OrangeMedical
Pain Management

NEW PATIENT REGISTRATION INFORMATION

DATE: _____

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

Sex: □ Male □ Female **Race**: _____ **Ethnicity**: _____

Date of Birth: _____ **Social Security #**: _____ **Driver License #:** _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Home Address: _____ **Apt#**:_____

City: _____ **State**: _____ **Zip**: _____

Email Address: _____

Marital Status: □ Single □ Married □ Divorced □ Partnered □ Widowed

Employer: _____ **Occupation**: _____

Emergency Contact: _____ **Relationship**: _____

Emergency Cell Phone: _____ **Work Phone**: _____

Referred by: _____

How did you hear about Orange Medical? □ **ZocDoc** □ **Facebook** □ **Google** □ **Yelp** □ **Family**
□ **Friend** □ **Other** _____

Preferred Pharmacy

Pharmacy Name: _____ **Phone**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

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NEW PATIENT REGISTRATION INFORMATION

Insurance Information

Primary Insurance: _____

Group #:_____ **Policy/ID#:** _____

Complete this box if you are not the policy holder for your primary insurance.

Policy Holder Name: _____

Date of Birth: _____ **Social Security #**: _____

Sex: □ Male □ Female **Relationship to Insured**: _____

Secondary Insurance: _____

Group #:_____ **Policy/ID#:** _____

Complete this box if you are not the policy holder for your secondary insurance.

Policy Holder Name: _____

Date of Birth: _____ **Social Security #**: _____

Sex: □ Male □ Female **Relationship to Insured**: _____

Workers Compensation Claim Information (If applicable)

Workers Compensation Company: _____ Phone Number: _____

Adjuster Name: _____ Case Manager Name: _____

Date of Injury: _____ Claim Number: _____

Personal Injury (If applicable)

Have you been injured in a motor vehicle accident or other accident? □ No □ Yes

Have you hired an attorney for purposes of making claims arising from that accident? □ No □ Yes

Firm Name: _____ Phone Number: _____

Attorney Name: _____ Phone Number: _____

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NEW PATIENT REGISTRATION INFORMATION

REVIEW OF SYSTEMS

Are You <u>CURRENTLY</u> Experiencing Any of the Following?

Constitutional: □ Fever □ Chills □ Difficulty Sleeping □ Fatigue □ Loss of Libido □ Unexplained Weight Gain □ Unexplained Weight Loss □ Weakness □ Antibiotic Use: _____ _____	**Respiratory:** □ Difficulty Breathing □ Wheezing □ Bronchitis □ Cough **Cardiovascular:** □ Chest Pain □ Swelling in Feet □ Fainting □ Lightheadedness	**GI/GU/Hepatic:** □ Bowel Incontinence □ Bladder Incontinence □ Diarrhea □ Constipation □ Nausea/Vomiting □ Bloody stool/vomit	**Eyes/Ears/Nose/Throat/Mouth:** □ Jaw Pain □ Visual Disturbances □ Sinus Disturbances
Musculoskeletal: □ Joint Pain □ Muscle Spasm □ Joint Swelling	**Neurological:** □ Dizziness □ Headache □ Numbness/Tingling □ Peripheral Neuropathy □ Unsteady Walking □ Recent Falls	**Psychiatric:** □ Suicidal Thoughts □ Suicidal Planning □ Depression □ Crying Spells □ Anxiety	**Other (Please Explain):** _____ _____ _____ _____ _____ _____ _____

MEDICATIONS (including Over the Counter, Vitamins, Herbs etc)

□ I am not taking any medications

Medication Name:	Dose/How Many Times per Day?	Medication Name:	Dose/How Many Times per Day?

Are You Taking Blood Thinning Medication? **□ NO** **□ YES, Medication:** _____

OrangeMedical Pain Management

NEW PATIENT REGISTRATION INFORMATION

ALLERGIES

□ **I do NOT have any allergies**

Allergy:	Reaction:	Are You Allergic to Latex?	Are You Allergic to Shellfish or Iodine?
		□ No □ Yes	□ No □ Yes

PERSONAL MEDICAL HISTORY

Height: _____ Weight: _____

Have You Been Treated for Any of the Following?

