Patient Information

Acct #:_____ Date:_____

PATIENT INFORMATION

PATIENT NAME Last First M.I.		SOCIAL SECURITY NUMBER	
ADDRESS Street		DATE OF BIRTH	SEX ☐ Female ☐ Male
City State Zip	HOME PHONE NO.	CELL PHONE NO.	WORK PHONE NO.
E-MAIL		MARITAL STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed	

PREFERRED METHOD OF CONTACT ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Fax ☐ E-Mail

RACE ☐African American ☐Asian ☐Hispanic ☐Caucasian ☐Filipino ☐Native American ☐Native Hawaiian ☐Pacific Islander ☐Other

ETHNICITY ☐Hispanic ☐Non-Hispanic

PREFERRED LANGUAGE

2ND/SEASONAL ADDRESS Street City State Zip

EMPLOYER	PATIENTS OCCUPATION
EMPLOYER ADDRESS Street City State Zip	
PHARMACY NAME	PHARMACY PHONE NO.

HOW DID YOU HEAR ABOUT US? ☐Community Event ☐ Patient/ Friend/ Family ☐Employer ☐High School/Sport ☐Hospital/Urgent Care ☐Insurance ☐Magazine or Newspaper ☐Physician ☐Radio or Television ☐Website or Online

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.

If patient is child please indicate if parents are : ☐ Married ☐ Separated ☐ Divorced

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	HOME PHONE NO.
EMPLOYER	EMPLOYER PHONE NO.
EMPLOYER ADDRESS: Street City State Zip	

If this is a job related injury, is this the employer you were working for at the time of injury? ☐ Yes ☐ No

If due to an injury, date of loss: _____/_____/_____ First symptoms: _____

Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: _____

Is injury related to: ☐ Accident ☐ Auto Accident ☐ Job Related ☐ Other: _____

If job related: Claim # _____ Case Manager: _____ Phone No.: _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE
ADDRESS Street City State Zip		

INSURANCE INFORMATION

Primary Insurance		**Secondary Insurance**	
Insurance Name:		Insurance Name:	
Policy/ID #:		Policy/ID #:	
Group/Account #:		Group/Account #:	
Cardholders Name:		Cardholders Name:	
DOB:		DOB:	
Social Security #:		Social Security #:	
Relation to Patient:		Relation to Patient:	

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Gilbert Physical Medicine contracts with many insurance companies, it is my responsibility to verify with my plan that Gilbert Physical Medicine is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Gilbert Physical Medicine will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Gilbert Physical Medicine to submit insurance claim forms a long with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines.

Patient Signature: Date:

Last Revision Date: 8/15/19

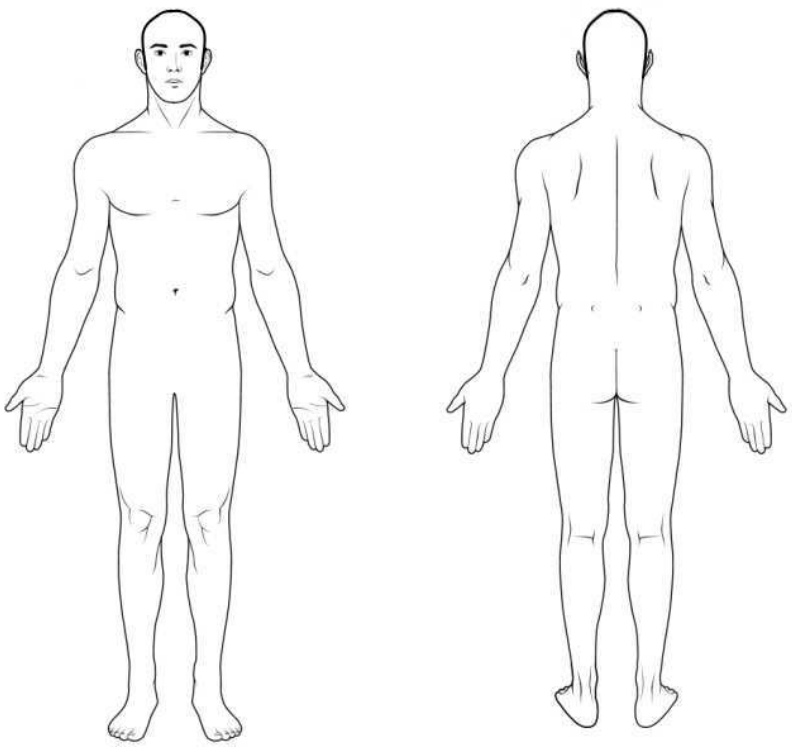
Pain Diagram

Acct #:_____ **Date:**_____

Patient Name: _____ Date: _____

Using the appropriate symbol, mark the area(s) on your body where you feel each of the following sensations:

