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Welcome and thank you for choosing Zion Pain Management Center LLC (Zion Pain) for treatment of your pain. We look forward to meeting with you on \_\_\_\_\_.  
Please bring the completed, enclosed packet with you as well as any pertinent X-rays and MRI's. **If you are more than 15 minutes late in arriving and/or you do not have your paperwork ready, your appointment will be rescheduled.**

Our board certified pain management specialists are dedicated to providing modern, compassionate care to patients suffering from acute or chronic pain through the use of advanced state of the art interventional pain management techniques that seek to identify the source of pain and to reduce or eliminate it.

We specialize in the most common pain disorders and many pain syndromes including:

- Sports and work-related injuries
- Back and Neck pain
- Myofascial pain
- Sciatica
- Shingles
- Post herpetic neuralgia
- Reflex Sympathetic Dystrophy
- Cancer pain
- Phantom limb/stump pain
- Peripheral neuropathy
- Headaches associated with neck pain
- Failed Back Surgery Syndrome....and many more

We utilize numerous advanced state of the art techniques depending on the nature of the pain disorder including:

- Cervical, Thoracic & Lumbar epidural injections
- Sympathetic Blocks
- Peripheral Nerve Blocks
- Celiac Plexus blocks
- IDET
- Spinal Cord Stimulator implantation
- Advanced drug delivery systems
- Radiofrequency lesioning

- Trigger point injections
- **All spinal injections are done under fluoroscopic guidance**

Zion Pain is staffed by qualified personnel specially trained and certified in the field of pain management. Our goal is to relieve or help you manage the pain you have been experiencing so that you may be able to enjoy a better life.

Again, we look forward to meeting you at your appointed time. If you have any questions, please do not hesitate to contact this office.

## **NOTICE 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**

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to receive a copy of your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 1, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer"

For more information about HIPPA or to file a complaint:  
The U.S. Dept of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, DC 20201  
(202) 619-0257  
Toll free: 1-877-696-6775

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_

I hereby acknowledge that I have received a copy of Zion Pain’s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient’s Representative

**Relationship to Patient (if applicable)**

- Parent or guardian of unemancipated minor
- Court appointed guardian
- Executor or administrator of decedent’s estate
- Power of Attorney

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**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, \_\_\_\_\_ but acknowledgement could not be obtained because:

- Patient/representative refused to sign.
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a late date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Other (Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ***CONDITIONS OF MEDICAL SERVICE AND AGREEMENT***

In consideration of and as a condition of the medical services I will receive at Zion Pain Management Center, LLC (hereinafter "Zion Pain"), I agree to the following:

(1) I hereby assign and authorize payment of covered insurance benefits, including major medical benefits, whether payable to me by Blue Cross/Blue Shield, Medicare, any commercial insurance company or managed health care plan or directly payable to Zion Pain, now or in the future.

(2) I understand that my health insurance may not cover some or any of the medical services I receive. ***I understand that I am responsible for any and all charges not covered or actually paid by my health insurance to Zion Pain.*** That means, among other things, that I am responsible for deductibles, co-insurance and payments from an insurance company directly to me. I agree that I will pay all sums that are due and payable at the time of service. I will take responsibility for making certain that any payment I send gets to the billing office of Zion Pain, located at 302 North 200 East, Suite 2A, St. George, UT 84770. I will notify Zion Pain promptly of any change in my mailing address.

(3) I have disclosed to Zion Pain the names of all my health insurance providers and any tie-in health coverage. My health care coverage *is in full force and effect now*. If my health care coverage requires that I obtain a referral for these medical services and I did not obtain one, I promise to do so immediately and submit it to Zion Pain. I authorize the release of any and all medical information that may be required to process the claims for payment of the medical services I receive at Zion Pain and I waive all privilege and confidentiality to that extent.

(4) I will ask clarification of any medical service, treatment or procedure I may not understand prior to receiving it and I acknowledge and accept that the results of any such service, treatment or procedure are not and cannot be guaranteed.

(5) I understand that I am responsible for all fees incurred for services rendered by Zion Pain to me, my family and others that I may authorize and I understand that my financial responsibility extends to all past, present and future services rendered by Zion Pain to me, my family and others that I may authorize. I understand that insurance is a contract between the patient and the insurance company and that I am responsible for all charges under this agreement regardless of insurance coverage. I may terminate my responsibility under this agreement at any time by paying my account in full and giving written notice to Zion Pain. No oral agreements have been made and this agreement cannot be modified orally.

(6) I promise to pay Zion Pain all balances due within sixty (60) days of the presentation of my bill. My bill will be considered presented three (3) days after mailing to the address I provide. Sixty (60) days after presentation, I understand that my bill becomes delinquent, accrues interest at the rate of 18 % (eighteen percent) annually thereafter, and may be submitted for collection. If my bill has to be submitted for collection, I understand and promise that I will pay all costs associated with the collections, with or without suit, including any attorney's fees and court costs and a collection fee equal to 50% of the outstanding balance.

