ❑Yes How recent? _____

What started your problem? (please PRINT) _____

Was the onset: ❑Gradual ❑Sudden

Is your problem (circle one): ❑Getting worse ❑Getting better ❑About the same

Do you exercise? ❑Daily ❑Regularly ❑Weekly ❑Occasionally ❑Never

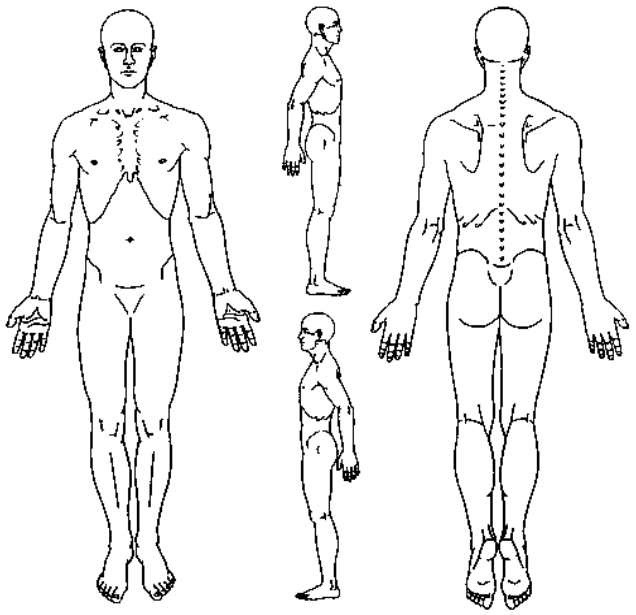
Do you use an assistive device? ❑Yes ❑No (cane, walker, wheelchair, etc.) Type: _____

Please indicate where you are experiencing pain on the diagram.

vvvv =Aching/Dull
oooo =Pins and Needles
xxxx =Burning
///// =Stabbing/Sharp
++++ =Numbness

Please rate your pain from 0 to 10
(0=No pain, 10=Most severe pain imaginable)

Pain Today_____ Average Daily Pain_____
Minimum Pain_____ Maximum Pain_____



RIGHT LEFT LEFT RIGHT

Check the activities that INCREASE your pain or problem: ❑Turning head ❑Gripping ❑Arm Raising
❑Lying Down ❑Sitting ❑Standing ❑Walking ❑Climbing Stairs ❑Going Down Stairs ❑Driving
❑Lifting ❑Bending ❑Twisting ❑Cough ❑Other: _____

Check the activities that IMPROVE your pain or problem:
❑Lying Down ❑Sitting ❑Standing ❑Walking ❑Bending ❑Other: _____

Upper extremity weakness ❑No weakness of arms|hands
Right ❑Shoulder ❑Upper arm ❑Forearm ❑Hand|Finger
Left ❑Shoulder ❑Upper arm ❑Forearm ❑Hand|Finger

Lower extremity weakness ❑No weakness of legs
Right ❑Buttock ❑Thigh ❑Calf ❑Ankle|Foot
Left ❑Buttock ❑Thigh ❑Ankle ❑Ankle|Foot

SONORANSPINE

Farhad Mosallaie, DO, PhD
Physical Medicine & Rehabilitation

CURRENT PAIN MEDICATIONS

Include all prescription and non-prescription pain medications **PLEASE PRINT**

List Names of Medications	Dose or Strength	How Often Taken

PAIN TREATMENT HISTORY – INTERVENTIONS

Treatment	When (Date)	% Helped
Physical Therapy		
Manipulation/Massage		
Injections_____ _____	_____ _____	_____ _____

PAIN TREATMENT HISTORY – PREVIOUS PAIN MEDICATIONS

Name of Previous Pain Medications	Did It Help?	Any Adverse Reaction

Do you have a history of drug addiction or dependence? ❑Yes ❑No If yes, explain any treatment:

_____

_____

PREVIOUS DIAGNOSTIC TESTING FOR THIS CONDITIONPAIN MEDICATIONS

❑None ❑Plain x-rays ❑MRI Scan ❑CT Scan ❑Myelogram ❑Nerve Tests (EMG, NCS)

ALLERGIES

❑ **No Known Drug Allergies** **PLEASE PRINT**

Any Medication Allergy:	Describe Reaction:	Any Medication Allergy:	Describe Reaction:

Are you allergic to Iodine? ❑ Yes ❑ No Are you allergic to Latex? ❑ Yes ❑ No

OTHER NON-PAIN MEDICATIONS YOU CURRENTLY TAKE

Include any vitamins or nutritional supplements **PLEASE PRINT**

1.	2.	3.
4.	5.	6.

