Patient Demographic Form

Patient Name: _____
First Middle Last

Sex: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Date of Birth:** _____
M/F Years 0'00" lbs. MM/DD/YYYY

Address: _____
Number Street Apt City State Zip

Social Security #: _____ **Driver's License #:** _____ **Marital Status:** _____

Email: _____ **Home Phone:** _____ **Cell Phone:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Ethnicity: _____ **Preferred Language:** _____ **Race:** _____

Emergency Contact: _____ **Phone:** _____

Referral Source: ☐Doctor ☐Patient ☐Insurance ☐Other **Name:** _____

Payment Type: ☐Health Insurance ☐Medicare ☐Personal Injury ☐Worker's Compensation ☐Private Pay

Carrier Name: _____ **Group #:** _____

Primary Insured: _____ **Policy #:** _____

Primary Date of Birth: _____ **Effective Date:** _____ **Claim #:** _____
MM/DD/YYYY MM/DD/YYYY

Reason for your visit: _____

_____

_____

We invite you to discuss any questions regarding our services with us. The best services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I approve e-mail and/or text notifications of my appointments.

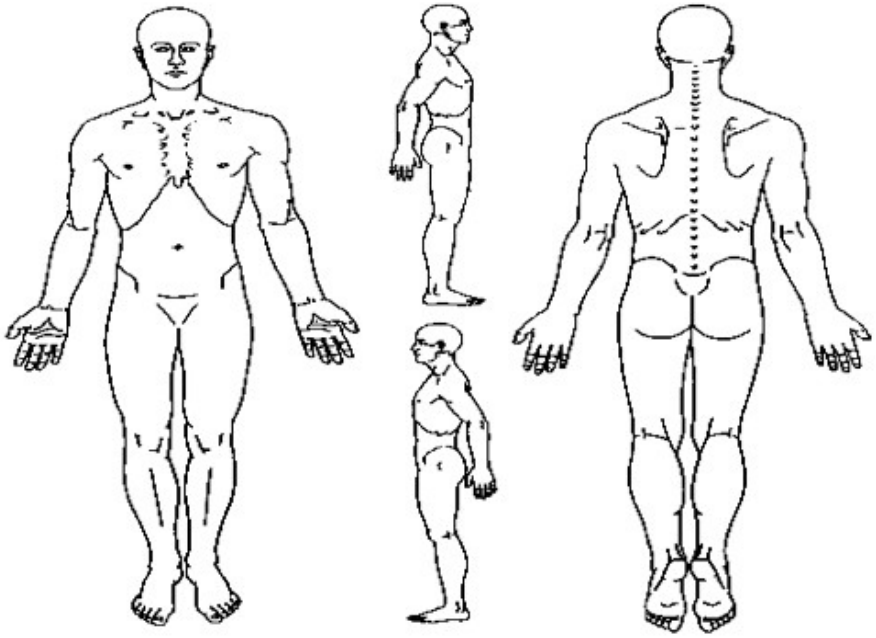
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Date: _____ **Signature:** _____
MM/DD/YYYY

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now

A = ACHE **B = BURNING** **N = NUMBNESS**

P = PINS & NEEDLES **S = STABBING** **O = OTHER**



QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

headache neck low back

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

##########

1. What is your pain RIGHT NOW?

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

Date: _____ **Signature:** _____

MM/DD/YYYY

Uptown Painstop, LLC 3724 N. 3rd St., Suite 300, Phoenix, AZ 85012 Phone: 602-892-9667 Fax: 602-892-4862

Patient Medical History

Patient Name: _____ **Date of Birth:** _____
First Last MM/DD/YYYY

Ongoing Medical Issues:

Arthritis? ☐Yes ☐No
Cancer? ☐Yes ☐No
Currently Pregnant? ☐Yes ☐No
CVA/Stroke? ☐Yes ☐No
Depression? ☐Yes ☐No
Diabetes? ☐Yes ☐No
Hepatitis? ☐Yes ☐No
Alcohol Consumption? ☐Yes ☐No
How much? _____
Smoking? ☐Yes ☐No
How much? _____

Other Ongoing Medical Issues: _____

Major Hospitalizations or Surgeries: _____

Allergies (Non-Drug): _____

Family Medical History (serious illnesses - please include diagnosis, relation and current status):

Preventative Care Measures (steps you've taken to prevent additional injury):

Drug Allergies:	Drug Name	Location of Reaction	Severity	Type of Reaction	Start Date

Current Medications (please list all medications you are currently taking):

Drug Name	Strength (E.g. 5mg)	Dose (E.g. 1 @ 3 x day)	Purpose	Prescribing Physician