Numbness	Pins and Needles	Burning	Aching	Stabbing
----------	oooooooooooooo	^^^^^^^	XXXXXX	ϕϕϕϕϕϕ



R L L R

The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling at this time.

| ———————————————————————— |

No Pain Worst Pain Ever

• ———————————————————————— •

All Back/Neck Back/Neck Equals Arm/Leg All Arm/Leg

Medical History

Acct #:_____ **Date:**_____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____

E-Mail: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Clinic/Practice Name: _____

Reason for Visit: _____

Which body part(s) is/are involved?

Neck: ☐ Arm: ☐ R ☐ L Shoulder: ☐ R ☐ L

Back: ☐ Leg: ☐ R ☐ L Knee: ☐ R ☐ L

Face/Head: ☐ Hip: ☐ R ☐ L Other: ☐ _____

Does your back pain radiate into your leg? ☐ Left ☐ Right ☐ Neither Which is more painful? ☐ Back ☐ Leg ☐ Equal

Does your neck pain radiate into your arm? ☐ Left ☐ Right ☐ Neither Which is more painful? ☐ Neck ☐ Arm ☐ Equal

How long have you had this pain? _____ Have you had this pain before? ☐ No ☐ Yes How long ago? _____

Was there any injury or accident? ☐ No ☐ Yes Explain: _____

How would you describe the pain? ☐ Dull / Aching ☐ Sharp/Stabbing ☐ Throbbing ☐ Tightness ☐ Burning

☐ Other: _____

How often does the pain occur? ☐ Changes in severity but always present ☐ Intermittent (comes and goes, sometimes no pain)

My pain symptoms are: ☐ Improving ☐ Getting worse ☐ Staying the same

PAIN LEVEL – Numerical Rating Scale (0 to 10)

Current pain level:	***No Pain-***	☐*0*	☐*1*	☐*2*	☐*3*	☐*4*	☐*5*	☐*6*	☐*7*	☐*8*	☐*9*	☐*10 -**Worst***
Lowest level in past week:	***No Pain-***	☐*0*	☐*1*	☐*2*	☐*3*	☐*4*	☐*5*	☐*6*	☐*7*	☐*8*	☐*9*	☐*10 -**Worst***
Highest level in past week:	***No Pain-***	☐*0*	☐*1*	☐*2*	☐*3*	☐*4*	☐*5*	☐*6*	☐*7*	☐*8*	☐*9*	☐*10 -**Worst***
How severe is your low back pain?	***No Pain-***	☐*0*	☐*1*	☐*2*	☐*3*	☐*4*	☐*5*	☐*6*	☐*7*	☐*8*	☐*9*	☐*10 -**Worst***
How severe is your leg pain?	***No Pain-***	☐*0*	☐*1*	☐*2*	☐*3*	☐*4*	☐*5*	☐*6*	☐*7*	☐*8*	☐*9*	☐*10 -**Worst***
How severe is your neck pain?	***No Pain-***	☐*0*	☐*1*	☐*2*	☐*3*	☐*4*	☐*5*	☐*6*	☐*7*	☐*8*	☐*9*	☐*10 -**Worst***
How severe is your arm pain?	***No Pain-***	☐*0*	☐*1*	☐*2*	☐*3*	☐*4*	☐*5*	☐*6*	☐*7*	☐*8*	☐*9*	☐*10 -**Worst***

ACTIONS AFFECTING PAIN LEVEL

*If you have **LOW BACK** pain, please address the following activities (otherwise, skip this section):*