(7) If I am currently involved, or, if after beginning my treatment at Zion Pain, I become involved in pursuing a personal injury claim against a third party, I understand that at my request and with my authorization Zion Pain can and will provide my attorney with all my records of treatment. As a condition of treatment, I agree that having requested and received certified copies of my medical records, I (or my attorney) will not subpoena my physician(s) at Zion Pain to deposition (nor participate in any such deposition initiated by another party) or trial to provide any factual information already referenced or contained in or covered by my records, nor to provide any expert testimony (nor to include their names on any list of expert witnesses) in my case without their prior written consent.

(8) I understand that Zion Pain is a pain specialty clinic and that the providers at Zion Pain do not provide primary care or disability or rehabilitation services. In the event that I need primary care, disability or rehabilitation services, I may ask for a referral, but I will not ask Zion Pain to provide those services.

(9) I understand that medical providers commonly prescribe medications for so called "off label" use, which simply means that the medication is prescribed for a medical purpose not contemplated when it was approved by the Federal Drug Administration. I understand that my provider may legally do this if in his or her best medical judgment it may alleviate a condition for which I am being treated and I acknowledge and accept this practice in my own treatment.

(10) I have read through this document and assert that I understand and sign it freely. Any signed copy of this document may be considered as valid as the original.

X \_\_\_\_\_  
Signature of Patient

X \_\_\_\_\_  
Signature of insured (if applicable)

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

**MEDICARE LIFETIME MEDIGAP ASSIGNMENT**  
***Sign below if you have a MEDIGAP insurance policy***

I assign and authorize payment of MEDIGAP benefits to Zion Pain Management Center, LLC for any services I receive there. I authorize any holder of medical information that may be necessary to determine my benefits to release it to the Health Care Financing Administration (HCFA) and its agents.

X \_\_\_\_\_

Dated \_\_\_\_\_

## OUR PAYMENT POLICY

“Payment is due at the time of services”

### Insurance billing services

As a service to our patients with insurance, we fill out and send your insurance claim into your insurance carrier. Upon admission to Zion Pain, you have contractually agreed to pay for services rendered to you. If you have health insurance coverage, Zion Pain will agree to file your initial claim(s) provided we have complete information at the time of service. However, your health insurance contract(s) is between you and the insurance carrier. Because of this relationship, you have primary responsibility to pay for the services and provide follow-up communication with your health insurance carrier(s), if necessary. Should your insurance reject our claim for any reason, you are financially responsible. If your health insurance coverage requires you to pay a deductible, percentage and/or co-pay, these amounts will be due the day of service. We will try to give you an estimate of the amount you may owe before your visit upon your request. If we are contracted providers with your plan, you are not eligible for any additional discounts beyond the discount agreed upon with your health insurance carrier.

### YOUR RESPONSIBILIITY IS TO KNOW YOUR PLAN:

- Know your yearly deductible and when it is due
- Know your maximum allowed fee for service in a calendar year
- Know what percentage your coverage pays for our services
- Follow up on claims submitted to your insurance company

### WE REQUIRE:

- Balance paid in full by patient 60 days after processing of claim(s) by insurer

### NON-INSURED PATIENTS:

Upon receipt of a \$100.00 deposit, we will make the initial appointment for you. On the day of your visit, the balance must be paid. Any services following your initial visit will be eligible for a 25% discount. You will be informed of the amount due for each visit. **We do not accept attorney liens.** All services must be paid on the day of your appointment. No payment plans are available at this time.

I have read and understand the office policy on payment for services rendered at Zion Pain. I have also signed the Conditions Of Medical Service and Agreement form and agree to the contents of both forms.

Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Dated \_\_\_\_\_

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## PATIENT QUESTIONNAIRE

Thank you for taking the time to answer this questionnaire. Please bring it with you to your appointment. It will be reviewed with you at that time.

### **PERSONAL INFORMATION:** *(Confidential)*

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex: M F

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Who Referred You? \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE:** \_\_\_\_\_ **ID#** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Policy holder: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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### **PAIN HISTORY:**

**Location:** Use the figures below to shade in the area where you have pain. If your pain moves around, put an "X" where it starts and draw an arrow to where it spreads.

