Precision
Spine & Sports
Rehabilitation

P.O. Box 906
Higley, AZ 85236
(480) 923-6655
www.johncjonesmd.com

Patient Registration Form

Patient's Legal Name: _____

Date of Birth: _____ Sex: _____ Social Security Number: _____

Address: _____ City, State & Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Do you wish to receive appointment reminders? Choose one: ☐ Text, ☐ Email, ☐ Phone call

Please list your preferred pharmacy to expedite your prescriptions:

Pharmacy Name: _____ Pharmacy Phone: _____

Referring Provider: _____ Primary Care Provider: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Insurance: _____

Group ID: _____

Member ID: _____

Secondary Insurance: _____

Group ID: _____

Member ID: _____

Tertiary Insurance: _____

Group ID: _____

Member ID: _____

Policyholder Name: _____ Relationship to Insured: _____

Address: _____ City, State & Zip: _____

Social Security Number: _____ Date of Birth: _____

I verify that the above information is factual and true to the best of my knowledge.

_____ _____

Signature of Responsible Party Date

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Financial and Office Policies

Welcome to Precision Spine & Sports Rehabilitation. This document explains some of our most important policies. Please read, initial, and sign, prior to your appointment.

For our clinic to run efficiently and respectfully to patients, we require that you arrive 30 minutes early as a new patient and 10 minutes early for routine follow-up appointments. If you are late, we will help reschedule you for the next available appointment.
_____ Initial here

If you are unable to keep an appointment, please call at least 48 hours in advance. There is a $25 charge for clinic appointments and a $100 charge for more complex tests and procedures that are not cancelled with proper notice. Missed appointments or late cancellations represent times that other patients could have been seen sooner. Persistent failure to keep scheduled appointments may result in dismissal from the practice.
_____ Initial here

As a courtesy to you, we will bill your insurance with the information you have provided. This information must be accurate. Please bring a current copy of your insurance card and other documentation to verify your address, such as a driver's license, utility bill, or other official statement that shows your residence. Services may not be provided without proper verification and identification.
_____ Initial here

We appreciate payment at the time of service. Prompt payment helps keep both our costs and fees down. We accept cash, check, or credit card payment. All deductibles, coinsurances, copays, and service fees are required to be paid at the time of service.
_____ Initial here

Health insurance is a contract between you and your insurance company. It is your primary responsibility to know your benefits and coverage. It is also your responsibility to know if we are in your provider network. We will attempt to verify your benefits, as a service to you. Nevertheless, please contact your insurance company prior to any medical service to verify your coverage. Although we may estimate what your insurance company may pay, the insurance company makes the final determination of coverage.
_____ Initial here

Please be aware that insurance may not cover some or all services. They routinely determine whether a service is medically necessary under your policy. Should a service not be covered by your insurance, you agree to pay any portion of the charges not covered.
_____ Initial here

If your insurance does not pay within 60 days from the time services are rendered, the balance may be billed to you. Unpaid accounts may be transferred to a collection agency. Please let our office know if your payment will be arriving late to avoid being sent to collections. If you are having difficulty making a payment, please discuss this with our office manager. We can work with you on a payment plan.
_____ Initial here

In the event of an unpaid and delinquent account, you agree to pay attorney's fees, court costs, and/or collection agency fees associated with any collection process.
_____ Initial here

Our office charges a $25 service fee for payments returned by the bank with insufficient funds.
_____ Initial here

There is a $25 charge for paperwork or forms completed at the request of the patient. Please allow at least 1 week for completion.
_____ Initial here

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Clinic appointments are required for consultations, medication prescriptions and refills, diagnostic orders, and pre-procedural planning to ensure proper documentation and rationale for medical decision making.
_____ Initial here

