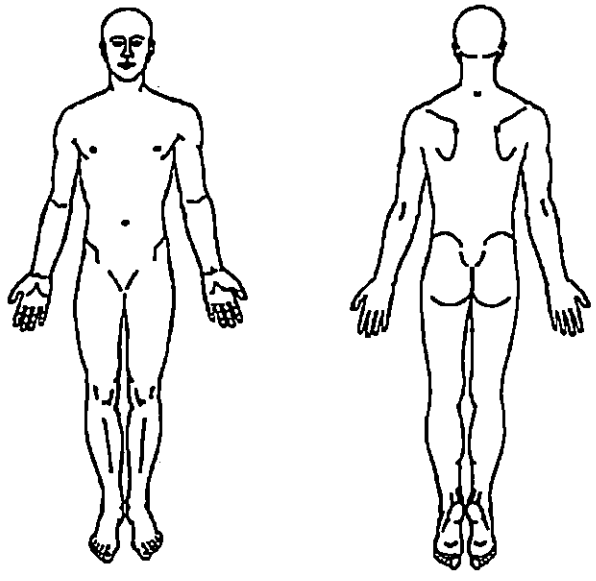
PALOVERDE
PAIN SPECIALISTS

NEW PATIENT FORM

Patient Name :		**DOB:**	**Age :**		☐ M ☐ F
Name of Referring Physician :			**Pharmacy:**		
Reason for Visit:			**Pharmacy Cross Streets:**		
How long have you had this pain?		**Average Pain Level** (1 (no pain) to 10 (worst)) :		-	

Average Pain Level over the last week: _____

On the diagram below, mark the area where you have pain.



Height:_____ **Weight:**_____

Describe the pain

☐ Aching	☐ Mild	☐ Moderate
☐ Burning	☐ Throbbing	☐ Severe
☐ Pins/needles	☐ Constant	☐ Sharp/stabbing
☐ Numbess	☐ Intermittent	

What makes your pain Worse:

What makes your pain Better:

Do you have WEAKNESS in your : ☐ Arms ☐ R ☐ L
☐ Legs ☐ R ☐ L

Do you have NUMBNESS in your : ☐ Arms ☐ R ☐ L
☐ Legs ☐ R ☐ L

Does your pain RADIATE? ☐ Yes ☐ No **If Yes, Where** _____

TREATMENT HISTORY

For your current symptoms, please mark the boxes for the following imaging/studies that have been performed

☐ X-Ray ☐ MRI ☐ CT scan ☐ Discogram ☐ EMG/NCV (nerve test) ☐ CT myelogram

Where was this Imaging/study done?

Please 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: _____

Spine Surgery: ☐ Better ☐ Worse ☐ No Change
Type of surgery and year?

TENS unit: ☐ Better ☐ Worse ☐ No Change

Chiropractor: ☐ Better ☐ Worse ☐ No Change

Massage: ☐ Better ☐ Worse ☐ No Change

Physical Therapy: ☐ Better ☐ Worse ☐ No Change
How recently? _____

Bracing: ☐ Better ☐ Worse ☐ No Change
Type:

Heat / Ice: ☐ Better ☐ Worse ☐ No Change

Acupuncture: ☐ Better ☐ Worse ☐ No Change

Psychology: ☐ Better ☐ Worse ☐ No Change

PALOVERDE
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PAST MEDICATIONS

Please indicate which medications you have used in the past for your current pain condition (OTHERWISE DO NOT CHECK):

ANTI-INFLAMMATORY	Helped? Yes	No
Naproxen (aleve)	☐	☐
Ibuprofen (advil, motrin)	☐	☐
Diclofenac (voltaren)	☐	☐
Tylenol (acetaminophen)	☐	☐
Flector patch	☐	☐

MUSCLE RELAXANTS	Helped? Yes	No
Carisoprodol (soma)	☐	☐
Cyclobenzaprine (flexeril)	☐	☐
Skelaxin (Metaxolone)	☐	☐
Methocarbamol (robaxin)	☐	☐
Tizanidine (zanaflex)	☐	☐