Constitutional: □ Cancer, please explain:_____ _____ _____ □ HIV/AIDS □ Autoimmune Disorder (Explain): _____ _____ _____	**Respiratory:** □ Asthma □ Bronchitis □ COPD/Emphysema □ Pneumonia □ TB/tuberculosis □ Home Oxygen	**Cardiovascular:** □ High Blood Pressure □ Stroke □ Irregular Pulse □ Heart Attack □ High Cholesterol □ Anemia/Bleeding Disorders □ Pacemaker □ Defibrillator	**GI/GU/Hepatic:** □ Bowel Incontinence □ Bladder Incontinence □ GERD □ GI Bleeding □ Kidney Disease □ Dialysis □ Constipation □ Hepatitis A □ Active □ Inactive □ Hepatitis B □ Active □ Inactive □ Hepatitis C □ Active □ Inactive
Endocrine: □ Diabetes Type 1 □ Diabetes Type 2 □ Hypothyroidism □Hyperthyroidism **Eyes/Ears/Nose Throat/Mouth:** □ TMJ □ Glaucoma □ Visual Disturbances □ Hearing Loss	**Musculoskeletal:** □ Osteoarthritis □ Osteoporosis □ Rheumatoid Arthritis □ Amputation □ Vertebrae Fracture □ Bursitis □ Fibromyalgia □ Joint Replacement: _____ _____	**Neurological:** □ Seizures □ RSD/CRPS □ Cerebral Palsy □ Peripheral Neuropathy □ Parkinson's Disease □ Alzheimer's/Dementia □ Paralysis □ Multiple Sclerosis □ Insomnia □ Migraines/Headaches □ Other (Please Explain): _____ _____ _____	**Psychiatric:** □ Depression □ Bipolar Disorder □ Anxiety □ Schizophrenia/Schizoaffective Disorder **Other (Please Explain):** _____ _____ _____ _____ _____

OrangeMedical Pain Management

NEW PATIENT REGISTRATION INFORMATION

FAMILY HISTORY

□ **I Have NO Significant Family History** □ **I Am Adopted and Medical History is Unknown**

High Blood Pressure	□ Mother	□ Father	Cancer, Type:	□ Mother	□ Father
High Cholesterol	□ Mother	□ Father	Diabetes	□ Mother	□ Father
Stroke	□ Mother	□ Father	Thyroid Disease	□ Mother	□ Father
Heart Disease	□ Mother	□ Father	Kidney Disease	□ Mother	□ Father
Respiratory Disease	□ Mother	□ Father	Neurological Disease	□ Mother	□ Father
Rheumatoid Arthritis	□ Mother	□ Father	Osteoarthritis	□ Mother	□ Father

SOCIAL HISTORY

Tobacco Use:	**Alcohol Use:**	**Substance Use (please include any past history of use):**	**Have you ever inappropriately used prescription medications?**	**FEMALE patients:**
□ No/Never □ Current Smoker _____ packs/day □ Previous Smoker (quit date):_____ □ Chew	□ No/Never □ Social Use _____ drinks/week □ History Alcoholism	□ No/Never □ Marijuana (including medical card holders) □ Methamphetamine □ Heroin □ Cocaine □ Other:	□ No/Never □ Yes, please explain:	Are you sexually active? □ No □ Yes Are you using birth control? □ No □ Yes Type: _____ Are you breastfeeding? □ No □ Yes Post-menopausal? □ No □ Yes

SURGICAL HISTORY

TYPE OF SURGERY	DATE OF SURGERY	TYPE OF SURGERY	DATE OF SURGERY

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NEW PATIENT REGISTRATION INFORMATION

