Avicenna Spine & Joint Care
8706 South 700 East, Suite 206
Sandy, UT 84070

Confidential Patient Information

Patient's Full Name _____ Date:_____/_____/_____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____

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

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children _____

Occupation:_____ Hours/Week_____ Employer:_____ Business Phone_____

Spouse's Name:_____ Employer:_____ Business Phone_____

Emergency Contact:_____ Relationship:_____ Phone: _____

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

Family Physician: _____ City: _____ State:_____ Phone_____

Do You Have Health Insurance? _____Primary Insurance Carrier_____

Primary person on policy?_____ Primary's Date Of Birth?_____ Policy #?_____

Secondary Insurance Carrier?_____

How did you find out about our clinic? OR Referred By?:_____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No
Is Today's Visit Due To A Personal Injury or Auto Accident: ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)
Date Of Injury:_____

Person Responsible for Account: _____ Phone: _____

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

Method of Payment Preferred: ☐ Cash ☐ Check ☐ Credit Card

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Utah.
5. I hereby agree that the payment of medical and/or medicare benefits are to be made directly to Simon Voitanik M.D. and/or any other physician that may treat me at Avicenna Spine & Joint Care.
6. I further agree that this Authorization and Assignment is irrevocable until all moneys owed Avicenna Spine & Joint Care are paid in full.

Patient Signature_____ Date_____

Date:_____ **Name:** _____ **Age:**_____
Referred by:_____

Chief complaint (Where do you hurt most since the injury? or since the pain started):
_____.
Pain radiates to (please circle): Left arm___ Right arm__ Left leg__ Right leg__ _____
Intensity- On a scale of 1 to 10, with 10 being the worst you can imagine, how bad does it get?_____
Pain character: Burning__; Tingling__; Pins & needles__; Itching__; Shooting__; Numbness__; Cramping__

Which symptoms are associated w/your complaints? (Check all that apply to your major complaint ONLY):
nausea__; vomiting__; light sensitivity__; sound sensitivity__; vertigo__; visual changes__; arm numbness/tingling__; leg numbness/tingling__; bladder difficulties___; bowel difficulties___;
Please list other associated changes: _____

Onset date- When did you first notice this problem? (give exact date if possible):
_____
Have you ever had a similar problem to this before? No Yes If "yes" explain:
_____

Describe injury *if* applicable:
_____
_____

Workman's Compensation (Please note only if related to an injury incurred on the job); DATE OF INJURY_____
Describe injury:_____

Auto Accident-related (Please note only if problem is related to an auto accident); DATE OF ACCIDENT_____
_____
_____

Pain frequency- (How often do you feel it?) Constant (always) ____Frequent (daily) ___Occasional (weekly)____

Exacerbating factors- Do symptoms get worse with physical activity? Yes or No

Is there anything else that seems to **make your problem worse?** sitting__ , standing__ , changing position

Relieving factors- Is there anything that helps you to feel better? rest__, medications__ , sitting _ , laying down__

Who did you see first? Family Practice, Emergency Room, Orthopedic, Chiropractor, Other_____
Diagnosis: _____

HISTORY OF TREATMENTS

Please indicate whether or not you have had any of these tests for your present problem: X-ray____; MRI____; EMG_____; other_____

Please indicate the following treatments you have tried in the past on the chart below.

TREATMENTS	DATE	BETTER		OUTCOME	NA
		yes	no		
Exercise					
Physical Therapy					
Occupational Therapy					
Chiropractic					
Counseling					
Biofeedback					
Injections/Nerve Block					
TENS Unit					
Medications					
Acupuncture					

HISTORY OF PAST PROVIDERS

Please list the names of all physicians, chiropractors, psychiatrists, psychologists, osteopaths, or other pain facilities whom you have seen for your present problem. List them in the order in which you saw them from first to last:

NAME OF PHYSICIAN	SPECIALTY	DATE FIRST SEEN	DATE LAST SEEN

PAST MEDICAL HISTORY: Do you have or have you had any of the following conditions? (Please Check All That Apply)

ENDOCRINE
__Diabetes
__Hypo/Hyperthyroid

HEMATOLOGY
__Bleeding disorder
__Anemia

RHEUMATOLOGY
__Arthritis, Type_____
__Fibromyalgia

CARDIAC
__Heart Attack
__Congestive Heart failure
__Coronary Artery Disease
__Valvular heart Disease
__High Blood Pressure

