Arizona Pain & Posture, LLC
Marc Bonacci, DC, PMMTP
Jeanne Hills, PT, GCFP

14555 N. Scottsdale Rd., #120, Scottsdale, AZ 85254
Office: 480-585-0252, Fax: 480-502-4336 www.arizonapainandposture.com

ARIZONA PAIN & POSTURE
PROMOTING WELLNESS SINCE 1998

Patient History Questionnaire

Date_____

Name:_____ DOB_____ Age:_____ Gender: _____

Address:_____ City: _____ State:_____ Zip:_____

SSN:_____ Home Phone: _____ Mobile:_____

Employer: _____ Occupation: _____ Work Ph:_____

Email:_____ Primary Care Physician:_____

How did you hear about us?_____ Referring Doctor?_____

Do you have children? How many? List ages/genders:_____

Do your children have any major medical issues? Please describe:_____

List, in order of importance, your primary medical issues:

1. _____

2. _____

3. _____

4. _____

5. _____

List other medical issues for which you may be seeing other providers:

1. _____

2._____

3. _____

4. _____

Have you seen other providers for your presenting complaints today?_____

If yes, please specify name and specialty:_____

What treatment have you received?_____

Medications and dosages:_____

Have you ever had an X-ray?_____ When?_____ For What?_____

Have you ever had an MRI?_____ When?_____ For What?_____

Other tests? Studies?_____

Is your condition related to a work accident/auto accident? _____

Have you ever been in an auto accident? When?_____

Have you ever received treatment for an work injury? When? _____

General Health Questions:

Do you use tobacco products? What kind and how often? _____

Have you used tobacco products in the past? What kind and how often?_____

How well do you sleep? _____ Hours?_____ ◯ Trouble falling asleep ◯ Trouble staying asleep

◯ Insomnia ◯ Wake up tired ◯ Balanced diet ◯ Not balanced diet

Rate your stress level (1 lowest, 10 highest): _____ Rate how you handle stress (1-10): _____

Recreational activity: ◯ Sufficient ◯ Not sufficient Exercise: ◯ Sufficient ◯ Not sufficient

How do you like your work? ◯ Above average ◯ Average ◯ Below average

I experience: ◯Nervousness ◯Irritability ◯Fatigue ◯Depression ◯Run Down

Does past history include: ◯falls ◯head injuries ◯broken bones ◯hospitalizations ◯surgeries

If yes, please explain:_____

Details of Your Pain:

Pain is: ◯Sharp ◯Stabbing ◯Aching ◯Dull ◯Burning ◯Throbbing ◯Tingling ◯Cramping

Scale of 1-10:_____ How long have you had pain?_____

What makes the pain worse?_____ Better?_____

Does the pain travel? Where?_____

Is it worse at a certain time of day?_____

Date of onset?_____ Symptoms?_____

Affected by the pain: ◯Standing ◯Walking ◯Sitting ◯Sleeping ◯Hygiene ◯Working ◯Hobbies ◯Cleaning ◯Cooking ◯Sex ◯Parenting

Please check-mark the following conditions that you have or have ever had:

◯AIDS	◯arthritis	◯heart attack	◯hardening of arteries
◯cancer: When?_____ Type?_____	◯stroke	◯irritable bowel syndrome	◯other_____

Head:

◯Frequent headaches	◯Facial numbness	◯Vertigo
◯Severe headaches	◯ Lightheadedness	◯Loss of balance
◯Head feels heavy	◯ Loss of smell/taste	◯Previous head trauma

Neck:

◯Neck pain w/movement	◯Pinched nerve in neck	◯Muscle spasms in neck
◯Swelling in neck	◯Dizziness w/neck movement	◯Abnormal sounds in neck
◯Stiff neck	◯Neck feels out of place	◯Previous neck injury

Shoulders:

◯ Pain in shoulders	◯ Tension in shoulders	◯ Can't raise arm above shoulder
◯ Pain across shoulders	◯ Muscle spasms in shoulders	◯ Can't raise arm overhead

Arms & Hands:

◯ Pain in upper arm	◯ Fingers go to sleep	◯ Cold hands
◯ Pain in forearm	◯ Pins & needles in hands	◯ Swollen finger joints
◯ Pain in hand	◯ Pins & needles in arms	◯ Sore finger joints
◯ Pain in fingers	◯ Pins & needles in fingers	◯ Loss of grip strength

Back:

◯ Pain between shoulders	◯ Pain from front to back	◯ Muscle spasms in mid-back
◯ Mid-back pain	◯ Pain over kidney area	◯ Pain below shoulder blades
◯ Low-back pain	◯ Low back feels out of place	◯ Muscle spasms in low-back

Hips, Legs & Feet:

◯ Pain in buttocks	◯ Pins & needles	◯ Cold feet
◯ Pain down leg	◯ Numbness in legs	◯ Swollen ankles/feet
◯ Knee pain	◯ Numbness in toes	◯ Leg cramps

Cardiovascular:

◯ General swelling	◯ Heart "jumps"	◯ Poor circulation
◯ Swelling in legs	◯ Rapid/pounding heartbeat	◯ Heart murmurs
◯ Swelling in face/eyes	◯ Irregular heartbeat	◯ Difficulty laying flat
◯ High blood pressure	◯ Blue or purple skin	◯ Chest pain with exercise
◯ Chest pain	◯ Fainting	◯ Pacemaker

Eyes & Ears:

◯ Blurred vision	◯ Pain in eyeballs	
◯ Loss of hearing	◯ Vertigo	◯ Ringing in ears

Nose/Nasopharynx/Sinuses

◯ Nasal allergies	◯ Frequent colds	◯ Sinusitis

Respiratory:

◯ Shortness of breath	◯ Difficulty breathing lying down	◯ Coughing up blood
◯ Asthma	◯ Difficulty sleeping lying down	◯ Wheezing
◯ Chronic cough	◯ Productive/Dry Cough	◯ Abnormal chest X-rays

Gastrointestinal:

◯ Poor appetite	◯ Gall bladder disease	◯ Loss of bowel control

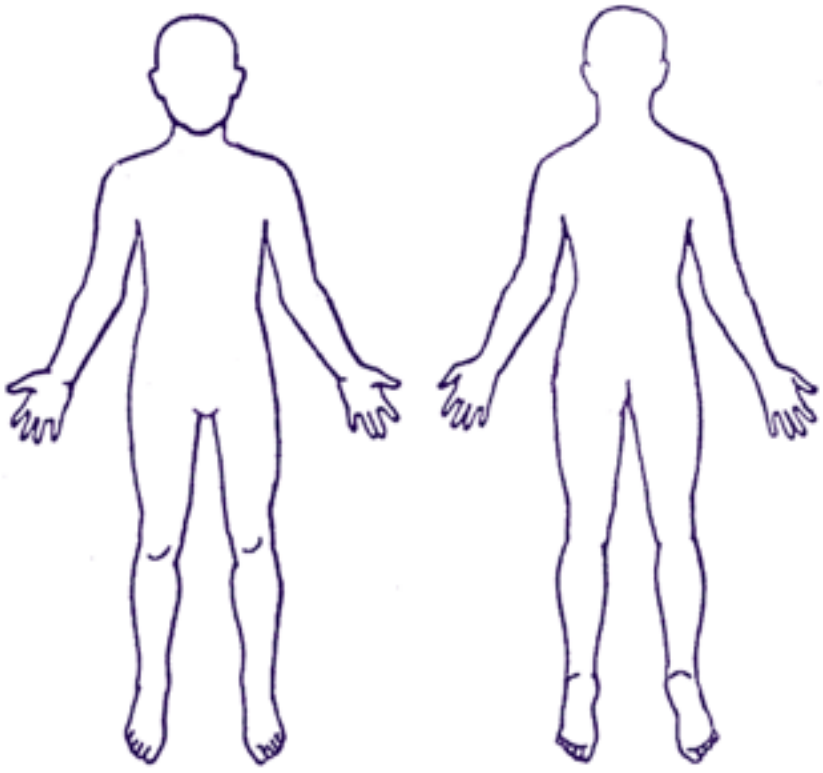
Female only:

◯ No. of pregnancies	◯ No. of vaginal deliveries	◯ No. of C-sections

Clinical Pain Drawing

To help us better understand the nature of your pain, please complete this drawing. Use the symbols listed below to mark where you have pain and what type of pain.

