Doctor: _____

ARIZONA NEUROSURGERY & SPINE SPECIALISTS, P.C.

PATIENT INFORMATION

Name: _____ Patient ID: _____ Sex: ☐M ☐F

Address: _____ Date of Birth: _____

_____ Social Security #: _____

City, State, Zip: _____ Married Status: ☐Married ☐Single ☐Divorced

Phone:_____☐home ☐work ☐other Referring Physician: _____

Phone:_____☐home ☐work ☐other Primary Physician: _____

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Other

Phone: _____

Employer: _____

EMERGENCY CONTACTS

Name	Relationship	Phone

GUARANTOR INFORMATION

☐ Same as patient

Name: _____ Employer: _____

Address: _____ Phone: _____

_____ Phone 2: _____

SSN: _____

City, State, Zip: _____ Date of birth: _____

PRIMARY INSURANCE INFORMATION

☐Same as patient ☐Same as Guarantor ☐Other

Insured Party Name: _____

Insured Phone: _____

Insurance Company: _____

Relationship to Insured: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Insured's date of birth:_____

SECONDARY INSURANCE INFORMATION

Insured Party: _____

Insured Phone: _____

Insurance Company: _____

Relationship to Insured: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

WORK or AUTO RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Claim Number: _____ Date of Injury: _____

Employer at the time of injury: _____

ASSIGNMENT AND RELEASE:

I understand that I am financially responsible for all services. I hereby assign my insurance benefits to be paid directly to Arizona Neurosurgery & Spine Specialists, P.C. when applicable. I also authorize the physician to release any information required to process this claim.

_____ _____

Patient/Guardian Signature **Date**

ARIZONA NEUROSURGERY
& SPINE SPECIALISTS, P.C.

CONTRACT FOR CONTROLLED SUBSTANCE AND OTHER PRESCRIPTIONS

Arizona Neurosurgery & Spine Specialists, P.C. and I understand that THE MAIN TREATMENT GOAL IS TO IMPROVE MY ABILITY TO FUNCTION AND OR WORK. In consideration of that goal, I AGREE TO HELP MYSELF BY FOLLOWING BETTER HEALTH HABITS, specifically involving exercise, weight control, and the use of tobacco or alcohol. I understand that only through following a healthy lifestyle can I hope to have the most successful outcome to my treatment.

Controlled substance medications (narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and abuse and are, therefore, clearly controlled by the local, state, and federal governments. They are intended to relieve pain or to improve function and/or ability to work and not simply to feel good, because my doctor is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I AM REPONSIBLE FOR MY CONTROLLED SUBSTANCE MEDICATIONS. If the prescription or medication is lost, misplaced, or stolen or if I use the medication up sooner than prescribed, I understand that IT WILL NOT BE REPLACED.
2. I WILL NOT REQUEST NOR ACCEPT controlled substance medication from another physician or individual while I am receiving such medication from Dr. Brown, Dr. Willis, Dr. Kumar, Dr. Menendez, Manda Chatelain ANP, Karen Taylor PA-C, or Nicole Hairston ACNP. It is illegal to do so and may endanger my health. The only exception is if it is prescribed while I am admitted to the hospital.
3. REFILLS OF MEDICATIONS:
    A. WILL BE TAKEN ONLY MONDAYS THROUGH THURSDAYS, 9:00 AM TO 5:00 PM. YOU MUST ALLOW 24 HOURS TIME FOR THE REFILLS TO BE AUTHORIZED BY YOUR DOCTOR, NP, OR PA AND CALLED IN. REFILLS WILL NOT BE MADE AT NIGHT, HOLIDAYS OR WEEKENDS. **THERE ARE NO EXEPTIONS.**
    B. **WILL NOT BE MADE IF I "RUN OUT EARLY"**. I am responsible for taking my medication in the dose prescribed and for keeping track of the amount on hand.
    C. **WILL NOT BE MADE AS AN "EMERGENCY**" such as Friday afternoon because I suddenly realize that I will "run out tomorrow". I must keep track of the medication and plan ahead. I WILL CALL AT LEAST 42 HOURS AHEAD IF I NEED ASSISTANCE with a controlled substance medication prescription.
4. I understand that IF I VIOLATE ANY OF THE ABOVE CONDITIONS, my controlled substance prescriptions and/or treatment may be ended immediately. If there is a violation involved in obtaining controlled substances from another individual as described above, I may also be reported to my primary physician, local and medical facilities, and other authorities.
5. I also give permission for Arizona Neurosurgery & Spine Specialists to request from other healthcare providers and pharmacies a list of controlled substances that I may be taking, if necessary. A copy of this contract will be sent if necessary to the appropriate health care providers.

_____ _____
Patient's Signature Date

_____
Patient's Name (Please Print)

1331 N. SEVENTH STREET • SUITE 275 • PHOENIX, AZ 85006
P 602.254.3151 F 602.256.9581

ARIZONA NEUROSURGERY
& SPINE SPECIALISTS, P.C.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand ANSS's Notice of Information Practices. I understand that ANSS may use or disclose my personal health information for the purpose of carrying out the treatment, obtaining payment, treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Company in writing. I also understand that ANSS will consider requests for restriction on a case-by-case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purpose as noted in ANSS's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing any time.

I understand that I have the right to various forms (i.e. restriction request, denial of restriction request, designated individuals authorization form, and PHI access request form) at any time upon request if applicable.

_____ _____

Patient's Signature Date & Time

_____

Patient's Name (Please Print)

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ARIZONA NEUROSURGERY
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PATIENT DESIGNATED INDIVIDUAL AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that identity of designated parties must be verified before the release of any information.

Authorized Designees & Physicians:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Patient's Signature Date

_____
Patient's Name (Please Print)

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& SPINE SPECIALISTS, P.C.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE READ IT CAREFULLY.

Arizona Neurosurgery & Spine Specialists, P.C. LEGAL DUTY

ANSS is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

ANSS uses your personal health information primarily for treatment, obtaining payment for treatment conduction internal administrative activities, and evaluation the quality of care that we provide. For example, ANSS may use you personal health information to contact you to provide appointment reminders, or information about treatment alternative or other health related benefits that could be of interest of you.

ANSS may also use or disclose you personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and emergencies. We also provide information when required by law.

In any other situation, ANSS's policy is to obtain you written authorization before disclosing your person health information. If you provide us with a written authorization to release you information for any reason, you may later revoke that authorization to stop future disclosers at any time.

ANSS may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of ours. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENTS INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in you records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. ANSS will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ANSS may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPPA Compliance Office at the address listed below. You may also send a written complaint to the US practices, or if you have a complaint, please contact the following office:

HIPPA Compliance Department
Arizona Neurosurgery & Spine Specialists
1331 N. 7th Street, Suite 275, Phoenix, AZ 85006, phone 602-254-3151

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