Patient Information

Last Name	First Name	MI	DOB

Address	City	State	Zip

Phone (H)	Phone (C)	Email	Gender

Insurance Policy Holder	DOB	Relationship

Emergency Contact	Emergency Phone	Relationship

Provider Information

Referring Physician ☐NONE	Primary Care ☐NONE	Cardiologist ☐NONE

How did you hear about us? ☐Doctor ☐Family/Friend ☐Google ☐Internet ☐Newspaper ☐Article ☐Magazine ☐Other_____

Race		Ethnicity	Marital Status	Language
☐African American	☐Other Race	☐Hispanic/Latino	☐Single ☐Widowed	☐English
☐American Indian	☐White	☐Not Hispanic/Latino		☐Spanish
☐Asian	☐Decline to Specify	☐Decline to Specify	☐Married ☐Divorced	☐Other

Pharmacy Information

Pharmacy	Phone #	Cross Streets/Address

Current Medications – Please list ALL medicine information

Medication ☐ **NONE**	Strength	Times per day	Reason ex-Diabetes, Migraines, High Blood pressure

Are you currently taking (check any that apply):	☐Blood Thinners or Aspirin	☐Fish Oil	☐NSAIDs	☐Ibuprofen	☐Aleve

Allergies – Please list ALL allergies

Are you allergic to:	☐Iodine	☐IVP Dye	☐Shellfish	☐Tape	☐Latex

Allergy: ☐ **NONE**	Reaction:

Past Surgeries – Please list ALL past surgeries and Year performed

Surgery: ☐ **NONE**	Year:

Medical History – Please check all that apply and list relation (mother, father, etc.)

☐ Arthritis Relation ☐ Mother ☐ Father ☐ Sibling	☐ Diabetes Relation ☐ Mother ☐ Father ☐ Sibling	☐ High Cholesterol Relation ☐ Mother ☐ Father ☐ Sibling
☐ Back Issues Relation ☐ Mother ☐ Father ☐ Sibling	☐ Heart Disease Relation ☐ Mother ☐ Father ☐ Sibling	☐ Bleeding Disorder Relation ☐ Mother ☐ Father ☐ Sibling
☐ Kidney Issues Relation ☐ Mother ☐ Father ☐ Sibling	☐ Liver Problems Relation ☐ Mother ☐ Father ☐ Sibling	☐ High Blood Pressure Relation ☐ Mother ☐ Father ☐ Sibling
☐ Stroke Relation ☐ Mother ☐ Father ☐ Sibling	☐ Headaches Relation ☐ Mother ☐ Father ☐ Sibling	☐ Cancer Relation ☐ Mother ☐ Father ☐ Sibling

Tobacco Usage	Alcohol Consumption	Illicit Drug Use	Medical Marijuana
☐ Every day	☐ Every day	☐ Every day	☐ No ☐ Yes
☐ Some days	☐ Some days	☐ Some days	Prescriber:
☐ Former Year Stopped_____	☐ Former Year Stopped_____	☐ Former	
☐ Never	☐ Never	☐ Never	

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Review of Systems – Please check ALL that apply	
General:	☐ Recent Fever ☐ Weight Loss
Cardiovascular:	☐ Chest Pain ☐ Palpitations
Eyes:	☐ Vision Changes ☐ Irritation
ENT:	☐ Difficulty Hearing ☐ Sore Throat ☐ Hoarseness
Respiratory:	☐ Shortness of Breath ☐ Coughing ☐ Wheezing ☐ Sleep Apnea
Gastrointestinal:	☐ Change in Appetite ☐ Abdominal Pain ☐ Reflux ☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Loss of Bowels
Genitourinary:	☐ Difficulty Urinating ☐ Painful Urination ☐ Loss of Urine ☐ Incontinence
Musculoskeletal:	☐ Back Pain ☐ Muscle Weakness ☐ Muscle Aches ☐ Neck Pain ☐ Joint Pain ☐ Neck Pain ☐ Swelling in the Extremities
Psychiatric:	☐ Depression ☐ Anxiety ☐ PTSD ☐ Hallucinations
Addiction:	☐ Alcohol Abuse ☐ Drug Abuse ☐ History of in/outpatient abuse treatment
Endocrine:	☐ Heat/Cold Intolerance ☐ Increased Thirst ☐ Hair Loss ☐ Fatigue
Hematological:	☐ Excessive Bleeding ☐ Easy Bruising ☐ Swollen Glands
Immunological:	☐ Hepatitis ☐ HIV/AIDS
Allergies:	☐ Runny Nose ☐ Sinus Pressure ☐ Hives
Gynecological:	☐ Pregnancy ☐ Menopause

Diseases & Conditions – Please check ALL that apply ☐ **NONE**

Respiratory:	**Cardiovascular:**	**Endocrine:**
☐ Asthma	☐ Arrythmia	☐ Diabetes
☐ Bronchitis	☐ Chest Pain	☐ Thyroid Issues
☐ Chronic Cough	☐ Heart Attack	**CNS:**
☐ Emphysema	☐ High Blood Pressure	☐ Head Injury
☐ Shortness of Breath	☐ High Cholesterol	☐ Migraines
☐ Sleep Apnea	☐ Pacemaker	☐ Seizures
☐ Use of CPAP	**GI**	☐ Stroke/TIAs
☐ COPD	☐ Hepatitis	**Blood/Coagulation:**
GU:	☐ Liver Disease	☐ Anemia
☐ Bladder Issues	☐ Hiatal Hernia	☐ Factor V
☐ Kidney Disease	☐ GERD	☐ HIV