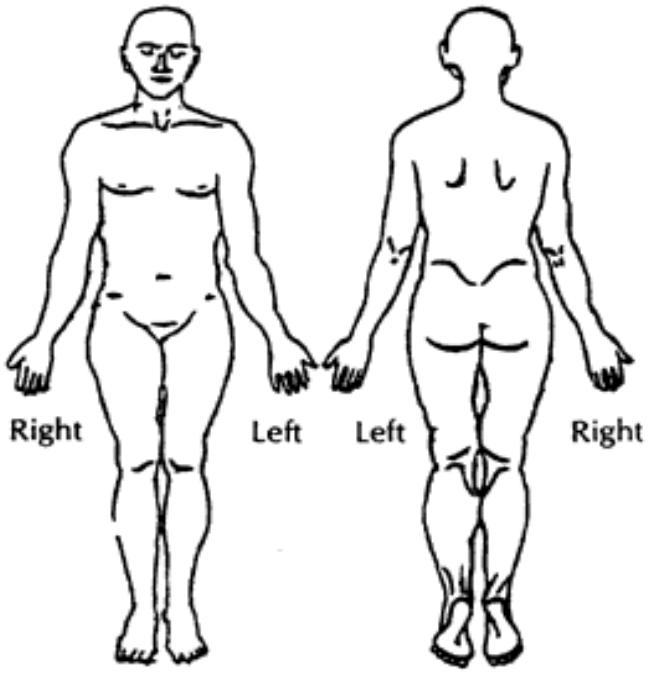
PAIN HISTORY

□ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Arm/Leg Pain □ Headache/Migraine □ Radiating Pain

□ Other: _____

When Did Your Pain Begin: _____ What Caused Your Pain: _____

Did Your Pain Begin (circle one): **Suddenly** **Gradually** □ **Left Handed** □ **Right Handed** □ **Ambidextrous**

Please Mark Your Pain on the Diagram	
Label Areas with the Following→ **"P"=Pins and Needles** **"B"=Burning** **"S"=Stabbing** **"A"=Aching** **"N"=Numbness**	

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NEW PATIENT REGISTRATION INFORMATION

DESCRIBE YOUR PAIN

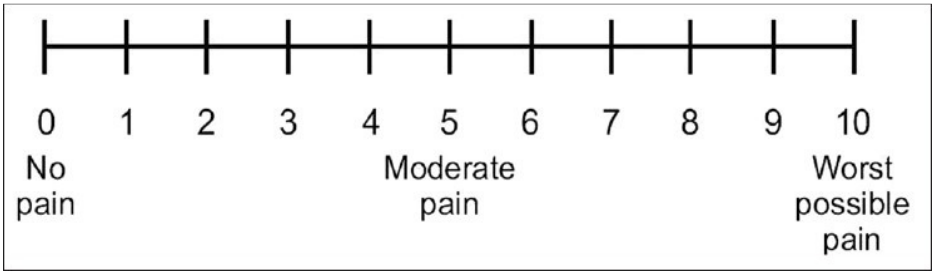
Using the 0-10 Pain Scale Please Rate Your Pain:

_____ Your Pain **Today**

_____ Your **Worst** Pain

_____ Your **Least** Pain

_____ **Average** Pain the Past Week



DESCRIBE YOUR PAIN

□ Constant □ Intermittent □ Unchanged □ Worse □ Better □ Occasional □ Other: _____

□ Aching □ Burning □ Cramping □ Deep Pressure □ Numbness □ Sharp □ Sharp-Shooting □ Spasming □ Stabbing

□ Throbbing □ Tightness □ Tingling □ Other: _____

What Makes Your Pain Worse?

□ Bending Forward/Backward □ Cold □ Coughing □ Driving □ Grasping □ Gripping □ Head Movement □ Sitting

□ Standing □ Walking □ Rising from a Seated Position □ Noise □ Light □ Sound □ Smells □ Laying Down

□ Other: _____

What Aspects of Your Life Have Been Affected By Your Pain?

