ADVANCED PAIN MANAGEMENT

Phone: 623-466-6350 Fax: 602-358-8698

APPOINTMENT CONFIRMATION

Patient Name *(Nombre Del Paciente)*: _____

Your consultation is scheduled on:

Su cita está programada para:

Date *(Fecha)*: _____ Time *(Hora)*: _____ **Check in time** *(Hora de registro)*: _____

Please arrive **30 minutes** before your scheduled appointment time to complete your registration form, if you arrive **late**, you may be asked to **reschedule** your appointment for another day.

*Favor de llegar **30 minutos** antes de su cita programada para poder llenar las formas requeridas con suficiente tiempo, si usted llega tarde puede que se le tenga que reprogramar su cita para otro dia.*

You are going to be seen by:

Usted sera visto por:

( ) BRIAN S. PAGE, DO
( ) D. CHINTHAGADA, DO
( ) NATHAN FRANKE, PA-C
( ) NICHOLE BROWN, FNP-C
( ) KELLY CARR, FNP
( ) LINDSAY BURK, PA-C
( ) ELIZABETH COLMAN, FNP-C
( ) LIANA FLORES, FNP
( ) LESLIE KOTSIS, A-NP
( ) MARYBETH BARCOME, FNP
( ) AMELIA CAMPBELL, FNP-C
( ) SUSAN BAILEY, FNP-C
( ) ALYSON VIGNEAU, FNP-C
( ) ANGELA MARTON, NP-BC
( ) VANESSA SCHLAUDERAFF, FNP-C

In our office located at:

En la oficina localizada en

( ) **MAIN OFFICE**-20325 N 51st Ave Bldg. 8 Ste. 160 Glendale, AZ 85308
( ) **West Valley**-4140 N 108TH Ave Ste. 134 Phoenix, AZ 85037
( ) **N. Central**-3201 W Peoria Ave Ste. D-804 Phoenix, AZ 85029
( ) **Central Phoenix**-2701 N 16TH St Ste. 111 Phoenix, AZ 85006
( ) **Tucson**- 6560 E. Carondelet Dr. Tucson, AZ 85710
( ) **NORTH PHX/SCOTTSDALE**-15255 N. 40th St. Ste. 131 Phoenix AZ 85032
( ) **Surprise**-14811 W. Bell Rd. Ste.103 Surprise, AZ 85374
( ) **Mesa**-3035 S Ellsworth Rd Ste. 135 Mesa, AZ 85212
( ) **Chandler**-815 E. Warner Rd. Ste. 104 Chandler AZ 85225
( ) **AHWATUKEE**-4425 E. Agave Rd. Ste. 152 Phoenix, AZ 85044

PLEASE NOTE!!

POR FAVOR TENGA EN CUENTA

******Medication Management: Medication is only prescribed in conjunction with other forms of treatment******

******Medication Management: Medicamentos son recetados únicamente en conjunto de otros tratamientos******

Maximum Dosages:

Morphine 15 mg four times a day
Oxycontin 80mg three times a day
MS Contin 60 mg three times a day
Norco 10 mg/325 four times a day
Methadone 90 mg/day
Oxycodone 15 mg four times a day
Baclofen 20 mg three times a day
Fentanyl 100 mg/day

Please bring your insurance card, one form of ID and a list of your medications, keep in mind that **MEDICATION** is only prescribed in conjunction with other forms of treatment.

*Por favor de traer su tarjeta de aseguranza, una forma de identificación, lista de sus medicamentos, tenga en mente que **MEDICAMENTOS** son solo recetados en conjunto de otra forma de tratamiento.*

A form of identification is mandatory in order to be seen. Failure to do so will result in having to reschedule your appointment. ***Una forma de identificación es mandatoria para poder ser atendido.*** *Si usted no tiene una forma de identificación su cita será reprogramada para otro día.*

Thank you! ***Gracias!***

ADVANCED PAIN MANAGEMENT

PATIENT REGISTRATION FORM

Date: _____
Fecha

First Name: _____ **Last Name:** _____
Primer Nombre *Apellido*

Address: _____
Domicilio

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Codigo Postal*

Race/Ethnicity: _____ **Language:** _____
Raza/Etnicidad *Idioma*

Home Number: _____ **Cell:** _____
Telefono de casa *Celular*
E-mail: _____

Social Security: _____ - _____ - _____ **Date of Birth:** _____/_____/_____ **Age:** _____
Seguro Social *Fecha de Nacimiento* *Edad*

Marital Status: Married _____ **Single** _____ **Divorce** _____ **Widow** _____ **Separated** _____
Estatus Marital *Casado* *Soltero* *Divorciado* *Viudo* *Separado*

Patient's Employment: _____
Empleador Del Paciente

Address: _____
Domicilio

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Codigo Postal*

Next of Kin in Case of Emergency: _____
Contacto de Emergencia

Relationship to Patient: _____ **Phone:** _____
Relación con el Paciente

Description of Illness or Injury *Descripción de enfermedad o lesión*:

