New Patient Packet

6252 E. Grant Rd. Suite 150 Tucson, AZ 85712
Ph. 520.886.7246 • **Fax 520.901.2929** • www.tpiaz.com

Date:

Welcome to Tucson Pain Institute (TPI). You have been referred to our facility for pain management treatment and we are happy to have you join our clinic and look forward to managing your pain.

We have made an appointment for (name) ____ on (date) ______ / ______ / ______ at (time) ______ : ______ . Please arrive 30 minutes earlier than your scheduled time.

This new patient packet must be filled out for your first appointment. Please make sure each form is filled out appropriately. If it is not filled out, your appointment may be cancelled and/or rescheduled.

Please follow these steps to make your appointment run smoothly:

1.) Complete the Medical History Form and bring it with you to the appointment.
2.) Please bring the following to your appointment:
- Driver's License or Valid Photo ID
- Current Health Insurance Card(s)
- List of current medications that include the pill strength and dosage information

Please be advised that we require 24 hours notice for any rescheduling or cancellations this is to avoid incurring a $25 fee. This fee applies to "No Shows" as well.

Medical History (List medications you currently take):

Medication Name:	Dose:	Frequency:

New Patient Intake Form

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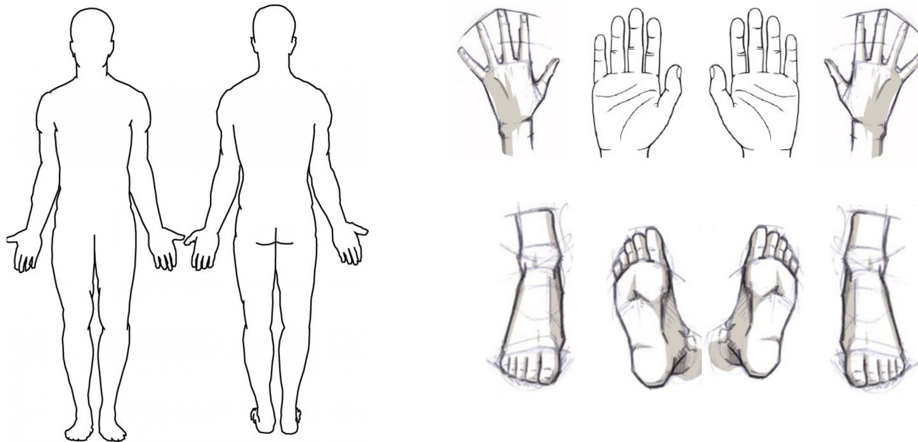
Today's Date: ______ / ______ / ______ Patient Name: ________________________ Height: ________ Weight: ________

Primary Care Doctor: _________________________ What is the reason for your visit today? ___________________________

Explain where your pain is located (please shade in the area where you feel pain):



Is your pain (please check all that apply):

◯ Constant ◯ Intermittent

◯ Dull ◯ Sharp ◯ Shooting ◯ Aching ◯ Numbness ◯ Tingling ◯ Burning

Does your pain radiate to any other part of your body? If yes, where to?

____

What helps to relieve your pain?

____

What causes your pain to be worse?

____

WITHOUT medication, on a scale from 1-10, what is your pain level? ________ WITH medication? ________

What daily tasks/functions are you able to do, with minimal limitations, when taking your medication that you are unable to do without them (i.e. walking, running, making breakfast, grocery shopping, bend over to tie shoes)?

____

____

In terms of pain relief, on scale of 0%-100%, how much pain relief do you get from taking your medication? _______ %

Past Medical History (Please check all that apply):

- ◯ Seizure Disorder
- ◯ Osteoarthrosis
- ◯ Diabetes: Type I or II
- ◯ Rheumatoid Arthritis
- ◯ Heart Attack
- ◯ Thyroid Disease
- ◯ Migraines
- ◯ Pacemaker
- ◯ HIV
- ◯ Fibromyalgia
- ◯ High Blood Pressure
- ◯ Lupus
- ◯ Stroke
- ◯ Atrial Fibrillation
- ◯ Kidney Disease
  Currently in Dialysis? Y / N
- ◯ Cancer
  Type: __________________
  Diagnosis Year:_________
  Remission? Y / N
- ◯ Blood Clots
- ◯ Other
  ____

Past Surgical History:

Date of Surgery:	Procedure:	Surgeon:

Previous Treatment History:

Physical Therapy? Y / N Facility Name: ______________________________ Date of Last Treatment: ____ / ____ / ____

Epidural Steroid Injections? Y / N Physician Name: _____________________ Date of Last Injection: ____ / ____ / ____

Trigger Point Injections? Y / N Physician Name: _________________________ Date of Last Session: ____ / ____ / ____

Chiropractic/Acupuncture? Y / N Physician Name: _______________________ Date of Last Session: ____ / ____ / ____

What medications have you taken in the past for your pain?

Medication Name:	Was this medication effective for pain relief? Why or why not?