□ Work (explain: _____) □ Mood □ Relationships □ Exercise □ Sleep

□ Walking □ Personal Care □ Social Activities (explain: _____

DIAGNOSTIC TESTING

Which Tests Have You Completed For Your Current Pain? **□ I Have Not Completed Testing Previously**

□ MRI Date of Test: _____ □ X-Ray Date of Test: _____

□ CT Scan Date of Test: _____ □ Ultrasound Date of Test: _____

□ EMG/NCV Date of Test: _____ □ Lab Work Date of Test: _____

Where Did You Have the Above Testing Completed? _____

OrangeMedical Pain Management

NEW PATIENT REGISTRATION INFORMATION

PREVIOUS PAIN TREATMENTS

Which Treatments Have You Completed For Your Pain?

□ Rest □ Ice □ Heat □ Massage □ Physical Therapy # of sessions: _____ □ Chiropractic Therapy □ TENS Unit □ Trigger Point Injections □ Joint Injections □ Epidural Steroid Injections □ Nerve Blocks □ Radiofrequency Ablation	□ Spinal Cord Stimulator Location:_____ □ Spine Surgery Type/Location: _____ □ Anti-Inflammatory/Acetaminophen □ Nerve Medications □ Muscle Relaxers □ Opioids □ Topical Creams/Patches □ Vitamins/Herbs Other: _____

OrangeMedical Pain Management

NEW PATIENT REGISTRATION INFORMATION

Patient, please fill out below:

Circle Each Box That Applies

OPIOID RISK TOOL		
Circle Each Box That Applies	**Female Patients**	**Male Patients**
Family History of Substance Abuse		
• Alcohol Abuse	**1**	**3**
• Illegal Drug Abuse	**2**	**3**
• Prescription Drug Abuse	**4**	**4**
Personal History of Substance Abuse		
• Alcohol Abuse	**3**	**3**
• Illegal Drug Abuse	**4**	**4**
• Prescription Drug Abuse	**5**	**5**
Age Between 16-45 Years	**1**	**1**
History Pre-Adolescent Sexual Abuse	**3**	**0**
Psychological Conditions		
• ADD; OCD; Bipolar; Schizophrenia	**2**	**2**
• Depression	**1**	**1**
TOTAL SCORE		

Staff enter score into the 'Vital Signs' segment of chart

NEW PATIENT REGISTRATION INFORMATION

CONTROLLED SUBSTANCE AGREEMENT & INFORMED CONSENT

PATIENT NAME: _____ DATE OF BIRTH: _____

Respect, confidence and trust are necessary components to the provider/patient relationship. We thank you for allowing our practice to manage your pain. The purpose of this agreement is to inform you, the patient, of our practice's intent to provide safe & responsible pain management when using controlled substances (this includes the use of prescription pain medications). Please review carefully and sign/date where indicated.

- I understand that controlled substance medications (including prescription pain medicines) may be associated with adverse side effects, which include but are not limited to: nausea, itching, drowsiness, dizziness, respiratory depression or arrest, altered mental status, low blood pressure, low heart rate, interactions with my other prescribed and/or over the counter medications, constipation, allergic reaction, decreased libido, urinary retention, low testosterone levels, altered pain tolerance, altered medication tolerance, physical dependency and/or addiction, and fatal overdose (death).
- I understand that each patient's pain is different. The medication regimen selected for me is individualized based on my reported pain, the thorough evaluation from my medical provider (including the review of diagnostic test results), my medical and social history and the pain management goals discussed with me by my medical provider. I understand that my medication regimen will change appropriately according to the changes in my reported pain and treatment plan.
- Controlled substance medications (including opioids) are not guaranteed with my office visit, these medications are prescribed based upon medical necessity.
- To safely serve each patient's pain management needs, Orange Medical, LLC will not provide controlled substance prescription refills during your procedure visit. You will need to schedule a separate medication refill office visit.
- I will only obtain controlled substance medications for my pain from Orange Medical, LLC. I will not fill a controlled substance medication for pain from another prescriber (including the emergency room, urgent care, a surgeon or dentist) without discussing with and getting approval by the office.
- I will utilize one designated pharmacy to fill my controlled substance medication prescriptions. Should I change pharmacies, it is my responsibility to inform the office and update the information.
- I understand that lost, misplaced or stolen prescriptions or medication (pills/patches) will **not** be replaced.
- I understand that early refills will not be granted, therefore I am not to misuse or self-escalate my medications. I am to take my medication only as prescribed.
- I understand that I am not to share my controlled substance medication with others, nor am I to take anyone else's controlled substance medication.
- I understand that selling my controlled substance medication is illegal and will refrain from this activity.
- In order to prevent harm to others, it is my responsibility to secure my controlled substance medication. Doing so prevents misuse, abuse, or accidental ingestion by others. We recommend a locked device (safe/lock box).
- I will discuss the need to dispose of my controlled substance medication with the office to ensure disposal is completed safely.
- I will not drink alcohol, use marijuana or other illegal substances while utilizing controlled substance medication.
- *Female patients:* I am not currently pregnant or breast feeding. I will notify my prescriber should I plan to, or become pregnant. I understand that a pregnancy test may be ordered to be considered an opioid candidate.

