Dr. Eugene Johnson, MD
Dr. Ryan Zate, DO

SOUTHWEST
sports & spine

Cynthia Thiem, FNP-C
Johnna Hayse, FNP-C

7494 N. La Cholla Blvd.
Tucson, Arizona 85741
www.swsportsandspine.com
Phone: (520) 395-0512 | Fax: (520) 505-4108
info@swsportsandspine.com

Dear New Patient,

Welcome to our practice! We are grateful that you have chosen us to take care of your health care needs. The following information is provided to introduce you to our practice and practice policies.

Please complete the included forms and bring them to your first appointment.

> **If you are unable to complete your paperwork prior to arrival, please arrive 45 minutes early and a staff member can assist you with completing it. If your paperwork is completed, please arrive at least 15 minutes to allow our office time to prepare your charts and complete the administrative portion of your appointment.** ***Please be aware, if you do not arrive early for your initial appointment, we may be forced to reschedule.***

Be sure to bring all updated insurance cards and a photo ID. It is also necessary for you to be prepared to pay any copays, co-insurance, or deductibles, according to your health insurance benefits, at check in. We accept cash, credit/debit cards, and checks.

If for any reason, you will not be able to come to your appointment, kindly give at least 24 hours' notice to avoid a $25 cancellation fee.

Thank you, we look forward to meeting you!

SOUTHWEST SPORTS AND SPINE LLC

7494 N. La Cholla Blvd. TUCSON, AZ 85741
Phone: (520) 395-0512

PATIENT REGISTRATION

Patient First Name:_____ **Last Name**:_____ **MI**:____

Address:_____ APT#_____ City:_____ ST:_____ ZIP:_____

Mailing Address:_____ City:_____ ST:_____ ZIP:_____

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Birthdate:____/____/____ Gender: ☐ Male ☐ Female SSN:_____ - _____ - _____

Email Info:_____ @_____ . _____ Primary Care Physician:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced Language Preference:_____ Referring Physician:_____

Work related Injury ☐ Yes ☐ No Date of Injury: _____ **Auto Accident** ☐ Yes ☐ No Date of Accident: _____

Employment: ☐ Employed ☐ Not Employed ☐ Self-employed ☐ Retired Race: _____ ☐ Declined

Employer name:_____ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Primary Insurance Information (Please provide card – for copy of front and back)

Indicate patient's relationship to primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (POA, Attorney, etc)

POLICY HOLDER'S NAME (If self, write self):_____

Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's SSN#:_____ - _____ - _____

Insurance Company Name:_____

Policy Number:_____ Group Number:_____ Copay Amt: $_____ . _____

Secondary Insurance Information (Please provide card – for copy of front and back)

Indicate patient's relationship to primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (POA, Attorney, etc)

POLICY HOLDER'S NAME (If self, write self):_____

Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's SSN#:_____ - _____ - _____

Insurance Company Name:_____

Policy Number:_____ Group Number:_____ Copay Amt: $_____ . _____

Emergency Notification Information: (Person to notify in case of emergency, other than parents)

Name:_____ Relationship to Patient:_____

Address:_____ Home number: (_____) _____ - _____

City:_____ ST:_____ ZIP:_____ Other Number: (_____) _____ - _____

NOTICE:

Our office provides the service of "reminder calls". To protect your privacy, please indicate how you would prefer this to be done.

☐ You prefer that staff does not confirm your appointment.
☐ Cell Phone (Leave message? ☐ Yes ☐ No)
☐ Home Number (Leave message? ☐ Yes ☐ No)
☐ Work number (no message)

Please read and sign:

I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of benefits to **SOUTHWEST SPORTS AND SPINE LLC**. I fully understand that if my insurance denies payment for any service defined as "non-covered", I will be responsible for that amount due. **.** In the event this account must be placed with Surety Acceptance Corporation for collection; patient or responsible party agrees to pay all collection costs.

SIGNATURE:_____ **DATE:**_____

Patient / Parent or Guardian

Southwest Sports and Spine, LLC

Privacy Practices and HIPAA

Our practice is committed to educating our patients about the healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our new Notice of Privacy. Our practice is complying with HIPAA regulations.

What is HIPAA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the Federal Government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice, and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable health information (IIHI)?

Any health information you provide, including your mailing address is IIHI. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual is also IIHI. What is the Notice of Privacy Practice? Our practice has an official Notice of Privacy Practice posted in our treatment areas informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure or your IIHI. This notice applies to all records created or retained by our treatment areas and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

- Treatment
- Appointment Reminders
- Release of information to family/friends
- Payment
- Treatment Options
- Disclosures Required by Law
- Healthcare Operations
- Health related benefits & services

The following categories describe unique situations in which we may use or disclose your individually identifiable health information:

- Public risks
- Health oversight activities
- Lawsuits
- Law enforcement
- Deceased patient's organ and tissue donation
- Serious health threats/safety
- Research

What are your rights concerning your individually identifiable health information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy Practices you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential communications
2. Requesting restrictions
3. Inspection and copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this notice
7. Right to file a complaint
8. Right to provide and authorization for other uses

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ do hereby acknowledge receipt of a
Please Print
copy of the Notice of Privacy Practices, Policies and procedures.