	WORSE	BETTER	NO EFFECT	REMARKS
Bending forward	☐	☐	☐	
Leaning back	☐	☐	☐	
Sitting	☐	☐	☐	
Standing	☐	☐	☐	
Walking	☐	☐	☐	
Physical Activity	☐	☐	☐	
Rest	☐	☐	☐	
Lying flat	☐	☐	☐	
Lying with hips and knees bent	☐	☐	☐	
Rising out of bed/chair	☐	☐	☐	
Coughing/Sneezing	☐	☐	☐	

Other: _____

What activities are the most bothersome? _____

What helps the most to improve your pain? _____

Gilbert Physical Medicine

Medical History

Acct #:_____ **Date:**_____

ACTIONS AFFECTING PAIN LEVEL

If you have NECK pain, please address the following activities (otherwise, skip this section):

	WORSE	BETTER	NO EFFECT	REMARKS
Looking down towards ground	☐	☐	☐	
Looking up towards ceiling	☐	☐	☐	
Turning head left or right	☐	☐	☐	
Computer or watching TV	☐	☐	☐	
Coughing / Sneezing	☐	☐	☐	
Driving	☐	☐	☐	
Overhead activities (with arms)	☐	☐	☐	

Other: _____

What activities are the most bothersome? _____

What helps the most to improve your pain? _____

*If you have **PAIN ANYWHERE ELSE**, please fill out this section (otherwise, skip this section):*

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

ASSOCIATED SYMPTOMS

Do you have any of the following symptoms? And, if so, please describe:

	NO	YES	REMARKS
Numbness / tingling	☐	☐	Where?
Weakness in the arm or leg	☐	☐	Describe:
Bladder incontinence	☐	☐	If yes, is this a change from previously? ☐ No ☐ Yes
Bowel incontinence	☐	☐	If yes, is this a change from previously? ☐ No ☐ Yes
Joint swelling or stiffness	☐	☐	Which joints?
Sleep interrupted by pain	☐	☐	
Headaches	☐	☐	
Fever or chills	☐	☐	

Activities or hobbies limited due to pain: _____

Do your legs tire/hurt if you walk too far? ☐ No ☐ Yes If yes, how far can you walk? ☐ Less than 1 block ☐ 1-3 blocks ☐ More than 3 blocks

Which of the following relieves your leg pain when walking? ☐ Leaning forward on a cart ☐ Sitting ☐ Stopping and standing without sitting ☐ Nothing

Do you exercise regularly? ☐ No ☐ Yes How often? _____ times per week Type of exercise: _____

Do you use a walking aid, wheelchair, other assistive device? ☐ No ☐ Yes Specify: _____

For your current back or neck pain, please mark the boxes for the timeframe that any tests were done?

☐ X-Ray	☐ <6 mo	☐ <12 mo
☐ MRI	☐ <6 mo	☐ <12 mo
☐ CT Scan	☐ <6 mo	☐ <12 mo
☐ Myelogram	☐ <6 mo	☐ <12 mo
☐ Discogram	☐ <6 mo	☐ <12 mo
☐ EMG/NCV (nerve test)	☐ <6 mo	☐ <12 mo

Gilbert Physical Medicine

Medical History

Acct #:_____ **Date:**_____

PRIOR TREATMENTS

Please **ONLY** mark the type of treatment(s) that you have had in the past and how well they worked, **OTHERWISE LEAVE BLANK**:

Injections	☐ Better	☐ Worse	☐ No Change	Type:
Physical Therapy	☐ Better	☐ Worse	☐ No Change	How recently?
Surgery (back/neck)	☐ Better	☐ Worse	☐ No Change	Type of surgery and year?
TENS unit	☐ Better	☐ Worse	☐ No Change	
Heat / Ice	☐ Better	☐ Worse	☐ No Change	
Chiropractor	☐ Better	☐ Worse	☐ No Change	
Acupuncture	☐ Better	☐ Worse	☐ No Change	
Massage	☐ Better	☐ Worse	☐ No Change	
Psychology	☐ Better	☐ Worse	☐ No Change	

PAST MEDICAL HISTORY

Do you have a history of any of the following?

