FORTITUDE HEALTHCARE

Patient Demographics

GENERAL

Name: _____ Cell Phone: _____

Date of Birth: _____ Home Phone: _____

Email: _____ Work Phone: _____

Address: _____

_____

INSURANCE

Carrier: _____ Effective Dates: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relation to Patient: _____

Insurance Subscriber's Employer Name & Address

_____

_____

_____

EMERGENCY CONTACT INFORMATION

Patient Information

First Name _____ Last Name _____

Emergency Contact Information

Primary Contact Name _____

Relationship to Patient _____

Contact Number to call in the event of an emergency:

_____ or _____

Comments:

_____ _____ _____

Print Name **Signature** **Date**

“Out of Network” Medical Benefits Election

To whom it may concern:

This letter shall serve as notice that I am electing to engage my “Out of Network” medical benefits which may require an informed disclosure by my medical provider.

Since I have paid a higher premium for the ability to seek an “Out of Network” provider, I wish to have my provider compensated for any and all treatments/procedures which he/she believes to be medically necessary to treat my existing condition/ailment/injury.

Please be advised that benefits have been checked prior to receiving services, and if I do not receive an adverse benefit determination within 48 hours of the claims submission, I will assume all costs related to the treatment/procedure will be covered in their entirety as it states in my Summary of Benefits Coverage (SBC) documentation.

If an adverse benefit determination is received within 48 hours, please provide me with the entire claim file, including your copy of the SBC, that was utilized to make the determination so I can comply with the claims procedure process according the Patient Protection Affordable Care Act (PPACA) and the benefit plan in which I am enrolled.

_____

Print Name

_____

Signature

Patient Information:

Today's Date: _____

Your Name: _____

Date of Birth: _____ Age: _____

Referring Physician: _____

Primary Care Physician: _____

Your completed intake paperwork helps our physician and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call 602-775-5670 if you have any question on how to complete any section of this form.

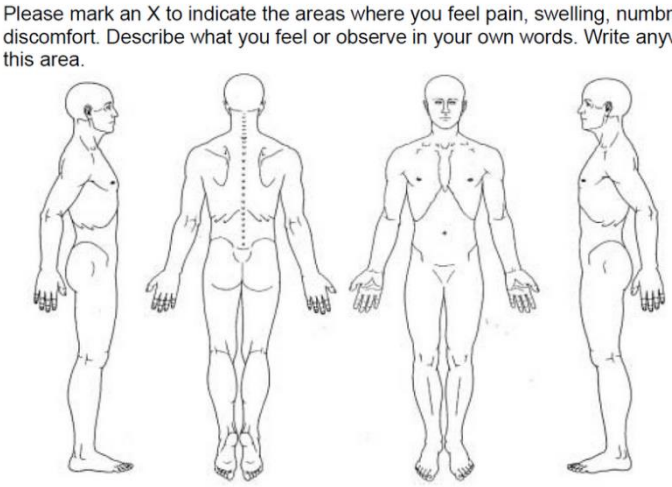
Pain History:

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms:

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description:

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐Tingling/ Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the Night

☐ Always the Same

How often does the pain occur?

☐ Constant ☐Changes in severity but always present

☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____ The Best it Gets _____ The Worst it Gets _____

Mark the effect each of the following have on your pain level:

	Increases	Decreases	No change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking Downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

_____

_____

Associated Symptoms

	NO	YES	Comments (Where?)
Numbness/Tingling	☐	☐	_____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____

Please mark all of the following treatments you have used for pain relief

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other: _____

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections – (circle levels) Cervical/Thoracic/Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression) - _____

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle levels) - Cervical/ Thoracic/Lumbar

☐ Spinal Cord Stimulator - Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other - _____

Which of these procedures listed above have helped your pain?