OrangeMedical
Pain Management

NEW PATIENT REGISTRATION INFORMATION

CONTROLLED SUBSTANCE AGREEMENT & INFORMED CONSENT (continued)

PATIENT NAME: _____ DATE OF BIRTH: _____

- I do not have suicidal thoughts or plans. I am not planning to harm others. Should these circumstances change, I will immediately notify Orange Medical, LLC. The National Suicide Hotline can be reached at: 1-800-273-8255
- Controlled substance medications may impair (and decrease) cognitive function, decision making, reflexes, concentration, mental stability and coordination. Therefore, Orange Medical, LLC recommends **no** driving a motor vehicle or operating heavy machinery while taking controlled substance medications.
- I will submit to urine/serum drug tests and/or requested medication counts (pill counts) as deemed necessary by my medical provider.
- Orange Medical, LLC complies with all federal and state regulations/recommendations with regards to prescribing controlled substance medications. Therefore, we will coordinate with your previous or current prescribers and pharmacies to assist in developing and monitoring your medication regimen.
- I understand the long-term use of controlled substance medications (particularly for pain) may have advantages and disadvantages. Orange Medical, LLC will utilize a comprehensive approach to treat and monitor my chronic pain. It is my responsibility to comply with my treatment plan, which includes attending my scheduled appointments, completion of requested diagnostic testing and active participation in my care.

I understand the terms of this agreement are in place for my safety and the safety of those around me. The terms of this agreement are my responsibility. I will adhere to the terms of this agreement. Should I violate any terms of this agreement, I understand that my medical provider will determine the most appropriate course of action which may include discontinuing the prescribing of my controlled substance medications, a referral to an addiction specialist and/or termination from Orange Medical, LLC. Orange Medical, LLC will obtain an updated Controlled Substance Agreement from me as per practice protocol. I will clarify any questions I have regarding the agreement with my medical provider.

Date: _____

Signed By: _____ _____

Signature of Patient or Legal Guardian | Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable | Relationship to Patient

OrangeMedical
Pain Management

NEW PATIENT REGISTRATION INFORMATION

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Orange Medical, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Orange Medical, LLC describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Orange Medical, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Orange Medical, LLC, 2626 E. University Drive #110 Mesa, Arizona 85213.

With this consent, Orange Medical, LLC may call my home or other alternative location an leave a message on voicemail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to clinical care, including laboratory test results, among others.

With this consent, Orange Medical, LLC may mail to my home or other alternative location and leave a message on voicemail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment remind cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Orange Medical, LLC may email to my home or other alternative location and any item that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Orange Medical, LLC will also be loading email into our new electronic health records system (EHR) and patient will have access to their information but it will be limited to their demographics, lab and x-rays.

I have the right to request that Orange Medical, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Orange Medical, LLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Orange Medical, LLC may decline to provide treatment to me.

Date: _____

Signed By: _____ _____

Signature of Patient or Legal Guardian | Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable | Relationship to Patient

NEW PATIENT REGISTRATION INFORMATION

RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the Notice of Privacy Practices.

Date: _____

Signed By: _____ _____

Signature of Patient or Legal Guardian — Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable — Relationship to Patient

COMMUNICATIONS CONSENT

To service your account or to collect any amount you may owe, you agree that Orange Medical, LLC and our agents may contact you by telephone at any telephone 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/artificial voice messages and/or use of automatic dialing devices.