NARCOTICS / OPIOIDS	Helped? Yes	No
Tramadol	☐	☐
Tylenol with codeine	☐	☐
Hydrocodone (Vicodin)	☐	☐
Oxycodone (Percocet)	☐	☐
Morphine, MS Contin	☐	☐
Hydromorphone	☐	☐
Nucynta (tapentadol)	☐	☐
Fentanyl patch	☐	☐
Methadone	☐	☐
Opana	☐	☐
Suboxone	☐	☐

NERVE MEDICATIONS	Helped? Yes	No
Gabapentin (neurontin)	☐	☐
Lyrica	☐	☐
Amitriptyline (elavil)	☐	☐
Nortriptyline	☐	☐
Cymbalta	☐	☐
Effexor	☐	☐
Savella	☐	☐
Lidoderm patch	☐	☐

PAST MEDICAL HISTORY

Please document all medical history below , including any of the following medical conditions :

☐ **Anxiety Disorder**	☐ **Depression**	☐ **High Blood Pressure**	☐ **Obsessive Compulsive d/o**
☐ **Bipolar Disorder**	☐ **Diabetes** type:_____	☐ **Heart attack/disease**	☐ **Abuse during childhood**
☐ **Schizophrenia**	☐ **Cancer** type:_____	☐ **Attention deficit d/o**	☐ **Kidney/Liver disease**
☐ **Osteoporosis**	☐ **Gout**	☐ **Attention deficit d/o**	☐ **Rheumatoid arthritis**
☐ **HIV or AIDs**	☐ **Stroke**	☐ **Hepatitis (A , B, C)**	☐ **Peptic Ulcer Disease**

Other past medical history:

ALLERGIES TO MEDICATIONS AND REACTIONS

Iodine Allergy	☐ Yes ☐ No	**Latex Allergy**	☐ Yes ☐ No
Shellfish Allergy	☐ Yes ☐ No		

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PAST SURGERIES AND DATES

FAMILY HISTORY (MOTHER AND FATHER ONLY)

MOTHER:	
FATHER:	

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 ☐ Plavix ☐ Xarelto ☐ Pradaxa ☐ Eliquis ☐ Brilinta

☐ Asprin ☐ Other Perscribing Doctors Name _____

NAME OF MEDICATION	DOSE and # of pills/day
Last Does of Pain Medication _____	

SOCIAL HISTORY

Occupation :
Are you currently working? ☐ Yes ☐ No ☐ Part-time ☐ Full-time
Education : ☐ Elementary ☐ High School ☐ College ☐ Graduate school
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Significant Other
Children : ☐ Yes ☐ No If Yes, how many? _____
Do you have any lawsuits pending? ☐ Yes ☐ No Do you use Medical Marijuana? ☐ Yes ☐ No
Are you on disability? ☐ Yes ☐ No Worker's Comp? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No # of packs / day _____ How many years? _____
Do you use alcohol? ☐ Yes ☐ No # of drinks / day _____ How many years? _____
Do you use illicit substances? ☐ Yes ☐ No If Yes, describe _____

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REVIEW OF SYSTEMS:

Are you CURRENTLY experiencing any of the following symptoms? If so, check mark Yes. Otherwise, check no (blank also implies no)

GENERAL:	Yes	No	ENDOCRINE:	Yes	No	EARS/NOSE/THROAT:	Yes	No
Loss of appetite	☐	☐	Thyroid disease.....	☐	☐	Sinus Problems.....	☐	☐
Recent weight loss.....	☐	☐	Heat/Cold intolerance....	☐	☐	Sinusitis.....	☐	☐
Fever or chills	☐	☐		☐	☐	Hearing loss.....	☐	☐
RESPIRATORY:	**Yes**	**No**	**CARDIOVASCULAR:**	**Yes**	**No**	**PSYCHIATRIC:**	**Yes**	**No**
Shortness of breath	☐	☐	Chest pain.....	☐	☐	Depression.....	☐	☐
Chronic cough	☐	☐	Palpitations.....	☐	☐	Drug/Alcohol addiction	☐	☐
Sleep Apnea.	☐	☐				Suicidal Thoughts.....	☐	☐
KIDNEY/BLADDER:	**Yes**	**No**	**EYES:**	**Yes**	**No**	**NEUROLOGICAL**	**Yes**	**No**
Painful urination.....	☐	☐	Blurred vision.....	☐	☐	Headaches.....	☐	☐
Blood in urine.....	☐	☐	Double vision.....	☐	☐	Seizures.....	☐	☐
Kidney problems	☐	☐	Loss of vision.....	☐	☐	Dizziness.....	☐	☐
GASTROINTEST	**Yes**	**No**	**HEMATOLOGIC:**	**Yes**	**No**	**SKIN:**	**Yes**	**No**
Nausea/vomiting	☐	☐	Easy bruising.....	☐	☐	Frequent Rashes	☐	☐
Blood in stool.....	☐	☐	Easy bleeding.....	☐	☐	Skin ulcers.....	☐	☐
Heartburn.....	☐	☐				Lumps.....	☐	☐
Constipation.....	☐	☐						