Auto Accident Information

Patient Name: _____ **Date of Birth:** _____
First Last MM/DD/YYYY

Date of Accident: _____ **Were you the?** ☐Driver ☐Front Passenger ☐Rear Passenger
MM/DD/YYYY

Make & Model of vehicle you were occupying: _____ **# of Passengers:** _____

Is your vehicle driveable? _____ **Was your vehicle towed?** _____

Make & Model of vehicle other vehicle(s): _____

Location of the accident (e.g. Main ST & 1st Ave): _____

Please describe the accident: _____

_____

_____

Were you wearing your seatbelt? ☐Yes ☐No

Did the airbags go off? ☐Yes ☐No

Did the accident render you unconscious? ☐Yes ☐No
How long? _____

Did your body strike anything in the vehicle? _____

Did emergency responders come to the accident site? ☐Yes ☐No

Were you cited at fault? ☐Yes ☐No

Have you been able to work since this injury? ☐Yes ☐No

Are your work activities restricted as a result of this accident? ☐Yes ☐No
How so? _____

Were you:
☐Surprised by the impact?
☐Braced for the impact?

Were you facing:
☐Left
☐Forward
☐Right

Did the impact to your vehicle come from the?
☐Left Side
☐Front
☐Right Side
☐Rear

Please describe how you felt immediately after the accident:

_____

_____

_____

Where & When did you seek treatment after the accident?

1.) _____

2.) _____

3.) _____

Were X-Rays taken? ☐Yes ☐No

Were medications prescribed? ☐Yes ☐No

Indicate symptoms you have as a result of the accident:

☐Arm/Shoulder Pain
☐Back Pain
☐Blurred Vision
☐Chest Pain
☐Difficulty Sleeping
☐Dizziness
☐Ears Ringing
☐Fatigue
☐Headache(s)
☐Jaw Problems
☐Leg/Hip Pain
☐Memory Loss
☐Nausea
☐Numb/Tingling
☐Neck Pain

Date: _____ **Signature:** _____
MM/DD/YYYY

Personal Injury Insurance Info

Patient Name: _____ **Date of Birth:** _____
First Last MM/DD/YYYY

Please provide as much information as possible, so your case can be setup to your financial advantage. In the state of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment may occur. We only need to be paid once, so all over-payments will be reimbursed to you at the time you after all claims and insurance settlements have been completed and your balance is paid in full.

Patient Initials: _____

Date of Accident: _____ **Were you a?** ☐Driver ☐Passenger
MM/DD/YYYY

Attorney's Information:

Attorney Name: _____ **Case #:** _____

Firm Name: _____ **Phone #:** _____

Primary Insurance (Health Insurance that covers you):

Carrier Name: _____ **Group #:** _____

Primary Insured: _____ **Policy #:** _____

Primary Date of Birth: _____ **Effective Date:** _____ **Phone #:** _____
MM/DD/YYYY MM/DD/YYYY

Medical Payment Coverage: On your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be coverage called "Med-Pay." This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or wasn't your fault, to slamming your finger in the care door. Using this portion of the policy cannot raise your premium or affect your record in anyway. In fact, this is exactly why you pay for "Med Pay" on your insurance policy.

Patient Initials: _____

Claimant: _____ **Claim #:** _____

Policy Holder: _____ **Policy #:** _____

Carrier Name: _____ **Phone #:** _____

Adjuster Name: _____ **Phone #:** _____

Third Party Liability: This is the insurance for the person who was in the "other car." The information can be found on the Accident Report.

Driver's Name: _____ **Claim #:** _____

Policy Holder: _____ **Policy #:** _____

Carrier Name: _____ **Phone #:** _____

Adjuster Name: _____ **Phone #:** _____

Designation of Authorized Representative

Patient Name: _____

Date of Birth: _____

I_____, do hereby designate _____ Healthcare, LLC dba PainStop Clinics, to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503- 1(b) 4, and any applicable Arizona Insurance Statutes, to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named doctor.

These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

Date: _____ **Signature:** _____

MM/DD/YYYY

HIPPA Notice of Privacy Policies

Patient Name: _____ **Date of Birth:** _____
First Last MM/DD/YYYY

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, a necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as require by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Continued on next page

PAINSTOP CLINICS

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. You request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Operations Manager

For more information about HIPAA, please contact:
The U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Signature below is acknowledgment that you have received this Notice of our Privacy Practices.

