Phoenician Medical Center
"Quality Healthcare Begins with Us"

PHOENICIAN PAIN MANAGEMENT

NEW PATIENT INFORMATION

DATE: **ACCT#**

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Social Security # _____

Age: _____ Sex: _____ Home Phone: _____ Work: _____ Cell: _____

Referring Physician: _____ Phone: _____ Fax: _____

Employer: _____ Phone: _____

Employer Address: _____

Name of Spouse: _____ Social Security # _____

Emergency Contact (not living with you)

Name: _____ Phone: _____ Relationship: _____

HEALTH INSURANCE Copays are expected at time of service and will not be billed

Primary Carrier: _____

Policy Holder: _____ Group #: _____ Policy #: _____

Address: _____ Phone: _____

Secondary Carrier: _____

Policy Holder: _____ Group #: _____ Policy #: _____

Address: _____ Phone: _____

How did you hear about us?

☐ Primary Care Provider ☐ Internet ☐ Insurance Carrier

☐ Other: _____

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PHOENICIAN PAIN MANAGEMENT

Check Box if Appropriate	
☐ **WORKERS COMPENSATION INJURY**	☐ **MOTOR VEHICLE ACCIDENT**
Employer When Injured: _____	
Insurance Company Name: _____	
Date of Accident/Injury: _____	Claim #: _____
Address: _____	
Adjuster's Name:_____	Phone #: _____

My signature below authorized the release of all pertinent information requested by the insurer, SSI, HCFA, and/or any parties involved in the payment and/or settlement of my Medicare or insurance claims. A copy of this authorization may be used in place of the original and should be considered effective until revoked by me in writing. Payment should be directed to: Phoenician Pain, as medical assignment of benefits applied.

Signature: _____ Date: _____

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PHOENICIAN PAIN MANAGEMENT

Patient Intake Form

Patient Name: _____ Date of Birth: _____ Age: ___ Sex: ___ Date: _____

Referred by: _____ Doctors/Neurologists seen for this complaint: _____

Personal/Social History

Marital Status: (Circle) Married Widowed Divorced Separated Single Number of Children: _____ Ages: _____

Occupation: _____ Education: (Circle) Grade School High School College College graduate

Habits: Do you smoke? Yes No How many years? _____ How many per day? ____ Quit when? _____

Do you ever drink alcohol? Yes No How many per week? _____ Do you use recreational Drugs? Yes No If yes, which ones? _____

Caffeine intake? Yes No (How many per day?) Coffee ____ Tea ____ Sodas ____

Current Complaint / Reason for Visit:

1. _____Since: _____
2. _____Since: _____
3. _____Since:_____
4. _____Since:_____

Drug Allergies / Reaction:

_____

Recent accidents or injuries:

_____

_____

Current Medications (List all medications including nonprescription/over the counter that you currently take

Name of Medication	Mg	Times a day	Prescribed by	Name of Medication	Mg	Times a day	Prescribed by
1.				10.			
2.				11.			
3.				12.			
4.				13.			
5.				14.			
6.				15.			
7.				16.			
8.				17.			
9.				18.			

List All Prior Hospitalizations:

Name of Hospital	Year	Reason for Hospitalization	Name of Hospital	Year	Reason for Hospitalization
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Surgical History: (List All Prior Surgical Procedures)

Procedure	When & Where Performed	Procedure	When & Where Performed
1.		10.	
2.		11.	
3.		12.	
4.		13.	
5.		14.	
6.		15.	
7.		16.	
8.		17.	
9.		18.	

Prior Radiographic/Diagnostic Tests (Check Normal or Abnormal, name of ordering Doctor & location performed)

Test Name	Date Performed	Normal (check box)	Abnormal (check box)	Ordered By	When & Where
CT scan of					
CT Scan of					
EMG/NCV					
MRI of					
MRI of					
Sleep Study					
X-ray of					
X-ray of					