Consent to treatment: I consent to the administering of diagnostic procedures and medical treatments as deemed advisable and/or necessary by my medical provider at Precision Spine & Sports Rehabilitation, LLC. I understand that I have a right to refuse medical services at any time. I also understand that medical treatment involves risks and side effects, both known and potentially unknown. Due to the nature of medicine as a science, I understand that no guarantees regarding outcomes can be made.
_____ Initial here

Release of Information: I authorize Precision Spine & Sports Rehabilitation, LLC, to release any information necessary to my insurance company, their agents, and/or financially responsible party to determine benefits and payments for services provided. I also authorize the release of any or all clinical information to my referring and/or primary care provider to help me receive coordinated medical care.
_____ Initial here

Assignment of Benefits: I authorize and request all insurance carriers, health maintenance organizations, managed care organizations, and other payors with whom I have coverage, to pay directly to Precision Spine & Sports Rehabilitation, LLC, any and all benefits due under the terms of my agreements for items or services provided, including any settlements or judgments for such items or services.
_____ Initial here

I agree to forward all insurance and third-party payments that I receive for services rendered to me immediately upon receipt. Furthermore, I agree to cooperate in the collection of such benefits.
_____ Initial here

By signing in the space below as Patient/Legal Representative or Guarantor, I acknowledge that I have read and understand these agreements and wish to proceed.

_____
Printed Patient Name

_____
Signature of Responsible Party

_____
Date

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Notice to Patients

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the nonroutine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(gg). We support this law, because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised we have a direct financial interest in the diagnostic or treatment agency named below.

SurgCenter Gilbert
3345 S. Val Vista Dr., Suite 110
Gilbert, AZ 85297

Further, goods or services we have prescribed are available elsewhere on a competitive basis.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file; you may receive a copy.

Acknowledgement: I have read this "Notice to Patients" form, and I understand the disclosures that it contains.

_____
Printed Patient Name

_____
Signature of Responsible Party

_____
Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I have read and have access to a copy of this office's Notice of Privacy Practices, which outlines how my protected health information may be used and shared. It also describes my health privacy rights.

_____
Printed Patient Name

_____
Signature of Responsible Party

_____
Date

FOR OFFICE USE ONLY

Written acknowledgement of the receipt of the office's Notice of Privacy Practices could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier
- ☐ Medical urgency/emergency
- ☐ Other:

_____
Witness

_____
Date

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Patient Medical History

Name: _____
Date of birth: _____ Age: _____ Gender: _____
Referring Provider: _____

Ht.	
Wt.	
H.R.	
SaO_2	

Chief Complaint

Reason for visit: _____

History of Present Illness or Injury

Date of onset of symptoms (approximate, if unknown): _____
If injured, was it:

- ☐ Sports-related. What sport? _____
- ☐ Job Accident. Have you filed a ☐ Worker's Compensation claim?
  - Is your claim ☐ Active/open, ☐ Supportive care, ☐ Closed?
- ☐ Motor Vehicle Accident. Is there a possible ☐ Lawsuit pending or ☐ Case closed?
  - Were you the ☐ Driver, ☐ Passenger, ☐ Bystander?
  - Were you wearing a seatbelt? ☐ Yes or ☐ No.
  - Did you ☐ Hit your head or ☐ Lose consciousness?

Briefly describe how you were injured yourself or what caused your symptoms:

_____

_____

_____

Was the onset of symptoms:

☐ Abrupt ☐ Gradual?

Is the timing of your pain:

☐ Constant ☐ Intermittent ☐ Waxing and waning?

Is the trend of your pain:

☐ Improving ☐ Stable ☐ Worsening?

What is your pain severity range? (Circle the best and worst numbers in a typical day.)

0 1 2 3 4 5 6 7 8 9 10

(None at all) (Unspeakable)

What makes your pain worse? _____
What makes your pain better? _____

Have you had any of these treatments for your current symptoms?