Depression ☐ No ☐ Yes	High blood pressure ☐ No ☐ Yes	Rheumatoid arthritis ☐ No ☐ Yes	1
Attention deficit disorder ☐ No ☐ Yes	Diabetes ☐ No ☐ Yes	Gout ☐ No ☐ Yes	2
Obsessive compulsive disorder ☐ No ☐ Yes	Heart attack/disease ☐ No ☐ Yes	Peptic ulcer disease ☐ No ☐ Yes	2
Schizophrenia or bipolar ☐ No ☐ Yes	Osteoporosis ☐ No ☐ Yes	Stroke ☐ No ☐ Yes	2
Abused during childhood ☐ No ☐ Yes	Cancer ☐ No ☐ Yes	Kidney or liver disease ☐ No ☐ Yes	3 0
Hepatitis (A B C) ☐ No ☐ Yes	HIV or AIDS ☐ No ☐ Yes	Hypothyroidism ☐ No ☐ Yes	

Other past medical history:

PAST OPERATIONS/HOSPITALIZATIONS

Have you had any surgery for a problem in this same body area either recently or in the past? ☐ No ☐ Yes

Please list any operations or hospitalizations you have had, the year, surgeon and city they took place.

TYPE	YEAR	SURGEON	CITY

Have you or a family member had a reaction to anesthesia? ☐ No ☐ Yes If yes, describe:

ALLERGIES

Do you have any history of an allergic reaction to medications or other substances?

☐ No known allergies ☐ Yes, specify: _____

Have you ever had an allergic reaction to: ☐ Iodine? ☐ Contrast? ☐ Latex? ☐ Dental Numbing Medications?

PRESENT MEDICATIONS

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

☐ Coumadin/Warfarin ☐ Aspirin ☐ Plavix ☐ Aggrenox ☐ Ticlid ☐ Brilinta

Medical History

Acct #:_____ **Date:**_____

NAME OF MEDICATION	DOSE (include strength and	NAME OF MEDICATION	DOSE (include strength and
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

If you need additional room, please provide a list.

PRIOR MEDICATIONS

Please **ONLY** indicate which medications you have used in the past for your current pain condition **(OTHERWISE LEAVE BLANK):**

ANTI-INFLAMMATORY	Helped?	**NARCOTICS / OPIOIDS**	Helped?	**NERVE MEDICATIONS**	Helped?
☐ Naproxen (aleve)	☐ No ☐ Yes	☐ Hydrocodone (Vicodin)	☐ No ☐ Yes	☐ Gabapentin neurontin	☐ No ☐ Yes
☐ Ibuprofen (advil, motrin)	☐ No ☐ Yes	☐ Tylenol with codeine	☐ No ☐ Yes	☐ Lyrica	☐ No ☐ Yes
☐ Diclofenac (voltaren)	☐ No ☐ Yes	☐ Oxycodone (Percocet)	☐ No ☐ Yes	☐ Amitriptyline (elavil)	☐ No ☐ Yes
☐ Tylenol (acetaminophen)	☐ No ☐ Yes	☐ Oxycontin	☐ No ☐ Yes	☐ Nortriptyline	☐ No ☐ Yes
☐ Celebrex	☐ No ☐ Yes	☐ Morphine, MS Contin	☐ No ☐ Yes	☐ Cymbalta	☐ No ☐ Yes
☐ Flector patch	☐ No ☐ Yes	☐ Hydromorphone (dilaudid)	☐ No ☐ Yes	☐ Effexor	☐ No ☐ Yes
MUSCLE RELAXANTS	Helped?	☐ Tramadol	☐ No ☐ Yes	☐ Savella	☐ No ☐ Yes
☐ Carisoprodol (soma)	☐ No ☐ Yes	☐ Nucynta (tapentadol)	☐ No ☐ Yes	☐ Lidoderm patch	☐ No ☐ Yes
☐ Cyclobenzaprine (flexeril)	☐ No ☐ Yes	☐ Fentanyl patch	☐ No ☐ Yes		
☐ Skelaxin (Metaxolone)	☐ No ☐ Yes	☐ Methadone	☐ No ☐ Yes		
☐ Methocarbamol (robaxin)	☐ No ☐ Yes	☐ Opana	☐ No ☐ Yes		
☐ Tizanidine (zanaflex)	☐ No ☐ Yes	☐ Suboxone	☐ No ☐ Yes		

