Sobel Spine and Sports
Medical Questionnaire

Name: Age: DOB: DOS:
Referral: Handedness: Right / Left

What problem is Dr. Sobel seeing you for today? _____
Where is your pain located? _____
When did it start? _____
How did it start? _____
What makes the pain worse? Sitting Standing Walking Lying down Bending Lifting Not using Other
What makes it better? Sitting Standing Walking Lying down Bending Lifting Not using Other
Is this related to a car accident or a work related injury Yes No _____
What diagnostic tests have you had for this problem? **X-Ray MRI CT Scan EMG Other**
What treatments have you had? **Physical therapy Chiropractic Injections Massage Other**
How would you describe your pain? **Dull Aching Burning Stabbing Numbness Tingling Cramping Tightness**
Is your pain: **Constant or Intermittent Worsening or Improving or Staying about the same**
If there is numbness where is it located? _____
Have you experienced weakness? Yes No _____
What part of the day is your pain at its worst? _____
Have you had surgery for your problem? _____

Exercise frequency: Daily 3-5 times/week 1-2 times per week Rarely
Smoking history Current Quit Never
If you smoked in the past when did you quit? _____
If you smoke now, how many packs/day? _____ How many years? _____
How many alcoholic drinks do you have per week? _____ Do you use marijuana? Yes No
What is your occupation _____
Have you ever had a problem with substance abuse or addiction? Yes No

Notes: (MA use only) _____
_____
HPI: (for office use only) _____
_____
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Past Medical History(please circle all that are apply)

AIDS/HIV
Anemia
Rheumatoid arthritis
Asthma
Atrial fibrillation
Enlarged prostate
Cancer
Diabetes
Heart stents/bypass
Emphysema
Crohn's disease
Lupus
Depression/Anxiety
Blood clot
Fibromyalgia
Osteoarthritis
Gallbladder disease
Hearing loss
Heartburn
Gout
Liver disease
Hepatitis
High cholesterol
High blood pressure
Low blood pressure
Ulcerative colitis
Kidney disease
Headaches
Migraines
Multiple Sclerosis
Osteoporosis
Spinal fracture
Parkinson's disease
Psoriasis
Scoliosis
Bleeding disorder
Vascular disease
Low back pain
Neck pain
Seizures
Peripheral neuropathy
Sleep apnea
Spinal stenosis
Low thyroid
Heart valve disease
Glaucoma/eye disorder
Joint replacement
Stroke
Carpal tunnel syndrome
Joint pain
Pacemaker
Gastric bypass
Recent infection
Autoimmune disorder
Shingles
Seasonal allergies
Other _____
Other _____
Other _____
Other _____

Past Surgical History (please list the surgeries you have had)

1. _____
2. _____
3. _____
4. _____
5. _____

Review of Systems (please circle all that apply)

Constitutional
Chills
Fever
Fatigue
Night sweats
Weight loss

Allergy/Immunologic
Congestion
Watery eyes
HIV positive
Rash
Seasonal allergies

HEENT
Blurry vision
Eye pain
Dry eye
Hearing loss
Ringing in ear
Swollen glands

Cardiovascular
Chest pain
Palpitations
Fluid in legs
Chest pain

Respiratory
Asthma
Shortness of breath
Wheezing
Cough up blood
Chest pain
Breathing difficulty

Gastrointestinal
Abdominal pain
Black stools
Blood in stools
Heartburn
Difficulty swallowing

Genitourinary
Blood in urine
Difficulty urinating
Frequent urination
Painful urination

Musculoskeletal
Joint stiffness
Joint pain
Swollen joints
Leg cramps

Neurological
Numbness
Weakness

Hematology/Vascular
Blood clots in legs
Bleeding problems
Anemia

Endocrine
Cold intolerance
Heat intolerance
Dizziness
Hot flashes
Weakness
Excessive thirst

Psychiatric
Anxiety
Depressed mood
Difficulty sleeping
Loss of appetite
Psychiatric condition

How many times have you fallen in the past 12 months? None 1 2+ with/without injury

Family History (please circle all that apply)

Father:	Living/Deceased	Cancer	Heart disease	Stroke	Diabetes	Hypertension
Mother:	Living/Deceased	Cancer	Heart disease	Stroke	Diabetes	Hypertension

Current Medications:

