CAMELBACK SPINE CARE
CENTER FOR MINIMALLY INVASIVE SURGERY

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on The accuracy and completeness to provide you with the best care possible.

Patient Information

Today's Date: _____

Patient's Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

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

Email: _____

Physical Address Same as Mailing? Yes ☐ No ☐

If not, please list mailing address: _____

Occupation: _____ City: _____

Preferred Phone: _____ ☐Home ☐Mobile ☐Work

Secondary Phone: _____ ☐Home ☐Mobile ☐Work

Email: _____ Driver's License #_____ State: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other: _____

Primary Language: ☐English ☐Spanish ☐Other: _____

Referring Provider and PCP: _____ Phone: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

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

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

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

Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Insurance (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

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

Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim.

Workers Comp Company: _____

Agent Name: _____ State of Injury: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

Injury Claim

Is your pain the result of a motor vehicle accident or job-related accident, which occurred within the last two years, and was caused by the fault or negligence of another? ☐ yes ☐ no

Have you hired an attorney for purposes of making any claims arising from that accident? ☐ yes ☐ no
If yes to either question, you will be asked to complete two additional forms.
I certify that the above information is accurate, complete and true.

Patient Signature: _____ Date: _____

CAMELBACK SPINE CARE
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Onset of Symptoms

Chief Complaint/Reason for visit: _____

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

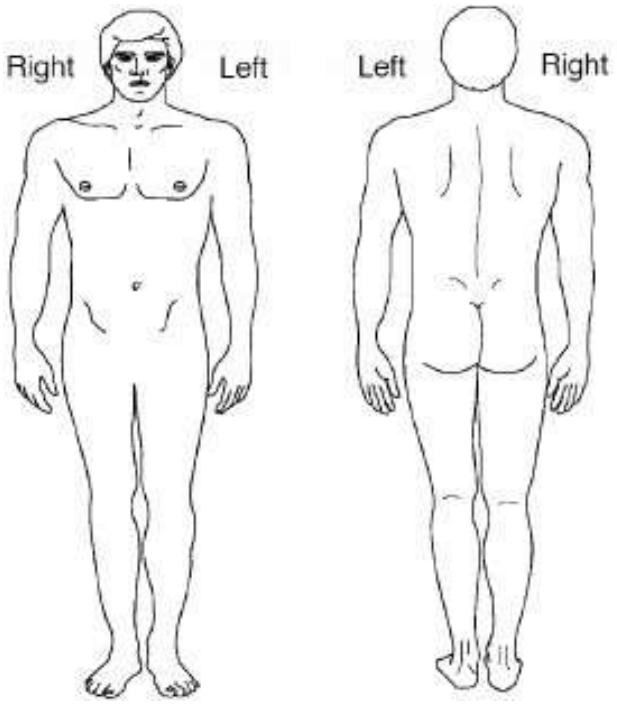
"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A" = aching



Pain Description - Check all of the following that describe of your pain:

☐ Aching	☐ Numbness	☐ Spasming	☐ Throbbing
☐ Cramping	☐ Shock-like	☐ Squeezing	☐ Tingling/Pins & Needles
☐ Dull	☐ Shooting	☐ Stabbing/Sharp	☐ Tiring/Exhausting
☐ Hot/Burning			

Pain Frequency

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

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Mark all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life ☐ Normal Work ☐ Sleep
☐ General Activity ☐ Recreational Activities ☐ Walking
☐ Mood ☐ Relationship with people ☐ Other: _____
☐ My goal is to resume normal activities

In the past three months have you developed any new:

☐ Balance Problems ☐ Fevers ☐ Nausea ☐ Vomiting
☐ Difficulty Walking ☐ Sleep ☐ Chills
☐ Numbness/Tingling-Where? ☐ Bowel incontinence ☐ Others: _____
☐ Progressive Weakness ☐ I Have Not Recently Developed Any of the Above Conditions

Diagnostic Tests and Imaging

☐ MRI of the_____ Date:_____ Facility: _____
☐ X-ray of the_____ Date:_____ Facility: _____
☐ CT scan of the_____ Date:_____ Facility: _____
☐ EMG/NCV study of the_____ Date:_____ Facility: _____
☐ Ultrasound of the_____ Date:_____ Facility: _____
☐ Other diagnostictesting: _____
☐ **I Have Not Had Any Diagnostic Tests Performed for My Current Pain Complaints**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:		**Beneficial**
o Chiropractic	☐ Yes	☐ No
o Physical Therapy	☐ Yes	☐ No
o Psychological Therapy	☐ Yes	☐ No
o Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar	☐ Yes	☐ No
o Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar	☐ Yes	☐ No
o Joint Injection – Joint(s)	☐ Yes	☐ No
o Medial Branch Blocks or Facet Injections – (circle all that apply) Cervical / Thoracic/Lumbar	☐ Yes	☐ No
o Nerve Blocks – Area/Nerve(s)	☐ Yes	☐ No
o Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar	☐ Yes	☐ No
o Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant	☐ Yes	☐ No
o Spine Surgery	☐ Yes	☐ No
o Trigger Point Injection –Where?_____	☐ Yes	☐ No
o Vertebroplasty / Kyphoplasty – Level(s)	☐ Yes	☐ No
o Other:		

☐ **Have Not Had Any Prior Treatments for My Current Pain Complaints**

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Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐ No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐ No

Which type of anesthesia did you react adversely to? Please check all that apply.