**For office use only:**

Ht: \_\_\_\_\_

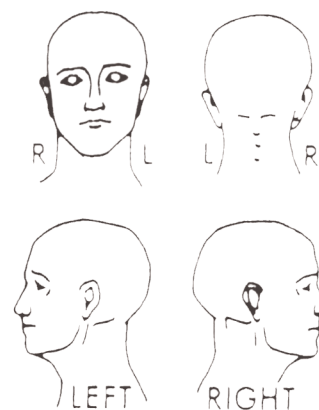
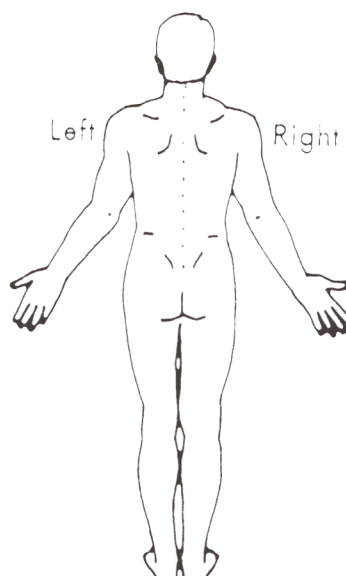
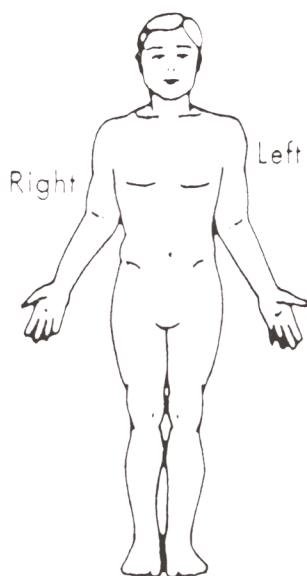
Wt: \_\_\_\_\_

B.P: \_\_\_\_\_

Pulse: \_\_\_\_\_

SPO<sub>2</sub>: \_\_\_\_\_

Temp: \_\_\_\_\_



**Chief Complaint**Where is/are your chief area(s) of Pain? *(Describe, or check below)* \_\_\_\_\_

	Head		Upper Back		Legs	R	L
	Neck		Lower Back		Arms	R	L
	Chest		Groin		Hands	R	L
	Abdomen		Buttocks		Feet	R	L

**Duration:**

When did your current pain problem begin? \_\_\_\_\_

**Onset:**How did your pain problem first start? ( )Job Injury ( )Sports Injury ( )Car Accident ( )Disease  
( )Cancer ( )Unknown ( )Other \_\_\_\_\_

Describe the speed of onset of your pain. ( )Sudden/Abrupt ( )Gradual

**Frequency:**

How often do you have this pain? ( )Constantly ( )Daily ( )Weekly ( )Monthly

What time of day is your pain the worst? ( )Morning ( )Afternoon ( )Evening ( )Night

What time of day is your pain the least? ( )Morning ( )Afternoon ( )Evening ( )Night

**Severity:**Rate the severity of your pain right now by circling the corresponding number below.

0    1    2    3    4    5    6    7    8    9    10  
*(No Pain)* *(Worst Pain Imaginable)*

Rate the severity of your pain on average by circling the corresponding number below.

0    1    2    3    4    5    6    7    8    9    10  
*(No Pain)* *(Worst Pain Imaginable)*

**Character:**

Describe in your own words what your pain is like. (I.e. sharp, dull, burning etc.) \_\_\_\_\_

**Associated Signs and Symptoms:**

Are you experiencing any of the following?

	Yes	No	Location or Description
Muscle Weakness			
Numbness or Tingling			
Bladder or Bowel Dysfunction			
Rash			
Fever			
Visual Disturbance			
Other:			

**Aggravating and Alleviating factors:**

What activities or factors improve or worsen your pain? *(Please check all that apply.)*

Activity	Worsens	Relieves	No Change	Activity	Worsens	Relieves	No Change
Exercise				Bright Lights			
Climbing Stairs				Cold			
Walking				Heat			
Standing				Noise			
Sitting/Driving				Emotion			
Lifting				Weather Change			
Cough/Sneeze				Rest			
Lying Down				Touch			
Eating				Other:			

**Effects on Activities of Daily Living:**

Are there areas of your life that have been adversely affected by your pain problem? *(Check below all those that apply, and please describe.)*

- Sleep \_\_\_\_\_
- Appetite \_\_\_\_\_
- Relationships \_\_\_\_\_
- Work \_\_\_\_\_
- Finances \_\_\_\_\_
- Physical Activity \_\_\_\_\_
- Use of Alcohol, or Recreational Drugs \_\_\_\_\_
- Other \_\_\_\_\_

**Treatments:**

What Treatments have you received for your pain in the past? *(Please check if helpful or not helpful.)*

Treatment	Helpful	Not Helpful	Comments
Surgery			
Nerve Block			
Steroid Injection			
Trigger Point Injection			
Acupuncture			
TENS Unit			
Heat/Ice Treatment			
Biofeedback			
Hypnosis			
Relaxation Training			
Counseling			
Traction			
Chiropractic Treatment			
Occupational Therapy			
Physical Therapy			
Other (Explain)			

**Diagnostic Testing:**

Have you had any of the following tests performed within the past 24 months?

