Date:

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/AKA

Date of Birth | Social Security Number | Gender ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to respond ☐ Non-Binary/Non-conforming

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed | **Language:** (other than English)

Race
☐ Black- Non-Hispanic ☐ White- Non-Hispanic ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Other ☐ Prefer not to respond

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone Cell ☐ Pager ☐ Fax ☐

Email Address | Employment | Active-Duty Military | Employed Full-Time | Not Employed | Student Full-Time | Child | Employed Part-Time | Student Part-Time | Retired | Disabled | Homemaker | Self Employed | Other

Employer | Employer Phone

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | Referring Physician

How did you hear about us? Friend Family Member Event Insurance Website Google Yahoo Radio Television Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ☐ Cell ☐ Pager ☐ Fax

Employer | Employment | Active-Duty Military | Employed Full-Time | Not Employed | Student Full-Time | Child | Employed Part-Time | Student Part-Time | Retired | Disabled | Homemaker | Self Employed | Other

Employer Phone

If Known: How much is your deductible? | How much have you used?

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ☐ Cell ☐ Pager ☐ Fax

IF PATIENT IS A STUDENT

If Patient is of School Age, 15+, it is OK to treat in my Absence

Parent or Guardian Signature:

Assignment of Benefits

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to APR Med Group, LLC, Union Pain Group, LLC, Western Med Group, LLC, Hayden Anesthesia Group, LLC; Western Anesthesia Group, LLC; Union Anesthesia Group, LLC; Gila River Surgical Center, LLC; Lake Pleasant Surgical Center, LLC; Shea Surgical Center, LLC (each dba Arizona Pain Relief) my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above- named provider or their attorneys in order to claim such benefits. I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and statelaws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature:____Date:__________________

Name:____

ARIZONA PAIN RELIEF CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended chiropractic, medical, physical therapy or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your medical team about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Alternative treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you choose to use on of the above noted “alternative treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers of remaining untreated:
If you choose not to move forward with care you acknowledge that any symptoms and diagnoses have the potential of getting worse.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I voluntarily request a chiropractor, and/or physician/mid-level provider (Nurse Practitioner, Physician Assistant), physical therapist and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

I have read [ ] or have read to me [ ] the above explanation of the treatment in our office. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name ____

Patient/Guardian Signature____

Date _________________

ARIZONA PAIN RELIEF
Patient Privacy Notice

[In accordance with the Federal Health Information Portability and Accountability Act of 1996, (H.I.P.A.A.)]

WE CARE ABOUT YOUR PRIVACY

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Arizona Pain Relief we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed via paper or electronically to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you prefer a specific phone number or address be used to attempt to reach you, please note that number or address next to your signature at the end of this form.

*If you are not at home to receive an appointment reminder, a message may be left on your answering machine.

*It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes.

Your signature indicates your authorization of this activity. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you choose not to authorize this information use your decision will have no adverse effect on your care from our doctors or therapists, your relationship with our staff or the reimbursement avenues associated with your care.

You may refuse to sign this Privacy Notice. You may also revoke your authorization at any time. Revocation must be in writing delivered by U.S. Mail Certified Return Receipt Requested to the applicable office's address which can be found online or will be given to you on request. Revocation will not apply to situations where actions have been taken previously relying on the authorization.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences as outlined above.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

This office utilizes an “open”-adjusting and physical therapy environment for ongoing patient care. Open adjusting or physical therapy involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices please contact: Arizona Pain Relief in writing.

This notice is effective as of September 11th, 2018. This notice, and any alterations or amendments made here at Arizona Pain Relief will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________________ ______________________________ ________________
Name (Printed Please) Signature Date

If you are a minor, or if you are being represented by another party

______________________________ ______________________________ ________________
Personal Representative (Printed) Personal Representative Signature Date

____
Description of the authority to act on behalf of the patient.

Arizona Pain Relief Automated Messaging Consent Form

Dear Patient,

The Federal Communications Commission now requires consent to receive automated emails/text messages.
*****Please fill out this form to ensure you continue to receive appointment emails and text messages*****

Arizona Pain Relief utilizes an automated notification service to send you email and text messages to provide you with important information about your upcoming appointments. We will utilize the notification service to notify you of upcoming appointments, rescheduling, and cancellations.

Patient Name (Please Print): ____

Primary Phone Number for Text Messages: (________)_________- ______________

Primary Email Address: ____

By signing this form, you are authorizing Arizona Pain Relief to use an automated system to periodically deliver automated informational emails or text messages to the phone number(s) and email address provided above. Standard message & data rates may apply. If you change your phone number or no longer want to receive automated emails or texts, you agree to inform Arizona Pain Relief immediately. You agree that this consent will remain valid and you will continue to receive automated phone calls until you revoke consent.

Patient Signature:____**Date:** _____________