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

☐ Gallbladder removal _____
☐ Appendectomy _____
☐ Other _____

Joint Surgery

☐ Shoulder _____
☐ Hip _____
☐ Knee _____

Female Surgeries

☐ Caesarean section _____
☐ Hysterectomy _____
☐ Laparoscopy _____
☐ Ovarian _____
☐ Other _____

Spine/Back Surgery

☐ Discectomy (levels) _____
☐ Laminectomy _____
☐ Spinal fusion (levels) _____

Heart Surgery

☐ Valve replacement _____
☐ Aneurysm repair _____
☐ Pacemaker _____
☐ Other _____

Other Common Surgeries

☐ Hemorrhoid surgery _____
☐ Hernia repair _____
☐ Thyroidectomy _____
☐ Tonsillectomy _____
☐ Vascular surgery _____

Please list any other surgeries and dates (attach additional sheet if necessary): _____

_____

☐ **I Have Never Had Any Surgical Procedures Done**

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Current Medications

Are you taking a prescribed **blood-thinner** medication? ☐ Yes ☐ No If yes, please check which one:

Prescribing Physician:_____

☐ Aggrenox ☐ Coumadin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pleta ☐ Pradaxa

☐ Ticlid ☐ Warfarin ☐ Xarelto ☐ Other _____

☐ Aspirin ☐ Advil, Aleve, other NSAIDS

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name: **Allergic Reaction Type:**

_____

_____

_____

_____

_____

Please check if you are allergic to ☐ Iodine or ☐ Tape **Are you allergic to shellfish**? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

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Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other medical problems: _____

☐ I Have No Significant Family Medical History ☐ I Am Adopted (No Medical History Available)

Are parents deceased? If so, who and at what age: _____

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No **If so, are you currently pregnant?** ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar School ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Current Alcoholism ☐ Daily Limited Alcohol Use ☐ History of Alcoholism

☐ Never Drink Alcohol ☐ Social Alcohol Use

Tobacco Use: ☐ Current Tabaco User ☐ Former Tobacco User ☐ Never Used Tobacco

Prescribed Medical Marijuana: ☐ Yes ☐ No

Drug Use: ☐ Denies Any illegal Drug Use ☐ Currently Using Illegal Drugs (Which: _____)

☐ Currently Using Someone Else's Prescription Medications

☐ Formerly Used Illegal Drugs (not currently using) (Which: _____)

☐ History of any addiction: ☐ Personal ☐ Family

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No (Which: _____)

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Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type _____
- ☐ Diabetes – Type _____
- ☐ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraines
- ☐ Sinusitis
- ☐ Hearing Loss
- ☐ Snoring

Cardiovascular / Hematologic
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Pacemaker/Defibrillator
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Stroke

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema / COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ PE
- ☐ Obstructive Sleep Apnea

Musculoskeletal
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid arthritis
- ☐ Tennis Elbow
- ☐ Vertebral Compression Fracture
- ☐ Reflex Sympathetic Dystrophy/CRPS

Gastrointestinal
- ☐ Bowel Incontinence
- ☐ Acid Reflux (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation

Genitourinary/Nephrology
- ☐ Bladder Infection(s)
- ☐ Dialysis
- ☐ Kidney Infection(s)
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Hepatic
- ☐ Hepatitis A
active / inactive / unsure)
- ☐ Hepatitis B
(active / inactive / unsure)
- ☐ Hepatitis C
(active / inactive / unsure)

Neuropsychological
- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Prescription Drug Abuse
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Other Diagnosed Conditions

Who and (approximately when) was the last provider to prescribe you pain medications or other controlled substances?

_____

_____

_____

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Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, on previous page.