Signature of Patient:_____ Date: _____

In the event this request is made by the individual's personal representative:

Signature of Personal Representative:_____Date:_____

ASSIGNMENT OF BENEFITS AGREEMENT

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Southwest Sports and Spine, LLC for medical or surgical services or items rendered to me or my dependents by Southwest Sports and Spine, LLC. Should my insurance carrier deny Southwest Sports and Spine, LLC payment, I understand that I am financially responsible for the charges. I authorize Southwest Sports and Spine, LLC to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of my/our medical expenses. I certify that the information provided or to be provided by me/us is correct and complete to the best of my knowledge. It is my/our responsibility to update any and all personal, insurance health information.

It is our office policy to collect specialist office visit copays at the time of service. Be advised, however, that certain services, including but not limited to: Mri readings, Fluoroscopy guidance, or injection procedures may apply towards your deductible and/or coinsurance. It is the patient's responsibility to verify their plan benefits.

_____ _____
Signature of Patient Date

SWSS
Southwest Sports and Spine, LLC
7494 N. La Cholla Blvd.
Tucson, AZ 85741 520-395-0512

SOUTHWEST
sports & spine

Consent for Release of Medical Information To **Family Members**

Patient Name:_____ Date of Birth:_____

☐ I do not authorize Southwest Sports and Spine to release any or all information concerning my medical care to any individual.

I,_____, give my permission to have any/and or all of my medical information, including financial, released to the following persons:

Name_____ Name_____

Address_____ Address_____

_____ _____

Phone _____ Phone_____

Relationship_____ Relationship _____

Name_____ Name_____

Address_____ Address_____

_____ _____

Phone_____ Phone_____

Relationship_____ Relationship_____

Patient Signature:_____ Date:_____

Patient Financial Responsibility Policy

Patient Name: _____ DOB: _____

I understand and agree that I will be financially responsible for any and all charges for services rendered. This includes any evaluation/visit, procedure, lab or diagnostic testing, screening services, requested legal documentation, and all other medical services ordered by the physician or the physician's staff. I understand that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical services. I understand that an estimate for services may be given but the true cost will not be known until after insurance has processed the claim.

I understand that it is Southwest Sports and Spine's policy that I must pay my current copay, maintain my account balance below $250, and make monthly payments in order to reduce any remaining balance. I understand that if I do not keep my balance below $250, my future appointments may be cancelled, and my medication management may be placed on hold.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, or any other type of benefit limitation for the services I receive, and I agree to make full payment. I understand that it is my responsibility to update my insurances' coordination of benefits (COB) and that I am liable for claims denied for this reason. I agree to notify Southwest Sports and Spine within 30 days of any insurance changes.

I understand and agree that it is my responsibility to know if the physician I am seeing is a contracted, in-network, or preferred provider recognized by my insurance company or plan. If the physician I am seeing is not, it may result in claims being denied or higher out of pocket expenses to me and I understand this and agree to be financially responsible and make full payment.

If my visits are due to a motor vehicle accident, I understand and agree that Southwest Sports and Spine, LLC will be processing all claims through my medical health insurance. I understand that my claims may be denied by my insurance and I agree to be responsible for all charges deemed to be patient responsibility by my insurance. I understand that Southwest Sports and Spine, LLC will not delay billing due to any litigation and I will be financially responsible for any and all charges for services rendered.

I hereby authorize payment of medical benefits directly to Southwest Sports and Spine, LLC, for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees, if any. The duration of this authorization is indefinite and continues until revoked in writing.

Signature: _____ Date: _____

SOUTHWEST
sports & spine

Medication List

Patient Name:_____ DOB:_____

Pharmacy:_____

Medication	Dosage	How taken	How often taken
Example: Aspirin	Example: 81 mg	Example: Orally	Example: once a day