_____

_____

_____

Referred By: _____ **Phone:** _____
Referido Por *Teléfono*

Primary Care Doctor: _____ **Phone:** _____
Doctor Primario *Teléfono*

INSURANCE INFORMATION *(INFORMACION DE LA ASEGURANZA)*

Insurance Name: _____
Nombre de la aseguranza

Claims Address: _____
Direccion

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Código Postal*

Policy or Identification Number: _____
Numero de Póliza o Identificación

Group Number: _____ **Telephone Number:** _____
Numero de grupo *Teléfono*

Insured Person's Full Name: _____
Nombre de la persona asegurada

WORKERS COMP OR MOTOR VEHICLE ACCIDENT
COMPENSACION A TRABAJADORES O ACCIDENTE AUTOMOVILISTICO

Date of Injury or Accident Occurred: _____
Fecha de Lesión o Accidente

Body Part: _____
Parte del Cuerpo

Attorney or Insurance Carrier: _____
Abogado o Compañía de Aseguranza

Case Worker or Adjustors Name: _____
Ajustador o Trabajador Social

Claims Address: _____
Direccion

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Codigo Postal*

File/Claim Number: _____ **Telephone Number:** _____
Numero de Reclamo *Teléfono*

Employer at time of Injury: _____
Empleador en el momento de Lesión

Company Address: _____
Direccion

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Codigo Postal*

Attorney Name: _____
Abogado

Law Office Name: _____ **Telephone Number:** _____
Officina de Leyes *Teléfono*

The above information is complete to the best of my knowledge:
La información anterior ha sido completada en lo mejor de mi conocimiento

Patient/Guardian Signature: _____ **Date:** _____
Firma del Paciente/Guardian *Fecha*

HEALTH QUESTIONNAIRE
(QUESTIONARIO DE SALUD)

Name: _____ **Age:** _____
Nombre *Edad*

1. **Are you allergic to any medication** *Usted es alergico a un medicamento*?

_____

_____

2. **Are you going to be requesting pain medications today?** **Yes** *(Si)* **No**
Solicitará medicamentos para el dolor el dia de hoy?

3. **List previous surgeries and dates** *Liste sirugias anteriores y las fechas*:

_____

_____

4. **List any serious injuries and dates** *Liste lesiones graves y las fechas*:

_____

_____

5. **Do you smoke** *Usted fuma*? **No** **Yes** *(si)*
If yes, # of packs/day *si usted confirmo si, # de paquetes al dia* ____ **Years smoked** *Años fumando* ____
If no, have you ever smoked *Si usted confirmo no, alguna vez ha fumado*? **No** **Yes** *(Si)* **Years smoked** *Años fumando* _____

6. **Do you drink alcohol** *Usted consume alcohol*? **No** **Yes** *(Si)*
If yes, # of drinks/week *Si usted confirmo si, # de bebidas a la semana* _____

7. **Do you have any history of overdosing on meds** *Tiene usted un historial de sobredosis en medicamentos*? **No** **Yes** *(Si)*
If yes, how long ago, and on what medication *Si confirmo si, hace cuanto y en que medicamento*?

_____

_____

8. **Do you have any history of illegal drug use** *Tiene usted historial de uso de drogas ilegales* ? **No** **Yes** *(Si)*
If yes, how long was use *Si confirmo si, por cuanto tiempo*? _____ **When did you quit** *Cuando renuncio?* _____

and on what drug? Please circle *Y en que droga? Por favor circule*:

Cocaine *Cocaina* **Heroine** *Heroina* **Methamphetamine** *Metanfetamina* **Alcohol** **Marijuana** **Other:** _____ *Otro*

Current use *Uso actual*? **No** **Yes** *(Si)*

9. **Have you ever been incarcerated due to illegal drug use?** **No** **Yes** *(si)*

If yes, please explain *Si su respuesta fue "si" por favor explique*: _____

_____

_____

HEALTH QUESTIONNAIRE
(QUESTIONARIO DE SALUD)

10. **Do you have any history of domestic violence** ***Tiene usted historial de violencia domestica***? **No** **Yes** *(Si)*

If yes, how long ago *Si usted confirmo si, hace cuanto*? _____

11. **Do any of the following apply to a blood relative? Circle all that apply.**
Alguno de los siguientes se aplican a un pariente de sangre? Circule el que aplique

	Relationship *(Relacion)*		
Arthritis *(Artritis)*	_____		
Asthma *(Asma)*	_____	**Hepatitis**	_____
Bleeding Tendency *(Tendencia a Sangrar)*	_____	**High Blood Pressure** *(Alta precion)*	_____
Blood Disorders *(Trastorno Sanguinio)*	_____	**Kidney Disorder** *(Trastorno del Riñon)*	_____
Cancer	_____	**Lung Disorder** *(Trastorno del Pulmon)*	_____
Diabetes	_____	**Nerve Disorder** *(Trastorno Nervioso)*	_____
Heart Disease *(Enfermedad del Corazon)*	_____	**Stroke**	_____

12. **Have you ever been treated for any of the following problems? (Mark all that apply)**
Alguna vez a sido tratado por alguno de los siguientes problemas (Marque lo que corresponda)