Allergies:

Allergy:	Reaction Symptoms:

Family Medical History:

(What medical conditions run in your family? Please be as specific as possible)

Father:	
Mother:	
Mother:	
Mother:	

Social History:

Occupation:

____

Marital Status:

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Domestic Partner ◯ Widowed

Tobacco Use: Y / N Type of Tobacco: ______________________ Frequency: ____________

Alcohol Use: Y / N Type of Alcohol: ______________________ Frequency: ____________

Caffeine Use: Y / N Type of Caffeine: ______________________ Frequency: ____________

Recreational Drug Use: Y / N Type of Drug(s): ______________________ Frequency: ____________

Review of Symptoms:

◯ Fatigue ◯ Change in Appetite ◯ Sleeping Problems ◯ Fever

◯ Chills ◯ Malaise ◯ Body Aches ◯ Night Sweats

◯ Weight Loss ◯ Weight Gain ◯ Loss of Appetite

◯ Back Pain ◯ Neck Pain ◯ Joint Pain

◯ Joint Swelling ◯ Leg Cramps ◯ Muscle Cramps

◯ Muscle Pain ◯ Shoulder(s) Pain ◯ Hip(s) Pain

◯ Leg(s) Pain ◯ Wrist Pain ◯ Knee Pain

◯ Ankle Pain ◯ Elbow Pain ◯ Limitation of Motion

◯ Congenital Muscular Disease ◯ Muscle Weakness

Additional Information:

(Please feel free to use the space below if there is any additional information you would like to inform the doctor about)

____

____

Patient Signature: ____ Date: _____ / _____ / _____

Physician Signature: ____ Date: _____ / _____ / _____

Tucson Pain Institute

Tucson Pain Institute
6252 E. Grant Rd. Suite 150
Tucson, Arizona 85712
Ph. 520.886-PAIN (7246)

We are committed to doing all we can to treat your chronic pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of chronic pain and related conditions all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the provider (provider may be a: physician's assistant) by establishing guidelines, within the last, for proper controlled substance use. I am receiving Chronic Narcotic Administration (CNA) to treat the following medical condition(s):

I understand that there are some risks associated with CNA such as dependence, addiction, change in personality, sleep changes, bowel changes (such as constipation and even bowel obstruction), bladder changes, changes in appetite with possible weight gain or loss, coordination (which may interfere with driving and with fine motor movement), sexual desire and performance, and other. Sudden stopping of CNA can lead to rebound pain and withdrawal symptoms. I have been informed not to stop CNA suddenly unless decided jointly by myself and by you, my physician.

1. All controlled substances have a potential for dependency and abuse.
2. All controlled substances must come from the provider whose signature appears below or during his/her absence, by the covering provider, unless specific authorization is obtained for an exception. This does include ER/Urgent Care visits.
3. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: ________________________Phone: ________________
4. The prescribing provider has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professionals who provide your health care for purpose of maintaining accountability.
5. You may not share, sell, or otherwise permit other including spouse or family members to have access to these medications.
6. Unannounced urine or serum toxicology screens may be requested and your cooperation is required. Presence of unauthorized substances may result in your discharge from our facility. Refusal of the test will result in your discharge from our care. Absence of substances that should be in your system may also result in discharge from our facility.
7. I will not consume excessive amounts of alcohol in conjunction with narcotics, nor will I use, purchase, or otherwise obtain any illegal substances.
8. Medications may not be replaced if they are lost, stolen, get wet, are destroyed, or get left intentionally or unintentionally elsewhere (i.e. airplane, bus, different city/state). If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities.
9. If the responsible legal authorities have questions concerning your treatment, as might occur, for example if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
10. Early refills will not be given. We require 3 days notice for refill requests. Refills are based upon keeping scheduled appointments. Refills will not be granted after hours or on weekends. Our hours are Monday-Friday 8:00 am-4:30 pm.
11. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
12. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by the provider.
13. Smoking increases multiple health risks including chronic pain. You will make every effort to refrain from smoking.

You affirm that you have full right and power to sign and be bound by this agreement and that you have read, understand, and accept all of its terms.

Patient Signature ____________ Date ____________ Provider Signature ____________ Date ____________

Patient Information:

Patient: ______________________________ D.O.B. ____________
Last First MI

◯ Male ◯ Female Social Security Number: ______________________

Address: ____

City: ______________ State: ____________ Zip: ____________

Phone: ______________________ Work: ______________________

Employer: ______________________ Occupation: ______________________

Primary Insurance Coverage:

◯ Private Pay ◯ Insurance Company ______________________

Phone: ______________________ Fax: ______________________

Address: ____

City: ______________ State: ____________ Zip: ____________

Insured: ____________ DOB: ____________ Policy #: ____________ Group: ____________

Relationship to Patient: ______________________ Person Responsible Employed By: ______________________

Worker's Compensation Only:

Employer: ______________________

Adjuster's Name/Adjuster's Phone #, Date of Injury

Diagnosis: ____

Secondary Coverage:

Insurance Company: ______________________

Phone: ______________________ Fax: ______________________

Address: ____

City: ______________ State: ____________ Zip: ____________

I HEREBY AUTHORIZE TUCSON PAIN INSTITUTE TO RELEASE ANY INFORMATION CONCERNING MY HEALTH INFORMATION TO MYSELF: ____________________ MY PARENT/GUARDIAN: ____________________ OTHER: ____________________.