SOCIAL HISTORY

Occupation: _____ When was the last time you worked? _____

☐ Restricted or Light-duty ☐ Temporary disability ☐ Permanent disability ☐ Retired ☐ Unemployed/Seeking job

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco: ☐ No ☐ Yes How many packs per day? _____ How many years? _____ ☐ Quit _____ years ago

Alcohol: ☐ No ☐ Yes How much do you drink daily? _____ ☐ Quit _____ years ago

Have you ever drank heavily or abused alcohol? ☐ No ☐ Yes

Illicit Drugs: Have you ever used any illicit substances? ☐ No ☐ Yes Type: _____

Have you ever been addicted to or misused prescription drugs? ☐ No ☐ Yes Type: _____

Medical Marijuana: ☐ No ☐ Yes Physician who issued medical marijuana card: _____

FAMILY HISTORY:

Is there a family history of any of the following? ☐ check here if unknown

Alcohol Abuse	☐No ☐Yes	Diabetes	☐No ☐Yes	Stroke	☐No ☐Yes
Illegal Drug Use	☐No ☐Yes	Heart disease	☐No ☐Yes	Cancer	☐No ☐Yes, type:
Prescription Drug Abuse	☐No ☐Yes	Hypertension	☐No ☐Yes	Other:	

Gilbert Physical Medicine

Medical History

Acct #:_____ **Date:**_____

REVIEW OF SYSTEMS:

Are currently experiencing any of the following symptoms?

GENERAL:

Loss of appetite	☐ No	☐ Yes
Recent weight loss	☐ No	☐ Yes
Fever or chills	☐ No	☐ Yes

RESPIRATORY:

Shortness of breath	☐ No	☐ Yes
Chronic cough	☐ No	☐ Yes

KIDNEY/BLADDER/URINE:

Painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Kidney problems	☐ No	☐ Yes

GASTROINTESTINAL:

Nausea or vomiting	☐ No	☐ Yes
Blood in stool	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Constipation	☐ No	☐ Yes

NEUROLOGICAL

Headaches	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes

HEMATOLOGICAL/LYMPHATIC:

Easy bruising	☐ No	☐ Yes
Easy bleeding	☐ No	☐ Yes

ENDOCRINE:

Thyroid disease	☐ No	☐ Yes
Heat/Cold intolerance	☐ No	☐ Yes

CARDIOVASCULAR:

Chest pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes

EYES:

Blurred vision	☐ No	☐ Yes
Double vision	☐ No	☐ Yes
Loss of vision	☐ No	☐ Yes

SKIN:

Frequent Rashes	☐ No	☐ Yes
Skin ulcers	☐ No	☐ Yes
Lumps	☐ No	☐ Yes

HEAD/EARS/NOSE/THROAT:

Hoarseness	☐ No	☐ Yes
Trouble swallowing	☐ No	☐ Yes
Hearing loss	☐ No	☐ Yes

PSYCHIATRIC:

Depression	☐ No	☐ Yes
Drug/Alcohol addiction	☐ No	☐ Yes
Suicidal Thoughts	☐ No	☐ Yes

REVIEW OF SYSTEMS:

Have we failed to ask anything that you believe is important for us to know?

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name: _____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Reviewed By: _____ **Date:** _____

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.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. We will post any revised notice in a prominent location in our office and, upon request, will provide to you a copy of the revised notice.