Medication	Dose	Frequency

List any known drug allergies: _____

For office use only:

Height: Weight:

BP: Pulse:

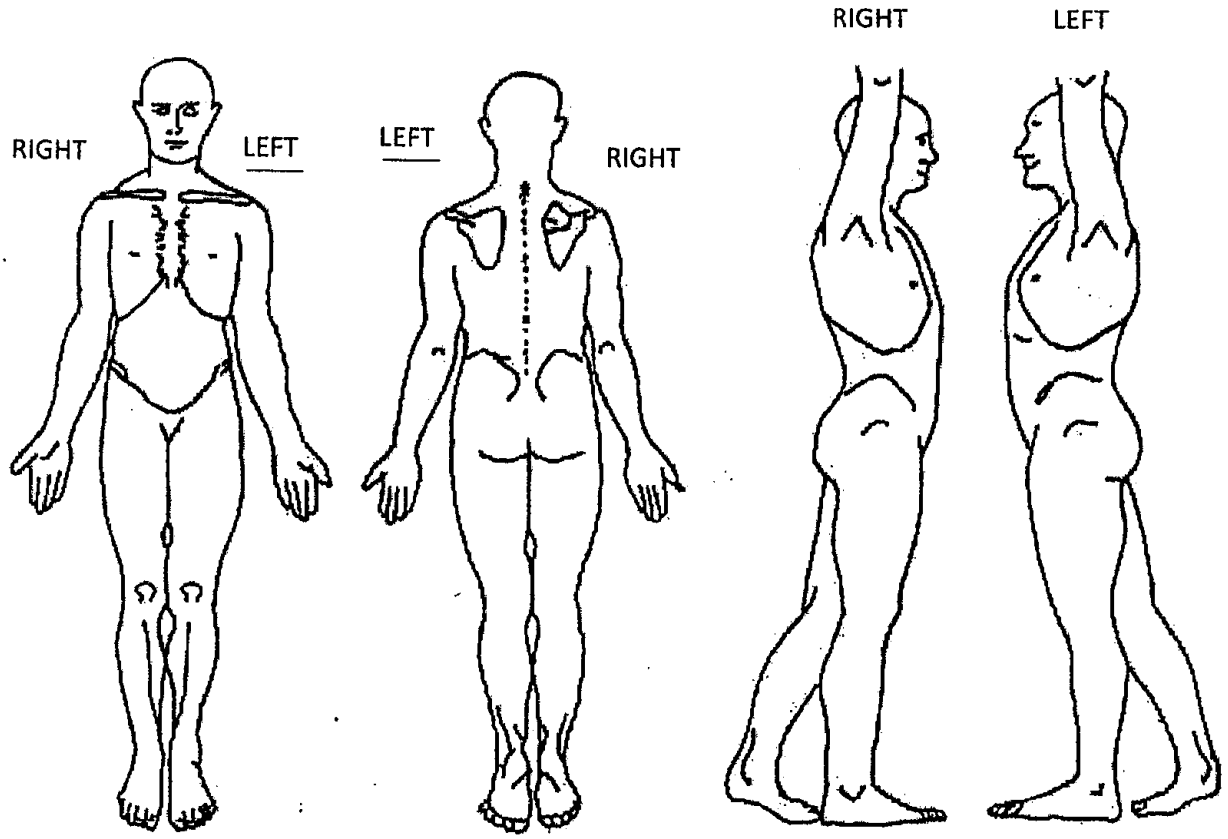
SOBEL SPINE AND SPORTS

Evaluation Form

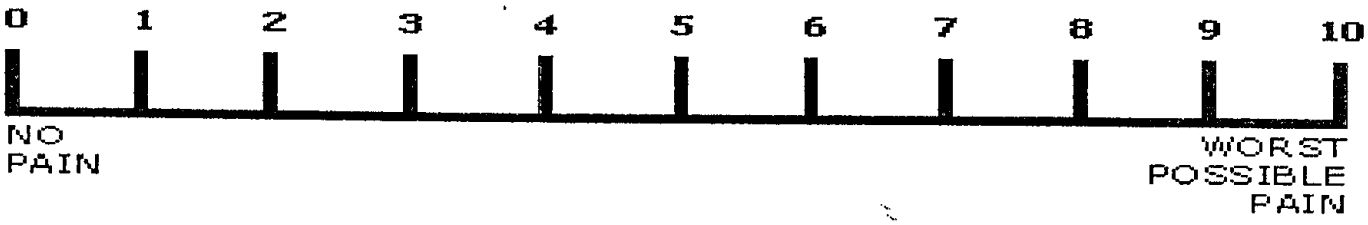
Patient's Name: _____ Date: _____ DOB: _____

