SONORANSPINE

TEMPE • PHOENIX • GILBERT • SCOTTSDALE • PEORIA • SHOW LOW
PHONE: (480) 962-0071 | FAX: (480) 962-0590
www.SonoranSpine.com | www.SpineResearch.org

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

❑ Family/Friend/Co-worker ❑ Worker's Comp Referral ❑ Spine seminar/class ❑ Attorney

❑ Online Search (circle one) Google – Yahoo – Bing - Other:_____ ❑ Sonoran Spine website ❑ Health Insurance

❑Phonebook/DEX ❑TV-The Doctors Show ❑TV-News ❑TV-ABC15 ❑TV-Channel 3

❑ Newspaper: ❑East Valley Tribune ❑Surprise Today ❑Glendale Star ❑Daily-News Sun ❑Peoria Times

❑Glendale-Peoria Today ❑El Mirage News ❑Youngtown Reporter ❑ Radio(KOOL 94.5) ❑ Radio(KEZ 99.9)

❑ Magazine: _____ ❑ 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

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 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

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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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

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.)

Dennis Crandall, MD · Jason Datta, MD · Farhad Mosallaie, DO, PhD
Terrence Crowder, MD · Michael Chang, MD · Lyle Young, MD
Claire Magnolo, PA-C · Daniela Pal, PA-C · Melissa Gebhardt Tsai, PA-C · Mara Immediato, PA-C · Katherine Looby, PA-C

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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) _____

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SONORANSPINE

EXPERTISE IN SPINE • EXCLUSIVELY SPINE

NAME:_____ **DATE OF BIRTH:** _____/_____/_____

A. ★★★ IF YOU ARE AN EXISTING PATIENT OF SONORAN SPINE CENTER AND HAVE NOT BEEN EVALUATED HERE IN THE PAST YEAR, PLEASE COMPLETE THE FOLLOWING INFORMATION: ★★★

1. Coughing or sneezing (☐ Increases ☐ Sometimes increases ☐ Does not increase) my symptoms.
2. There is: ☐ No loss of bowel or bladder control ☐ Loss of bowel or bladder control since_____.
3. I have: ☐ Not missed any work because of this problem ☐ Missed (how much?) _____ work
4. Treatments have included: ☐ No medicines, therapy, manipulations, injections, or braces

Neck	Back		Neck	Back	
☐	☐	Physical therapy, exercise	☐	☐	Anti-inflammatory medications
☐	☐	Massage & ultrasound	☐	☐	Narcotic medication
☐	☐	Traction	☐	☐	Epidural steroid injections _____ times which relieved the pain for (how long)?_____
☐	☐	Manipulation			
☐	☐	Tens Unit	☐	☐	Trigger point injections _____ times which relieved the pain for (how long)?_____
☐	☐	Shoulder injections			
☐	☐	Braces	☐	☐	Surgery (explain in section **I**)

5. Previous doctors seen about this problem: ☐ None

Doctor	Specialty	City	Treatments

B. MEDICATIONS YOU TAKE: ☐ None

_____ _____

_____ _____

_____ _____

C. ALLERGIES TO MEDICATIONS: ☐ No known drug allergies. If past adverse reaction, check boxes below:

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____

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D. MEDICAL HISTORY: Check all that apply. ☐ None apply

☐ Heart attack	☐ Diabetes	☐ Lung disease	☐ Liver trouble
☐ Heart failure	☐ Stroke	☐ HIV	☐ Hepatitis
☐ High blood pressure	☐ Seizures	☐ AIDS	☐ Thyroid trouble
☐ Osteoarthritis	☐ Mental illness	☐ Tuberculosis	☐ Bleeding disorders
☐ Rheumatoid arthritis	☐ Kidney stones	☐ Asthma	☐ Anemia
☐ Ankylosing spondylitis	☐ Kidney failure	☐ Blood clot in leg	☐ Serious injuries (explain)
☐ Gout	☐ Cancer	☐ Blood clot in lung	_____
☐ Osteoporosis	☐ Alcoholism	☐ Stomach ulcers	☐ Other: _____

E. SURGICAL HISTORY: Previous surgeries - List procedures, surgeon and date. ☐ None

OPERATION	SURGEON	DATE

F. FAMILY HISTORY: (Check all that apply) ☐ None apply

☐ Stroke	☐ Arthritis	☐ Mental illness	☐ Alcoholism
☐ Heart trouble	☐ Gout	☐ Kidney trouble or stones	☐ Other: _____
☐ High blood pressure	☐ Seizures	☐ Cancer	_____
☐ Diabetes	☐ Spine problems	☐ Bleeding disorders	_____

J. SOCIAL HISTORY:

1. Work status: ☐ Homemaker ☐ Retired ☐ Disabled ☐ On leave ☐ Unemployed
   ☐ Working: ☐ Full time ☐ Part time Occupation:_____
2. Marital status: ☐ Married ☐ Single ☐ Cohabitating ☐ Widowed ☐ Divorced
3. Number of living children: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
4. I live: ☐ Alone ☐ With: _____
5. I participate in sports (circle any): ☐ Golf ☐ Tennis ☐ Jog ☐ Bike ☐ Baseball ☐ Basketball
6. Tobacco use: ☐ Never
   ☐ Cigar ☐ Chew ☐ Pipe ☐ Cigarettes _____ packs per day for _____ years
   ☐ Quit – When? _____ after smoking _____ packs per day for _____ years (total)
7. Alcohol: ☐ Never or rare ☐ Social ☐ Frequently intoxicated (more than 2x a week)
   ☐ Alcoholic ☐ Recovering alcoholic
8. Drug overuse/abuse: ☐ Never ☐ Currently ☐ In the past
9. Because of this spine problem, I have filed or plan to file:
   ☐ A lawsuit ☐ A Worker's Compensation claim ☐ Neither a lawsuit or Worker's Comp

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K. REVIEW OF SYSTEMS: Check all that apply. ☐ None apply

☐ Reading glasses	☐ Abnormal heartbeat	☐ Frequent constipation	☐ Hot or cold spells
☐ Change of vision	☐ Swollen ankles	☐ Hemorrhoids	☐ Recent weight change
☐ Loss of hearing	☐ Calf cramps w/ walking	☐ Frequent urination	☐ Nervous exhaustion
☐ Ear pain	☐ Poor appetite	☐ Burning on urination	*Women only:*
☐ Hoarseness	☐ Toothache	☐ Difficulty starting urination	☐ Irregular periods
☐ Nosebleeds	☐ Gum trouble	☐ Get up more than once every night to urinate	☐ Vaginal discharge
☐ Difficulty swallowing	☐ Nausea or vomiting		☐ Frequent spotting
☐ Morning cough	☐ Stomach pain	☐ Frequent headaches	☐ Other_____
☐ Shortness of breath	☐ Ulcers	☐ Blackouts	_____
☐ Fever or chills	☐ Frequent belching	☐ Seizures	_____
☐ Heart or chest pain	☐ Frequent diarrhea	☐ Frequent rash	_____

1. Generally speaking, are your symptoms getting better or worse?
   - ○ Getting much better
   - ○ Getting somewhat better
   - ○ Staying about the same
   - ○ Getting somewhat worse
   - ○ Getting much worse

2. If you had to spend the rest of your life with the symptoms you have right now, would you be:
   - ○ Very dissatisfied
   - ○ Somewhat dissatisfied
   - ○ Neutral
   - ○ Somewhat satisfied
   - ○ Very satisfied

_____ _____ _____ _____

Patient Signature Date Physician Signature Date