☐ Cancer, Type:

Please list any other Illnesses:

Diagnostic Testing – Please check ALL that apply ☐ **NONE**

Test	Date(s)	Facility Performed	Body Part
☐ X-Ray			
☐ MRI Scan			
☐ CT Scan			
☐ EMG/NCS			
☐ Myelogram			
☐ Bone Scan			
☐ Bone Density			

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Pain Assessment

When and how did your pain/problem start (please explain in detail)?

_____

_____

_____

_____

On a scale of 0 – 10 (10 being the worst) the pain is:

Pain Scale: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Prior Treatment – Please check ALL that apply ☐ **NONE**

Treatment	Duration	Outcome
☐ Physical Therapy		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse
☐ Exercise		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse
☐ Chiropractor		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse
☐ Surgery (for this issue)		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse
☐ Injections		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse
☐ Tylenol		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse
☐ NSAIDS (Anti-inflammatories)		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse
☐ Opiate (Pain) Medication		☐ Very Helpful ☐ Some Help ☐ No Help ☐ Made Worse

Please list which medication you are CURRENTLY taking for your PAIN only ☐ **NONE**

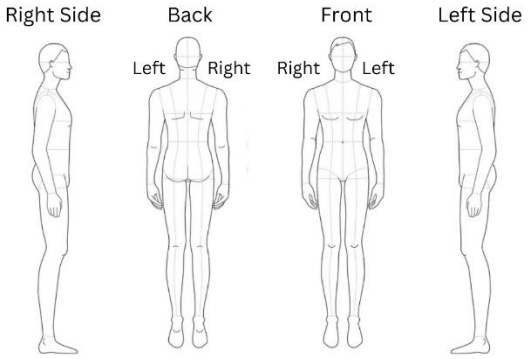
Medication	Strength	Times per Day	Date Started	Effectiveness 1-10 Scale

Please list which medication you have PREVIOUSLY tried for your PAIN only ☐ **NONE**

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

What type of pain are you experiencing?	☐ Sharp ☐ Deep ☐ Dull ☐ Aching ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Electrical ☐ Tingling ☐ Cramping

Mark where you feel pain:



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Acknowledgement - Receipt of Patient Rights & Responsibilities and Notice of Privacy Practices

By signing this form, I acknowledge receipt of Gateway Pain Solutions' Patient Rights & Responsibilities and Notice of Privacy Practices (HIPAA) and have been given the opportunity to read it. I understand these policies are available to me by request.

Acknowledgement - Medical Record Request

By signing this form, I hereby authorize Gateway Pain Solutions to obtain and/or disclose my medical records for medical treatment purposes only to my physician(s), clinic, hospital, or insurance without further written permission for continuation of care.

General Consent and Right to Refuse Treatment

General Consent to Treatment: By signing this form I (or my authorized representative on my behalf) authorize Gateway Pain Solutions and staff to conduct any diagnostic exams, tests, and procedures and to provide any medications, treatment to effectively assess and maintain my health, and to assess, diagnose and treat my condition. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reason(s) for any diagnostic examination, test or procedure, the available treatment options and common risks and benefits associated with these options as well as alternative courses of treatment. Right to Refuse Treatment: In giving my general consent to treatment, I understand I retain the right to refuse any examination, test, procedure, treatment, or medication recommended or deemed medically necessary as prescribed by my referring physician. I also understand the practice of medicine is not an exact science and no guarantees have been made to me as the result of my evaluation and/or treatment. Unless otherwise revoked, this authorization will expire in one year from date of signature.

Advanced Directives

You have the right to information on Gateway Pain Solutions' policy regarding Advanced Directives. Advanced Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives honored, the patient will be offered care at another facility that will comply with their wishes. A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. IMPORTANT: Under Arizona law a Prehospital Medical Directive or DNR must be on letter sized paper or wallet sized paper of orange background to be valid. If you have any questions, please talk to your physician or anesthesiologist. Visit https://www.caringinfo.org/ for more information.

☐ I have an Advanced Directive ☐ I do not have an Advanced Directive ☐ Copy given to Gateway Pain Solutions

Appointment Policy

To re-schedule or cancel, please call 480-924-7091 at least 1 full business day prior to your scheduled appointment. If the notice is less than 24 hours, you may be charged $35. If you miss an appointment without contacting the office with at least 24-hour notice, you may be charged $75 as a no-show fee. These fees are not covered by your insurance. If you are more than 10 minutes late for an appointment, you may not be seen. Disability/FMLA paperwork will be completed with a separate, scheduled appointment and fees will be collected at that time.