Alcoholism	Chills	Glaucoma	Kidney Disease	Neuropathy	Stroke	Cancer of _____
Allergy	Chronic fatigue	Gout	Kidney Stone	Overactive Bladder	Suicide Attempt	Fibromyalgia
Anemia	Chronic Pain	Heart Attack	Learning Disability	Pacemaker/Stent	Syphilis	Irritable Bowel
Arthritis	Colon Problems	Heart Disease	Liver Disease	Parkinson's	Thyroid disease	Neck Pain
Arrhythmia	Concussion	Hepatitis	Loss of Appetite	Peptic Ulcer	TIA	Spinal Cord Injury
Asthma	COPD	Herpes Zoster	Lung Disease	Psychiatric treatment	TMJ	
Atrial Fibrillation	Depression/Anxiety	High Blood Pressure	Lupus	Psychological Disorder	Tremor	
Back Pain	Diabetes	High Cholesterol	Meningitis	Rheumatic Fever	Tuberculosis	
Bladder Problems	Drug Use	HIV	Mental Disease	Sexual Problems	Vertigo	
Bleeding/Clotting	Emphysema	Possible HIV contact	Migraine	Seizures (spells)	Ulcers/Colitis	
Blood Disorders	Encephalitis	Hyperlipidemia	Multiple Sclerosis	Sinus Disease	Weight loss/gain	
Blood transfusion	Fevers	Immune Disorder	Narcolepsy	Sleep Disturbance		

Neurological History: (Circle all that apply)

Balance Problems	Double Vision	Headache	Numbness	Swallowing Problem	Weakness
Bowel/Bladder	Facial Numbness	Hearing Loss	Personality Change	Tingling	Prior Neurology Consult
Confusion	Facial Pain	Involuntary movement	Ringing in ears	Visual Loss	Psychiatry consult
Coordination	Fainting	Low back pain	Smell/Taste	Vitamin Deficiency	Psychology consult
Dizziness	Head Injury	Memory Loss	Speaking problem	Walking problem	

Family History:

Family History	Alive	Deceased	Age	Medical Problem (S)
Father				
Mother				
Sister(s) Brother(s)				

Name: _____ **Date: _____**

CIRCLE WHERE YOUR PAIN IS TODAY: 0 -1-2-3-4-5-6-7-8-9-10

Please use the following scale to give us an estimate of your pain:

0: Pain Free

1: Very minor annoyance, occasional minor twinges

2: Minor annoyance, occasional strong twinges

3: Annoying enough to be distracting

4: Can be ignored if you are really involved in your work, but still distracting

5: Can't be ignored for more than 30 minutes

6: Can't be ignored for any length of time, but you can still go to work and participate in social activities

7: Makes it difficult to concentrate, interferes with sleep, you can still function with effort

8: Physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors of pain

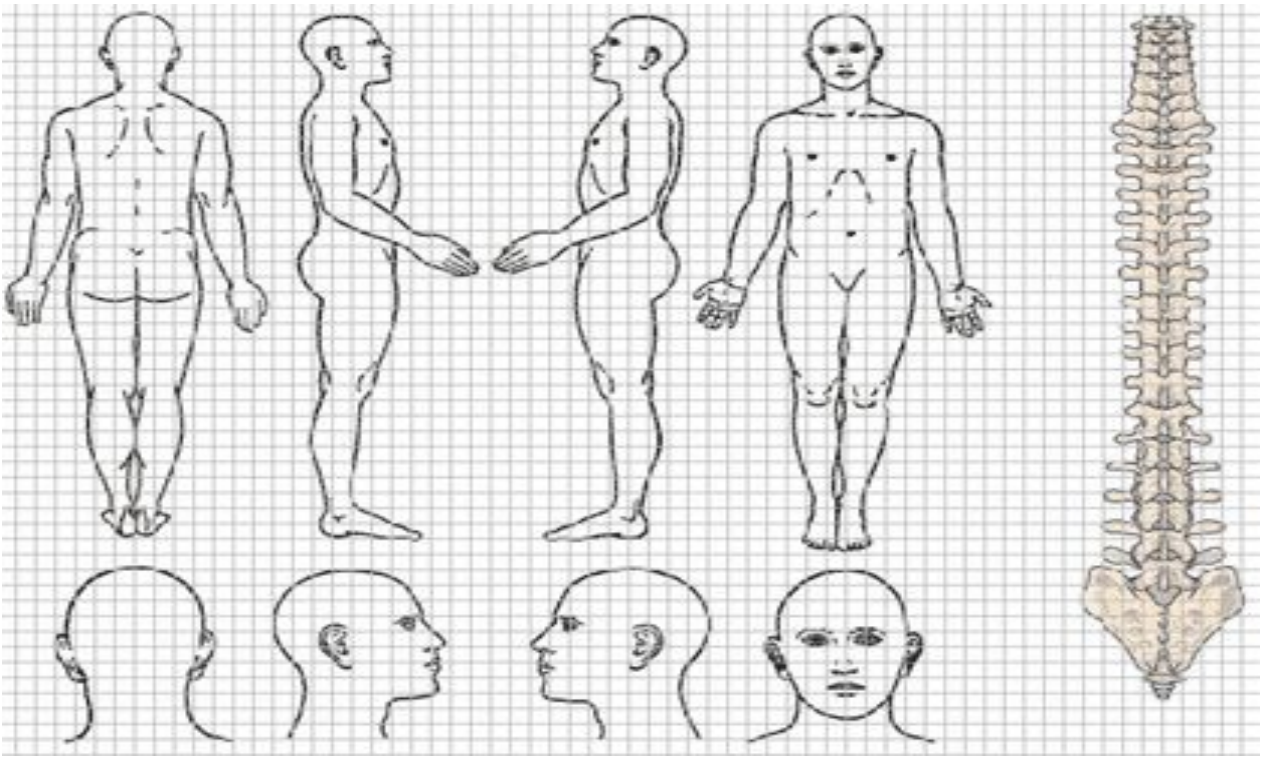
9: Unable to speak, crying out or moaning uncontrollably, near delirium

