Pain & Rehab Consultants

Name _____
Last First Middle

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

May we leave a message on your Answering Machine/Voice Mail? YES or NO

Date of Birth __ /____/____ Age_____ Social Security Number _____

Please Circle One: Male Female Marital Status: S M D W

Email Address _____@_____

Pharmacy Name and Location _____

Current Employer Name _____

Employer Address _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____ Cell/Work _____

Referred Physician _____ Phone _____

Primary Insurance _____ Secondary Insurance _____

Please list any names that we may speak with regarding your care: _____

I, _____, hereby authorize Ehab Abdalah, MD to apply for benefits on my behalf for covered services rendered and request that the payments from my insurance company be made directly to Pain & Rehab Consultants or to the party who accepts my assignment. I certify that the information that I have reported with regard to my insurance coverage is correct and I authorize the release of my medical information requested by insurance company when necessary. I, or my insurance company, may revoke in writing this authorization. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for my medical services provided when a statement is rendered.

Signature _____ Date _____

9515 W Camelback Rd, Suite 126 Phoenix, AZ 85037

Phone: 623.247.0850 * Fax: 623.247.0997 * www.azpainrehab.com

Ehab Abdalah, MD

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Consent for the Treatment of Pain with Narcotic (Opiate) Painkillers

I,_____, agree to all of the following:

1) I agree to obtain prescriptions for narcotics only from the physicians or physician's assistant of Pain & Rehab Consultants.
2) I agree to use only one pharmacy for the filling of narcotic prescriptions and to supply the name, address and phone number of that pharmacy to Pain & Rehab.
3) I agree to allow Pain & Rehab to communicate with other physicians or pharmacies regarding my treatment and use of the narcotic painkillers.
4) I agree to take narcotic pain killers prescribed by Pain & Rehab only as directed.
5) I agree to follow the advice of Pain & Rehab with regards to stopping narcotic painkillers if I am asked to do so.
6) If I am a woman, I certify that I am not pregnant. I will also use appropriate measures to prevent pregnancy while taking narcotic painkillers. If I become pregnant, I will notify Pain & Rehab within 72 hours upon learning of my pregnancy. Pregnancy may warrant discontinuation of narcotic painkillers.
7) I agree to have my other physicians or healthcare providers notify us of any changes in my medical condition or treatment promptly.
8) I will attend scheduled appointments with the physicians or staff of Pain & Rehab.
9) I understand that no allowance will be made for lost or stolen prescriptions or medications.
10) I understand that Pain & Rehab will stop prescribing narcotics for any of the following reasons.
    a) I give, sell, misuse or am careless with these medications.
    b) I am non-compliant with this treatment or with this agreement.
    c) I develop rapid tolerance or loss of effectiveness from this treatment.
    d) I develop side effects considered unacceptable by Pain & Rehab.
    e) My functional activities decline.
    f) I obtain narcotics or narcotic prescriptions from anyone other than Pain & Rehab.
    g) I use alcohol while taking narcotic painkillers.
11) I agree to cooperate with treatments that can reduce or eliminate the need to take narcotic painkillers.
12) If asked, I agree to give a blood or urine sample on the day requested to screen for the appropriate use of these medications as well as the possible misuse of other substances.
13) I understand that the physicians and staff of Pain & Rehab will be reasonable, but firm in interpreting these rules to protect both the patient and the physician.
14) Questions concerning my treatment and my treatment with narcotic painkillers have been fully and completely explained to me to my satisfaction and I have all the information that I need to make an informed choice about signing this consent.
15) I further agree that I will not hold the physicians or staff of Pain & Rehab liable to any civil, administrative, judicial or criminal action that may arise from my treatment with narcotic painkillers.
16) I am aware that I may develop a withdrawal syndrome from stopping these medications, which happens to everyone: If I become psychologically dependent on these medications, I will notify Pain & Rehab for appropriate treatment.
17) I understand that narcotic painkillers may have such side effects as depression, fatigue, hormone deficiency, osteoporosis, sexual dysfunction, vasomotor instability, weight gain and in women, menstrual cycle irregularities.

_____ _____

Patient Signature | Pain & Rehab Physician or Staff Signature

_____ _____

Witness | Date

Pharmacy name/address/phone# _____

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Pain & Rehab Consultants - Consent/ Authorizations

Patient Name:_____Date of birth: _____

Please read carefully:

- All charges (e.g. co-pay, deductibles, self-pay, etc.) are due at the time professional services are rendered.
- For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to **Pain & Rehab Consultants.**
- The patient is responsible for all fees.
- The fee ticket may be used to file insurance claims.
- For minor: I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by **Pain & Rehab Consultants.**
- I hereby authorize **Pain & Rehab** to furnish information to any insurance company, or authorized agency specified, regarding information concerning my medical care.

