virtuous
PAIN CENTERS

Patient Demographics

Purpose of this form: To have your information on file to: identify you in our office, to have an emergency contact on record, to contact your doctors and insurance companies for information used in your treatment and billing, and to identify your preferred pharmacy.

Patient Information

First Name_____MI____ Last Name_____

Birth Date_____Age_____Sex_____ Social Security#_____

Marital Status _____ Home Phone#_____

Cell Phone# _____ Work Phone#_____

Home Address_____ City_____

State _____Zip Code_____ Email_____

If you have a resuscitation limitation, please provide us with documentation. Otherwise, all patients are considered for resuscitation in an emergency.

Race ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian/ Pacific Islander
☐ Asian ☐ Black/African American ☐ Decline to specify
☐ Other _____

Ethnicity/culture/heritage ☐ _____ ☐ Decline to specify

Primary Language ☐ English ☐ Spanish ☐ Other_____

Emergency Contact Information Person Name and relationship _____

Phone number _____

Primary Care Physician

Name _____Phone number _____

Referring Provider Information

Name _____Phone number _____

How did you hear about us? _____

Claims

Do you have an open Workers Compensation claim related to this visit? ☐ Yes ☐ No

Do you have an open car accident injury claim related to this visit? ☐ Yes ☐ No

Pharmacy

Name _____ Phone number _____

Financial Policies

Purpose of this document: To inform you of our policies regarding billing and payment.

Assignment of Benefits

I permit Virtuous Pain Centers to receive payment for medical services rendered in my care. Understand that I am responsible for all charges whether or not covered by insurance.

For Patients with Insurance Accepted by Virtuous Pain Centers

I authorize Virtuous Pain Centers to directly bill and receive payments from my primary or secondary insurance company. If my insurance company has not paid within 30 days of a submitted claim, I am responsible for the balance. I understand that services will not be rendered unless copayments and deductibles are collected before the visit including the allowed amount for the visit, lab tests, and procedures.

For Patients Without Insurance, Insurances Not Accepted, or Who Decline to Have Their Insurance Billed

If I do not have insurance or my insurance is not accepted by Virtuous Pain Centers, I understand that I am responsible for payment before services are rendered. If I do not want Virtuous Pain Centers to bill my insurance, I understand that the physicians and Virtuous Pain Centers are not liable for pre-authorization penalty, usual and customary quote, or provider discounts and that I am responsible for payment before services are rendered.

Non-covered Services

I understand that my insurance company might designate a service not “reasonable and necessary” and, although that service would otherwise be covered, may deny payment for that service. If my insurance denies payment, I agree to be personally and fully responsible for payment before services are rendered.

No Show and Cancellation Fees / Unpaid Balances

Virtuous Pain Centers requires a 24-hour notice for all appointments that need to be cancelled or rescheduled. If a 24-hour notice is not provided a fee equal to my insurance allowable amount will be charged for injections. As for follow ups, there will be a $50.00 charge. I understand I am responsible for paying all fees and all unpaid balances in full before any future appointments and services are rendered.

By signing below, I attest that I have read the Financial Policies document of Virtuous Pain Centers and agree to its terms.

Print Name _____

Sign Name _____ Date _____

Privacy Practices and Policies

Purpose of this document: To allow us permission to treat you. To make patients aware of their legal right to access and use of their protected health information and how this information may be shared with others. At Virtuous Pain Centers, your protected health information is not released without your permission unless required by law.

Treatment Authorization

I authorize Virtuous Pain Centers, physicians, and staff to render care to me.

Availability of Privacy Practices and HIPAA Rules

I acknowledge that I have access to and been given the option of reviewing the document "Privacy Practices and Policies" of Virtuous Pain Centers through their website and/or available for review in the office and that a copy will be furnished to me upon request.