10: Unconscious, pain makes you pass out

Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms.

"N" = numbness. **"S"** = stabbing pain. **"B"** = burning pain. **"P"** = pins and needles.

"A" = aching pain.



HIPAA CONSENT

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PHI WITH CONDITIONS

Patient Name: _____ DOB: _____

I hereby authorize the use or disclosure of my personal health information as described below. I understand the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal regulations.

1. Persons within the physician's practice authorized to use or make disclosure of the information: **ALL EMPLOYEES OF Phoenician Medical Center Group of Companies**
2. Persons or organizations authorized to receive the information:

Spouse Yes No If yes, list person (s) name: _____

Parent Yes No If yes, list person (s) name: _____

Other individual, i.e., boyfriend/girlfriend, brother, sister, etc. Yes No

If yes, please list name (s) and relation: _____

3. Specific description of information that may be used or disclosed: e.g.: **Contact information Tests results, referrals, prescriptions, paperwork, pertinent medical record**
4. The information will be used/disclosed for the following purposes:
   A. To inform me of my medical condition (s) by phone, mail, email or in person.
   B. To give information/referrals/medical records/samples/prescription, paperwork, and or test results to you or the person (s) named on this form, by phone, mail email or in person.
   C. For treatment, payment and health care operations.
5. This authorization expires on: _____.

I understand that I may revoke this authorization at any time by notifying the physician's office providing the information in writing. However, the revocation will not be valid, if:

A. The physician has taken action in reliance of this authorization, or
B. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____

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PHOENICIAN PAIN MANAGEMENT

Informed Consent for Chronic Opioid Therapy

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____ Email: _____

I understand that Dr. _____ ("my physician") is recommending opioid medicine, sometimes called narcotic analgesics, to treat my _____.

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving – and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain relieving properties of the medication (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)
- Addiction
- Failure to provide pain relief
- Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.)
- Changes in hormonal levels In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that,

should I carry a baby to delivery while taking this medication; the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

Furthermore, I recognize that the long-term consequence on a child's development that was exposed to opioids is not understood.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. Having been informed of these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the narcotic/opioid medication.

I would note that I have been given the opportunity of ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medications early, and early refills may not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

Taking too much of my pain medication, or mixing my pain medications with drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated, experience extreme sleepiness, respiratory depression, coma and death.

I will obtain all opioids prescriptions from my physician or, during his or her absence, by the covering physician. Requests for pain medications from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.

I will submit to random pill counts and urine and/or blood drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency only period.

I will not share, sell or otherwise permit others to have access to these medications.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID PAIN MEDICINES. I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

_____ _____

Patient Signature Date

Phoenician Medical Center
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PHOENICIAN PAIN MANAGEMENT

OPIOID CONTRACT INITIAL ALL PLEASE!

NAME: _____ **DOB:** _____

_____ I understand the purpose of this agreement is to prevent misunderstandings about certain medications I will be taking for pain management. This is to help me and my doctor comply with the law regarding controlled medications.

_____ I understand that if I break this agreement, _____ will stop prescribing me medications.

_____ I will not use any illegal substances, i will not increase or decrease the dosage, if I feel that adjustments in the medication dosage is required, i agree to contact the prescribing provider.