( ) **Weight loss, chronic fevers** *(Perdida de peso, fiebre cronica)*
( ) **Asthma** *(Asma)*
( ) **Hepatitis**
( ) **Skin Lesions/Rashes** *(Lesiones de la piel / Erupciones)*
( ) **Visual Disturbances or Loss** *(Trastornos visuales o perdida)*
( ) **Breast Lesions** *(Lesiones de Pecho)*
( ) **Dizzy Spells / Blackouts** *(Mareos/Desmayos)*
( ) **Seizures** *(Convulciones)*
( ) **Diabetes**
( ) **Arthritis** *(Artritis)*
( ) **Difficulty Swallowing** *(Dificultad para Tragar)*
( ) **Vomiting Blood** *(Vomitando Sangre)*
( ) **Hearing Loss** *(Perdida Auditiva)*
( ) **Stomach Ulcers** *(Ulceras Estomacales)*
( ) **Ear / Sinus Infections** *(Infecciones de Oido/Sinucitis)*
( ) **Blood in Stools** *(Sangre en defeco)*
( ) **Arm or Leg Weakness** *(Debilidad en Brazos o Piernas)*
( ) **High Blood Pressure** *(Alta Precion)*
( ) **Heart Attacks** *(Ataques al Corazon)*
( ) **Urinary Tract Infections** *(Infecciones Urinarias)*
( ) **Blood in Urine** *(Sangre en la Orina)*
( ) **Thyroid Disease** *(Enfermedad de la Tiroides)*
( ) **Arrhythmia / Palpitations** *(Arritmia/Palpitaciones)*
( ) **Difficulty Voiding** *(Dificultad al defecar)*
( ) **Anemia/Bleeding Problems** *(Anemia/Problemas de sangrado)*
( ) **Tuberculosis**
( ) **Shortness of Breath** *(Falta de aliento)*
( ) **Sexual Difficulties** *(Dificultades Sexuales)*
( ) **Drug Addiction** *(Adiccion a las drogas)*
( ) **Psychiatric Illness** *(Enfermedad Psiquiatrica)*
( ) **Infectious disease (HIV, Hepatitis, H1N1)** *(Enfermedades infecciosas [SIDA, Hepatitis, H1N1])*

Signature: _____ **Date:** _____

Firma *Fecha*

ADVANCED PAIN MANAGEMENT

DATE *(FECHA)*: _____

YOUR NAME *(NOMBRE)*:_____ **PHONE NUMBER** *(TELEFONO)*: _____

ADDRESS *(DOMICILIO)*: _____

INSURANCE *(ASEGURAZA)*: _____

PRIMARE CARE PROVIDER NAME *(DOCTOR PRIMARIO)*:_____

1. **WHERE IS YOUR MAIN AREA OF PAIN TODAY?(PLEASE CHECK ✓ ALL THAT APPLY)** *(DONDE ESTA SU AREA PRINSIPAL DE DOLOR)*

( ) **HEAD** *(CABEZA)*	( ) **CHEST** *(PECHO)*	( ) **ABDOMEN**	( ) **NECK** *(CUELLO)*
( ) **UPPER BACK** *(ESPALDA ALTA)*	( ) **LOWER BACK** *(ESPALDA BAJA)*	( ) **MIDDLE BACK** *(ESPALDA MEDIA)*	
( ) **KNEES** *(RODILLAS)*	( ) **Left** *(Izquierda)*	( ) **Right** *(Derecha)*	( ) **Both** *(Ambas)*
( ) **SHOULDERS** *(HOMBROS)*	( ) **Left** *(Izquierdo)*	( ) **Right** *(Derecho)*	( ) **Both** *(Ambos)*
( ) **HIPS** *(CADERAS)*	( ) **Left** *(Izquierda)*	( ) **Right** *(Derecha)*	( ) **Both** *(Ambas)*
( ) **ARMS** *(BRAZOS)*	( ) **Left** *(Izquierda)*	( ) **Right** *(Derecha)*	( ) **Both** *(Ambos)*
( ) **LEGS** *(PIERNAS)*	( ) **Left** *(Izquierda)*	( ) **Right** *(Derecha)*	( ) **Both** *(Ambas)*
( ) **HANDS** *(MANOS)*	( ) **Left** *(Izquierda)*	( ) **Right** *(Derecha)*	( ) **Both** *(Ambas)*
( ) **FEET** *(PIES)*	( ) **Left** *(Izquierdo)*	( ) **Right** *(Derecho)*	( ) **Both** *(Ambos)*

OTHER *(OTRO)*: _____

2. **HOW WOULD YOU RATE THE PAIN ON A SCALE FROM 1-10? (PLEASE CIRCLE)**
   COMO CALIFICARIA SU DOLOR EN LA ESCALA DEL 1-10? (POR FAVOR CIRCULE)
   1 2 3 4 5 6 7 8 9 10 **with pain medication** *(con medicamentos)*
   1 2 3 4 5 6 7 8 9 10 **without pain medication** *(sin medicamentos)*

3. **HOW WOULD YOU DESCRIBE THE PAIN? (PLEASE CIRCLE)***(COMO DESCRIBIRIA SU DOLOR? FAVOR DE CIRCULAR)*

   Aching *(Doloroso)*, **Burning** *(Ardor)*, **Stabbing** *(Cuchillada)*, **Shooting** *(Disparo)*, **Sharp** *(Fuerte)*, **Electricity** *(Electrico)*, **Numbness** *(Adormecido)*, **Tingling** *(Hormigueo)*, **Soreness** *(Infamado)*, **Throbbing** *(Palpitante)*, **Pressure** *(Presion)*, **Other** (Otro): _____