Patient/Representative Name (print) _____

Signature_____

Date _____

PALOVERDE
PAIN SPECIALISTS
Patient Health Questionnaire (PHQ-2)

Patient Name:_____ Date of Visit:_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

If you answered YES to any of the above questions please complete the below questions:

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
2. Feeling tired or having little energy	0	1	2	3
3. Poor appetite or overeating	0	1	2	3
4. Feeling bad about yourself- or that you're a failure or have let yourself or your family down	0	1	2	3
5. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
6. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
7. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____+_____+_____

Add Totals Together _____

8. If you checked off any problems, how difficult have those problems made it for you to do you work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐ Very difficult ☐ Extremely difficult

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

PainEDU.org

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

PALOVERDE
PAIN SPECIALISTS

PATIENT REGISTRATION FORM

Address: 13090 N 94th Drive Suite 212, Peoria AZ 85381 Phone: 833.5PV.PAIN (578.7246) Fax: 602.714.7176

Patient Information (confidential):

Name: _____ Date: _____
(First) (Middle) (Last)

Address: _____ City _____ State ____ Zip _____

Phone: Home (___) _____ Work (___) _____ Cell (___) _____

Birth Date: _____ SS# ___-___-_____ E-Mail: _____

Employer (if Minor, Parent's Employer) _____

Employer Address: _____ City _____ State ____ Zip _____

Spouse Name (if Minor, Parent's Name) _____ Phone: (___) _____

Primary Care Physician: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____

Relationship to patient: _____

Who should we thank for referring you? _____ Phone: (___) _____

Responsible person if different from above.

Do you have medical insurance coverage: □ Yes □ No

Name of Person on account : _____ Phone : _____

Relationship to Patient: _____ SS# ___-___-_____ Birth Date: _____

Insurance Company: _____ Policy No: _____ Group Number: _____

Phone Number of insurance company: _____

Do you have additional insurance? □ Yes □ No If yes, please complete the following:

Name of Insured: _____ Relationship to patient: _____

SSN: _____ DOB: _____

Insurance Company: _____ Policy No: _____ Group Number: _____

If you are covered under worker's compensation or motor vehicle insurance, enter info below:

Name of Worker's Comp or Motor Vehicle Accident Insurance Carrier: _____

Employer: _____ Claim No.: _____

Date of Injury: _____ Adjuster/Case Manager: _____

Adjuster/Case Manager Phone No.: _____

Carrier Address: _____

Patient Initial: _____

PALOVERDE
PAIN SPECIALISTS

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, IPCW DBA Palo Verde Pain Specialists/ Palo Verde Pain Specialists originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Palo Verde Pain Specialists notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Palo Verde Pain Specialists Notice of Information practices prior to signing this consent;
- that Palo Verde Pain Specialists reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I have provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that Dr. Adam Kramer is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that Dr. Adam Kramer has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness:_____

Patient Name:_____ **Date:** _____

PALOVERDE
PAIN SPECIALISTS

Financial Disclosure Agreement

State law, A.R.S. 32-1401 (ff), requires that a physician notify the patient that the physician has a direct interest in a separate diagnostic or treatment agency to which the physician is referring the patient and if this is available elsewhere on a competitive basis. We support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, Dr Adam Kramer has a direct interest in the following diagnostic/treatment agencies:

- Premier Pain Consultants ASC, LLC
- Premier Pain Consultants, LLC
- ZJRA, PLLC Dba Mountainside Anesthesia
- Banner Peoria Surgery Center, LLC
- Pain, LLC
- Sonoran Pain Consultants, PLLC
- IPCW, PLLC
- Sonoran Anesthesiology, PLLC
- Sonoran Pain Specialists, PLLC

Further as indicated, goods and services that we have prescribed are available on a competitive basis at other facilities and it is your right to choose.