_____ I agree and understand that I can not test positive for the if prescribed schedule II opioid medications (even with a valid medical marijuana card).

_____ I will not share my medications with anyone nor will I take another person's medications.

_____ I will not receive any controlled medications from any other doctors, and I will only use one pharmacy (as listed below.)

_____ I understand that it is my responsibility to safeguard my medication. Should they be lost, stolen or destroyed or if they are used up early, the medication(s) will not be filled under any circumstances.

_____ I agree not to sell, lend or in any way give my medication to another person.

_____ I agree not to drink alcohol or other mood altering drugs while I am taking controlled medications.

_____ I understand that there may be risks associated with the use of controlled medication, including risk of death, respiratory depression, bowel and bladder dysfunction, sexual dysfunction, change of appetite with possible weight gain or loss, change of coordination (which may interfere with driving, operating machinery and fine motor movement) and others.

_____ Additionally, the continuous use of controlled medication may result in dependence, addiction, changes in personality, and sleep changes. I also understand that I will not mix alcohol with controlled medication and I will report any changes in my mental state as well as possible side effects.

_____ I agree to submit to urine drug screens or blood work testing on an as needed basis to monitor for medication complications and compliance with recommended treatment.

_____ I understand that sudden stopping of pain medication can lead to rebound pain, withdrawal symptoms, seizures and other symptoms. I have been informed not to stop any controlled medication suddenly unless decided jointly by myself and my pain doctor.

_____ I agree to allow my physician to review any of my past medical or psychological records.

_____ I agree that when i have any contact with the phoenix neurological & pain institute staff members: medical assistants, physicians, assistants, phone schedulers, etc. That I will not be rude, aggressive, swear or be disruptive.

_____ I agree that I will not use benzodiazepines while undergoing chronic pain management with opioids at phoenix neurological and pain institute. I understand the use of benzodiazepines and other substances/medications is a violation of this contract.

_____ I understand that failure to comply with my provider's treatment plan is a violation of this contract and I may be discharged due to non-compliance. This includes no showing and canceling appointments and surgeries, failure to complete physical therapy and/or sleep studies, etc.

_____ I have read and understand the above information. I agree and understand that non-compliance with the above will result in formal discharge with notification to my physician and other treating physicians.

PATIENT SIGNATURE: _____ **DATE:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

PHARMACY NAME: _____ **PHONE #:** _____

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PHOENICIAN PAIN MANAGEMENT

FINANCIAL POLICIES AND ARRANGEMENTS

We recognize the need for understanding the areas of payment arrangements and insurance filings. This sheet has been put together to address some of these areas for you.

INSURANCE, FILING/BENEFITS/PAYMENT

There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make a co-payment. If you are covered by one of these plans, please show us your card. Be prepared to make your co-payment, or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, Visa, and MasterCard. With plans that we are not contracted with, you will be asked to pay at the time service is rendered.

If we are billing your insurance for you, it is extremely important that you furnish us with accurate and updated information so your claim can be filed. It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Contraception, immunizations, and other services, may not be covered on your particular plan. Services provided that are not a covered benefit are your responsibility and payment is due at the time services are rendered. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for 45 days. If your carrier does not remit payment within 45 days, you will be responsible for the full balance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim, you will continue to receive statements until the account is paid in full.

PAYMENT ARRANGEMENTS

Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit may be rescheduled. Also, we recognize the need to set up payment plans for patients who require extensive treatment. Our business office will be happy to help you with these arrangements.

DELINQUENT ACCOUNTS

Bills that are delinquent for more than ninety (90) days may be transferred to an outside collection agency unless prior arrangements have been made. If you have questions or think an error has been made, please discuss them with us prior to the 90 days in order to help us resolve this.

RETURNED CHECKS

There is a $25.00 service fee for checks returned for insufficient funds. We belong to the Maricopa County Attorney's Check Enforcement Bureau. We request a copy of your driver's license or ID card as identification.

CANCELLATION OF APPOINTMENTS/ NO-SHOW APPOINTMENTS

We ask that you give us 24 hours notice to cancel an appointment. If you do not cancel an appointment, you can be charged $25.00 as this will be considered a no-show. Three no-show appointments are grounds for dismissal from the office.

