4838 E Baseline Rd. Suite 108
Mesa, AZ 85206
Phone 480-924-7091 Fax: 480-854-1445

PATIENT DEMOGRAPHICS

Full Name:_____ **Sex:**☐ M or☐ F **Date:** _____

SSN:_____-_____-_____ **Driver's License No.:** _____ Height_____ Weight ____

Date of Birth:_____ **Age:** _____ **Marital Status:**_____

Address:_____ **City/State:** _____ **Zip Code:** _____

Home phone:_____ **Cell Phone:**_____

Email Address:_____

Who may we thank for referring you: _____

Primary Care Doctor:_____

Referring Provider: _____

Are you currently: EMPLOYED RETIRED DISABLED UNEMPLOYED

Employer:_____ **Work:**_____

Emergency Contact Name:_____

Phone #:_____ **Relationship:**_____

Pharmacy Name:_____**Location:**_____

Insurance Information

Primary Insurance: _____**Policy Number:** _____

Group number:_____**Phone #:**_____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Relationship to Patient: _____

Secondary Insurance:_____ **Policy Number:**_____

Group number:_____**Phone #:**_____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

X _____-- _____

Patient Signature Date

PERSONAL INJURY/ACCIDENT MEDICAL HISTORY INTAKE FORM

Have you retained an attorney? ☐ Yes ☐ No

Your Attorney's Name: _____ **Attorney's Phone:**_____

Your Attorney's Address: _____ **City/State:** _____ **Zip Code:** _____

ACCIDENT INFORMATION

Date of Accident: _____ **Time of Accident:** _____a.m / p.m

Your Vehicle: Year _____ Make _____ Model _____

Other Vehicle: Year _____ Make _____ Model _____

Were you wearing a seatbelt? ☐ Yes ☐ No Accident Type: ☐ Rear Ended ☐ Head-On ☐ Broad-Sided

Damage to Your Vehicle: $_____ **Other Vehicle Damage**: $_____

Describe the Accident: _____

_____

ACCIDENT SPECIFICS: (Mark a X on each that applies to the accident)

Was this injury accident related? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other

Was this a Job or Work related injury? ☐ Yes ☐ No Were you the: ☐ Driver ☐ Passenger

If passenger, where were you sitting: ☐ Front Seat ☐ Back Seat Did the airbags deploy: ☐ Yes ☐ No

Impending Collision, were you: ☐ Aware ☐ Unaware ☐ Braced ☐ Not Braced

Did you head: ☐ Strike Object ☐ Not strike Object ☐ Break Glass ☐ Other _____

Did your experience: ☐ Shock ☐ Loss of Consciousness ☐ Whiplash ☐ Other _____

What were the Weather Conditions? ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The Road was: ☐ Dry ☐ Wet ☐ Icy Time of Day: ☐ Dawn ☐ Day ☐ Dusk ☐ Night

State your emotions and physical state immediately following the accident: _____

_____

State your emotions and physical state after the first few days: _____

_____

IMMEDIATELY FOLLOWING THE ACCIDENT (Mark a X on each that applies to the accident)

☐ Ambulance/Paramedics were called

☐ I went to the hospital on my own

☐ I was diagnosed at the hospital

☐ Medication was prescribed

☐ I was transported to Hospital by Ambulance

☐ I was treated on the scene

☐ I was treated at the hospital

☐ Follow up was recommended

PAIN ASSESSMENT

When and how did your pain/problem start? Please explain in detail. _____

_____

Treatment	Tried	Duration (ex. 1 week, 1 month)	Very Helpful	Some Help	No Help	Made Worse
Physical Therapy						
Exercise						
Chiropractor						
Surgery (for this issue)						
Injections						
Tylenol						
NSAIDS (Anti-Inflammatories)						
Opiate (Pain) Medication						

Please list which medication you are **CURRENTLY** taking for your **PAIN** only:

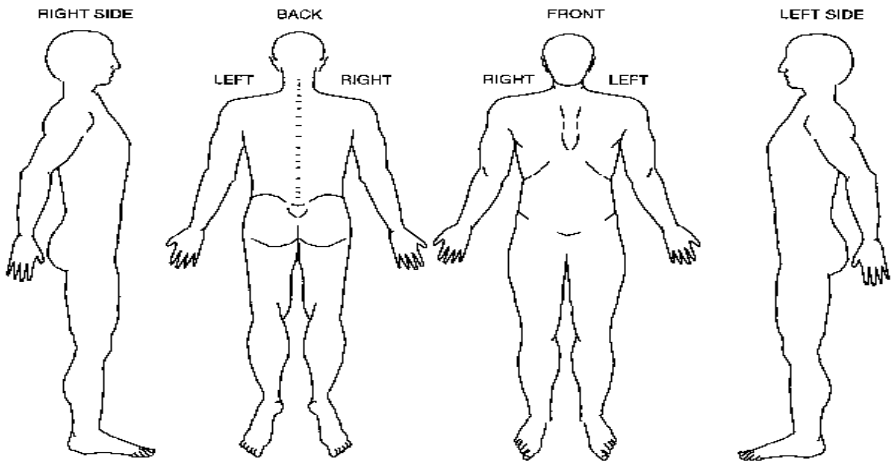
Medication	Strength	Times per Day	Date Started	Effectiveness 1-10 Scale