Are you ALLERGIC to any medications? ☐ YES ☐ NO

Allergy	Reaction	Allergy	Reaction

SOUTHWEST
sports & spine

Medical History

Patient Name:_____ DOB:_____

Present Absent Alcoholism	Present Absent Allergic rhinitis
Present Absent Alzheimer's disease	Present Absent Anemia
Present Absent Anxiety	Present Absent Arthritis
Present Absent Asthma	Present Absent Atrial fibrillation
Present Absent Carpal tunnel syndrome	Present Absent Cerebral palsy
Present Absent Chest pain	Present Absent Circulatory system disorder
Present Absent Congestive heart failure	Present Absent Depression
Present Absent Diabetes	Present Absent Emphysema
Present Absent Fibromyalgia	Present Absent Fracture of unspecified parts of l umbosacral spine and pelvis, sequela
Present Absent Gout	Present Absent Guillain-barre syndrome
Present Absent Headache	Present Absent Hearing loss
Present Absent Heart attack	Present Absent Heartburn
Present Absent Herniated Disc	Present Absent High blood pressure [hypertension]
Present Absent High cholesterol	Present Absent High lipids
Present Absent Hypothyroid	Present Absent Insomnia
Present Absent Irritable bowel syndrome	Present Absent Kidney failure
Present Absent Leptospirosis icterohemorrhagica	Present Absent Low back pain
Present Absent Migraine	Present Absent Mitral valve disorder
Present Absent Multiple sclerosis	Present Absent Osteoporosis
Present Absent Other bursitis, not elsewhere classified, unspecified site	Present Absent Other cervical disc degeneration, unspecified cervical region
Present Absent Other intervertebral disc degeneration, lumbar region	Present Absent Pain in unspecified elbow
Present Absent Pain in unspecified joint	Present Absent Pain in unspecified knee
Present Absent Raynaud's syndrome	Present Absent Sciatica
Present Absent Sinusitis	Present Absent Skin disorder
Present Absent Smoking	Present Absent Spondylosis without myelopathy or radiculopathy, cervical region
Present Absent Stroke	Present Absent Trigeminal neuralgia
Present Absent Visual impairment	
Present Absent	

SOUTHWEST
sports & spine

Medical History

Patient Name:_____ DOB:_____

Gastrointestinal: (Please circle) Difficulty controlling bowels, Abdominal, Diarrhea, Nausea, Vomiting

Do you have constipation? If so, please answer the next 2 questions:

How many bowel movements do you have per week? (Please Circle)

0-2 3-4 5-6 7+

What over the counter laxatives/medications/supplements have you tried?

_____

Surgical History

Date of Surgery	Surgery

SOUTHWEST
sports & spine

Family History

Patient Name:_____ DOB:_____

Please indicate with a check mark family members who have had any of the following:

Medical Condition	Mom	Dad	Sist.	Bro.	Medical Condition	Mom	Dad	Sist.	Bro.
Alcoholism					Allergic rhinitis				
Anemia					Anxiety				
Arthritis					Asthma				
Atrial fibrillation					Carpal Tunnel Syndrome				
Chest Pain					Circulatory system disorder				
Congestive heart failure					Depression				
Diabetes					Emphysema				
Fracture: Spine,Pelvis					Gout				
Headache					Hearing loss				
Heart Attack					Heartburn				
Herniated Disc					High blood pressure				
High cholesterol					High Lipids				
Hypothyroid					Insomnia				
Irritable bowel Syndrome					Kidney failure				
Low back pain					Migraine				
Mitral valve disorder					Osteoporosis				
Pain in elbow					Pain in joint				
Pain in knee					Sinusitis				
Skin disorder					Smoking				
Stroke					Visual impairment				

Social History

Tobacco Use

Cigarettes:

Quit: Date_____

Never

Current smoker: Packs/Day____# of yrs_____

Other Tobacco: Pipe___ Cigar___ Snuff___ Chew__

Are you interested in quitting? Yes___ No___

Alcohol Use

Do you drink alcohol? Yes___ No___ # drinks/wk___

Is alcohol use a concern for you or others?____

Drug Use

Do you use recreational drugs? Yes____ No____

Have you ever used needles? Yes___ No___

Exercise

Do you exercise regularly? Yes___ No___

Opioid Risk Tool

Patient Name:_____ DOB:_____

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Circle each box that applies	**Female**	**Male**
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 18-45	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Scoring Totals		

CHECK BOX IF NONE OF THE ABOVE APPLY TO YOU. ☐

SOUTHWEST
sports & spine

Patient Name:	
Date of Birth:	
Phone #:	
Date:	

Cognitive Assessment

Have you ever experienced:

If yes, please select how often below symptoms are occurring

- Sensation of not feeling right, being a little confused or unsteady? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Spells you would describe as feeling faint or as if you might pass out? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Events where you've experienced altered awareness? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

If yes, please select how often below symptoms are occurring

- Episodes of temporary confusion or brain fog? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Dizziness accompanied by loss of awareness or confusion? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Difficulty finding the right words or expressing yourself? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Lapse of time or zoning out? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Difficulty recalling the details of conversations you just had or TV shows you just watched? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

Are you experiencing migraines associated with the following symptoms?

- Aura or flashing/shimmering lights, zigzagging lines, or stars ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Dizziness ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Loss of awareness/consciousness ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly
- Nausea ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly

Do you have a history of:

- Sensation of not feeling right, being a little confused or unsteady? ☐ Yes ☐ No
- Sensation of not feeling right, being a little confused or unsteady? ☐ Yes ☐ No
- Spells you would describe as feeling faint or as if you might pass out? ☐ Yes ☐ No
- Events where you've experienced altered awareness? ☐ Yes ☐ No

_____ _____

Patient Signature Date