Patient Name_________________________________DOB__________

CONSENTS, BILLING AND POLICY INFORMATION

Patient Information

Your Name ______________________________ Preferred Name: ______________

Social Security Number ______________________________ Date of Birth ____________ Age

Street Address ______________________________ Height ____________ Weight (lbs)

City/State/Zip ______________________________ Gender ❑Male ❑Female

Physical Address Same as Mailing? ❑Yes ❑No If Not, ______________________

Preferred Phone ______________________________ ❑Home ❑Mobile ❑Work

Secondary Phone ______________________________ ❑Home ❑Mobile ❑Work

Email ______________________________ Driver License #/State ______________

Emergency Contact Name ______________________________ Phone __________ Relationship __________

Race ❑American Indian or Alaskan Native ❑Asian or Pacific Islander ❑Black ❑White ❑Refuse to Report

Ethnicity ❑Hispanic ❑Non-Hispanic ❑Refuse to Report Primary Language ❑English ❑Spanish ❑ Other

Referral

Who is your Primary Care Provider? ______________________________

Were you referred to our clinic by another physician? If so, whom ______________________________

If not, how did you hear about us? ❑Insurance Company ❑Family ❑Friend

❑www.IPCAZ.ORG ❑Facebook ❑Twitter ❑YouTube ❑Other Website ______________________

Preferred Pharmacy

Pharmacy Name ______________________________ Phone Number ______________

Street Address ______________________________ City/State/Zip ______________

Primary Insurance Plan

Payer (e.g. BCBS) ______________________________ Plan ______________

Policy/I.D. Number ______________________________ Group Number ______________

Complete this box if you are not the policy holder for your primary insurance

Insurance policy holder ❑Self ❑Spouse ❑Child ❑Other

Policy Holder Name ______________________________ Policy Holder Gender ❑Female ❑Male Date of Birth ______________________________ Social Security Number

Payer (e.g. BCBS) ______________________________ Plan ______________

Policy/I.D. Number ______________________________ Group Number ______________

Complete this box if you are not the policy holder for your primary insurance

Insurance policy holder ❑Self ❑Spouse ❑Child ❑Other ______________

Policy Holder Name ______________________________ Policy Holder Gender ❑Female ❑Male

Date of Birth ______________________________ Social Security Number ______________

Patient Name_____________________________________DOB___________

CONSENTS, BILLING AND POLICY INFORMATION

Patient Communication Directive

Disclosures We Can Make Without Your Written Authorization

If in our professional judgment, we consider that you are a danger to yourself, another person, or we find you are unable to make decisions regarding your medical care we may disclose to a family member, other relative, or any other person you identify, Protected Health Information (PHI) relevant to that person's involvement in your protection, the protection of another, or your medical care. We may also disclose relevant PHI to a family member, other relative, or any other person you identify to obtain payment for such care.

Employers We may release PHI about you to your employer if we provide health care services to you at the request of your employer. The services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury.

Deceased Persons We may disclose PHI to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties.

Disclosures Requiring Patient Authorization

Family member(s) and/or other individual(s) designated below will have access to your PHI. Such information may include but is not limited to medical care, medications, and billing information. This does not include copies of medical records. This authorization will be in effect until notified by the patient.

Name ______________________________ Relationship ____________________ Date

Name ______________________________ Relationship ____________________ Date

Name ______________________________ Relationship ____________________ Date

Please list any restrictions regarding release of information:

____

____

X

____ ____________________

Signature of patient or Responsible Party Date

Patient Name_____________________________________DOB___________

CONSENTS, BILLING AND POLICY INFORMATION

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Integrative Pain Center of Arizona and any associates, assistant, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Integrative Pain Center of Arizona to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Integrative Pain Center of Arizona's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Integrative Pain Center of Arizona to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Integrative Pain Center of Arizona to release any information required in obtaining procedure authorization of the processing of any insurance claims. I understand that Integrative Pain Center of Arizona will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to Ameritox Labs my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to Ameritox Labs. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financial responsible for all charges whether or not they are covered by my insurance. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

X Signed ____ Date

Parent/Guardian Name (if under 18)

Patient Name_______________________________________DOB____________

CONSENTS, BILLING AND POLICY INFORMATION

Payment and Appointment Policy

Copayments / Coinsurance / Deductible: Copayments, coinsurance, and deductibles for clinic visits and procedures are due at the time of service. If you are unable to make your copayment at the time of service, Integrative Pain Center of Arizona reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

Late Arrivals and Missed Appointments: If you are more than 15 minutes late your appointment may be rescheduled. You are asked to "check-in" 15 minutes prior to your appointment and will be considered late if it is not within that time frame.

If you are a "no-show" for your appointment, or do not cancel your appointment within 24 hours, you will be responsible for a $50 fee. Missed appointments are subject to a $50 charge. These charges are your responsibility and will not be billed to any insurance carrier.

I understand and agree to the Payment and Appointment Policy.

X ____

Patient or legally authorized individual signature
Date

Acknowledgement of Receipt of

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

X ____

Patient or legally authorized individual signature Date

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company ________________________________ Adjuster Name

Phone Number ________________________________ Fax Number

Claim Number ________________________________ Date of Initial Injury

Complete this section only if your visit today is related to a Motor Vehicle Accident

Insurance Company ________________________________ Adjuster Name

Phone Number ________________________________ Fax Number

Claim Number ________________________________ Date of Initial Injury