SOUTHWEST
SPINE & PAIN CENTER

PATIENT INFORMATION

Name:	Date of Birth:	Age:	Sex:
Race:	Ethnicity:		Primary Language:
Address: (City, State, Zip)			
Billing Address:	SSN:		
Employment: Full/Part/None	Employer:		
Primary Phone #:	Work Phone #:	Cell Phone #:	
Email Address: (used to set up your patient portal)			

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Cell Phone #:
Relationship:	Home Phone #:

INSURANCE INFORMATION

Primary Insurance: Copay:	Secondary Insurance: Copay:
Certificate#/Policy ID:	Certificate #/Policy ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB/Relationship:	Subscriber DOB/Relationship:

REFERRALS

Referring Physician:	How did you hear about us? (Referring doctor, friend, family, self referral, internet, magazine, newspaper, advertisement, other)

PRIMARY CARE

Primary Care Physician:	Last Office Visit:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my provider when they accept assignment.
Authorization To Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.
I certify that the above information is correct as of the date signed.

_____ _____

Signed (parent of patient if minor) Date

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(Please read and sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Southwest Spine and Pain Center** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Southwest Spine and Pain Center** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I am able to have access to a complete copy of the Southwest Spine and Pain Center "Notice of Privacy Practices". I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initials: _____**

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable services to **Southwest Spine and Pain Center.**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) signature **Date**

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Authorization to release or use information for treatment, payment, or healthcare options

I herby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Southwest Spine and Pain in order to carry out treatment, payment, or health care options. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing the Consent form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

VIA PRIMARY PHONE NUMBER — PLEASE INITIAL

- ☐ OK TO LEAVE DETAILED MESSAGE _____
- ☐ LEAVE CALL BACK NUMBER ONLY _____

VIA EMAIL

- ☐ OK TO SEND DETAILED MESSAGE _____
- ☐ EMAIL ADDRESS: _____ _____

PERMISSION TO RELEASE TO FOLLOWING INDIVIDUALS
(medical records, billing, payment, appointments, healthcare options)

_____ _____

_____ _____

By signing below, I attest that the information provided above is true and accurate.

Signature of Patient (Guardian): _____ Date: _____

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FINANCIAL AGREEMENT

Thank you for choosing us as your pain clinic. Our team of providers is committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. **Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. _____ ***(initial)***
2. **Patient payment:** All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company. _____ ***(initial)***
3. **Registration:** All patients must complete our patient information form, which will be entered into our medical records system to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Many insurance companies have a time limit as to when claims can be filed; For example, if a claim is not received within 30 days of the date of service, it can be deemed ineligible for payment and you will be responsible for the balance if you fail to provide us with complete and accurate information. _____ ***(initial)***
4. **Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and your insurance company. _____ ***(initial)***
5. **Uninsured patients:** We offer a cash pay discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action. __ ***(initial)***
6. **Credit and collection:** If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. In the event any amount is referred to a third party debt collection agency, you agree that in addition to any other amount allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc), you will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah code Annotated, sec.12-1-11. _____ ***(initial)***
7. **Missed appointments:** Our policy is to charge $25 for missed appointments (no shows) not canceled within 24 hours of appointment time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. _____ ***(initial)***

Thank you for reviewing our patient financial policy. Please let us know if you have any questions regarding the policy.

By signing below, you acknowledge the terms of the policy and agree to be bound by them.

X_____ Date _____

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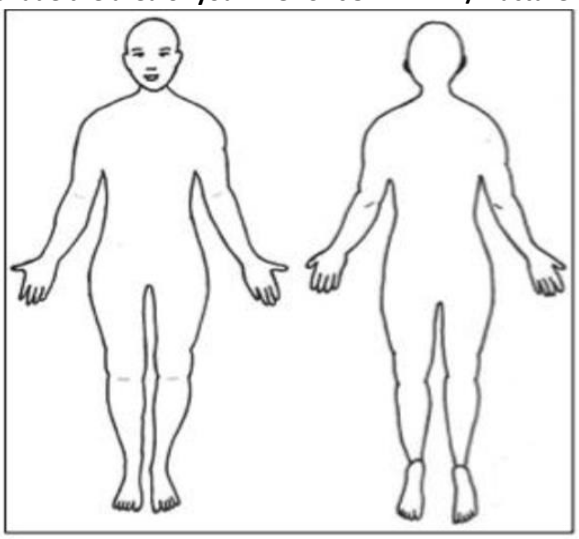
Referring Provider: _____
OSTEOPOROSIS PATIENT: _____
Location of Recent Fracture: _____