Financial Policy

Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance company unless you give us current and valid plan information. Proof of Insurance: We require a copy of your driver's license or ID and valid insurance card as proof of insurance. If we are given incorrect information, you will be held responsible for all charges. Coverage Changes: You must notify us immediately of any changes to your insurance coverage. Non-Insured: You are responsible for payment at time of service if you do not have insurance. Out of Network: If you have insurance coverage with a plan that Gateway Pain Solutions and Dr. Ranson do not participate in, charges for your care are due at time of service. You may bill your insurance if we are not contracted, and we will provide you with any necessary paperwork. Covered 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 decisions. You are responsible for knowing your personal insurance benefits, including but not limited to your deductible, co-insurance/co-payment amounts, as well as labs, radiology facilities and hospitals contracted with your plan. Co-pays, Deductibles, & Co-Insurance: All co-payments, deductibles and co-insurance amounts must be paid at time of service per your contract with your insurance plan. Payment is due on receipt of a statement from our office. Collections: Patient/Guarantor agrees to pay all costs of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance. Such contingency fees to be added by the provider and collected by the collection agency immediately upon the referral of your account to the collection agency of our choice. Once an account is placed in collection status all future services must be paid for in full at the time of service. A fee of $25 will be charged for returned checks. Assignment & Acknowledgement: I hereby assign all insurance benefits to Gateway Pain Solutions and Dr. Ranson for services performed. By signing this form, I acknowledge Gateway Pain Solutions' Appointment and Financial Policies.

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Treatment Policies & Procedures

This is a general notice to explain our policies and procedures in the treatment of pain management. Dr. Matthew T. Ranson, MD, specializes in Interventional Pain Medicine; he does not provide long-term opioid medication management except in rate cases such as chronic cancer pain. It is up to the doctor and his best discretion whether he will take over any medication that you are currently taking. 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 injections procedures, heat/cold therapy, not-controlled substances and in some cases, controlled substances.

If the doctor decides to prescribe a controlled substance to you as part of your treatment plan, he will and must follow all federal and state law regulations regarding controlled substance prescribing. Below is a list of some of the things we may ask you for that are in coordination with our patient selection and treatment procedures.

1. All the information you may have and from your doctors about your medical history and past pain treatments. This includes a list of all current medication.
2. We may ask if you or anyone in your family has had a problem with alcohol, drugs, prescription drug use, or tobacco.
3. We ask patients to submit a urine drug screen as part of our initial patient selection. We do not guarantee insurance coverage for payment for this service, in which case you are responsible for payment. If we accept you into our pain management program, we may ask you to submit additional urine samples as part of your ongoing treatment. All urine samples are requested at the discretion of the doctor and if you choose not to cooperate, 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. We are committed to treating your pain in an acceptable and appropriate manner.

Telehealth Visits

Telehealth provides an alternative way to visit with your healthcare provider. You are able to talk to your provider by phone, computer, or tablet, and video capabilities may be required. Since you are not in the room with your provider, it may feel different than a traditional office visit. Your insurance plan determines your cost, it will not cost any more than an office visit. Concerns surrounding Telehealth visits include:

1. The potential for a mistake because the provider cannot examine you as closely as in person (We don't know if mistakes are more common with Telehealth visits.)
2. Your provider may decide you need an in-person office visit.
3. Technical problems may interrupt or stop the visit before it's completed.
4. You may be overheard by people who are close to you. You should be in a private place.
5. You should use a network that is private and secure.
6. There is a chance that technology could be used to hear or view your Telehealth Visit.

Please feel free to ask any questions you may have regarding Telehealth visits. You can stop using Telehealth at any time, even during a Telehealth visit. Office visits will continue to be available to you.

By signing below, I acknowledge that I have read and understand the policies and procedures of Dr. Matthew T. Ranson, MD and Gateway Pain Solutions. Any questions have been asked and answered.

Patient or Authorized Representative's Signature: _____ Date: _____

Last Name	First Name	MI	DOB

Authorization to Communicate Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

In the event I am unavailable, I hereby authorize Gateway Pain Solutions to communicate my protected health information, including information regarding my billing, condition, treatment and diagnosis to the following individual(s) or entity:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

If your records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, mental health information, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing the disclosure of this information.

Text Message Communication – Duty to Warn: By providing my e-mail or telephone number, I agree that Gateway Pain Solutions and staff may contact me by e-mail or text. I understand that an e-mail or text may not be secure and that there is some risk that it may be read by third parties.

To the extent consent is required the Telephone Consumer Protection Act (TCPA), I hereby authorize delivery of messages containing non-health care communications like appointment reminders, patient satisfaction surveys, account calls, etc. through the use of an automatic/artificial telephone dialing system, pre-recorded voice messages, or e-mail. I am not required to agree to receive such communications and my agreement is not a condition of receiving items or services. Notwithstanding the foregoing, Gateway Pain Solutions does not waive and expressly reserves the right to contact me by any means for any purposes as otherwise permitted by law. By signing below, I have consented to receive e-mails or non-healthcare pre-recorded communications to the e-mail address or telephone number I have provided. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand this authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire one (1) year from date of-signature.

Patient or Authorized Representative's Signature: _____ Date: _____