- ☐ Over-the-counter medications ☐ Primary Care ☐ Emergency room
- ☐ Chiropractor. Did it help? ☐ Yes or ☐ No. When last performed: _____
- ☐ Physical therapy. Did it help? ☐ Yes or ☐ No. When last performed: _____
- ☐ Pain psychology. Did it help? ☐ Yes or ☐ No. When last performed: _____
- ☐ Injections. Did it help? ☐ Yes or ☐ No. When last performed: _____
- ☐ Surgery. Did it help? ☐ Yes or ☐ No. When last performed: _____

Medications that have helped: _____
Medications that did NOT help: _____

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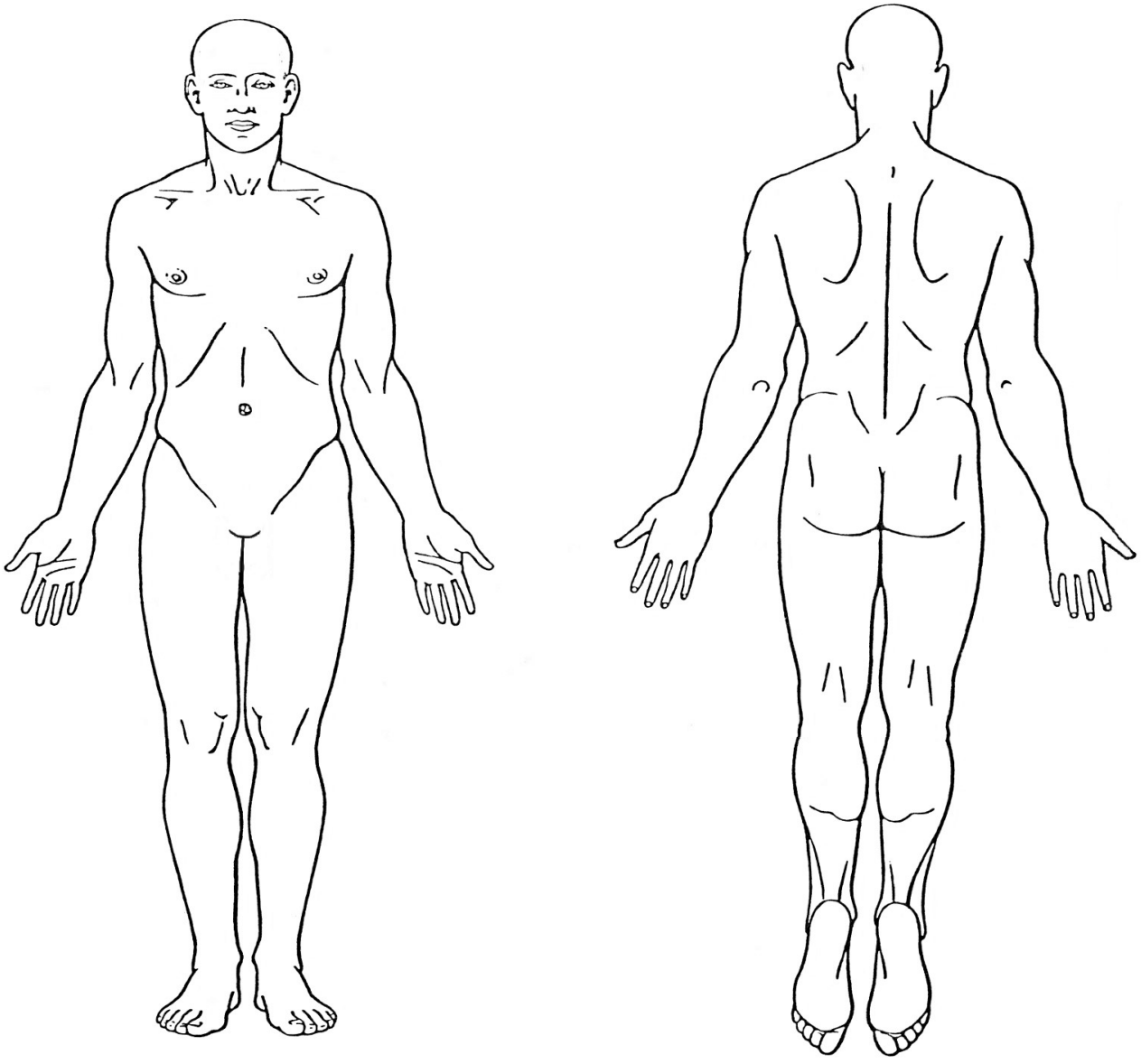
Name: _____