_____

_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the: _____ Date: _____

☐ X-Ray of the: _____ Date: _____

☐ CT Scan of the: _____ Date: _____

☐ EMG/NCV study of the: _____ Date: _____

☐ Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialist you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

☐ Other: _____

Please list the names of other Pain Physicians you have seen in the past? _____

_____

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

☐ Cancer – Type _____

☐ Diabetes – Type _____

Cardiovascular/Hematologic

☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stroke/TIA
☐ Heart Valve Disorders

Gastrointestinal

☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ Constipation

Urological

☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Neuropsychological

☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures
☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat

☐ Headaches
☐ Migraines
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Glaucoma

Respiratory

☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Musculoskeletal/Rheumatologic

☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Join Pains

Other Diagnosed Conditions

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

☐ I have NEVER had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners of anti-coagulants? ☐ YES ☐ NO

If YES, which ones? ☐ Aspirin ☐ Coumadin ☐ Lovenox ☐ Other: _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication Name	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Allergies

Do you have any drug/medication allergies? ☐ YES ☐ NO

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first-degree relatives:

☐ Arthritis ☐ Cancer ☐ Diabetes

☐ Headaches/Migraines ☐ High Blood Pressure ☐ Kidney Problems

☐ Liver Problems ☐ Osteoporosis ☐ rheumatoid arthritis

☐ Seizures ☐ Stroke

☐ Other Medical Problems: _____

☐ I have no significant family medical history

Social History

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

Who is in your current household? _____

Are there any stairs in your current home? _____ If so, how many? _____

☐ Temporary disability ☐ Permanent disability ☐ Retired ☐Unemployed

Are you currently under worker's compensation? ☐ NO ☐ YES

Is there an ongoing lawsuit related to your visit today? ☐ NO ☐ YES

Alcohol use:

☐Social Use ☐ History of Alcoholism ☐ Current Alcoholism ☐Never

☐Daily Use of Alcohol

Tobacco use:

☐ Current user ☐ Former user ☐ Never used

☐Packs per day? _____ ☐ How many years? _____ ☐Quit date: _____

Illegal Drug use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ YES ☐ NO

Review of Systems:

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐ Difficulty Sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained weight gain	☐ Unexpected weight loss	
	☐ Weakness		
Eyes:	☐ Recent Visual Changes		
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐Earaches	☐Hearing Problems
	☐ Nosebleeds	☐ Sinus Problems	
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia
Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness
	☐ Joint Swelling	☐ Muscle Spasms	☐ Neck Pain
Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		
Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☐ Numbness/Tingling		☐ Seizures
Psychiatric:	☐Depressed mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	☐ Thoughts of harming others

☐ All other review of systems negative

Date/Time: _____

Patient Signature: _____

Medical History and Consent for Treatment

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

I authorize Fortitude Healthcare and any associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize effectiveness.

Initial Here _____

Medication History Consent

A medication history is a list of medicines that Fortitude Healthcare has recently prescribed for a patient. It is collected from a variety of sources, including a patient's pharmacy, health plans, other healthcare providers, and the Arizona State Pharmacy Board.

I give my consent for Fortitude Healthcare to retrieve and review my medication history. I understand that this will become part of my medical record.

Initial Here _____

Privacy Practices and Consent to Release Protected Health Information

The Notice of Privacy Practices for Fortitude Healthcare 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 acknowledge I have had the opportunity to review the Notice of Privacy Practices.

I authorize Fortitude Healthcare 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 Fortitude Healthcare to release any information require in obtaining procedure authorization or the processing of any insurance claims. I understand that Fortitude Healthcare 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 Healthcare Information" form, available at the front desk.

Initial Here _____

Authorization

I authorize Fortitude Healthcare to proceed as indicated in the above Consent sections.

Signed: _____ Date: _____

Medicare Release

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT:

I request that payment under the medical insurance program must be made on my behalf to Fortitude Healthcare for any services furnished me by its physician(s) and/or practitioners. I authorize any h0lder of medical information about me to release it to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a ($20) fee; a same day cancellation will result in a 50% charge of the cancellation fee. This will not be covered by your insurance company.

*****Cancellation fee subject to change*****

Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and the doctor on time. **If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled.** This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day, if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

Account Balances

We will require that patients with self-pay balances have an account balance of ($0.00) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Collection Agency

I understand if I have an unpaid balance to Fortitude Healthcare and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possible including reasonable attorney's fees if so incurred during collection efforts.

In order for Fortitude Healthcare or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Fortitude Healthcare and the designated external collection agency are authorize to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) Contact me by sending test messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_____	_____	___/_____/_____
Print Name	**Patient Signature**	**Date**

Patient Account #: _____