GENITOURINARY
__Incontinence
__Bladder control problems
__Kidney disease
__Kidney infections

GASTROINTESTINAL
__Ulcers
__Gallstones
__Liver Disease
__Hepatitis, Type: ___
__Pancreatitis
__GERD/reflux disease

OTHER
__Cancer,
Type_____

RESPIRATORY
__Asthma
__Bronchitis
__Emphysema/COPD

NEUROLOGICAL
__Stroke/TIA
__Migraines

PSYCHIATRIC
__Bipolar disease
__Depression
__History of Drug/Alcohol problems
__Other mental illness_____
__Anxiety

Please provide any additional information about the above conditions, or list other conditions not covered on the above list_____
_____

Past Surgical History:
Please list any surgeries you have had including date and physician information:

Surgery	Year	Facility/Physician

CURRENT MEDICATIONS

ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS? (e.g. ASPIRIN, COUMADIN, HEPARIN, TICLID, PLAVIC (CLOPEDIGREL) PLETAL, LOVENOX, ARISTA, JANTOVEN, WARFARIN, OTHER_____ YES____ NO_____

Please list any medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.

Medication & Dose	How often	Medication & Dose	How often
1)		**10)**	
2)		**11)**	
3)		**12)**	
4)		**13)**	
5)		**14)**	
6)		**15)**	
7)		**16)**	
8)		**17)**	
9)		**18)**	

Check the medications you have used for your current pain problem:
Narcotics : Demorol__ Morphine__ Dilaudid__ MS Contin__ Methadone__ Darvocet__ Percocet__ Vicodin__ Lortab__ Tramadol__ Oxycodone__
Codeinen__ Tylenol__ Fentanyl Patch__ Oxycontin__ Avinza__ Hydromorphone__
NSAIDs: Asprin__ Motrin__ Ibuprofen__ Advil__Naprosyn__Relafen__Mobic__ Celebrex DvoltarinD Lodine
Sedatives/Relaxant: Soma__ Ativan__ Xanax__ Valium__ FIexeril__ Parafon Forte_
Sleep Medicine: Halcion __ Ambien__ Restoril__ Benadryl__
Antidepressants: Elavil__Pamelor__ Desipramine__ Effexor__ Desyrel__Prozac__ Zoloft__ Paxil__ Serzone__ Remeron__ Cymbalta__
Anticonvulsants: Neurontin__ KIonopin__ Tegretol__ Dilantin__ Lyrica__ Topamax_
Neuropathic Pain Medications: Baclofen__ Phenoxybenzamine__Urtram__Prazosin_

Notes:_____
_____
_____

DRUG ALLERGIES

DO YOU HAVE ANY ALLERGIES? □ YES □ NO If yes, please list the item/medication and the reaction:

*Please include allergies to medications, food, latex, iodine, environmental agents or irritants

Item/Drug	Reaction	Item/Drug	Reaction

Family History (please list medical problems of biological family members)
Mother_____Father_____
Sister(s)_____Brother(s)_____
Children _____ Grandparents:_____

Social History (please complete information below)
Do you drink alcohol? YES__ NO__ If yes, specify quantity: _____
Do you smoke cigarettes? YES__ NO___ If yes, how many packs per day?:_____
Current employment status (select one): employed full time __; employed part time___; retired____; self employed___
unemployed due to pain_____ unemployed due to other reason _____
Present or most recent occupation:_____
Marital History: single___; married___; remarried___; divorced___; separated__; widowed__
Litigation History: IS there any litigation in progress in regard to your pain conditions? _____
_____

Do you have a history of drug and/or alcohol abuse? YES__; NO__ (If yes, check all that apply) Alcohol __; marijuana__; cocaine__; heroin__; other_____

FEMALES ONLY (circle answers):
Are you currently pregnant? Yes or No Are you post-menopausal? Yes or No
Could you be pregnant? Yes or No Last menstrual period: _____