Test	Date	Facility Where Test Was Done	Results
X-ray film			
CT Scan			
MRI			
Laboratory			
EMG			
Nerve Conduction			
Discogram			
Myelogram			
Other			

**PAST MEDICAL HISTORY:**Please check any of the following **medical problems** you have had or presently have:

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes _____             | <input type="checkbox"/> Arthritis _____          |
| <input type="checkbox"/> Cancer _____               | <input type="checkbox"/> Ulcer _____              |
| <input type="checkbox"/> Heart Problems _____       | <input type="checkbox"/> Kidney Problems _____    |
| <input type="checkbox"/> Respiratory Problems _____ | <input type="checkbox"/> Bleeding Problems _____  |
| <input type="checkbox"/> Infectious Disease _____   | <input type="checkbox"/> Seizures _____           |
| <input type="checkbox"/> High Blood Pressure _____  | <input type="checkbox"/> Neurologic Disease _____ |
| <input type="checkbox"/> Migraines _____            | <input type="checkbox"/> Head Injury _____        |
| <input type="checkbox"/> Other _____                |   |

**PAST SURGICAL HISTORY:**Please list all past **surgeries and hospitalizations**.

Date	Procedure/Illness	Date	Procedure/Illness

**ALLERGIES:**Please list all **medication allergies** below.

Medication	Reaction

Have you ever had a reaction to **Iodine, Shellfish or Contrast Dye?** Yes  No *(If so, please explain)* \_\_\_\_\_

## **MEDICATIONS**

Please list all of your current medication, including both prescription and “over-the-counter” medication.

Medication	Amount	Times Per Day	Effectiveness

Please list any other **pain** medications you have used in the past.

Medication	Amount	Times Per Day	Effectiveness

Have you been on any **Blood Thinners** recently? (*I.e. PLAVIX, Coumadin, Warfarin, Heparin, or Aspirin*)

Yes  No (*If so, please list*)

## **SOCIAL HISTORY:**

### **Marital Status:**

What is your current marital status?

Single  Living with significant other  Married  Divorced  Widowed

Has your marital status changed since your pain problem began?  Yes  No

Number of Children living with you: \_\_\_\_\_

### **Education:**

What is the highest level of education you've finished? \_\_\_\_\_

### **Employment:**

Are you currently working?  Yes  No  Retired Occupation \_\_\_\_\_

Is this the same occupation you had before your pain started?  Yes  No

If you are not working, has pain forced you to stop working?  Yes  No

If you are not working, what was your occupation before your pain became a problem? \_\_\_\_\_

Does your spouse work?  Yes  No Spouse's occupation? \_\_\_\_\_

Are you being treated under Worker's Compensation?  Yes  No

Are you currently receiving disability benefits?  Yes  No

**Habits:**

Do you smoke? ( ) Yes ( ) No How many packs per day? \_\_\_\_\_ #Years? \_\_\_\_\_

Do you drink alcoholic beverages? ( ) Yes ( ) No How many drinks per day? \_\_\_\_\_

Do you use any "recreational" or "street" drugs? ( ) Yes ( ) No (If yes, please list.) \_\_\_\_\_

Do you drink beverages with caffeine? ( ) Yes ( ) No (If yes, how much per day?) \_\_\_\_\_

**FAMILY HISTORY:**

Please check below if you have a family history of any of the following:

	Brother	Sister	Mother	Father	Aunt	Uncle	Grandfather	Grandmother
Diabetes								
Cancer								
Heart Disease								
Stroke								
Hypertension								
Migraines								
Chronic Pain								
Anesthetic Problems								
Substance Abuse								
Other:								

**SYSTEMS REVIEW:**

Please check below if you are experiencing or have recently experienced any of the following:

**General:**( ) Weight Loss/Gain \_\_\_\_\_  
( ) Chills**Ear, Nose, and Throat:**( ) Sinus Pressure/Drainage  
( ) Sore Throat  
( ) Difficulty Hearing  
( ) Vision Problems**Pulmonary and Cardiovascular:**( ) Chest Pain  
( ) Cough  
( ) Trouble Breathing**Gastrointestinal:**( ) Abdominal pain  
( ) Nausea/Vomiting  
( ) Diarrhea  
( ) Constipation  
( ) Black/Bloody Stools**Genitourinary:**( ) Trouble Urinating  
( ) Frequent Urination  
( ) Bloody Urine**Women:**( ) Vaginal Bleeding  
( ) Vaginal Discharge  
Could you be pregnant? ( ) Yes ( ) No  
Are you trying to become pregnant? ( ) Yes ( ) No  
Last Normal Menstrual Period: \_\_\_\_\_**Neurological and Psychological:**( ) Headache  
( ) Blackout  
( ) Confusion  
( ) Depression

Patient Signature: \_\_\_\_\_