Minor Patient's Name (if applicable): _____

Printed Name: _____

Date: _____ MM/DD/YYYY

Signature: _____

Treatment Attestation for Pain Management

Patient Name: _____ **Date of Birth:** _____
First Last MM/DD/YYYY

I, _____, am seeking healthcare services for the treatment of my painful condition from Pain Stop Clinics and I understand that my accuracy, completeness and truthfulness in reporting my history and symptoms will directly contribute to the development of my treatment plan and the improvement in my painful condition. I acknowledge that I intend to provide all necessary releases for healthcare information so Pain Stop Clinics may receive my previous healthcare records from other clinicians. I know that if I am not accurate, complete and truthful in providing my history and symptoms, Pain Stop Clinics providers cannot safely treat me for my painful condition.

Patient Initials: _____

I intend to disclose the names of all prior treating practitioners and to inform Pain Stop Clinics about all current prescribers of controlled substances. I do not intend to seek medications for any purposes other than my personal medical needs. I will not deliberately misrepresent my history, prevent Pain Stop Cinics from obtaining my previous medical records, fail to inform Pain Stop Clinics about the existence of other sources of prescription medication, or allow anyone other than myself to take medications prescribed to me.

Patient Initials: _____

I understand that obtaining controlled substances (prescription medicines) through false representations is a crime and that I will be reported to law enforcement officials for attempting to fraudulently obtain these medications for non-therapeutic purposes.

Patient Initials: _____

I am seeking treatment for the purpose of reducing or relieving my pain. I am not appearing to seek care from Pain Stop Clinics or any of its' providers as part of an ongoing investigation of Pain Stop Clinics or any if its' providers. I am a legitimate patient voluntarily seeking healthcare services for a painful condition.

Patient Initials: _____

Date: _____ **Signature:** _____
MM/DD/YYYY

Witness Name: _____

Date: _____ **Witness Signature:** _____
MM/DD/YYYY

Chiropractic Informed Consent

The nature of the chiropractic manipulation: I will use either my hands, an instrument, or both to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatment recommended: Ice, Moist Heat Peaks, Electrical Muscle Stimulation, Stretching/Strengthening Exercises, Massage Therapy, Neuromuscular Re-education and Passive/Regainer Traction.

Risks involved with the recommended ancillary treatments: Ice and Electrical Muscle Stimulation (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Mechanical Traction can cause temporary post treatment soreness or reflex muscle spasms. This list is not all inclusive.

Other treatment options for your condition can include: Medical care with prescription drugs, self-management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self-dosages and surgical risks including complications from either the procedure and/or the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Minor Patient's Name (if applicable):_____

Printed Name: _____

Signature:_____ **Date:** _____
MM/DD/YYYY

Patient Financial Agreement

Patient Name: Enter First and Last Name Date of Birth: Click or tap to enter a date.

BENEFIT ASSIGNMENT CONTRACT/EQUITABLE LIEN AND INDEMNIFICATION AGREEMENT

I the undersigned Patient hereby agree to establish a lien/assignment of benefits or claim in favor of Pain Stop Clinics by this contract and pursuant to any state statues that apply. I give my permission for Pain Stop Clinics and/or their agent, to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from this accident and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so I have entered into a contract with the above named health care or service provider. I direct that a photocopy of this lien be considered valid as the original.

Date of Accident: Click or tap to enter a date.

This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy, settlement, disability benefits, medical payments benefits, no-fault benefits, health and/or accident benefits, workers' compensation benefits, compromise, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary to fully compensate the health care or service provider from whom I have received care.

I hereby authorize and direct my attorney to pay directly to Pain Stop Clinics such sums as may be due and owing for medical services rendered to me by reason of this accident and to withhold such sums from any settlement or judgment or verdict as may be necessary to adequately protect said medical provider. I understand that no settlement, verdict, or judgment proceeds can be disbursed to me without first satisfying this lien. I agree to fully to protect Pain Stop Clinics by disallowing the use of the common/general fund dispersal and/or a reduction based upon LaBombard v. Samaritan Health System (195 AZ 543,991 P.2d App. 1998) or Andrews v. Samaritan Health System (201 AZ 379, 36 P.3d 57 app. 2001).

I fully understand that I am directly and fully responsible to Pain Stop Clinics for all bills submitted for services rendered to me and on my behalf in preparing my case for trial or settlement and that this agreement is made solely for Pain Stop Clinics additional protection and in consideration of Pain Stop Clinics awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may recover said fees. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and/or serving notice of this lien/assignment upon any liable parties and their insurance companies.

Date: Click or tap to enter a date. Signature: _____

The undersigned, being attorney of record for the above patient does hereby acknowledge receipt of the above lien, and agrees to observe all the terms of the above agreement and agrees to abide by his/her ethical obligations and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Pain Stop Clinics. This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Date: Click or tap to enter a date. Signature: _____