ADVANCED BENEFICIARY AGREEMENT

Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If payment is denied for services or tests, (i.e. routine exam/lab work, vaccinations, contraception, procedures, and non-related diagnoses for the services provided), then the patient is personally and fully responsible for payment.

Consent for Treatment

I consent to evaluation and treatment of the condition for which I, or my child or dependant, have come to Phoenician Pain Management and authorize the physicians and other health care providers affiliated with Phoenician Pain Center & Phoenician Medical Center group of companies to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by Phoenician Pain. I authorize Phoenician Pain Center to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Phoenician Pain.

Consent for Shared Electronic Medical Records

I understand Phoenician Pain Management shares an electronic medical record system (eclinicalworks) with Phoenician Medical Center Group of Companies. I also understand only the minimum necessary will be viewed by staff members and only for continuation of patient care.

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.

I have read and agree to the above policy of Phoenician Pain Center. I understand the contents and by signing below accept the aforementioned financial responsibilities.

Patient/Guardian’s Signature: _____ Date: _____

Screening & Assessment Form

_____ _____ _____

Name DOB Date

This form is given to all patients wishing to establish care at Phoenician Pain wishing to be seen by one of our Pain Management physicians. Answer every question on this form with complete honesty, to the best of your ability. Clinical treatment will not be based upon these answers alone. All your answers will be held confidentially by our practice.

Please answer the following questions based on the numerical value below:

0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently 4 = Very Often

Do you experience mood swings?	**0 1 2 3 4**
Do you smoke a cigarette shortly after waking up?	**0 1 2 3 4**
How often have any of your family members had any issues of addiction or abuse to any alcohol or drugs?	**0 1 2 3 4**
How often have any of your friends had any issues of addiction or abuse to any alcohol or drugs?	**0 1 2 3 4**
Do others mention that you may have an issue with alcohol or drug abuse?	**0 1 2 3 4**
Do you attend any Alcoholic Anonymous or other addiction support meetings?	**0 1 2 3 4**
How often do you see a Psychologist or Psychiatrist?	**0 1 2 3 4**
Have you taken any medication other than the way it was prescribed?	**0 1 2 3 4**
Have you ever been treated for an alcohol or drug abuse problem?	**0 1 2 3 4**
Have you ever had your medication(s) go missing, be lost or stolen?	**0 1 2 3 4**
Have others ever told you they are concerned with your medication(s)?	**0 1 2 3 4**
Do you ever have a craving for your medication(s)?	**0 1 2 3 4**
Have you been asked to give a urine or blood screen for substance abuse?	**0 1 2 3 4**
How often have you used illicit substances (marijuana, cocaine, etc.) in the past five years?	**0 1 2 3 4**
Have you ever had any legal problems or been arrested?	**0 1 2 3 4**

NOTICE OF HEALTH INFORMATION 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 see the receptionist to request a copy.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information

X

_____

- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
3. **Notification** – We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. **Communication With Family** - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
5. **Research** - We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
6. **Funeral Directors** – We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
8. **Marketing** – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
9. **Food and Drug Administration (FDA)** – We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.
10. **Workers' Compensation** – We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
11. **Public Health** – As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
12. **Law Enforcement** – We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice is effective as of 1/1/2010 and will remain in effect until revised.

Rights of the Patient: *Effective 8/15/2016*

You have the right to be treated with dignity, respect and consideration and you will not be subjected to:

* ABUSE * NEGLECT * EXPLOITATION * COERCION * MANIPULATION * SEXUAL Abuse or Assault
* RESTRAINT OR SECLUSION (except as allowed in R9-10-1012(B).
* RETALIATION for submitting a complaint to our office, The AZDHS or any other entity.
* Misappropriation of personal or private property by a staff member, volunteer or student

You or your representative:

- Except in an emergency, either consents to or refuses treatment
- May refuse or withdraw consent for treatment before treatment is initiated
- Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of proposed psychotropic medication or surgical procedure
- Is informed of our policy on Healthcare directives
- Is informed on the patient complaint process. (See “License Posting Notice”)
- To consent to a photograph before being photographed.
- Except as otherwise permitted by law, provides written consent to the release of information in the patient’s medical record or financial records.