Review of Systems: To your knowledge, do you now have or have you ever had any of the following:
Please check or add related.
Constitutional: fever __; weight loss__; sweats__; other__
Eyes: visual disturbance__; eye pain__; other__
Ears, Nose, Mouth Throat: pain__; hearing loss__; loss of smell__; difficulty swallowing__; other__
Cardiovascular: chest pain__; palpitations__; other__
Respiratory: cough__; sputum__; shortness of breath__; wheezing__; other__
Gastrointestinal: abdominal pain__; diarrhea__; constipation__; nausea__; vomiting__; other__
Musculoskeletal: weakness or paralysis in arms or legs__; pain__; other__
Integumentary: skin rashes__; lesions__; ulcers__; other__
Neurological: Headache__; seizure__; dizziness__; other
Psychiatric: depression__; anxiety__; psychosis__; other__
Endocrine: increased nighttime urination__; nighttime thirst__; heat or cold intolerance__; other__
Hematologic / Lymphatic: enlarged lymph nodes__; excessive bleeding__; other__

PATIENTS NOTES: _____
_____
_____
_____

DOCTORS NOTES:

_____
_____
_____
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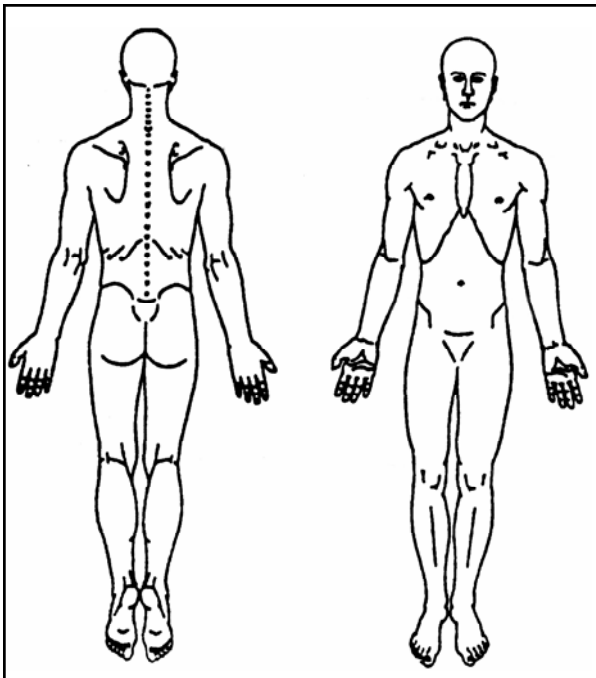

Write the number representing the pain intensity (0-10) below and mark the area of pain on the drawing.

(0= *No pain, 10= Worst imaginable pain*)
Head_____, Neck_____, Upper back_____, Mid-back_____,
Low back_____, Chest_____, Abdomen_____,
R/L buttocks_____, R/L upper/lower extremity_____
Other:_____
_____
_____
_____

Pain Quality (Please Circle)
1. Throbbing, Shooting, Stabbing, Sharp, Cramping, Burning, Aching, Stiffness, Heavy, Tender, Splitting, Numbness, Tingling

2. Tiring, Exhausting, Sickening, Fearful, Punishing-Cruel

Mood: Good_____ Depressed_____ Irritated_____
Appetite: Good_____ Bad_____
Sleep: Good_____ Bad_____ Pain wakes me ____ times/night

Instructions: Circle one number one each line:	Limited A Lot		Limited A Little		Not Limited	
Dress and bathe self	5	4	3	2	1	0
Bend, kneel or stoop	5	4	3	2	1	0
Lift and carry groceries	5	4	3	2	1	0
Walk one block	5	4	3	2	1	0
Walk several blocks	5	4	3	2	1	0
Walk more than a mile	5	4	3	2	1	0
Climb a flight of stairs	5	4	3	2	1	0
Climb several flights of stairs	5	4	3	2	1	0
Moderate activities such as vacuuming, golf, bowling, moving a table	5	4	3	2	1	0
Vigorous activities such as running or lifting heavy objects	5	4	3	2	1	0
Perform one's job	5	4	3	2	1	0

Pain Intensity (CIRCLE ONE ONLY)
1-Mild
2-Discomforting
3-Distressing
4-Horrible
5-Excruciating

Patient Notes _____

Relief Scale *(after last treatment)*
No Relief — **50% Relief** — **Complete Relief**

Relief Scale *(overall improvement)*
No Relief Of Pain — **50% Relief** — **Complete Relief Of Pain**

How long did your relief last?_____
Overall **Function**: Better_____ Worse_____ Same_____
Pain **Intensity**: Decreased___ Increased___ Same_____
Pain **Duration**: Shorter____ Longer____ Same_____
Pain **Localization**: No changes_____ Changed_____
Pain **Character**: Same_____ Different_____
Describe changes:_____
_____

Office Notes _____

Name _____
Date _____

BP _____ **/** _____
PR _____ **PO2** _____

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801-942-6000

Financial Policy

This is an agreement between us, Avicenna Spine and Joint Care, as a creditor, and you, the patient/debtor, named on this form. By executing this agreement, you are agreeing to pay for all services received.