Shade the area of your *WORST* JOINT PAIN/Fracture:



Height: _____ **Weight:** _____

Onset of Pain:

O Acute O Sudden O Gradual

Severity of Pain:

O Mild O Moderate O Severe

Description of Pain:

O Aching O Burning O Cramping
O Sharp O Shooting O Stabbing
O Tingling O Pressure O Numbness
O Throbbing O Deep O Dull
O Pins and Needles O Morning stiffness
O Fatigue O Joint pain

Pain Pattern:

O Episodic O Acute O Persistent O Intermittent

Course of Pain:

O Gradual worsening O Gradual Improving
O Rapidly worsening O Rapidly Improving
O Recurrent O Without Change

Duration of Pain:

O Years (How Many? _____)
O Months (How Many? _____)
O Weeks (How Many? _____)

Pain Aggravated/Impaired by:

O Nothing O Bending O Chores
O Dressing O Driving O Exercise
O Getting Up From Bed/Chair O Intimacy
O Lifting O Sitting O Sleeping
O Walking O Standing O Twisting
O Work O Recreational-hobbies

Pain Relieved by:

O Nothing O Bending O Exercise
O Lifting O Sitting O Sleeping
O Standing O Walking O NSAIDs
O Heat O Ice O Physical Therapy
O Massage O Twisting O Opiates

Tried & Failed:

O Physical Therapy O Bracing O Heat O Ice
O Modification of Activity O NSAID's
O Opiates OAlendronate O Prolia
O Risedronate O Boniva O Reclast O Evenity
Last Date of Injection/Infusion: _____

Associated Factors:

O Fractures O Morning stiffness O Painful urination
O Chills O Evening stiffness O Urinary retention
O Fever O Joint pain O Decreased energy
O Tingling O Leg weakness O Arm weakness
O Limited exercise/activity O Sleep problems
O History of Malignancy O Unintentional Weight Loss

Assistive Devices:

O None O Cane O Walker O Wheeled Walker
O Corset O Brace O Wheelchair

How are you?:

Energy: _____Low_____fair_____good
Recent/Last DEXA SCAN?_____
Are you currently taking: Calcium, Vitamin D, Testosterone, Progesterone, Estrodial
Have you previously took: Calcium, Vitamin D, Testosterone, Progesterone, Estrodial
-If so, What dose?_____, For How long?_____ (weeks, months, years)
Are you Post Menopausal? ___Yes, ____ No

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Constitutional:
O Chills O Weakness O Weight Loss
O Weight Gain O Appetite Loss O Fever

Head:
O Seasonal Allergies O Vertigo O Headaches

Eyes:
O Blurry Vision O Double Vision O Vision Loss
O Pain with Light O Dryness O Redness

Respiratory:
O Shortness of Breath O Sleep Apnea
O Chronic Cough O Difficulty Sleeping

Cardiovascular:
O Chest Pain O High Blood Pressure
O Short of Breath-Laying Flat O Swelling of Legs
O Leg Pain O Rapid Heart Rate
O Irregular Heart Beat O Heart Stent(s)
O Heart Murmur

Gastrointestinal:
O Abdominal Pain O Constipation O Diarrhea
O Black, Tarry Stool O Nausea O Vomiting
O Bloody Stool

Musculoskeletal:
O Joint Pain O Arthritis O Muscle Weakness
O Muscle Spasm O Muscle Loss O Swollen Joint
O Stiffness O Restricted Motion