Uses and Disclosures of Your Protected Health Information

- **Treatment**. We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. We may also disclose your protected health information to other healthcare providers who may be treating you or involved in your healthcare. For example – we may disclose your protected health information to a specialist involved in your treatment.
- **Payment**. We may use and disclose your protected health information to obtain payment for the healthcare services we provide you or to determine whether we may obtain payment for services we recommend for you. We may also disclose your protected health information to another healthcare provider, healthcare clearinghouse or health plan for their payment activities. For example – we may include with a bill to third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.
- **Healthcare Operations**. We may use and disclose your protected health information to support our business activities. For example – we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may disclose your protected health information for certain healthcare operations of another healthcare provider, healthcare clearinghouse, health plan for certain healthcare operations, and to an "organized healthcare arrangement" we participate in for its healthcare operations. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.
- **Facility Directory**. Unless you object, we may use and disclose in our facility directory your name, location in the facility, general condition and religious affiliation. All of this information, except for your religious affiliation, will be disclosed to persons who ask for you by name. Information in the facility directory may be shared with clergy.
- **Persons Involved in Your Care**. We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Notification**. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.
- **Disaster Relief**. We may use and disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.
- **Research**. We may use and disclose your protected health information to researchers whose 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. We may also disclose to certain third parties a limited data set containing your protected health information for research purposes.
- **Reminders.** We may use and disclose your protected health information to contact you about upcoming appointments and tests and orders, including appointment reminders, missed appointment notifications and updates regarding tests or orders my provider requests. These reminders may be communicated by using the following methods: text message, email and telephone.
- **As Required by Law**. We may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.
- **Public Health**. We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury or disability. If directed by the public health authority, we may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.
- **Abuse or Neglect**. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If we believe you are a victim of abuse, neglect or domestic violence, we also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.
- **Communicable Diseases**. If authorized by law, we may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.
- **Legal Proceedings**. We may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement**. If certain legal requirements are met, we may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes; identification and location of suspects, fugitives, material witnesses or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.
- **Coroners, Funeral Directors, and Organ Donation**. We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out her duties or in reasonable anticipation of death. Finally, we may use or disclose your protected health information for facilitating organ, eye or tissue donation and transplantation.

- **To Avert a Serious Threat to Public Health or Safety**. Consistent with applicable laws, if we believe using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; we may use and disclose your protected health information. We may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.
- **Military Activity and National Security**. When the appropriate conditions apply, we may use or disclose your protected health information: (1) for activities deemed necessary by appropriate military command authorities; (2) for determining your eligibility for benefits by the Department of Veterans Affairs; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- **Workers' Compensation**. We may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Department of Health and Human Services**. As required by law, we may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws.
- **Written Authorization**. Except as stated in this notice, we will not use or disclose your protected health information without your written authorization. You may revoke this authorization at any time, in writing, except to the extent that we have used or disclosed your information in reliance on the authorization.
- **Food and Drug Administration**. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.
- **Inmates**. We may use and disclose your protected health information if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

Your Health Information Rights

- **Copy of This Notice**. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
- **Inspect and Copy**. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer at 725 W Elliot Rd#115 Gilbert, Az 85233 . We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice sites. If the information is stored off-site, we have up to 60 days to respond, but must inform you of this delay.
- **Request Amendment**. You have the right to request that we amend your protected health information. You must make this request in writing to our Privacy Officer. The request must state the reason for the amendment. We may deny your request if it is not in writing or does not state the reason for the amendment. We may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.
- **Request Restrictions**. You have the right to request a restriction or limitation of how we use or disclose your protected health information for treatment, payment, or healthcare operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although we are not required to agree to your requested restriction, if we do agree, we will comply with your request unless the information is needed for emergency treatment. Please contact our Privacy Officer as set forth in this notice to request a restriction.
- **Accounting of Disclosures.** You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or healthcare operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12- months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.
- **Request Confidential Communications**. You have the right to request how we communicate with you to preserve your privacy. We may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our Privacy Officer. The request must specify how or where we are to contact you. We will accommodate all reasonable requests.
- **File a Complaint**. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our Privacy Officer must be in writing. We will not retaliate against you for filing a complaint.

For More Information. If you have questions or would like additional information, you may contact our Privacy Officer at 480-545-0000

Gilbert Physical Medicine

Patient Informed Consent

When a person seeks health care and we accept a patient for such care, it is essential for both parties to work towards the same objectives. It is important that each party understand both the objectives and the method(s) that will be used to accomplish the goals set forth. This document is meant to summarize services available and obtain your written consent for evaluation, testing, treatment, and/or referral.

Patient Messaging & Communications: **Initial: _____**

By supplying my phone number(s), email, and any other personal contact information, I authorize my health providers to employ third-party automated outreach and messaging to use my personal information, provider name, the time and date of scheduled appointments, and other limited information for the purpose of notifying me of pending appointments, balances, diagnostic results, or other communications. I also authorize my health care providers to disclose limited protected health information (PHI) regarding healthcare events.