1. Are you taking any blood thinners? ❑ yes ❑ no If yes, which one:_____
2. Do you have a pacemaker? ❑ yes ❑ no
3. Do you have a defibrillator? ❑ yes ❑ no
4. Do you have a cardiac stent? ❑ yes ❑ no
5. Have you seen a cardiologist during this past year? ❑ yes ❑ no
6. Have you seen a pulmonologist during this past year? ❑ yes ❑ no

SONORANSPINE

Farhad Mosallaie, DO, PhD
Physical Medicine & Rehabilitation

MEDICAL HISTORY

Are you affected by any of the following? ❑ **No Medical problems**

- ❑ Abnormal heart rhythm
- ❑ Alcoholism
- ❑ Anemia
- ❑ Ankylosing Spondylitis
- ❑ Anxiety
- ❑ Asthma ❑ Gout
- ❑ Bleeding disorders
- ❑ Blood clots
- ❑ Cancer (type:_____)
- ❑ Depression
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Gout
- ❑ Gynecological issue
- ❑ Heart attack
- ❑ Heart failure
- ❑ Hepatitis
- ❑ High cholesterol
- ❑ HIV|AIDS
- ❑ Hypertension
- ❑ Irritable bowel syndrome
- ❑ Kidney problem
- ❑ Liver disease
- ❑ Liver disease
- ❑ Lung disease (type:_____)
- ❑ Osteoporosis
- ❑ Peripheral neuropathy
- ❑ Peripheral vascular disease
- ❑ Rheumatoid arthritis
- ❑ Seizures
- ❑ Sleep apnea
- ❑ Stomach ulcers
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Other Medical Conditions:_____

SURGICAL HISTORY

1.	4.
2.	5.
3.	6.

CURRENT MEDICAL SYMPTOMS

Are you currently experiencing any of the following: (check all that apply) ❑ **None apply**

General: ❑Fever|Chills ❑Falls ❑Unexplained weight loss ❑Drowsiness ❑Night Pain
Head, Ears, Nose, Throat: ❑Headaches ❑Blurry/Double vision ❑Hearing changes ❑Dizziness
Heart or Vascular System: ❑Chest pain ❑Palpitations ❑Swelling
Respiratory System: ❑Cough ❑Shortness of breath ❑Home oxygen ❑Breathing pain with exertion
Digestive System: ❑Nausea ❑Vomiting ❑Diarrhea ❑Constipation ❑Incontinence
Urinary: ❑Frequency ❑Urgency ❑Hesitancy ❑Incontinence ❑Bladder infections
Skin: ❑Rash ❑Itching ❑Wounds or ulcers ❑Hair loss
Psychological|Neurological: ❑Sleep ❑Depression ❑Anxiety ❑Seizures ❑Memory problems ❑Balance issues

FAMILY HISTORY (PARENTS, SIBLINGS)

- ❑ Unknown
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Obesity
- ❑ Stroke
- ❑ Cancer
- ❑ Spinal Disorder
- ❑ Vascular Disease

SOCIAL HISTORY

A. Marital Status: ❑ Single ❑ Married ❑ Cohabitating ❑ Widowed ❑ Divorced
B. Living status: ❑ Alone ❑ Spouse ❑ Parents ❑ Roommate ❑ Assisted Living
C. Work Status: ❑Employed (Occupation:_____) ❑Unemployed ❑Disabled ❑Retired
D. Do you use tobacco: ❑ No ❑ Yes If yes, how much and how long? _____
E. Do you use alcohol? ❑ No ❑ Minimal ❑ Moderate ❑ Heavy ❑ Previous user

X _____

Signature of patient, parent, or guardian **Date**

I hereby acknowledge that I have been presented with a copy of Sonoran Spine's Notice of Privacy Practices. And I am requesting that the following individuals be allowed to my health information (HIPAA).

Date _____

Name _____

Relationship _____

Date _____

Name _____

Relationship _____

Date _____

Name _____

Relationship _____

I hereby acknowledge that I can revoke the authorization to the above mentioned invidiauals at my discretion with a written notification to Sonoran Spine.