/// = dull ache or throbbing
xxx = sharp or stabbing
bbb = burning
ooo = numbness
::: = tingling
ccc = cramping



INSURANCE DETAILS

Patient:_____**DOB:**_____

Primary Insurance Co._____ **Plan Name:** _____

ID #_____ **Group #**_____**Phone for Providers:**_____

Secondary Policy:_____**ID#** _____**Group #**_____

☐ **PLEASE CALL** your insurance company and fill out this form. It is always the patient's responsibility – at every doctor's office – to know your own benefits. Thank you!

Out-of-Network Chiro: Copay or Coinsurance?_____Deductible?_____No. of visits?_____

In-Network PT: Copay or Coinsurance?_____Deductible?_____No. of visits?_____

Out-of-Network PT: Copay or Coinsurance?_____Deductible?_____No. of visits?_____

Pre-Authorization Required?_____

Auto Accident?

YOUR Auto Ins. Co _____Phone:_____

Verify patient is covered: _____Patient is approved for # Chiro/PT visits:_____

CLAIM#_____ Lawyer:_____Phone:_____

MedPay Amount?_____Other Person's Ins. Co:_____Phone:_____

Worker's Compensation?

Company handling it:_____Claim#_____

Contact Name: _____Phone:_____

Patient Payment Policy

1. Insurance: We participate in most Insurance plans, including Medicare. If you are not insured with a plan we do business with, payment in full is due prior to your visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is due until we can verify your coverage. If you are out-of-network and the checks from your insurance company are delivered to you, it is your legal responsibility to sign them over to Arizona Pain & Posture. Knowing your insurance benefits is your responsibility. Please contact your insurance company for specific benefits.

2. Co-Payments, Co-Insurance and Deductibles: All co-pays, co-insurance and deductibles must be paid prior to the time of service, with the exception of Medicare. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles and co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible and co-insurance at each visit.

3. Proof of Insurance & Photo ID: *All patients must complete all patient forms prior to seeing the doctor.* We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you are responsible for the balance of the claim.

4. Claims Submission: We will submit your claims and assist you in any way we reasonably can to process your claim(s). Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

5. Coverage Changes: If your insurance changes, please notify us immediately so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

6. Nonpayment: If your account is over 30 days past due after your insurance has paid their portion and a statement has been sent out and you have failed to pay the remaining balance you owe, an *18% finance charge will be charged to your account as of the 30 days from the date the statement was mailed to you. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency, an additional 30% will be charged, and you and your immediate family members may be discharged from the practice. In the event of turning your unpaid balance over to a collections agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this is to occur, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

7. In Case of Divorce/Custody Issues: We cannot become involved with double billing in divorce settlements. Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service.

8. No-Show & Cancellation Policy: Failure to show up to your appointment within 15 minutes of your scheduled appointment time or failure to cancel your appointment at least one business day in advance will result in a $50 fee for New Patients or a $25 fee for Established Patients automatically charged to your account.

9. *Finance Charge: A finance charge of 18% per month will be charged to all accounts 30 days delinquent. All patients have a responsibility to keep their accounts (ie billing address) current.

10. Credit Card Policy: You will be asked for a credit card at the time of booking your Initial Evaluation as a new patient. If you wish to keep a credit card on file in order to fulfill your payment obligations in a timely manner, the information will be held securely in accordance with HIPPA Privacy Laws until your insurance(s) have paid their portion: If a patient balance remains, a statement will then be sent to you. Any balance remaining after 30 days will be charged to your card unless other payment arrangements have been made. **A finance charge of 18% per month will be charged to all accounts 30 days' delinquent if a valid credit card is NOT on file*. Additionally, failure to show up to your appointment within 15 minutes of your scheduled appointment time or failure to cancel your appointment at least one business day in advance will result in a fee ($50 for New Patients & $25 for Established Patients) automatically charged to your account. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Yes, I agree with the payment policy in its entirety:

Signature: _____Date: _____

Credit Card Information (please fill this in):

Type of Card: ☐ Visa ☐ American Express ☐ Mastercard ☐ Discover ☐ Care Credit

Card #: _____ Exp Date: _____

Security Code: _____ Billing Address: _____

City:_____ State:_____ Zip Code: _____

Phone:_____Signature:_____

Date: _____Printed Name (as on CARD)_____

Notice of Privacy Practices for Protected Health Information (P.H.I.)