Preferred Method of Contact: ☐Phone ☐Text ☐Email

Who would you like us to share information with: ☐N/A ☐_____

Examination, Therapies, and Chiropractic: **Initial: _____**

During the course of routine *examinations* some tests may be provocative in nature and cause exacerbations of existing conditions. X-ray exposure carries risk of radiation and cancers. Various *therapies* like electrical stimulation, mechanical muscle therapies, cold laser, and traction are intended to reduce pain, stimulate circulation, ease muscle tension/spasms, and accelerate healing time. Some of the following risks may be associated: Soreness in the area, electric shock, mild burns, bruising, or eye damage. *Chiropractic* has been proven safe and effective, however, it is not unusual to be sore especially after the first few visits. Although rare, it is possible to suffer from side effects such as muscle spasms, stiffness, rib fracture, headache, dizziness, and stroke.

Injection Therapies (Trigger points, Joints, Tendons, Ligaments): **Initial: _____**

These are local injections used to treat muscle pain, spasms, knots, and joint pain. Lidocaine is usually an ingredient added to help relieve pain. Other medications may be added such as homeopathics, enzymes, and/or corticosteroids. These injections are typically therapeutic, but are also diagnostic. The medications used can help decrease pain and restore normal function and motion. I understand and accept the most likely risks and complications of injections, which include but are not limited to: Infection, Needle Breakage, Numbness, Trauma to Nerves, Pneumothorax/Collapsed Lung,Vasovagal Reaction (fainting), Soft Tissue Swelling, Bruising or Hematoma Formation.

Gilbert Physical Medicine

Patient Informed Consent

Sphenopalatine Ganglion Nerve Block (SPG): **Initial: _____**

This treatment is to disrupt and break the cycle of headaches and migraines. It consists of a series of treatments to be determine by your provider to desensitize the nerve bundle associated with chronic headaches and migraines. Bupivacaine is the medication most commonly used. Inform your provider if you have a deviated septum, use any inhaled drugs, have had nasal congestion longer that 10 days, fever, or any bleeding disorders. Rare, but possible side effects include allergic reaction, nasal irritation or bleeding.

Pregnancy Release:

This is to certify that to the best of my knowledge, I am not pregnant and the provider(s) and associates have my permission to perform x-ray evaluation if clinically indicated.

Signature: _____

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____ have been explained, read, and fully understand the tests and/or treatments and hereby grant permission for my child to receive the recommended care.

Signature: _____

I, _____, give consent for the doctors, assistants, and clinic staff to evaluate and treat as medically necessary. I have been explained the recommended treatments, side effects, and options and do hereby consent to care.

_____ _____

Patient Signature Date

Gilbert Physical Medicine

Patient Informed Consent

Medical Department: (Please initial next to each item below)

_____ I understand that there is a $25 charge for medical appointments without a 24 hour advance notice for any appointment with the Medical Doctor, Physician Assistant, or Nurse Practitioner.

_____ I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claims. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct, or updated. Patients are responsible for the payments of copays, co-insurance and deductibles and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for an explanation of any service not covered. Payment is due at the time of service, and for your convenience, we accept cash, check and most major credit cards. Patients may incur, and are responsible for the payment of additional charges at the discretion of Gilbert Physical Medicine. These charges may include, but are not limited to supportive braces, vitamins, supplements, cash services, and special consultations (subject to change at any time).

Miscellaneous:

_____ I understand that there is a $50 charge for forms completion by our Providers, including, but not limited to disability and FMLA forms.

_____ I understand that there is a $35 charge for a returned check. There is a $25 restocking fee for pillows and supports.

Disclosures: A physician must notify a patient that the physician has a direct financial interest in separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27),(I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below goods or services (I/We) have prescribed are available elsewhere on a competitive basis. Diagnostic or treatment agency or non-routine goods and services:

South Mountain Surgical Center
Broadway Surgical Center
Revitalize Health and Wellness
Arizona Pain Solutions

These services are available elsewhere on a competitive basis. Local pain centers and laboratories found on internet search or through your insurance website. I have read, understand, and agree to the provisions of the Patient Financial Responsibility and Disclosure Form.

Printed Patient Name: _____ Date: _____

Signature of Patient: _____ Witness: _____