Consent for Treatment: I authorize providers at **Pain & Rehab Consultants** to perform examinations, procedures, laboratory tests and to administer such medications as, in his or her opinion, are necessary for my care.

Patient Signature:_____ Date:_____

Consent for Medication History: I consent to the use of my medication history from participating medical information exchanges.

I have chosen to opt out of this program: Patient Signature_____ Date:_____

Ancillary Services: I understand that Sonora Quest or LabCorp will be performing laboratory studies as ordered by my physician, and collected at **Pain & Rehab.** These studies will be billed to me by Sonora Quest or LabCorp. I understand that my insurance may not cover these services, and that I am fully responsible for these charges.

Release of information: Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize **Pain & Rehab** to release any information required in the course of my examination or treatment to the following designated persons:

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone#:_____ Phone#:_____

Signature:_____ Date:_____

Patient/ Guardian Signature:_____ Date:_____

Pain & Rehab Consultants **9515 W Camelback Rd. Suite 126** **Phoenix, AZ 85037**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name) Birth date (Mo/Day/Yr)

(Street address) Social security number

(City, state, zip code) Phone (Home)

(Parent/Guardian if patient< 18 yrs old) Chart#

At the request of the individual, _____ (Print Patients Name) do hereby authorize _____ to release:

SERVICE DATES REQUESTED _____

DISCHARGE SUMMARY	PATHOLOGY REPORTS	EMERGENCY REPORTS
HISTORY & PHYSICAL	LABORATORY REPORTS	ALL RECORDS
PROGRESS NOTES	RADIOLOGY REPORTS	LAST THREE YEARS
OPERATIVE NOTES	ECG/EEG/CARDI C CATH	OTHER _____

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Name of Company /Agency /Facility/Person

Our Fax:
Our Phone:

Street Address

City, State, zip

PURPOSE OF DISCLOSURE:

REFERRAL TO SPECIALIST	INSURANCE	WORKERS COMP	LEA YING PRACTICE
LEGAL INVESTIGATION	DISABILITY DETERMINATION	PERSONAL	RELOCATION/MOVE

OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I hereby authorize disclosure of the health infonnation for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or Personal Representative of patient's estate **Date (Power of Attorney Must Be Attached)**

NOTE: **Arizona State Laws permit a fee to be charged for copying/transfer of records. Medical providers may charge "a reasonable fee for the production of the records." Arizona Revised Statutes § 12-2295.**

MEDICAL INFORMATION RELEASED BY DISCOVERY SUPPORT SERVICES

ENTIRE LAB_ EKG

DS	EKG_	IMMUNE	ROI SPECIALIST
OP	X-Ray	OTHER_____	_____
HP	PATH	_____	DATE

Ehab Abdalah, MD

Pain & Rehab Consultants

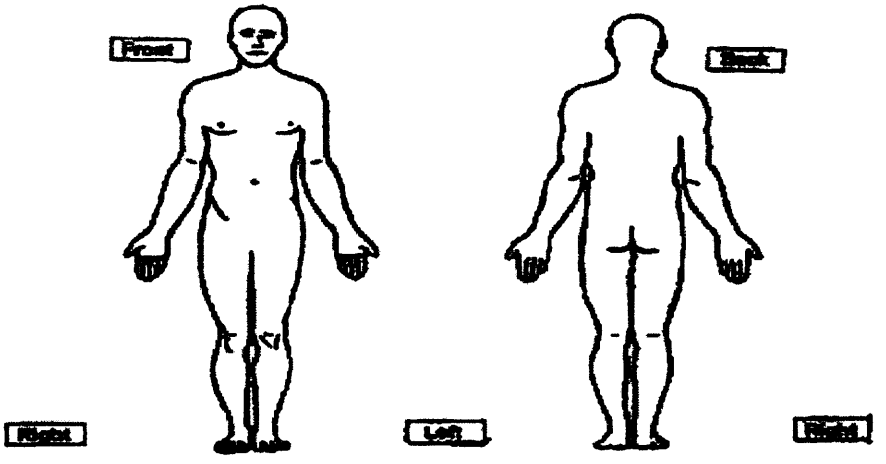
Patient Name:_____Male/Female Age:_____Today's Date_____

Home Phone#( )_____Cellphone# ( ).____e-mail_____

Home Address:_____City_____State___ Zip Code_____

Referring Doctor_____ How did you hear about us:_____

If this is a picture of your body, shade the area(s) where you feel pain. "X" the areas that hurt the most



BODY SITES where you experience pain

Body Site:_____ Body Site:_____ Body Site:_____

DESCRIBE how is your pain feels like:

Aching	Sharp	Penetrating	Throbbing	Tender	Nagging	Shooting	Burning
Stabbing	Exhausting	Miserable	Gnawing	Tiring	Unbearable	Tingling	Numbing

IINTESITY of your pain at its. LEAST, AVERAGE and WORST during the last week (Circle the number that best describes)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

TIMING of your pain: Constant___ _ Intermittent ___ Frequent_____Occasional____ _

What sorts of things make this pain feel BETTER (for example: heat, rest, medicine)?