This office is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use of disclose your health information except as described in this Notice. This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations in accordance with the American Recovery and Reinvestment Act (ARRA), Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in medical record and on a computer. Such information my include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

Notification/Communication of or with family/friends Employers/Worker's Compensation; Organ Procurement Organizations; Food and Drug Administration (FDA); Abuse, Neglect and Domestic Violence Law Enforcement/ Inmates; Health Oversight/Serious Threat Research; Public Health/Disaster Relief; Coroners, Medical Examiners, and Funeral Directors Appointment Reminders, Marketing & Treatment; Alternatives Sign in Sheet/Hospital Directory; Mental Health Care; Judicial/ Administrative Proceedings
for Specialized Governmental Function; Fund Raising

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you.

YOU HAVE THE FOLLOWING RIGHTS REGARDING MEDICAL INFORMATION WE MAINTAIN ABOUT YOU

The patient has the right to receive electronic copies of his or her PHI. This office will now provide patients with copies of PHI that is maintained by the office electronically, either in the electronic form or in a format requested by the patient (if such a format is readily producible). If the requested format is not readily available, the office will offer at lease one readable electronic format on a disk. If the patient and practice cannot agree on a format, a readable hard copy of the record will be provided. The practice can charge a "reasonable" fee for this record (paper or electronic) that covers the cost of producing it. Most states have laws that identify what you can charge the patient for this service. Practices, however, are not required to purchase software or hardware to accommodate the patients' request. The patient also has the following rights:

Right to Inspect and Copy; Right to an Accounting of Disclosures; Right to request Confidential Communications; Right to Appeal Denials or File a Statement of Disagreement Right to Amend, Right to Choose Someone to Act for You; Right to Request Restrictions [Section 13405 of Subtitle D of the Hitech Act (42USC 17935)]; Right to Revoke Authorizations; Right to a Paper Copy of this Notice

OUR RESPONSIBILITIES — The office is required to: Abide by the terms of this Notice; Maintain the privacy of your health information as required by law; Notify you if there is a breach in unsecured PHI; Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; Notify you if we cannot accommodate a requested restriction or request; and Accommodate your reasonable requests regarding methods to communicate health information to you.

The Privacy Rule allows covered health care providers to communicate electronically, such as through e-mail, with their patients, provided they apply reasonable safeguards when doing so. See 45 C.F.R. § 164.530(c) Our office will take all necessary steps in ensuring the safeguarding of this information but there may be some level of risk that the information in the email could be read by a third party. If you prefer unencrypted email, you have the right to receive protected health information in this manner. Please understand that we are not responsible for unauthorized access of protected health information while in transmission to you based on your request. Further, we are not responsible for safeguarding information once delivered to the individual.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT — If you have questions, would like additional information, want to report a problem regarding the handling of your information or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact this office and ask to speak with the Privacy Officer. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services. We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Those who may receive information regarding me:

Name_____ **DOB**_____ **Phone**_____

Name_____ **DOB**_____ **Phone**_____

Name_____ **DOB**_____ **Phone**_____

Yes, I agree with PHI policies:

Signature_____**Date**_____

Release of Medical Records

Fill this out in order to give permission for your doctors to share information.

Patient's Name: _____Date of Birth: _____

I request and authorize: Name of Physician or Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To exchange healthcare information of the patient named above with:

Marc Bonacci, DC, PMMTP
Jeanne Hills, PT, GCFP
Arizona Pain & Posture, LLC, 14555 N. Scottsdale Rd., #120, Scottsdale, AZ 85254

This request and authorization applies to:

▫ All healthcare information

▫ Healthcare information relating to the following treatment, condition or dates:_____

_____

▫ Other: _____

I authorize the release of any records regarding drug, alcohol or mental health treatment to the physicians listed above.

Patient Signature: _____Date signed: _____