Psychiatric:
O Anxiety O Depression O Hallucinations
O Mood Changes O Panic Attacks O Anger
O Hearing Voices O Irritability

Skin:
O Itching O Rashes O Open Wound O Ulcer
O Excessive Sweating O Bruising O Hives

Neurological:
O Headaches O Numbness O Strokes
O Trouble Walking O Seizures
O Leg Weakness O Buttock numbness
O Loss of Bowel or Bladder control
O Gait abnormality

Endocrine:
O Appetite Changes O Thyroid Problems

Hematologic/Lymph:
O Easy Bruisability O Nose Bleeds O Blood Clots
O Bleeding Easily O Anemia

ENT/Ears:
O Hearing Loss

Throat/Neck:
O Ulcer O Neck Mass O Swollen Glands

Allergies:

O Shellfish O Contrast Dye O Iodine O Latex
O Codeine O Penicillin O Seasonal Allergies
O Sulfa O Other: _____

Medications:

Current Prescriptions: (include all Rx's)

	Medication	Dose (mg)	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Are you taking any blood thinners? Y/N

Previously Tried Pain Medications:

1. _____Reason Discontinued: _____
2. _____Reason Discontinued: _____
3. _____Reason Discontinued: _____

Family History: *Please specify family member including maternal/paternal **and** alive/deceased

O Diabetes _____ O Alzheimer's _____
O Migraine _____ O Heart Disease_____
O Cancer_____ O Crohn's _____
O Stroke _____ O Osteoporosis _____
O High Blood Pressure_____
O Rheumatoid Arthritis_____ O Lupus _____

Past Medical History:

O Anemia	O Anxiety	O Arthritis
O Asthma	O Cancer	O Atrial Fibrillation
O BPH	O COPD	O Depression
O Diabetes	O Emphysema	O GI Ulcer
O Hepatitis	O HIV/AIDS	O Hypertension
O Kidney Disease	O Liver Disease	O Heart Attack
O Osteoporosis	O Seizures	O Shingles
O Stroke	O Thyroid Disease	
O Congestive Heart Failure		O Other: _____
O Coronary artery disease		_____

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Previous Imaging:

O X-ray Date: _____ Location: _____
O MRI Date: _____ Location: _____
O CT Scan Date: _____ Location: _____
O EMG Date: _____ Location: _____
O Bone scan Date: _____ Location: _____

Facility: IHC Revere Health
Other: _____

Previous Evaluations:

O None O Urgent Care O Psychologist
O Neurologist O Primary Care O Neurosurgeon
O Emergency Room O Pain Management
O Rheumatologist O Orthopedic Surgeon

Previous Procedures:

O None O Facet Injection
O Radiofrequency O Epidural Injection
O Kyphoplasty O SI Joint Injection
O Other _____ O Hip Injection
Relief: Mild Moderate Significant
Duration: _____ Days ____ Weeks ____ Months

Previous Physical Therapy or Chiropractic Care:

O None O Yes- Please indicate below
For what body region? _____
Dates: _____ # of Sessions: _____
Percentage of Relief: _____%

Previous Joint Surgery:

O None O Yes- Please indicate below
Type: _____
Date: _____
Surgeon: _____
Relief: Mild Moderate Significant
Duration: _____ Days ____ Weeks ____ Months
Type: _____
Date: _____
Surgeon: _____
Relief: Mild Moderate Significant
Duration: _____ Days ____ Weeks ____ Months

Social History:

Alcohol Use:
Do You Drink? Y/N If Yes, servings per week:
Beer: _____ Wine: _____ Hard Liquor: _____
Tobacco Use:
O Never Smoked O Former Smoker
O Current Smoker: O Light <10 O Heavy >10
O Tobacco Type: (Cig, Chew, Etc): _____
ORT:
Has anyone in your family had a history of:
O Alcohol Abuse (1-3) O Illegal Drugs (2-3)
O Prescription Drug Abuse (4-4)
Have YOU ever had a history of:
O Alcohol Abuse (3-3) O Illegal Drugs (4-4)
O Prescription Drug Abuse (5-5)
Please mark your age group:
O 0-16 O 16-45 (1-1) O 45+
Have you had a history of preadolescent sexual abuse?
O Yes (3-0) O No
Have you ever been diagnosed with:
O Attention Deficit Disorder (ADD) (2-2)
O Obsessive Compulsive Disorder (OCD) (2-2)
O Bipolar Disorder (2-2)
O Schizophrenia Disorder (2-2)
O Depression (1-1)