You have the right:

- Not to be discriminated against based on Race, National origin, Religion, Gender, Sexual orientation, Age, Disability, Marital Status or Diagnosis
- To receive treatment that supports & respects your individuality, choices, strengths and abilities
- To receive privacy in treatment and care for personal needs
- To review upon written request, your own medical record according to A.R.S 12-2293, 12-2294 & 12-2294.01
- To receive a referral to another healthcare institution if our office is not authorized or not able to provide care needed by you the patient.
- To participate or have your representative participate in the development of or decisions concerning treatment
- To participate or refuse to participate in research or experimental treatment
- To receive assistance from a family member, your representative or other individual in understanding, protecting or exercising your rights.

Responsibilities of the Patient:

- To provide accurate and complete information concerning your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
- To report perceived risks in your care and unexpected changes in you condition to your provider
- To ask questions if you do not understand what you have been told about your care or what you are expected to do
- To follow the treatment plan established by your provider, including the instructions of support staff as they carry out the providers orders
- To keep appointments and for notifying the office when you are unable to do so.
- For your actions should you refuse treatment or not follow your providers orders.
- To assure that the financial obligations of your medical care are fulfilled as promptly as possible.
- For being considerate of the rights of other patients and office staff & respectful of your personal property and that of other persons in the office.
- To have a surrogate decision maker identified if you are unable to make decisions about care, treatment or services.
- To involve the family in care, treatment and services with permission from you or your surrogate decision maker.

_____ _____

Signature Date

Phoenician Medical Center
"Quality Healthcare Begins with Us"

PHOENICIAN PAIN MANAGEMENT

AUTHORIZATION FOR RELEASE OF RECORDS

IN ORDER TO RELEASE OR OBTAIN YOUR RECORDS, ALL OF THE FOLLOWING INFORMATION MUST BE OBTAINED. IF ANY INFORMATION IS LEFT BLANK, YOUR REQUEST WILL NOT BE PROCESSED.

Patient Name: _____ Date of Birth: _____

Address: _____

Social Security # _____ Phone # _____

ARE YOU TRANSFERRING OUT OF OUR FACILITY? ☐ YES ☐ NO

If yes, the reason for leaving practice: _____

I AUTHORIZE Phoenix Neurological & Pain Institute To: **If releasing records to self, charges will apply**

☐ OBTAIN My Records from ☐ RELEASE My Records to

FACILITY NAME: _____ DR'S NAME_____

ADDRESS: _____

CITY: _____STATE:_____ZIP:_____

PHONE (_____) _____-_____ FAX (_____) _____-_____

I HEREBY CONSENT TO THE RELEASE OF ALL MEDICAL RECORDS AND OTHER DOCUMENTATION PERTAINING TO THE MEDICAL CARE RECEIVED IN THIS FACILITY, INCLUDING THE FOLLOWING:

☐ ALL TREATMENT * ☐ LAB REPORTS/X-RAY REPORTS

☐ TREATMENT RELATED TO SPECIFIC INJURY OR ILLNESS _____

☐ BEGINNING AND ENDING DATES OF TREATMENT _____ TO: _____

**I UNDERSTAND THAT I AM ONLY OBTAINING THE RECORDS PRODUCED BY THIS FACILITY AND NOT THE RECORDS THAT WERE FORWARDED FROM ANY PREVIOUS PRIMARY CARE PHYSICIANS, I SPECIFICALLY CONSENT TO THE RELEASE OF ANY INFO CONTAINED IN THE MEDICAL RECORDS, WHICH MAY RELATE TO THE INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV), AIDS OR RELATED CONDITIONS, AS WELL AS INFORMATION REGARDED AS CONFIDENTIAL. ** I UNDERSTAND THAT Phoenician Pain Center HAS NO RESPONSIBILITY FOR THE USE OR DISTRIBUTION OF THIS INFORMATION BY THE PARTY TO WHOM IT IS RELEASED.I RELEASE PHOENICIAN PAIN CENTER FROM ALL LIABILITY WHICH COULD ARISE FROM THE COMPLIANCE WITH THIS REQUEST TO RELEASE RECORDS. I AUTHORIZE PHOENICIAN PAIN CENTER TO TRANSMIT THIS INFORMATION BY FACSIMILE TRANSMISSION (FAX) AND/OR MAIL AND RELEASE PHOENICIAN PAIN CENTER FROM ANY LIABILITY FOR POTENTIAL BREACH OF CONFIDENTIALITY DUE TO MISDIRECTION OF TRANSMISSION OR FAILURE TO RECEIVE TRANSMISSION OF MY RECORDS.

PATIENT SIGNATURE: _____DATE:_____