Date: _____

Signed By: _____ _____

Signature of Patient or Legal Guardian — Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable — Relationship to Patient

OrangeMedical
Pain Management

NEW PATIENT REGISTRATION INFORMATION

FINANCIAL POLICY

1. **PAYMENT –** Payment for services is expected at the time of your visit. (This includes co-payments, deductibles, co-insurance, missed appointment fees, procedure prepayment; unpaid balance after insurance has paid their portion, past due, etc.). 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 are self-paying for services, full payment is expected before services are rendered. Orange Medical, LLC reserves the right to reschedule your appointment until outstanding balances are met. Any exception to the above must be discussed with our office before services are rendered.

2. **INSURANCE –** For your convenience, we will file all insurance claims. It is your responsibility to understand your insurance plan benefits and your associated co-payments, co-insurance, and deductibles (if applicable). Please contact your insurance company to clarify any of your insurance plan details.

- **Deductible:** A set annual amount that the patient is responsible for paying prior to the insurance making a payment. It is your responsibility to know if Orange Medical, LLC is an IN network or OUT of network provider under your insurance plan. Typically, there are separate deductibles for in-network vs. out-of-network services.
- **Co-Payment:** A set dollar amount per office visit that is the patient's responsibility. Your co-payment is due at the time of service.
- **Co-Insurance:** A percentage of the charge that is the patient's responsibility.

Your insurance company will send you and Explanation of Benefits (EOB) that details a summary of how your insurance company administered your benefits. The EOB will also detail your remaining financial responsibility. If you have questions regarding your EOB, please contact your insurance provider.

If your insurance company does not pay Orange Medical, LLC 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, minus any outstanding balance on your account.

I authorize Orange Medical, LLC 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 Orange Medical, LLC. I authorize Orange Medical, LLC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

3. **CANCELLATIONS OR MISSED APPOINTMENTS -** If you do not cancel your appointment at least 24 hours before, or if you no-show on the day of your appointment, we will charge the following fees:

- $25.00 missed clinic appointment
- $50.00 missed procedure appointment

4. **COMPLETION OF DOCUMENTS** – We are happy to complete additional documentation for your care. However, due to the nature of such documentation, we will need to collect the following fees at the time of request:

- $40.00 FMLA Documentation
- $20.00 Short Term Disability Documentation

5. **RESPONSIBILITY FOR PAYMENT -** I understand that I, personally, am financially responsible to Orange Medical, LLC for charges not covered by the assignment of insurance benefits.

NEW PATIENT REGISTRATION INFORMATION

Financial Policy

I have read and understand Orange Medical, LLC's Financial Policy:

Date: _____

Signed By: _____ _____

Signature of Patient or Legal Guardian — Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable — Relationship to Patient

OrangeMedical Pain Management

NEW PATIENT REGISTRATION INFORMATION

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Please allow 72 hours to process your request.

Date of Request: _____ Date Records Needed: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Phone Number: (_____)_____ SS# _____

Specific Records to be Released: □ Imaging Reports □ Lab Reports □ Office Visit Notes □ All Records

□ Obtain From

□ Release To

Name of Provider/Facility/Yourself: _____

Address: _____

City/State/Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____) _____

Date: _____

Signed By: _____ _____

Signature of Patient or Legal Guardian — Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable — Relationship to Patient

Medical Records Fee: $25.00 for first 25 pages, .50 for each page thereafter.

Phone: 480-526-5300 Fax: 480-550-8938

OrangeMedical
Pain Management

NEW PATIENT REGISTRATION INFORMATION

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____

I authorize Orange Medical, LLC and employees to use or disclose the following health information.

All of my health record information
I do not authorize disclosure of my health information.

Orange Medical, LLC may disclose this health information to the following recipient(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

Patient is a minor: _____ years of age Patient is unable to sign because: _____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: Parent Legal Guardian Court Order
Other: _____

Phone: 480-526-5300 Fax: 480-550-8938