I UNDERSTAND THAT MY PERSONAL HEALTH INFORMATION WILL BE USED BY TUCSON PAIN INSTITUTE ACCORDING TO ARIZONA STATE AND HIPAA.

By signing this form, I agree and consent to Tucson Pain Institute's use and disclosure of my protected health information to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, and to conduct normal healthcare operations such as quality assessments and healthcare provider certifications as stated in the notice of privacy practices, and that I have been provided or offered a copy of this notice.

I agree that all of the above demographic and insurance information is accurate and up-to-date. If there is an error in the information above, I understand I am responsible for the charges related to the error(s). I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services. I hereby assign all medical and/or treatment benefits including major medical benefits to Tucson Pain Institute for services rendered.

Patient Consent: ______________________ **Parent/Legal Guardian's Consent:** ______________________

Patient Bill of Rights and Responsibilities

As a patient, you have the right to:

- Considerate and respectful care.
- Knowledge of the name of the healthcare provider who has primary responsibility for coordinating the care, and the names and professional relationships of other healthcare providers who may see you.
- Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the provider who will carry out the procedure or treatment.
- Participate actively in any decisions regarding your medical care; to the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communications and records pertaining to your care.
- Reasonable continuity of care and to know, in advance, the time and location of appointment as well as the identity of persons providing care.
- Be advised if the healthcare provider proposes to engage in or perform human experimentation affecting care or treatment, you have the right to refuse to participate in such research projects.
- Have all your rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Have complaints forwarded to Administrative personnel for appropriate response.
- Know that all the Clinic/Office personnel will observe your rights.

The care a patient receives depends partially on the patient. Therefore, in addition to patient rights, you as the patient have certain responsibilities as well.

- You are responsible to provide accurate and complete information concerning your present complaints, past medical history, and other matters relating to your health.
- You are responsible for making it known whether you clearly comprehend the course of your medical treatment and what is expected of you.
- You are responsible for following the treatment plan established by your healthcare provider, including the instructions of nurses and other health professionals as they carry out the healthcare providers orders.
- You are responsible for keeping appointments and for notifying the office within 24 hours to cancel your appointment. We understand emergency situations occur, however, we reserve the right to initiate a $25.00 missed appointment fee per occurrence, with the possibility of dismissal after three occurrences.
- You are responsible for your actions should you refuse treatment or not follow the healthcare providers orders/recommendations.
- You are responsible for assuring that the financial obligations of your care are filled.
- You are responsible for being considerate of the rights of other patients and office personnel.

I understand my rights and responsibilities as a patient of Tucson Pain Institute:

Patient's Signature: ______________________________ **Date:** _____ / _____ / _____

Witness: ____________________________________ **Date:** _____ / _____ / _____

Financial Policy and Waiver

Insurance Benefits

Arizona State Law requires that medical claims be paid by the insurance carrier within 30 days. As a courtesy we will bill your insurance carrier for all covered services. If your insurance has not appropriately paid the submitted claim within 45 days, all outstanding balances will become patient responsibility.

Insurance Co-Payments

In accordance with my insurance contract, I understand that co-payments are due at the time of service. This contractual obligation requires that the co-payment be made at the time of service, so it may be necessary to reschedule your appointment if your co-payment is not made.

Deductible

If my insurance deductible has not been met, I understand that full payment up to the total deductible amount will be collected at the time of service.

Co-Insurance

I understand that my plan may have co-insurance amounts and that I will be responsible for the co-insurance amount when my insurance has acknowledged my claim. I will be sent a statement for these amounts and understand that I will need to pay in full any co-insurance balances before any other procedures are scheduled.

Private Pay

If I have no insurance coverage, or insurance with which Tucson Pain Institute does not participate, full payment is expected at the time of service.

Verification of Benefits and Non-Covered Services

Insurance policies may differ per patient plan. Tucson Pain Institute may provide services that my insurance plan excludes. ***It is my responsibility to verify and understand my coverage benefits and exclusions***. All non-covered services are my responsibility and are due at the time of service.

Collections

I understand that once an account is placed into collection status, all future services must be paid in full at the time of service. If my account is placed in collections, I will be responsible for all collection costs equal to 30% of my outstanding balance but no less than $25.00

No Show/Late Cancellations/Returned Checks

Cancellations made less than 24 hours in advance or “no show” appointments are subject to a $25.00 cancellation fee. These charges are my responsibility and will not be billed to my insurance carrier. Returned checks will be subject to a $25.00 returned check fee.

I have read and agree to abide by this financial policy and waiver.

Signature: ______________________________________ Date: ______ / ______ / ______

Acknowledgement of Receipt of Notice of Privacy

/ /

Signature of Patient or Authorized Representative Date

/ /

Printed Name of Patient or Authorized Representative Date

/ /

Printed Name of Patient or Authorized Representative Date

/ /

Relationship of Authorized Representative (if applicable) Date

/ /

Wellness Signature Date

Unable to obtain acknowledgement of receipts of Notice of Privacy Practices because:

/ /

Signature Date