Signature _____ Date _____
of patient or legally authorized individual signature

Patient Name (PRINT) _____ Date of Birth _____

Relationship _____
(Parent, Guardian, Personal Representative, etc.)

SONORAN SPINE INSURANCE POLICY

Welcome to Sonoran Spine. We want to make you aware of our policy regarding health insurance.

It is the responsibility of our insured patients to be aware of their health insurance benefits and restrictions prior to visiting our facility. This would include copayments, deductibles, coinsurance, authorization/referral requirements, policy exclusions, and pre-existing condition restrictions.

As a courtesy to our patients, our office will verify your eligibility prior to your visit. Please be aware that the insurance always has a disclaimer stating that **"this does not guarantee payment for services – the claim will be subject to policy benefits and restriction once the claim is received".** Therefore there is no way we can be 100% certain they will pay part or all of your claim.

If your visit requires pre certification or a referral, it is the patient's responsibility to obtain this from the primary care physician or insurance company directly.

If our patients require surgery, we will do our best to make sure we use a contracted facility and that precertification is obtained if necessary. If you have not met your deductible or your out of pocket maximum benefit, a deposit may be required prior to your surgery. If so we will discuss this prior to your surgery to avoid cancellations.

Please know that we do our best to provide you with the most accurate information available to us but it is ultimately the patient's responsibility for any charges incurred. If you disagree with the way the insurance has processed your claim, please contact your insurance company.

I understand that I am responsible for any charges incurred that are not covered by my insurance carrier.

Patient Signature _____ Date _____

Patient Name (PRINT) _____ Date of Birth _____

SONORANSPINE

HIPAA Omnibus Notice of Privacy Practices

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.

This notification is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and HIPAA Omnibus Rules.

_____ _____

Patient Name Date of Birth

Our commitment to your privacy

Our practice is dedicated to maintaining your privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our business associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical student, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose you protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroner, funeral directors, organ donation, research, criminal activity, military activity and national security, worker’s compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use of disclosure indicated in the authorization.

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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.

This notification is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and HIPAA Omnibus Rules.

YOUR RIGHTS

The following are statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used, in a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends you may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures; pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from even if you have agreed to receive the notice electronically We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPAA COMPLIANCE OFFICER	PHONE	EMAIL
Susan Dylo	480-962-0071	practiceadministrator@sonoranspine.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgement” form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Signature Date

Pt Name: _____ Date: _____
Athena ID: _____ Date of Birth: _____

Your surgeon may consult for companies and engage in implant design and research. If these products are approved by the FDA and appropriate for use in your surgery, they may be used.

Your surgeon may have an ownership stake in a facility where you receive healthcare. You can choose a different center if that is your desire.

Your surgeon may have an ownership stake or other participation in manufacturing companies that design and make spinal implants. If these products are approved by the FDA and appropriate for use in your surgery they may be used. If this is a concern for you, please consult with your surgeon before your procedure.

Your surgeon may elect to use an FDA approved product in an "off Label" way, if it is judged to be more beneficial to your surgery's success than other methods. An example may include screws in the back of your cervical spine for stabilization.

Your surgeon may have a relationship with the distributor who provided the spinal instrumentation or other medical product.

Bone morphogenic Protein (BMP) has been FDA approved but it is commonly used "off label" to help the spine heal in fusion procedures involving the spine. Your surgeon may elect to use this FDA approved fusion enhancement technology in an "off label" way, if it is judged to be more beneficial to your surgery's success than other methods.

If you have any concerns with the information above, please feel free to discuss them with your surgeon prior to your surgery.

Sonoran Spine Center, PC

Patient Signature _____ _____
I have read and acknowledge the above Date

PRINT NAME _____

Dennis Crandall, MD · Jason Datta, MD · Farhad Mosallaie, DO, PhD
Terrence Crowder, MD · Michael Chang, MD · Lyle Young, MD · Robert Waldrop, MD · Erik Curtis, MD
Daniela Pal, PA-C · Mara Immediato, PA-C · Katherine Looby, PA-C · Bryce Hilmo PA-C
Jelena Macanovic, FNP-C · Yolanda Smith, FNP-C · Kelli Patterson, FNP-C

1255 W. Rio Salado Parkway, Suite 107, Tempe, AZ 85281
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