Patient Acknowledgement for Use of Protected Health Information

I, the patient, acknowledge that my protected health information may be used as described below:
Entity authorized to accept and share my health information:
I authorize my physician to release any information regarding my medical care, including disability or employment related information concerning my claims to insurance carriers, authorized agents, or attorneys for the purpose of validating and delineating benefits payable in connection with my incurred medical expenses. Virtuous Pain Centers, 823 N San Francisco St Ste A, Flagstaff, AZ 86001.

For Use In

☐ Consulting, assessing, and planning my medical treatment.
☐ Other _____

Description of health information to be authorized for release (check one)

☐ Complete chart
☐ Complete chart except _____
☐ Only the following items _____

Birth Date _____
Print Name _____
Sign Name _____ Date _____

Controlled Substances Agreement

The following is an agreement between you, the patient, and our clinic Virtuous Pain Centers and its providers regarding terms as they relate to the prescription of controlled substances including narcotics and sedatives.

1. You may not receive narcotics or sedatives from other providers unless our staff is not available and you have first received consent from our office to do so.
2. You must inform us of any controlled substances prescribed by other providers.
3. Refill requests will only be honored during business hours Monday – Friday 9am-5pm and messages left will be returned the next business day.
4. Participation in urine drug screens is required and collection will be observed by our staff. If the observed results are non-compliant with your prescribed regimen, the urine sample is subject to be sent to a laboratory for further testing. Prescriptions will not be provided until a urine sample is given. We recommend drinking water before each visit. Should the occasion arise that you are unable to provide a urine drug screen, we are able to obtain a screening through a blood draw.
5. Participation in random prescription pills counts may be required if you are called. Should you be called for a pill count, you are required to bring your remaining pills with you to our office within the same day.
6. An office visit is required for refills. Certain medications cannot be refilled and require a new prescription each month.
7. Marijuana, even for state legal medicinal purposes, is not allowed by our facility.
8. Reasons for immediate cessation of prescription of medications by our clinic include: tampering with prescriptions, giving prescribed medications to others, taking the medications of others, losing medications for any reason (including theft), presence of illegal drugs, and taking more medications than the prescribed amount. You may continue care with us, however, you will be required to seek prescription of controlled substances elsewhere.

By signing below, I agree to follow the terms of this agreement. I understand that if I violate any of these terms, I may be discharged from the care of Virtuous Pain Centers.

Patient		**Provider**	
Print Name	_____	Print Name	Wladislaw Fedoriw, MD
Sign Name	_____	Sign Name	_____
Date	_____	Date	_____

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Patient Medical History

Purpose of this form: To gather personal and medical information that will help us understand and plan for your visit. Please check the appropriate boxes. Thank you.

Last Name_____ First Name_____ Birth Date_____ Date_____

Reason for Visit	Right	Left	Middle
☐ Back Pain	☐	☐	☐
☐ Neck Pain	☐	☐	☐
☐ Leg Pain	☐	☐	
☐ Arm Pain	☐	☐	
☐ Stroke	☐	☐	
☐ Other _____			

Describe your pain

☐ Shooting pain ☐ Burning pain ☐ Numbness ☐ Weakness
☐ Tingling ☐ Sharp pain ☐ Stabbing pain

When did the problem start?_____

How did the problem start?_____

Has the problem recently gotten worse?_____

Did this injury occur as a result of an accident or at work?_____

What treatments have you had for this problem? (Please explain)

☐ Physical Therapy _____

☐ Chiropractic _____

☐ Medications that have helped_____

☐ Medications that have NOT helped_____

☐ Injections _____

☐ Surgery _____

☐ Other _____

Allergies Please list any allergies you may have

_____

☐ No Known Drug Allergy

Last Name_____ First Name_____ Birth Date_____ Date_____

Past Medical History: Do you or have you ever had any of the following medical problems?