The law provides for the acknowledgement of you having read and understood this disclosure by dating and signing this form in the space provided. We will keep that signed original in your patient file and you will receive a copy.

Acknowledgment

I have read this Notice to Patients, and I understand the disclosure that it contains.

Date: _____

Patient Signature: _____

I have witnessed the above patient signature and have given them a copy of this notice.

Witness:_____

PALOVERDE

PAIN SPECIALISTS

Financial Policy

Palo Verde Pain Specialists believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT - is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment IPCW PLLC DBA Palo Verde Pain Specialists/Palo Verde Pain Specialists reserves the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). If a prepayment is made for any services and a refund is due after insurance processes, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. INSURANCE - We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you. If our providers are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim is rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Palo Verde Pain Specialists only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/insurance company changes and we bill your old carrier we may miss the time

limit to process the claim. In this case, the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. TOXICOLOGY LAB - 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 the Laboratory 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 the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.

4. COLLECTION - If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Palo Verde Pain Specialists reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Palo Verde Pain Specialists for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

5. RETURNED CHECKS - will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

6. ACCOUNTING PRINCIPALS - Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. FORMS AND CONSULTS FEES - Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the provider. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

8. CANCELLATIONS OR MISSED APPOINTMENTS - If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $25 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you may be assessed a $150.00 missed procedure fee. Multiple missed visits may result in discharge from the practice.

9. RESPONSIBILITY FOR PAYMENT - I understand that I, personally, am financially responsible to Palo Verde Pain Specialists for charges not covered by the assignment of insurance benefits.

10. ASSIGNMENT OF INSURANCE BENEFITS - I hereby assign, transfer, and set over directly to Dr. Adam Kramer sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Palo Verde Pain Specialists to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Dr. Adam Kramer. I authorize Palo Verde Pain Specialists to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. RELEASE OF INFORMATION - I hereby authorize the and direct Palo Verde Pain Specialists to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy of Palo Verde Pain Specialists and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Palo Verde Pain Specialists. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Palo Verde Pain Specialists/IPCW DBA Palo Verde Pain Specialists. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable) _____ **Date:** _____

Please print the name of the patient _____

Medical History and Consent for Treatment

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

I authorize IPCW PLLC DBA Palo Verde Pain Specialists / Palo Verde Pain Specialists and any associates, assistants, 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 Palo Verde Pain Specialists 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 Palo Verde Pain Specialists 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 Palo Verde Pain Specialists 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 Palo Verde Pain Specialists to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand Palo Verde Pain Specialists will not release my Protected Health Information to any other party (including family) without my completing an 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, oral swab 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 the Laboratory 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 the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 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 owed.

Signed:_____ **Date:**_____

Your Name:_____ Date of Birth:_____

Authorized Parties

By signing below, I authorize Palo Verde Pain Specialists, its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party Relationship

_____

_____

_____

Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacyregulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Patient orLegal Guardian:_____Date: _____

Authorization to Disclose Health Information to PaloVerde Pain Specialists

Patient's Name: _____ Date of Birth: _____

I hereby authorize _____

Attorney: _____

Phone: _____ Fax: _____
or it's agent(s) to disclose my health information as described in this authorization to:

Dr. Adam Kramer
13090 N 94th Dr, Suite 212
Peoria, AZ 85381
Phone: 833-578-7246
FAX: 602-714-7176

The health information is being disclosed for the following purpose (check appropriate box):

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care

I understand I may revoke this Authorization at any time by sending written notice of my revocation to Dr. Adam Kramers health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event or condition. If no date, event or condition is written, this authorization will expire one (1) year from the date signed. A photocopy of this Authorization will expire one (1) year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse to psychiatric illness and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

I understand that the office of Dr. Adam Kramer may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.

_____ _____
Signature of Patient, Guardian or Authorized Representative Date

_____ _____
Printed Name of Authorized Representative and Phone number Relationship