Please list the medications you have **PREVIOUSLY** tried for your **PAIN** only:

Medication	Strength	Times per Day	Date Stopped	Effectiveness 1-10 Scale	Reason for Stopping (ex. No help, caused headaches)

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:

Stabbing/Cutting; //// Tingling: **** Burning: XXXX Cramping: ++++ Numbness: NNNN Dull/Ache: ####



Review of Symptoms

Please Circle All that apply:

General: Recent fever, weight loss

Cardiovascular: Chest pain, palpitations

Eyes: Vision changes, irritation

ENT: Difficulty hearing, sore throat, hoarseness

Respiratory: Cough, shortness of breath, wheezing, sleep apnea

Gastrointestinal: Abdominal pain, change in appetite, reflux, constipation, diarrhea, nausea, vomiting, loss of bowels

Genitourinary: Difficulty urinating, painful urination, incontinence, loss of urine

Musculoskeletal: Back pain, muscle aches, muscle weakness, neck pain and joint pain/ swelling in the extremities

Psychiatric: Depression, anxiety, PTSD, hallucinations

Addiction: alcohol abuse, drug abuse, history of inpatient or outpatient substance abuse treatment

Endocrine: Fatigue, increased thirst, heat and cold intolerance, hair loss

Hematological: Excessive bleeding, easy bruising, swollen glands

Allergies/immunologic: Runny nose, sinus pressure, hives, HIV/AIDS, hepatitis

Gynecologic: Pregnancy, Menopause

Past Medical History

Please list all other medications you are currently taking:

Medication	Strength	Times per Day	Reason Taken (ex. Diabetes, Migraines, High Blood Pressure)

Do you have any drug allergies? ____ Yes ___ No

If so, please list all medications you are Allergic to: _____

_____

Are you allergic to? (please circle) Iodine IVP Dye Shellfish Tape Latex

List Past Surgeries: _____

_____

Do you have or have you ever had diseases or conditions of (place an X to the ones that apply)

Respiratory:

Asthma	Yes ___	No ___
Bronchitis	Yes ___	No ___
Chronic Cough	Yes ___	No ___
Emphysema	Yes ___	No ___
Shortness of Breath	Yes ___	No ___
Sleep Apnea	Yes ___	No ___
Use of CPAP	Yes ___	No ___
COPD	Yes ___	No ___

GU

Bladder Issues	Yes ___	No ___
Kidney Disease	Yes ___	No ___

Cardiovascular

Arrythmia	Yes ___	No ___
Chest Pain	Yes ___	No ___
Heart Attack	Yes ___	No ___
High Blood Pressure	Yes ___	No ___
High Cholesterol	Yes ___	No ___
Pacemaker	Yes ___	No ___

GI

Hepatitis	Yes ___	No ___
Liver Disease	Yes ___	No ___
Hiatal Hernia	Yes ___	No ___
GERD	Yes ___	No ___

Endocrine

Diabetes (1 or 2)	Yes ___	No ___
Thyroid Issues	Yes ___	No ___

CNS

Head Injury	Yes ___	No ___
Migraines	Yes ___	No ___
Seizures	Yes ___	No ___
Stroke/TIAs	Yes ___	No ___

Blood/Coagulation

Anemia	Yes ___	No ___
Factor V	Yes ___	No ___
HIV	Yes ___	No ___

Cancer (type)_____ Please list any other illness you have _____

Test	Date(s)	Facility/Office Performed	Location on body (ex-Neck, Back, Thoracic Spine)
X-Ray			
MRI scan			
CT scan			
EMG/NCS			
Myleogram			
Bone Scan			
Bone Density			

Social History

Marital Status: _____ Are you currently employed: Yes ____ No____ Occupation: _____

Tobacco Use: Never Used Tobacco ___ Former Tobacco Smoker ___

Current Tobacco User: Type and Frequency (ex-Cigarettes 1 pack a day) _____

Alcohol Use: Denies Alcohol Use ____ Social Drinker ____ History of Alcoholism ___ Current Alcoholism ___

Drug Use: Denies any illegal drug use ___ Currently using illegal drugs: List_____ Former Drug User ____

Medical Marijuana Card: Yes___ No ___ If yes who prescribed it for you? _____

Medical History

Please circle and list relationship (mother, father, etc.) next to each one you circle

Arthritis _____ Diabetes _____ High Cholesterol _____

Back Issues _____ Heart Disease _____ Bleeding Disorder _____

Kidney Issues _____ Liver Problems _____ High Blood Pressure _____

Stroke _____ Headaches _____ Cancer _____

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FINANCIAL POLICY GUIDELINES

WELCOME

Thank you for choosing us as your healthcare provider. We are committed to providing quality medical care. Please read and sign prior to the commencement of any treatment.

