



A division of Arizona Spine and Pain Specialists, LLC

Patients' Rights and Responsibilities

At Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC our goal is to provide excellent health care to every patient. Our patients have the following rights and responsibilities regardless of race, color, culture, language, ethnicity, religion, sex, sexual orientation, gender identity or expression, socioeconomic status, age, national origin, physical or mental disability, and / or veteran status:

It is your responsibility to:

- Give correct and complete information about your health status and health history.
- Ask questions if you do not understand information or instructions.
- Inform your caregivers if you do not intend to or cannot follow the treatment plan.
- Accept health consequences that may occur if you decide to refuse treatment or instructions.
- Cooperate with your caregivers.
- Respect the rights and property of other patients.
- Tell your caregivers of any medications you take at home.
- Report any changes in your health status to your caregivers.

You have the right to:

- Respect and Privacy
 - Respect in a caring and safe environment
 - Personal privacy and confidentiality of your information
- Quality Care
 - Proper evaluation and treatment
 - Proper pain assessment and pain management
 - Be free from abuse.
 - Have access to protective services.
 - Have your concerns heard and resolved when possible
- Information & Communication
 - Know the names and roles of those caring for you.
 - Communicate with your caregivers in a language or method you can understand.
 - Be informed about your health status, recommended treatments, options, risks and benefits.
 - Information about the costs of your care and payment methods.
 - Review and receive a copy of your medical record, subject to state law and hospital policy.
- Make Decisions
 - Be involved with your care through discussions with your caregivers.
 - Be informed of benefits and risks of your treatment options and agree to or refuse a course of action.
 - Designate a support person (or persons) of your choosing to be involved in your care when appropriate.
 - Direct your care through an Advance Directive. Advance Directives are legal forms which state your choices about the care you want to receive in serious health situations. Advance Directives are also used to name someone to make decisions for you if you cannot speak for yourself. At your request, we will help you create an Advance Directive.
 - Seek an alternate doctor or ask for a second opinion.



BARBEE™ PRIMARY CARE

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PATIENT INFORMATION

Date ___/___/___

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ___/___/___ Social Security Number ___/___/___ Gender Male Female

Marital Status Married Single Divorced Separated Widowed

Email address: _____

Address _____ Apartment/Suite _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Race: _____ Ethnicity: _____ Primary Language: _____

Employment Status Employed Self Employed Unemployed Disabled Retired Student

Occupation _____ Employer _____

Emergency Contact _____ Relation _____ Phone _____

Previous Primary Care Doctor _____ Phone _____

Spouse/Partner/Parent/Guardian _____ Phone _____

Who may we thank for referring you? _____

Primary Insurance Information

Name of Insurance Company _____ Phone _____

ID/Subscriber Number _____ Group or Plan# _____

Subscriber Name _____ Relationship to Patient _____

Subscriber SSN ___/___/___ Subscriber Date of Birth ___/___/___ Subscriber Gender Male Female

Additional Insurance Information (if applicable)

Name of Insurance Company _____ Phone _____

ID/Subscriber Number _____ Group or Plan# _____

Subscriber Name _____ Relationship to Patient _____

Subscriber SSN ___/___/___ Subscriber Date of Birth ___/___/___ Subscriber Gender Male Female

We are required to gather Pharmacy information in order to use electronic prescriptions and exchange information with your Pharmacy. By providing us with the crossroads to your Pharmacy, we will be able to send and receive refill authorizations in a more HIPPA compliant and timely manner. We will also be able to receive current medication information directly from your Pharmacy, which will eliminate your need to bring us lists or try to remember what medication and dosages you are currently taking.

Please look up on your smart phone while waiting.

Pharmacy name, address with zip code and x-streets: _____

Consent to allow electronic exchange between your pharmacy and Barbee Primary Care a division of Arizona Spine and Pain Specialists, LLC:

Signature: _____

Name: _____

Date: _____

HABITS/SOCIAL

Exercise (amount)? _____
Alcohol (amount)? _____
Tobacco? _____
Packs per day? _____
Number of years? _____
Year quit? _____

GYNECOLOGICAL

Method of birth control _____
First day of last period _____
of pregnancies _____
of miscarriages _____
of abortions _____
of childbirths _____

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Diabetes	Anemia	Stroke
Hypertension	Heart Attack	Cancer (type) _____
Pneumonia	High Cholesterol	Valley Fever
Tuberculosis	Asthma	HIV/AIDS
Hepatitis	Depression/Anxiety	Kidney Stones
Thyroid problem	Abnormal Pap _____	Other: _____

PLEASE CHECK IF YOU HAD ANY OF THE FOLLOWING IN THE PAST 30 DAYS:

Head/Eyes/Ears/Nose/Throat

___ Headache
___ Visual Changes
___ Glasses/Contacts
___ Hearing loss
___ Dizziness
___ Sinus/allergy problems
___ Bleeding gums
___ Sore throat

Gastrointestinal

___ Nausea/Vomiting
___ Loss of appetite
___ Rectal bleeding
___ Difficulty swallowing
___ Indigestion
___ Constipation
___ Diarrhea
___ Abdominal pain

Neurological/Psychiatric

___ Seizures
___ Tremors
___ Fainting/Dizziness
___ Migraine
___ Numbness
___ Depression
___ Anxiety
___ Insomnia

Respiratory

___ Shortness of breath
___ Cough
___ Coughing up blood
___ Wheezing
___ Abnormal chest x-ray
Explain: _____

Genitourinary

___ Frequent urination
___ Blood in urine
___ Decreased urination
___ Frequent infection
___ Incontinence
___ Irregular periods
___ Pelvic pain

Hematological

___ Bleeding tendencies
___ Anemia
___ Previous transfusion
Explain: _____

Vascular

___ Varicose veins
___ Deep vein thrombosis
___ Pulmonary embolus

Cardiac

___ Heart murmur
___ Palpitations
___ Chest pain
___ Feet/ankle swelling
___ Abnormal EKG

Musculoskeletal

___ Back pain
___ Neck pain
___ Muscle pain
___ Joint pain/stiffness
___ Tendonitis

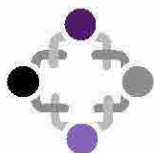
Skin

___ Itching
___ Rash

Explain: _____

General

___ Weight loss/gain
___ Fatigue
___ Fevers/night sweats



COMPLETED BY: _____ RELATIONSHIP TO PATIENT _____



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Preventive Health Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____

1. Date of last Flu vaccination: **(6 months & Older)** _____

2. Over the last 2 weeks: **(12 & Older)** None Few Days >1/2 Days Every Day

I have had little interest or pleasure in doing things _____ _____ _____ _____

I am feeling down, depressed or hopeless. _____ _____ _____ _____

3. Do you use any form of tobacco? **(18 & Older)** YES _____ NO _____

4. Date and results of last Mammogram. _____

5. Have you have had a colorectal cancer screening? (ages **50-75**) YES _____ NO _____

*If yes, date of last screening: Colonoscopy: _____ Sigmoidoscopy: _____

Results: _____ Repeat Due: 3 yrs 5 yrs 10 yrs

6. Have you been to the Emergency Room or hospitalized for any reason within the last 30 days?

(65 & Older) YES _____ NO _____

*If yes, list any changes to your Medications:

7. Date and type of Pneumococcal vaccination: **(65 & Older)** _____

8. Date of Tetanus vaccination: _____

9. Date of Shingles vaccination: **(50 & Older)** _____

10. Date of last PAP **(Women Only)**: _____

11. Date of last Bone Density: _____

Please look up on your smart phone while waiting.

Pharmacy name, address with zip code and x-streets: _____



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Medical History and Consent for Treatment

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

I authorize Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC 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 Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC 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 Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC 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 Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC 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 Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

I understand that data collected during assessment or treatment may be utilized for research and teaching purposes and all identifying demographic PHI will remain confidential.

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 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 you owe.

Signed: _____ Date: _____



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Patient Authorization for Use and Disclosure of Protected Health Information

Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC to release your medical records to parties indicated.

Barbee Primary Care takes your privacy seriously!

Your Name: _____ Date of Birth: _____

Authorized Parties

By signing below, I authorize Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC, 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.



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Authorized Parties

I acknowledge that I have had the opportunity to review Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC 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 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 Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC. 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

Barbee Primary Care, A division of Arizona Spin and Pain Specialists, LLC
20280 N 59th AVE #115 – 617 Glendale, AZ 85308

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 _____



“A division of Arizona Spine and Pain Specialists, LLC”

Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC, 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 Barbee Primary Care a division of Arizona Spine and Pain Specialists, LLC reserves 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. **INSURANCE** - 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 doctors 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 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.

Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC 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. **TOXICOLOGY LAB** - In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.
4. **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. Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC 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.

5. **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.

6. **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.

7. **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 doctor. 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.

8. **CANCELLATIONS OR MISSED APPOINTMENTS** - If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a \$25 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a \$150.00 missed procedure fee. Any missed visits may result in discharge from the practice.

9. **RESPONSIBILITY FOR PAYMENT** - I understand that I, personally, am financially responsible to Barbee Primary Care, a division of Arizona Spine and Pain Specialists LLC care for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby assign, transfer, and set over directly to Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC 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 Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC 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 Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC. I authorize Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **RELEASE OF INFORMATION** - I hereby authorize and direct Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC 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 Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC. 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 _____