Surgical History:

O None
O Adenoidectomy
O Appendectomy
O Knee Arthroscopy
O Back Surgery
O Cervical
O Thoracic
O Lumbar
O Brain Surgery
O Carpal Tunnel
O L O R
O Cataract Surgery
O Heart Bypass Surgery
O Coronary Artery Dilation
O Detached Retina Repair
O Gallbladder Removal
O Hemorrhoidectomy
O Hernia Repair
O Hysterectomy
O Lumpectomy
O Large Bowel Resection
O Mastectomy
O Prostate Surgery
O Plastic Surgery
O Shoulder Surgery
O L O R
O Small Bowel Res.
O Thyroidectomy
O Tonsillectomy
O Hip Replacement
O L O R
O Knee Replacement
O L O R
O Tubal Ligation
O Vasectomy
O Pace Maker
O Other: _____

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Health Fusion #: _____ **Date of completion:** _____

Health and Wellness Questionnaire

At Southwest Spine and Pain Center, we believe in providing the best care possible. Answering the following questions will help us understand your needs in multiple areas of your life and how we can best help you to be well. Participation is voluntary. You are free to stop at any time or to leave questions blank if you would prefer not to answer them. However, the more information we have, the better able we are to provide quality care.

1. In general, would you say your health is:

□ Excellent □ Very Good □ Good □ Fair □ Poor

2. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)

□ Excellent □ Very Good □ Good □ Fair □ Poor

3. In general, how would you rate your physical health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

4. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

□ Completely □ Mostly □ Moderately □ A little □ Not at all

5. How would you rate your fatigue on average?

□ None □ Mild □ Moderate □ Severe □ Very severe

6. How would you rate your pain on average?

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)

7. In general, would you say your quality of life is:

□ Excellent □ Very Good □ Good □ Fair □ Poor

8. In general, how would you rate your mental health, including your mood and your ability to think?

□ Excellent □ Very Good □ Good □ Fair □ Poor

9. How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

□ Never □ Rarely □ Sometimes □ Often □ Always

10. In general, how would you rate your satisfaction with your social activities and relationships?

□ Excellent □ Very Good □ Good □ Fair □ Poor

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11. In the past 7 days, my sleep quality was:
□ Very Good □ Good □ Fair □ Poor □ Very Poor

12. In general, would you say your nutrition is:
□ Very Good □ Good □ Fair □ Poor □ Very Poor

13. In general, would you say your fitness is:
□ Very Good □ Good □ Fair □ Poor □ Very Poor

Over the last 2 weeks, how often have you been bothered by any of the following problems?

14. Feeling nervous, anxious or on edge.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

15. Not being able to stop or control worrying.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

16. Little interest or pleasure in doing things.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

17. Feeling down, depressed, or hopeless.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

18. Are past or present experiences with any of the following impacting you in your life in a negative way?

□ Yes □ No Abuse
□ Yes □ No Violence (e.g., domestic, work, military)
□ Yes □ No Military service or combat
□ Yes □ No Unexpected death of a family member or friend (i.e. suicide, accidents, etc)

19. Please answer these questions based on the **last 12 months**. These questions refer to use of alcohol, illegal drugs, prescription drugs not prescribed to you, or misuse of your prescriptions. **Do not** check "yes" in reference to taking your prescription medications as prescribed by your doctor.

□ Yes □ No Have you felt you ought to cut down on your drinking or drug use?
□ Yes □ No Have people annoyed you by criticizing your drinking or drug use?
□ Yes □ No Have you felt bad or guilty about your drinking or drug use??
□ Yes □ No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?