INSURANCE

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. All health plans are not the same and they do not always cover the same services. In the event your health plan determines a service is "not covered", you will be responsible for the complete charge. This office is not responsible for disputing your insurance company's decision regarding coverage. We will do our best to prior authorize any and all tests and procedures prior to them being done. We expect that you are responsible in knowing your insurance benefits, including but not limited to: deductible, co-insurance and co-payment amounts as well as labs, radiology facilities and hospitals contracted with your plan. If you have insurance coverage with a plan in which we do not participate or you have no health insurance plan, our charges for your care are due at the time of service. You may, however, bill your insurance company, even if we are not a contract provider. Our office will provide you with the necessary paperwork to do so.

ADMINISTRATIVE

Your insurance is your responsibility. As a courtesy to our patients, we will file claims for these plans which we have an agreement with. It is your responsibility to notify our office with current and valid insurance information. If your insurance does not pay within a reasonable amount of time, we will look to you for payment. Any costs incurred by this office because of incorrect information provided to us will be your responsibility. Payment is due upon receipt of a statement from our office. All monies owed including co-pays, co-insurance, deductibles or outstanding balances are collected at the time of service. Administrative Fees:

$25.00 for NSF returned checks

Disability/FMLA paperwork will need to be a scheduled appointment and any co-insurance or deductibles will be do at that time.

If this account should go into default, you understand that you will be held liable for all collection fees and attorney fees incurred to collect this debt.

I have read and understand the financial policy guidelines:

Patient:_____ Date:_____

Gateway Pain solutions

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CANCELATION AND NO SHOW POLICY

We strive to provide excellent medical care to you, your family and all our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for a patient. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. To reduce the number of such occurrences, we have a Medical Appointment Cancellation Policy. Our policy is as follows:

1. We request you give our office a notice of at least 1 full business day in the event you need to reschedule your appointment. Our phone number is 480-924-7091. For any appointment rescheduled within 1 business day of the original appointment, a **$35.00** late change charge may be assessed to you.
2. If you miss an appointment completely without contacting us with at least a 24-hour prior notice, we will consider this a missed appointment and a **$75.00** no-show fee will be assessed to you.
3. If you are more than 10 minutes late for an appointment, you may not be seen by Dr. Ranson or Chad Dance, CNP. Our providers take great care in ensuring all their patients get an extremely high level of attention during their appointment. This attention requires a specific amount of time. Our providers will not compromise their standards by spending less time with a patient due to a late arrival.
4. Our office makes reminder calls for appointments. If you are registered for the patient portal, you will receive email reminders as well. It is ultimately the patient's responsibility to remember their scheduled appointments. This fee will be billed to you directly and is not covered by your insurance

Thank you for understanding our high standards for patient care.

_____ _____

Patient or Representative Signature Date

_____ _____

Printed Patient or Representative Name Date of Birth

Relationship to Patient (If other than patient) _____

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HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy at any time by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Gateway Anesthesia and Pain provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I have the following rights and privileges:

• Protected health information may be disclosed or used for treatment, payment or health care operations, but I have the right to request restrictions as to how my information may be used or disclosed to carry out treatment, payment, or healthcare operations.

• Gateway Anesthesia and Pain has a Notice of Privacy Practices at each office location and the patient may review and request a copy of the Notice at any time.

• The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

• The right to review the notice prior to signing this consent.

•The right to object to the use of my health information for directory purposes.

This Consent was signed by:

_____ _____

Patient or Representative Signature Date

_____ _____

Printed Patient or Representative Name Date of Birth

Relationship to Patient (If other than patient) _____

Employee Witness Initials: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Last Name: _____ **First Name:**_____

Date of Birth:_____ **Phone Number:**_____

Address:_____

Date(s) of Service requesting: _____ **Purpose of Disclosure:** _____

Please Send:_____

I understand the information in my health records may include information relating to sexually transmitted disease Acquired Immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization is valid only for the realease of medical information dated prior to and including the on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

Release to:__Matthew Ranson, MD_____

Address: ____4838 E. Baseline Rd #108 Mesa, AZ 85206_____

Phone:_____480-924-7091_____ Fax:_____480-854-1445_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under policy. Unless otherwise revoked this authorization will expire on the following date: _____, if I fail to specify an expiration date this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.521. I understand that any disclosure of information carried with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above forgoing Authorization for Release for information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature:_____ **Date:**_____

Name of Authorized Representative: _____

Signature of Authorized Representative: _____

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Patient Policies and Procedures

This is a general notice to explain our policies and procedures in treatment of pain management. Dr. Matthew Ranson specializes in Interventional Pain Management, he does not provide long term opioid medication management except in rare cases such as chronic cancer pain. It is up to the Doctor and his best discretion of whether he will take over any medication that you are currently taking. If in the event he decides to take over, they will not be prescribed at your initial consultation.