What sorts of things make this pain feel **WORSE** (for example: prolonged sitting, standing, walking, etc)?

Patient Initials: ___ Doctor Initials:___

ASSOCIATED complaints (i.e. numbness, tingling, memory loss. tremor, fatigue, dementia, loss of vision, visual spots, neck pain, etc.)

LIMITATIONS : Circle the number (s) below that best describes how pain have interfered with your daily functioning this past week.

0 = Does not interfere 10 =Completely interferes

General Activity	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	S	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

What TREATMENT or MEDICATIONS are you receiving now or have received in the past?
(For example, pain medications, physical therapy, acupuncture, chiropractor, massage, TENS, spinal injections, surgery, etc.)
Circle the number next to the treatment to signify the amount of pain relief or help that treatment is providing or has provided.

Treatment or Medication	No Relief — Complete Relief	Check If Receiving Now
_____	0 1 2 3 4 5 6 7 8 9 10	( )
_____	0 1 2 3 4 5 6 7 8 9 10	( )
_____	0 1 2 3 4 5 6 7 8 9 10	( )
_____	0 1 2 3 4 5 6 7 8 9 10	( )
.....	0 1 2 3 4 5 6 7 8 9 10	( )

WHAT is the cause of your complaint (e.g. Injury, accident, scoliosis, unknown, etc-)_____

WHEN and HOW did your pain started?_____

_____

_____

What TESTS and studies have been done? For example: MRI, CAT Scan, X-rays, EMG, Discogram, block, etc...

Test *or* study	Month/Year Done	Done by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Initials: ___ Doctor Initials: ___

What DOCTORS have you seen for your pain since it started ?

Doctors Name:	Month/Year Seen	What was done?

Have you ever been dismissed from any pain clinic in the past because of incompliance with their narcotic agreement?

No_ Yes_ Explain:_____

Current or Past Medical History:

(such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, gynecological history, etc.)

_____

_____

Psychiatric History: (depression, anxiety, bipolar, suicidal attempts, schizophrenia, etc.) _____

_____

Surgical History: (do have any surgery in the past)_____

_____

Family History: e.g. DM, HTN, Back pain, Rheumatoid, cancer, etc_____

Allergies: (Include medication and food allergies)_____

Current Medications: (include vitamins and birth control pills, if applicable)

Medication	Dose	How many a day	Last filled	Doctor

Patient Initials: ___

Doctor Initials: _

Domestic Situation: With whom do you live?_____
Are you able to take care of yourself? Yes No Info, please enter name of caregiver_____

Family history for drugs or Alcohol abuse: (explain)_____
History of physical, sexual or psychological abuse_____

Work History: Job:_____Years Worked:_____Last Worked:_____
Are you on Disability: No__ Yes__ Date started: Cause of disability:_____

Legal Matters: Are you presently involved in a lawsuit (worker comp , No-fault) ? Yes No
If yes, Date of Injury_____Explain the accident:_____

Imprisonment: Yes__ No___ Date:_____

Substance Use: **Which of the following drugs or substances, if any, are you using currently or used in the past?**

Alcohol ___ Marijuana_____Cocaine ___ Heroin _____ Amphetamines ___ Barbiturates___ _

Prescription Drug Abuse____ _

Explain:

Are you in a METHADONE Program: NO Yes If yes, since when'--_____what is the current dose___ _
Last EKG Testing and Results_____

Program Name:_____ Contact Person information:_____
SMOKING: Do you presently smoke cigarettes or use tobacco in any form? Yes/ No

How many packs do (did) you smoke a day?_____ For how many years?_____ _

If not, did you ever smoke cigarettes or use tobacco in any form? Yes/No

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Review of System: Do you have any of the following symptoms? (Circle all that apply)

Musculoskeletal: Joint swellings. stiffness, muscle spasms.

HEENT: Vision changes, runny nose or voice changes

Respiratory: Difficulty breathing, cough.

Gastrointestinal: Nausea, stomach pain. constipation,

Neurological: Numbness. tingling, drowsiness or seizures

Constitutional: fever, fatigue, weight loss or weight gain

Skin: Itching, rash, sores

Hematological: bleeding tendency **Cardiovascular:**

Leg swelling, chest pain. **Genitourinary:** urine

incontinence, blood in urine. **Psychological:** sleep changes,

depression. anxiety

Other: .....

Are You Pregnant? **No** **Yes** **Last Menstrual period:**_____

Patient Initials: _ Doctor Initials: __