Constitutional:	☐Chills	☐Difficulty Sleeping	☐Easy Bruising
☐Excessive Sweating	☐Insomnia	☐Excessive Thirst	☐Fatigues
☐Fevers	☐Low Sex Drive	☐Night Sweats	☐Weakness
☐Unexplained Weight Loss	☐Unexplained Weight Gain	☐Hematology	☐Recurring Infections
☐		☐Easy Bleeding	
Eyes:	☐Recent Visual Changes		
Ears/Nose/Throat/Neck:	☐Dental Problems	☐Earaches	☐Hearing Problems
☐Nosebleeds	☐Recurrent Sore Throats	☐Ringing in the Ears	☐Sinus Problems
☐Snoring			
Cardiovascular:	☐High Blood Pressure	☐Deep Vein Thrombosis	☐Chest Pain
☐Cough	☐Irregular Heartbeat	☐Lightheadedness	
☐Fainting	☐Swelling in the Feet	☐Shortness of Breath During Sleep	
Respiratory:	☐Abdominal Cramps	☐Wheezing	☐Pulmonary Embolism
☐Shortness of Breath at Rest	☐Snoring	☐Shortness of Breath Exertion/Effort	
Gastrointestinal:	☐Vomiting	☐Acid Reflux	☐Constipation
☐Diarrhea	☐Hernia	☐Dark and Tarry Stool	
☐Coffee Ground Appearance in Vomit			
Musculoskeletal:	☐Joint Swelling	☐Back Pain	☐Muscle Spasms
☐Joint Pain	☐Neck Pain	☐Joint Stiffness	
Genitourinary/Nephrology:	☐Erectile Dysfunction	☐Blood in Urine	☐Flank Pain
☐Pelvic Pressure	☐Painful Urination	☐Decreased Urine Flow/Frequency/Volume	
Neurological:	☐Carpal Tunnel Syndrome	☐Dizziness	☐Headaches
☐Instability When Walking	☐Numbness/Tingling	☐Seizures	
Psychiatric:	☐Depressed Mood	☐Feeling Anxious	☐Stress Problems
☐Suicidal Thoughts	☐Suicidal Planning		
Skin:	☐Itching	☐Chronic Skin Infections	☐Rashes

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Camelback Spine Care and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Camelback Spine Care to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Camelback Spine Care Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Camelback Spine Care to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Camelback Spine Care to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Camelback Spine Care will not release my Protected Health Information to any other party (including family) without my completing an Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. This agreement can be revoked by me at any time with written notification and is valid until revoked. Payment in full is expected within 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance owed.

Signed: _____ Date: _____

Financial Policy

Camelback Spine Care believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT -** is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment Camelback Spine Care reserve the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). 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 do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. I**NSURANCE -** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice 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.

If our providers are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim is rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Camelback Spine Care only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case, the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **COLLECTION -** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Camelback Spine Care reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Camelback Spine Care for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at any 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 voice messages and/or use of an automatic dialing device.

4. **RETURNED CHECKS -** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

5. **ACCOUNTING PRINCIPALS -** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. **FORMS AND CONSULTS FEES -** Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the provider. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

7. **CANCELLATIONS OR MISSED APPOINTMENTS -** If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $35.00 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you may be assessed a $500.00 missed procedure fee. Multiple missed visits may result in discharge from the practice.

8. **RESPONSIBILITY FOR PAYMENT -** I understand that I, personally, am financially responsible to Camelback Spine Care for charges not covered by the assignment of insurance benefits.

9. **ASSIGNMENT OF INSURANCE BENEFITS -** I hereby assign, transfer, and set over directly to Camelback Spine Care sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Camelback Spine Care 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 Camelback Spine Care. I authorize Camelback Spine Care to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

10. **RELEASE OF INFORMATION -** I hereby authorize the and direct Camelback Spine Care to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy of Camelback Spine Care and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Camelback Spine Care. I hereby assign all medical and surgical benefits and authorize my insurance carrier
(s) to issue payment directly to Camelback Spine Care. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable)_____ Date:_____

Please print the name of the patient _____

Your Name: _____ Date of Birth: _____

Authorized Parties

By signing below, I authorize Camelback Spine Care, its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party **Relationship**

_____

_____

_____

Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42
C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient or Legal Guardian Date

Authorized Parties

I acknowledge that I have had the opportunity to review Camelback Spine Care Notice of Privacy Practices and Patient Rights and Responsibility, which is displayed for public inspection at its facility and on its website. These Notices describe how my protected health information and rights may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Camelback Spine Care. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

Privacy Officer
Camelback Spine Care
13760 N 93rd Ave #203
Peoria, AZ 85381

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

Signature

_____ _____
Signature of Patient or Legal Guardian Today's Date

_____
Relationship to Patient

Authorization to Disclose Health Information to Camelback Spine Care

*Patients Name:_____*Date of Birth: _____

*I hereby authorize _____

*Phone:_____*Fax: _____

or its agent(s) to disclose my health information as described in this authorization to:

Camelback Spine Care
13760 N 93rd Ave #203 Peoria, AZ 85381
Office: 602.714.6970
Fax : 602.714.5176

*The health information is being disclosed for the following purpose: (check appropriate box):

☐Change of Insurance or Physician ☐ Continuation of Care

*I understand I may revoke this Authorization at any time by sending written notice of my revocation to Camelback Spine Care health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will

expire on the following date, event, or condition. If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

*I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

*I understand that Camelback Spine Care may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

***I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.**

_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative — Date
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative and Telephone Number — Relationship / Capacity to