4. **WHAT RELIEVES THE PAIN? (PLEASE CIRCLE)** *(QUE ALIVIA SU DOLOR?)*

   Rest *(Descanso)*, **Ice** *(Hielo)*, **Heat** *(Calor)*, **Relaxation** *(Relajacion)*, **Medication** *(Medicamento)*, **Meditation** *(Meditacion)*, **Changing positions** *(Cambio de posicion)*, **Injections** *(Injecciones)*, **Lying down** *(Al recostarse)*, **stretching** *(Estirandose)*
   Other *(Otro)*: _____

5. **WHAT INCREASES THE PAIN? (PLEASE CIRCLE)** *(QUE AUMENTA SU DOLOR?(PORFAVOR CIRCULE)*
   Stress *(Estres)*, **Activity** *(Actividad)*, **Walking** *(Caminar)*, **Sitting** *(Sentado)*, **Standing** *(De Pie)*, **Pushing on area** *(Empujando el area)*, **Movement** *(Movimiento)*, **Cold weather** *(Clima frio)*, **Lifting** *(Levantamiento)*, **Bending** *(Al doblarse)*,
   Other *(Otro)*: _____

6. **WILL YOU BE REQUESTING PAIN MEDICATION AT TODAY'S VISIT** *(SOLICITARA MEDICAMENTOS EL DIA DE HOY)*? **YES** *(SI)* **NO**

*********FOR RETURNING PATIENTS ONLY *(SOLO PARA PASIENTES QUE REGRESAN)* *********

1. **DO YOU HAVE ANY NEW MEDICATION OR ALLERGIES SINCE YOUR LAST VISIT** (*TIENE USTED NUEVO MEDICAMENTO OR NUEVAS ALERGIAS)*? **YES** *(SI)* **NO**
   a. **If yes, what is the new allergy** *(Si confirmo si, cual es la nueva alergia)*? _____
   b. **What is the new medication** *(Cual es el Nuevo medicamento)*? _____
2. **Have you had any hospital or emergency room visits since the last office visit** *(Ha estado hospitalizado en el cuarto de emergencia desde su ultima visita)*? **Yes** *(si)* **No**

VITAL SIGNS: RR _____ **PULSE** _____ **BP** _____ **O2XAT** _____ **TEMP** _____ **HEIGHT** _____ **WEIGHT** _____.

Phone: 623-466-6350
Fax: 602-358-8698

Brian S. Page, DO
Interventional Pain Physician
Board Certified Pain Management
Board Certified Anesthesia

Dinesh Chinthagada, MD
Interventional Pain Physician
Board Certified Anesthesia

Nicole Brown, FNP-C

Susan Bailey, FNP-C

Nathan Franke, PA-C

Leslie Kotsis, ANP-C

Lindsay Burk, PA-C

Elizabeth Colman, FNP-C

Kelly Carr, FNP-C

Amelia Campbell, FNP-C

Liana Flores, FNP-C

Vanessa Schlauderaff, FNP-C

Angela Marton, AGPCNP-B

Marybeth Barcome, FNP

Alyson Vigneau, FNP-C

CONSENT FOR MEDICAL TREATMENT

CONSENTIMIENTO PARA TRATAMIENTO MEDICO

The following information is to be completed by the patient or the patient's legally authorized representative /parent:
La siguiente informacion tiene que ser completada por el paciente o un representate/familiar legalmente autorizado:

_____

Print Patient Name *(Nombre Del Paciente)*

I consent to medical treatment for myself or for the patient for whom I am the parent or, legally authorized representative. I understand that Advanced Pain Management (Dr. Brian Page) will share Patient health information according to federal and state law for treatment, payment, and operations.
Yo consiento tratamiento medico para mi o para el paciente del cual soy familiar o representante autorizado legal. Yo entiendo que Advanced Pain Management (Dr. Brian S. Page) compartira informacion medica del paciente de acuerdo a las leyes federales y estatales, pagos y otras opreraciones.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patent incurs the charges. I authorize the insurance provider to pay Advanced Pain Management (Dr. Brian Page). Please be advised that a separate co pay for services may be applied by your insurance company, in addition, to any facility co pay you may have already paid.
Yo entiendo que el paciente es responsable por todos los cargos incurridos independientemente del estatus de la aseguranza. El paciente esta de acuerdo en pagar los servicios incurridos. Yo autorizo a mi compañia de seguros a cubrir los servicios de Advanced Pain Management (Dr. Brian S. Page). Por favor tenga en mente que puede que su aseguranza requiera un copago en adicion del pago que usted ya ha dado a la compañia de aseguranza.

Please be advised there is a charge for filling out FMLA, Disability, or Work release paperwork. Prior to submitting forms please ask for a fee schedule. Payment is required prior to filling out forms.
Por favor tenga en mente que se cobrara por llenar las formas de FMLA, Desabilidad o formas para regresar a trabajar. Antes de someter las formas favor de pedir la lista de los cargos y pagar por adelantado.

Signature of Patient: _____ **Date:** _____
Firma del Paciente

Signature of Legally Authorized Representative:

_____
Firma del familiar o del representante autorizado

Relationship of Legally Authorized Representative to patient:

_____
Relacion del representante con el paciente

Advanced Pain Management

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MISSED APPOINTMENTS

CITAS PERDIDAS

Is the responsibility of the patient to call at least 24 hours in advance of their scheduled appointment if the patient cannot make their appointment.

Es la responsabilidad del paciente de llamar 24 horas antes de su cita si el paciente no se puede presentar.