Have you had any of these tests for your current symptoms?

- ☐ X-rays. Facility: _____
- ☐ CT scan. Facility: _____
- ☐ MRI. Facility: _____
- ☐ EMG/Nerve Conduction Study. Facility: _____

Please mark the areas where you feel your symptoms. Use the symbols listed. Please show where the symptoms travel, as well.

Aching	Sharp	Burning	Cramping	Numbness	Tingling
^^^^	////	XXXX	□□□□	○○○○	::::



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Name: _____

Allergies and reaction: ☐ No known allergies

_____

_____

Have you ever had an allergic reaction to contrast dye? ☐ Yes or ☐ No. Type or procedure: _____

Current Medications (including over the counter):

Name: _____ Dose: _____ How often: _____
Name: _____ Dose: _____ How often: _____
Name: _____ Dose: _____ How often: _____
Name: _____ Dose: _____ How often: _____
Name: _____ Dose: _____ How often: _____
Name: _____ Dose: _____ How often: _____

Have you recently taken any NSAIDs, e.g. Advil, Aleve? If so, please list above.

Past Medical History/Conditions: _____

_____

_____

Any history of exposure to ☐ Hepatitis or ☐ HIV?

Any history of ☐ Kidney disease, ☐ Stomach ulcers, ☐ Heart disease, or ☐ Stroke?

Past Surgeries: _____

_____

_____

Family Medical History (1st degree only): _____

_____

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student ☐ Retired ☐ Off-duty

Occupation: _____

Alcohol: ☐ Never ☐ Former ☐ Current Beverages per week? _____

Tobacco: ☐ Never ☐ Former ☐ Current some day ☐ Current every day

Marijuana use: ☐ Never ☐ Former ☐ Current some day ☐ Current every day

History of substance abuse or addiction? ☐ Yes or ☐ No.

Review of Systems (current problems with any of the following):

☐ Fevers	☐ Short of breath exerting	☐ Sexual dysfunction	☐ Weakness
☐ Chills	☐ Short of breath resting	☐ Muscle pain	☐ Bleeding disorder
☐ Drenching night sweats	☐ Productive cough	☐ Joint pain	☐ Depression
☐ Eye pain	☐ Constipation	☐ Skin rash	☐ Anxiety
☐ Vision changes	☐ Diarrhea	☐ Itching	☐ Other mental health:
☐ Hearing changes	☐ Bowel incontinence	☐ Swelling	_____
☐ Chest pain/tightness	☐ Bladder incontinence	☐ Numbness	

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Directions to the Office

The office address is:

4862 E. Baseline Rd., Suite 108
Mesa, AZ 85206

We are located off the U.S. 60 on the borders of Mesa and Gilbert, Arizona, near Banner Gateway Hospital.

Freeway access is from Higley Rd. or Greenfield Dr. The office complex address is at the intersection of Baseline Rd. and Pierpont Dr. on the northwest corner.

Within the complex, Suite 108 is at the northeast end, closest to the intersection of Pierpont and Banner Gateway Drs.

Parking is in front of the suite, behind the building, or along Pierpont Dr.

Please be sure to arrive early and bring the following items:

- Your completed patient paperwork
- Your current insurance card(s)
- Photo ID with current address or other proof of residence
- Payment or co-payment
- Relevant medical records
- Most recent pertinent imaging