Monthly Statement: If you have a balance on your account, Avicenna Spine and Joint Care will send you a monthly statement.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days of the statement receipt.

Charges to Account: Avicenna Spine and Joint Care shall have the right to cancel your privilege to make charges against your account at any time.

Insurance: Insurance is a contract between you and your insurance company. We are not a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Re-billing Fee: A re-billing fee of $5 may be imposed on each account that is over thirty days past-due.

Returned Checks: There is a fee (currently $20) for any checks returned by the bank.

Missed Appointment Fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a $50 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Past Due Accounts: If your account becomes past due, Avicenna Spine and Joint Care will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs and legal fees which are incurred. You understand if your account is turned over to a collection agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $15) if you want you to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred to us from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Effective Date: Once you have signed this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

Patient's full name:_____

Responsible party (if not the patient):_____

Signature:_____ Date:_____

Co-Signature:_____ Date:_____

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Consent Form

I, the undersigned patient, hereby authorize Avicenna Spine & Joint Care and Medical Spa (including all physicians, physical therapists, and assistants) to perform procedures deemed necessary for the completion of treatment as indicated by the physician and/or assistant.

I further verify that the physician or assistant(s) has fully explained to me the treatment, the risk of the procedure(s), the potential complications of the procedure(s), the potential benefits of the procedure(s), and the alternatives to the procedure(s) including the option of no treatment. I will inform the physician, physical therapist, and/or assistants of any changes in my health status. I have informed he/she of any medical complications to the best of my knowledge. I understand that the administration of injections with local anesthetic may cause an unpleasant reaction or side effect(s), which may include, but are not limited to: bruising, infection, hematoma, cardiac stimulation, pneumothorax, epidural space penetration, and rarely temporary or permanent numbness. I understand the adverse reactions to Botox can include: systemic weakness and temporary muscle paralysis. I also understand that some of the adverse reactions to Decadron Phosphate injections may include but are not limited to: fluid and electrolyte disturbances, hypertension, muscle weakness, impaired wound healing, vertigo, headache, and menstrual irregularities. The nature and clinical pharmacology of these medications have been discussed with me. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

I hereby warrant that I have not been legally judged as incompetent. I further certify that I am fully able to understand and weigh the benefits versus the risks of the above listed procedure(s). I understand that it is my right to determine the extent of my medical care, and that I may revoke this consent at any time. I warrant that I willfully consent to the procedure(s) and am under no duress by the physician and/or his/her assistants or staff.

I understand that no guarantees have been stated or implied by the physician, designated assistants, and/or staff at Avicenna Spine & Joint Care with the respect to the outcome of the procedure(s) to be performed.

Patient's full name:_____

Responsible party (if not the patient):_____

Signature:_____ Date:_____

Co-Signature:_____ Date:_____

MEDIATION/ARBITRATION AGREEMENT: Any claim or controversy between the patient and/or legally authorized representative of the patient and physician concerning the care or treatment rendered by the physician to the patient shall be resolved by mediation or arbitration according to the rules of Western Mediation. A claim or controversy shall first be submitted to non-binding mediation. If the claim or controversy is not resolved to the satisfaction of both parties through the mediation process it will be submitted to arbitration. Judgment(s) on the decision achieved through mediation or rendered by the arbitrator(s) can be entered in any court having jurisdiction thereof. The parties involved shall equally share the cost of mediation and/or arbitration services.

Signature:_____ Date:_____

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Statement of Privacy Practices

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

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment- We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or heath care operations.

Payment- We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation- We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies- We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health- As required by law, we may disclose your health information to public authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings- We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement- We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons- We may disclose your health information to coroners or medical examiners.

Organ Donation- We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research- We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety- It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies- We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing- We may contact you for marketing purposes or fund-raising purposes, as described: As a courtesy to our patients, it is our policy to call your home the day prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment.

Change of Ownership

In the event that this practice is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

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Affirmation of Receipt of Statement of Privacy Rights

I hereby acknowledge receipt of this office's Statement of Privacy Rights on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

_____

Patient Name

_____ _____

Patient's Signature Date