Before treatment we will explore all options within the scope of our practice to help you regain function and lead an active and healthy lifestyle. We will do so by using a variety of treatment methods to accomplish treatment goals that include physical therapy, basic injection procedures, heat/cold therapy, non-controlled substances and in some cases-controlled substances.

If your Doctor decides to prescribe a controlled substance to you as part of your treatment plan, He /She will and must follow all federal and state law regulations regarding controlled substance prescribing. Below you will find a list of some things we may ask you to bring to your initial consultation that are in coordination with our patient selection and treatment procedures.

- Gather all information you may have and from your doctors about your medical history and past pain treatments. This should include a list of all current medications.
- We may ask you if you, or anyone in your family has had a problem with alcohol, drugs, perception drug use, or tobacco.
- In addition, we ask patients to submit a urine drug screen as part of our initial patient selection. (**we do not guarantee coverage of payment for this service**) If we accept you into our pain management program, we also may ask you to submit additional urine samples as part of your ongoing treatment. All urine samples are requested at the discretion of your doctor and if you choose not to cooperate with us, we may find a way to treat you without controlled substances.

Your medical condition and use of medications will be monitored using various tools, in addition to urine drug testing, which may include medication counts, family conferences, physiological evaluations, and more. These policies are not intended to offend anyone, these are just policies and tools that are used in our practice.

On behalf of Gateway Anesthesia and Pain Associates, PLLC, we are committed to treating your pain in an acceptable and appropriate manner. We look forward to helping you, as it is our goal to control your pain.

Confidentiality Statement

Here at Gateway Anesthesia and Pain Associates, PLLC, we value your rights to privacy. All interactions and medical information/records are completely confidential. As a patient, you have rights to your privacy and we have listed some of your rights below regarding Health Insurance Portability and Accountability Act (HIPPA) You can learn more about HIPAA at www.hhs.gov/ocr/hipaa or by calling 1-866-627-7748.

You have the right to:

- Request any and all medical records
- Have corrections made to your health information
- Receive a notice of how your health information may be used or shared
- You can give authorization for release of your records
- Indicate where you would like to be contacted
- Request your information not be shared with anyone or any other doctor
- File a report if you believe your healthcare information isn't being protected

Disclosure: Your Doctor is obligated to disclose any relevant information to reduce or prevent serious threat to your healthcare or safety.

Protected Health Information Authorization

I hereby authorize the use and/or disclosure of my protected health information for whatever Dr. Matthew Ranson deems necessary for my medical care. This includes but is not limited to: Pharmacies, Hospitals, Physicians referred to/by, diagnostic facilities, nursing home, insurance companies work comp, health facilities and family members.

Should you wish to **exclude** a person(s) from obtaining your health information, please list them below:

_____
_____
_____
_____

I understand I have the right to revoke this authorization at any time. My revocation must be in writing and I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I have the right to inspect and copy my own protected health information to be used or disclosed. In alliance with federal privacy protection regulations found under 45 C.F.R (164.524).

I understand that I am not obligated to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Matthew Ranson, nor will it affect my eligibility for benefits.

I have read and understood all policies and procedures at this practice

Patient Name: _____

Patient Signature: _____ Date: _____

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AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE VISIT/ CONSULTATION

The Telemedicine visit/consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance.

1. My health care provider has explained to me how the video conferencing technology will be used to affect such a visit/consultation and it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine visit/consult if it is felt that the videoconferencing connections are not adequate for the situation.
3. I understand that my health information may be shared with other individuals for scheduling and billing purposes. I also understand that my insurance will be billed for this visit with the consulting health care provider and that I may be billed for what my insurance does not cover, dependent upon the provider. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payor.
4. The same confidentiality protections that apply to my other medical care also apply to the Telemedicine visit.
5. I will have access to all medical information resulting from the Telemedicine visit as provided by law.
6. The information from the Telemedicine visit (images that can be identified as mine or other medical information from the Telemedicine visit) cannot be released to researchers or anyone else without my additional written consent.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the benefits and risks of a Telemedicine visit/consultation.
- I understand the information listed above.

X _____

First Name Last Name