If a patient "no-shows" an appointment-which means not contacting the office staff directly in advance of their appointment to cancel-then the patient will be responsible for a "no-show" fee of $25.00. This fee will be billed to the patient-nor their insurance company-and will be due at their next scheduled appointment.

Si el paciente no se presenta a su cita sin haber contactado a la oficina directamente 24 horas antes para cancelar la cita habra un cobro de $25, este cobro sera enviado directamente al paciente y no a la aseguranza, el cobro se vencera en su siguiente visita a la oficina.

Is the responsibility of the patient to keep track of their appointment date and time, and to contact the office if unable to keep the appointment.

Es la responsabilidad del paciente de mantener seguimiento de sus citas, fecha y hora, y contactar a la oficina si es que no sera posible presentarse.

I, _____ have read the above, understand it fully, and agree to pay the $25.00 fee for any "no-show" appointment by signing below:

Yo, _____ *he leido, entendido y estoy de acuerdo de pagar el cobro de $25 por cualquier cita perdida.*

_____ _____

Patient Signature ***(Firma Del Paciente)*** **Date** ***(Fecha)***

HIPAA NOTICE OF PRIVACY PRACTICES

NOTICIA DE LAS PRACTICAS DE PRIVACIDAD HIPAA

Signature below is only acknowledgement that you have received this Notice of Our Privacy Practices:

Al firmar la parte de abajo es solo para dejar saber que usted a recibido la Noticia de las Practicas de Privacidad.

Signature: _____ **Date:** _____

Firma *Fecha*

Phone: 623-466-6350
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Patient Authorization for Use and Disclosure of Protected Health Information

Advanced Pain Management will not disclose your medical information (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Advanced Pain Management to release your medical information to parties indicated.

Authorized parties

By signing below, I authorize Advanced Pain Management, to use and/or disclose any and all of my protected health information of any kind and description to the following party or parties:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge that I have had the opportunity to review Advanced Pain Management Notice of Privacy Practices, which is displayed for public inspection at its facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Advanced Pain Management. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to address is listed below:

Advanced Pain Management
20325 N. 51st Ave Bldg. 8 Ste. 160
Glendale AZ 85308

Patient Name: _____

Signature of Patient or Legal Guardian: _____ Date: _____

ADVANCED PAIN MANAGEMENT

OFFICE POLICY ON MEDICATION & URINE DRUG SCREEN

POLIZA DE LA OFICINA SOBER LOS MEDICAMENTOS Y LAS PRUEBAS DE ORINA

Please initial on each line after reading

Favor de poner sus iniciales en cada linea después de leer

_____ All **opioids and muscle relaxant medications are prescribed through Advanced Pain Management and cannot be obtained from any other provider including emergency rooms, urgent cares, dentists, and hospitals.**
Todo medicamento opioide y relajante muscular es recetado a través de Advanced Pain Management y no puede obtenerse de cualquier otro proveedor incluso de las salas de emergencia, los centros de cuidados urgentes, los dentistas y los hospitales.

_____ Refills are done on a month to month basis **only**. Refills require a follow up visit before prescriptions are written. The patient must pick up the script themselves. Refills cannot be called into the pharmacy. Refills or medication changes cannot, and will not be prescribed before they are due.
*Los recambios se recetaran **solamente** de mes en mes. Los recambios requieren una visita mensual antes de que se escriba la nueva receta. El paciente **tiene** que recoger la receta personalmente. Los repuestos no se llevan a cabo simplemente llamando a una farmacia. Los recambios o los cambios de medicamento no se recetaran antes del periodo en que le toquen.*

_____ If your medications are lost, stolen, or destroyed, they **will not** be replaced even if you have a police report.
*Si se le han perdido, robado o se le han destruido los medicamentos, **no** serán reemplazados aun teniendo un reporte de policia.*

_____ If you have difficulty with a medication that has been prescribed to you, please call the office to report the problem and make an appointment to be evaluated.

Si tiene alguna dificultad con el medicamento que se le ha recetado, favor de llamar a la oficina para reportar el problema y haga una cita para se reevaluado.

_____ We strongly urge patients to make your next monthly follow up visit for medications at the time of your last visit. Please do not wait until your medication is out or a few days before due to limited availability for appointment.
Le rogamos a los pacientes que hagan la cita para la visita mensual para reponer los medicamentos estando en la última visita. Favor de no esperar hasta que se le agote la medicina o hasta que le falten pocos días para agotarse, dado que hay un número limitado de citas disponibles.

_____ If you "no show" an appointment there is a $25.00 charge.
*Si no se presenta para una cita hay un cargo de **$25.00***

_____ Urine drug screens are required for all patients receiving opioid prescriptions. You must provide an adequate sample. No opioids will be prescribed until you are able to. **If unable to provide a sample** within designated time, you will not receive prescription that day and will need to reschedule your appointment. If you are unable to provide a sample by 4:00 pm, you will not receive prescription that day and will need to reschedule your appointment. If you are scheduled at 4:00 pm or 4:15 pm and you are unable to go your will only be given until 4:30 pm, to provide a sample. If you still unable to provide a sample you will be asked to reschedule your appointment.
*Son obligatorios los análisis de orina para la detección de drogas para todo paciente que reciba recetas de opioides. Usted **tendrá** que proveer una muestra adecuada. No se le recetaran opioides antes de que usted cumpla con esto. **Si usted no puede proveer la muestra** dentro del periodo de tiempo designado, **no** recibirá la receta ese día y tendrá que hacer una nueva cita para otro día. Si usted no puede proveer una muestra para las 4:00pm, usted no recibirá su receta ese mismo día y tendrá que reprogramar su cita. Si a usted se le ha programado un acita a las 4:00pm o 4:15 pm y no puede proveer una muestra solo se le dará hasta las 4:30 pm para proveer la muestra. Su aun no puede proveer la muestra se le tendrá que reprogramar su cita para otro día.*