☐ Asthma	☐ Poor circulation	☐ Peripheral arterial disease
☐ Bleeding Disorder	☐ Stroke	☐ Cerebrovascular disease
☐ Cancer	☐ Diabetes Mellitus	☐ Restless leg syndrome
☐ Heart Disease	☐ Heart Attack	☐ Lower extremity trauma
☐ Kidney Disease	☐ High Blood Pressure	☐ Connective tissue disorder
☐ Liver Disease	☐ High Cholesterol	☐ Aortic aneurysm/dissection
☐ Osteoporosis	☐ Obesity	

Other: Please List

_____

_____

Past Surgical History:

☐ Back Surgery What_____

When_____

☐Neck Surgery What_____

When_____

☐ Coronary angioplasty implant or graft
☐ Leg angioplasty or stent or atherectomy
☐ Imaging of veins/arteries
☐ Other _____

Social History

What is/was your occupation _____ ☐ Retired ☐ On Disability

Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Widowed

Do you smoke? ☐Yes: How many packs per day / How many years_____/_____
☐No ☐Past Smoker

Do you drink Alcohol? ☐No ☐ Yes ☐ Former ☐ History of Alcoholism
Do you use recreational drugs? ☐No ☐ Yes ☐ Former ☐ Illegal drugs ☐Prescription drugs
Do you have a history of preadolescent sexual abuse? ☐Yes ☐No

Who do you live with? _____

How many levels is your home? _____

How many stairs to enter your home? _____

How many stairs inside your home? _____

Do you require any assistive devices for getting around? (cane, walker etc.)_____

Do you have any physical limitations or restrictions at work? _____

Last Name_____ First Name_____ Birth Date_____ Date_____

Medications: Please list your current medications

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy

Name _____ Phone number _____

Family History: indicate relationship and provide additional details below

☐ Cancer	☐ Heart Disease	☐ Poor Immunity	☐ Back Pain
☐ Alcohol Abuse	☐ Illegal Drug Abuse	☐ Rx Drug Abuse	
☐ Blood Clots	☐ Pulmonary Embolus	☐ Aneurysm/dissection	

Please list any medical problems of your parents or siblings:

_____

Your General Health: Please check if you have any of the following:

☐ Active cancer	☐ Blood in the stool	☐ Easy bleeding
☐ Previous cancer	☐ Constipation	☐ Easy bruising
☐ Always feeling cold	☐ Loss of bowel control	☐ Change in limb color or temperature
☐ Always feeling hot	☐ Nausea	☐ Change in erections
☐ Current pregnancy	☐ Vomiting	☐ Testicle pain
☐ Fever	☐ Vomiting blood	☐ Lower extremity discoloration
☐ Insomnia	☐ Bone cancer	☐ Lower extremity numbness
☐ Loss of appetite	☐ Fractures	☐ Lower extremity pain or heaviness
☐ Night sweats	☐ Anal numbness	☐ Lower extremity weakness
☐ Weight loss	☐ Buttocks numbness	☐ Pain in calves while walking
☐ Seasonal allergies	☐ Suicidal thoughts	☐ Leg fatigue that does improve with rest
☐ Itchiness	☐ Loss of balance	☐ Leg fatigue that does not improve with rest
☐ Rashes	☐ Paralysis	☐ Painful varicose veins or spider veins
☐ Cough	☐ Headaches	☐ Arterial claudication (cramping)
☐ Pain with coughing	☐ ADD	☐ Leg swelling
☐ Coughing up blood	☐ OCD	☐ Leg ulcers that don't heal
☐ Painful deep breath	☐ Bipolar	☐ Sciatica
☐ Bladder accidents	☐ Schizophrenia	☐ Chills or night chills
☐ Blood in the urine	☐ Depression	☐ Cold arms or legs
☐ Active infections	☐ Anxiety	

Have you ever:

☐Been in the ICU?
☐Had to be resuscitated?
☐Had to have a breathing tube inserted into your throat for an emergency?
☐Had a life threatening allergic reaction?
☐Do you get faint around needles?
☐Have you ever passed out?

☐ Had an allergic reaction to: ☐ ANTIBIOTICS ☐ DENTAL NUMBING MEDICINES
☐ CONTRAST DYE ☐ IODINE ☐ LATEX ☐ HEPARIN