_____ You can face discharge of opioid therapy if you test positive on your urine drug screen for alcohol, any illegal substances, and other opioid not prescribed by this office, or test negative for medication you are prescribed by our office.
Usted podrá ser despedido o se le podrá dar de alta de la terapia de opioides si usted da un resultado positivo en el análisis de orina para cualquier ***sustancia ilegal****, para cualquier opioide que* ***no*** *haya sido recetado por esta oficina o si da un resultado negativo para el medicamento que le fue recetado por nuestra oficina.*

_____ I am consenting to, and aware that Advanced Pain Management will be searching each month for pharmacy reports to insure compliance of our policies, misuse of medications etc. Failure to consent to these searches each month will result in no medications being provided during my care as per the policy of our practice. Injections and physical therapy would still be offered to patient.
Yo autorizo y estoy consciente que Advanced Pain Management revisara cada mes el reporte farmacéutico para asegurar que las pólizas están siendo Enforzadas, mal uso de medicamentos, etc... Si usted se niega a dar autorización, por póliza de la oficina, sus recetas médicas no serán abastecidas durante su cuidado médico. Tratamiento de Inyecciones y terapia física serán aun ofrecidas.

_____ We are interventional pain management facility. We do not provide medications for patients unless they are completing the intervention treatments prescribed for them. **If you are scheduled for an injection/treatment, and cancel or "no show" 3 times, you are subject to being weaned off opioid medications and/or candidate for discharge from our practice.**
Somos una oficina de manejo de dolor intervenciónal. Nosotros ***no*** *proveemos medicamentos para pacientes al menos que estén recibiendo tratamiento intervéncional. Si usted se le ha hecho una cita para inyecciones/tratamiento y cancela o "no se presenta" a su cita 3 veces seguidas puede resultar a ser dado de baja de los medicamentos y se convierte en candidato para ser dado de baja de nuestra práctica.*

_____ I understand that I may be prescribed potentially dangerous medication and that, if taken improperly, it may lead to excess sedation, respiratory depression and DEATH.
Yo comprendo que es posible que se me recete un medicamento potencialmente peligroso y que si yo lo tomo de forma inapropiada puede que cause sedación, depresión respiratoria y ***MUERTE****.*

_____ If you have a **MEDICAL MARIJUANA CARD**, we will be happy to provide physical therapy and interventional pain treatments to treat your pain. We will **NOT** prescribe narcotic medications in conjunction with medical marijuana.
Si usted tiene una ***tarjeta médica para marihuana*** *nosotros le podremos proveer terapia física y tratamiento intervenciónal para tratar su dolor. La oficina* ***NO*** *le recetara medicamentos narcóticos juntamente con la marihuana.*

_____ I will not give, lend, or sell my prescriptions to other people.
Yo no les daré, les prestare, ni les venderé mis recetas a otras personas.

_____ I have read and understand the policies on medication refills and urine drug screens and agree to abide by them.
Yo he leído y comprendo las pólizas vigentes sobre los recambios de medicamentos y los análisis de orina para detección de drogas. He recibido una copia y me comprometo a cumplir con ellas.

_____ I have read and understand the policies and the risks of taking opioids medications while pregnant and agree to abide by them.
Yo he leído y comprendo las polizas y riesgos de consumir opioides durante el embarazo y me comprometo a cumplir con ellas.

_____ _____
Print Name *(Nombre)* **Date** *(Fecha)*

_____ _____
Signature *(Firma)* **Date** *(Fecha)*

My Current Medication List

Name: ______________________________ **DOB:** ______________

(Nombre) *(Fecha de Nacimiento)*

Drug Allergies: ______________________________

(Alergia a medicametos)

Medication *(Medicamento)*	**Strength** *(Dosis)*	**How Often?** *(Cada cuando)*	**Comments** *(Comentarios)*

Phone: 623-466-6350
Fax: 602-358-8698

Brian S. Page, DO
Interventional Pain Physician
Board Certified Pain Management
Board Certified Anesthesia

Dinesh Chinthagada, MD
Interventional Pain Physician
Board Certified Anesthesia

Nicole Brown, FNP-C

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Liana Flores, FNP-C

Vanessa Schlauderaff, FNP-C

Angela Marton, AGPCNP-B

Marybeth Barcome, FNP

Alyson Vigneau, FNP-C

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

ADDRESS: _____

_____

BIRTH DATE: _____ PHONE NUMBER: _____

TO: _____

ADDRESS: _____

_____

PHONE NUMBER: _____ FAX: _____

PLEASE RELEASE A COPY OF MY MEDICAL RECORDS TO:

ADVANCED PAIN MANAGEMENT

20325 N 51ST AVE BLDG 8 STE 160 GLENDALE AZ, 85308

Phone: 623-466-6350 Fax: 602-358-8698

MEDICAL RECORDS MAY INCLUDE CONFIDENTIAL INFORMATION RELATED TO HIV, COMMUNICABLE DISEASE, ALCOHOL OR DRUG ABUSE AND MENTAL HEALTH DIAGNOSIS AND TREATMENT. I UNDERSTAND THAT I CAN
REFUSE THE RELEASE OF THIS TYPE OF INFORMATION.
(PLEASE INITIAL) _____
INFORMATION TO BE SENT: PLEASE CHECK ONE:
ALL: _____
OTHER _____ BE SPECIFIC: _____
I UNDERSTEND:

1. I MAY REVOKE THIS AUTHORIZATION EXCEPT THE EXTENT THAT IT HAS ALREADY BEEN ACTED ON.
2. TREATMENT WILL NOT BE CONDITIONED ON ME PROVIDING THIS AUTORIZATION, UNLESS THIS PROVISION OF HEALTHCARE IS SOLELY FOR THE PURPOSE OF CREATING PROTECTED HEALTH INFORAMATION FOR DISCLOSURE TO A THIRD PARTY.
3. ONCE THIS INFORMATION IS RELEASED, IT MAY BE REDISCLOSED BY THE RECIPIENT.
4. I MAY HAVE A SIGNED COPY OF THIS AUTHORIZATION
5. THIS FORM MUST BE ENTIRELY COMPLETED BEFORE INFORMATION WILL BE RELEASED.
6. THIS RELEASE IS VALID FOR ONE YEAR FROM SIGNED DATE.

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE'S SIGNATURE **DATE**

Phone: 623-466-6350
Fax: 602-358-8698

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POLICY FOR INCOMPLETE TREATMENT PLANS

POLITICA DE PLAN DE TRATAMIENTO INCOMPLETO

Our practice is an interventional pain management facility. We provide a variety of pain treatments that include, but not limited to, spinal and joint injections and physical therapy. We, also, provide medications (when requested/needed) to patients who are **completing** the interventional treatments prescribed for them in their treatment plan. **Failure to follow through with your treatment plan can result being weaned off of any medication s you have been prescribed, and/or will become a candidate for discharge from our practice.**

Nuestra práctica es una oficina para el tratamiento intervencional del dolor. Nosotros proveemos una variedad de tratamientos para controlar el dolor, eso incluye pero no se limita a, inyecciones para la columna, coyunturas y terapia fisica. Asi mismo proveemos medicamentos (cuando usted lo pida/necesite) a pacientes que han completado los tratamientos intervencionales que se le han recetado en su plan de tratamiento. ***No seguir adelante con su plan de tratamiento puede resultar a ser dado de baja de los medicamentos y se convierte en un candidato para ser dado de baja de nuestra práctica.***

FOR PROCEDURES: If you "no show" or cancel your procedures twice a row you are **failing to follow through with your treatment plan.**

PARA PROCEDIMIENTOS: *Si usted "no se presenta" o cancela sus procedimientos tres veces seguidas usted* ***no está siguiendo adelante con el plan de tratamiento.***

FOR PHYSICAL THERAPY: If you "no show" or cancel your procedures twice a row you are **failing to follow through with your treatment plan.**

PARA TERAPIA FISICA: *Si usted "no se presenta" o cancela sus procedimientos tres veces seguidas usted* ***no está siguiendo adelante con el plan de tratamiento.***

I have read, and understand the policy for incomplete treatment plans made for me by Advanced Pain Management.

He leido y entendido la politica para el plan de tratamiento incompleto que se ha hecho para mi por Advanced Pain Management.

_____ _____

PATIENT NAME (NOMBRE DEL PACIENTE) **DATE** (FECHA)

_____ _____

SIGNATURE (FIRMA) **DATE** (FECHA)

Advanced Pain Management

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OPIOID RISK TOOL FORM

Date/Fecha: _____

Print Name: _____ DOB: _____
Nombre *Fecha de nacimiento*

		Score if Female	Score if Male
1.Family History of Substance Abuse *Historial Familiar de Abuso de Sustancias.*	• Alcohol • Illegal Drugs *(Drogas Ilegales)* • Prescription Drugs *(Drogas Recetadas)*	☐1 ☐2 ☐4	☐3 ☐3 ☐4
2.Personal History of Substance Abuse *Historial Personal de Abuso de Sustancias.*	• Alcohol • Illegal Drugs *(Drogas Ilegales)* • Prescription Drugs *(Drogas Recetadas)*	☐3 ☐4 ☐5	☐3 ☐4 ☐5
3.Age (Mark Box if 16-45 years) *Edad (Marque la caja si 16-45años)*		☐1	☐1
4.History of Preadolescence Sexual Abuse *Historial de Abuso Sexual en la Preadolesencia.*		☐3	☐0
5.Psychological Disease *Enfermedad Psicologica*	○ • Attention-Deficit/Hyperactivity Disorder, • Obsessive Compulsive Disorder, Bipolar • Disorder, Schizophrenia. • *Por déficit de atención / hiperactividad, Trastorno* • *obsesivo-compulsivo, Desorden bipolar, esquizofrenia.* • Depression *(Depresion)*	☐2 ☐1	☐2 ☐1

Total Score: _____

(Puntuacion total)

'hone: 623-466-6350
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Consent for Electronic Communication

On occasion our office may need to communicate with you electronically. By utilizing our practice's electronic services, you agree that Advanced Pain Management may send to you any of the following that you identify as communication that can be sent through the internet to an email address you designate.

Consent and Acknowledgement

I, _____, agree that Advanced Pain Management may electronically communicate with me at the following email address.

Email Address: _____

Patient's Name: _____

Patient's Date of Birth: _____

I acknowledge that the practice may send the following to my email. Check each that apply and then provide your initials at the end of each item selected.

- Information about my invoice or accounts payable. _____(initial)
- Information about my appointments. _____(initial)
- Information about health concerns and recommendations for lifestyle, supplements, or any other instructions regarding my health concerns. _____(initial)

I acknowledge each of the following four statements, which is necessary before Advanced Pain Management can send communications electronically. _____ (initial)

Electronic communications sent to your personal email from Advanced Pain Management are not encrypted.
I am responsible for providing Advanced Pain Management with any updates to my email address.
I am able to receive information electronically and store it securely away from any public computer.
I can withdraw my consent to electronic communications by calling (623)295-4875.

Print Name: _____ Date: _____

Signature: _____

Relationship to patient (if patient is a minor or is unable to sign):_____

For office use only:

We attempted to obtain written acknowledgement and consent for electronic communication but acknowledgement could not be obtained because:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

CUESTIONARIO DE SALUD DEL PACIENTE

NAME: _____ **DOB:** _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer) ***Durante las unltimas dos semanas, con que frecuencia le han molestado los siguientes problemas?*** (Use "✓" para indicar su respuesta)	**Not at all** ***Para nada***	**Several Days** ***Varios Dias***	**More than half the days** ***Mas de la mitad de los dias***	**Nearly every day** ***Casi todos los dias***
1. Little interest or pleasure in doing things. *Poco interes o placer en hacer las cosas.*	0	1	2	3
2. Feeling down, depressed, hor hopeless. *Decaido, deprimido o sin esperanza.*	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much. *Problemas par conciliar o mantener el sueño o dormir demaciado.*	0	1	2	3
4. Feeling tired or having little energy. *Sensacion de cansancio o tener poca energia.*	0	1	2	3
5. Poor appetite or overeating. *Falta de apetito o comer en exceso.*	0	1	2	3
6. Feeling bad about your self-or that you are a failure or have let yourself or your family down. *Sentirse mal consigo mismo o que usted es un fracaso en su familia.*	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television. *Dificultad para concentrarse en las cosas, como leer el periodico o la televisión.*	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite-being so fidgety or restless that you have been moving around a lot more tha usual. *En movimiento o hablando tan lentamente que otras personas se han dado cuenta? O lo contrario-Estar tan inquieto que ha estado moviendo mucho mas de lo habitual.*	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself. Pensamientos que sería mejor estar muerto o pensamientos de hacerse daño asi mismo de alguna manera.	0	1	2	3

Columns Total: _____+ _____+ _____

Add Totals all together: _____

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

Si usted marco uno de estos problemas, con que dificultad a podido hacer su trabajo, ocuparse de su hogar o llevarse bien con otras personas?

☐ Not difficult at all *No dificultad*

☐ Somewhat difficult *Algo de dificultad*

☐ Very difficult *Muy dificultuoso*

☐ Extremely difficult *Extremadamente dificultoso*

GAD-7 EVALUATION

Transtorno de Ansiedad Generalizada

NAME: _____ **DOB:** _____ **DATE:** _____

Over the last two weeks, how often have you been bothered by the following problems? (Please circle your answer)
Durante las unltimas dos semanas, con que frecuencia le han molestado los siguientes problemas? (Por favor Circule su respuesta)

	Not at all *Para nada*	Several Days *Varios Dias*	More Than ½ the Time *Mas de la mitad de los Dias*	Nearly Every Day *Casi todos los dias.*
1. Feeling nervous, anxious or "on the edge" *Nervioso, ansioso, o al borde.*	0	1	2	3
2. Not being able to stop or control worrying. *No ser capaz de detener o controlar la preucupacion.*	0	1	2	3
3. Worrying too much about different things. *Preocuparse demasiado por diferentes cosas.*	0	1	2	3
4. Have trouble relaxing. *Problema al relajarse.*	0	1	2	3
5. Become so restless it's hard to sit still. *Estar tan inquieto que es muy dificil estarse quieto.*	0	1	2	3
6. Becoming easily annoyed or irritated. *Molestarse or irritarse facilmente.*	0	1	2	3
7. Feeling afraid as if something awful may happen. *Sentir miedo de que algo malo pueda pasar.*	0	1	2	3
Add Columns:	_____	_____	_____	_____
Total Score:	_____			

	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? **(circle one)** *Si usted marco cualquiera de estos problemas, con que dificultad a podido hacer su trabajo, ocuparse de su hogar o llevarse bien con otras personas? (Circule uno)*	*No dificultad*	*Algo de dificultad*	*Muy dificultoso*	*Extremadamente Dificultoso*

9. When did symptoms begin? _____.
Cuando comensaron los sintomas?

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt or our Notice of Privacy Practices or to document our

good faith effort to obtain that acknowledgment.

I, _____ have received a copay of this office's Notice of Privacy Practices. *You have the right of refuse to sign this document.*

_____

(Please Print Name)

_____

(Signature)

Date: _____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

☐ The patient or individual refused to sign this document.

☐ Communications conflicts prohibited us from obtaining the acknowledgment.

☐ An emergency situation prevented us from obtaining acknowledgment.

☐ Other (Please Specify) _____

_____

_____