On the drawing below, please indicate where you are experiencing pain by drawing the SYMBOLS on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Dull Pain - xxx **Sharp Pain - ooo** **Burning Pain - ***** **Numbness/Tingling - ^^^**



Below please indicate what your average pain level has been for the last week



(For Medical Assistant Use Only)

_____ PCP _____ Temp

_____ BP _____ Influenza _____ Falls

_____ HR _____ Pneumococcal _____ Were you Injured

SOBEL
SPINE & SPORTS

SPECIALIZING IN SPINE, SPORTS & PHYSICAL MEDICINE

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This will be effective for **1 year from the date signed below** unless we are notified in written to revoke consent.

I authorize Sobel Spine & Sports to release my records and any information to the following individuals.

Please put a check by what information you would like them to have access to:

1. _____ **Phone #:**_____ **Relation:** _____

   __ Billing ___ Scheduling ___Labs/X-rays ___All Records

2. _____ **Phone #:**_____ **Relation:** _____

   __ Billing ___ Scheduling ___Labs/X-rays ___All Records

3. _____ **Phone #:**_____ **Relation:** _____

   __ Billing ___ Scheduling ___Labs/X-rays ___All Records

☐ Please do not release any information

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment among the multiple healthcare providers who may be directly or indirectly involved in my treatment.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician's certification.

I have received and understand Sobel Family Medicine's Notice **of Privacy Practices**. I understand that Sobel Family Medicine has the right to change its **Notice of Privacy Practices** from time to time and that I may contact Sobel Family Medicine at any time, at the above address, to obtain a current copy of its **Notice of Privacy Practices**.

I understand I may request, **in writing**, that Sobel Family Medicine restricts how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand Sobel Family Medicine is not required to agree to my requested restrictions, but if agreed upon, it is bound to abide by such restrictions.

Patient Name (Print) _____

Signature: _____

Date: _____

Witness: _____

Our Privacy Promise to You, OUR PATIENTS.

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

FINANCIAL AND OFFICE POLICY

This is an agreement between Sobel Family Medicine & Sobel Spine and Sports and the Patient/Debtor. In this agreement the words "you", "your" and "yours's" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Sobel Family Medicine & Sobel Spine & Sports. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable within 10 days of the statement date or the end of the calendar month, whichever first occurs. For uninsured accounts, we may request payment in full or part or a payment deposit at the time of the visit for which the charges are incurred. We accept Cash, Check, Visa, MasterCard, and AMEX and any other major credit cards. Ana administrative processing fee of 1.5% of the amount charged is added to all credit card charges. The account is all due if the credit card is declined by the vendor. You hereby grant us a lien of all insurance and settlement proceeds obtained for services we tendered in whole or part. You grant us authority to submit our statements directly to your insurer or state and federal government programs such as Medicare and others. Your duty for payment is not conditioned upon whether any insurer or government program pays or should pay for your services in whole or part. That is between you and your insurer or program. The debt for services is always yours.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Due and Past Due Accounts: We do not carry or finance accounts. Any balance over 20 days past due will be assessed a late payment penalty of 1.5% of the principal amount then due. Services can be terminated by us on a late account. Without the requirement of an additional demand, the late account is in default when any balance remains due after 30 days past the original date due. In the event we are required to initiate collection action, we are entitled also to collection costs of 35% of the principal balance due, plus, if incurred and in addition, our attorney fees and any court costs. All personal and subject matter jurisdiction for delinquent payments and other disputes is agreed by you to be in Maricopa County, Arizona, USA.

Returned Checks: There is a fee (currently $35) for any checks returned by the bank.

Missed appointment fee: A 24 hour cancellation call must be made by the patient to cancel an appointment. If this call is not received, there will be a $50 "no show" fee for office visits and $75 "no show" fee for specialist office visit and a $150 "no show" fee for surgery center, added to your account.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Date: _____ **Initial** _____

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Contact Changes: You will advise us in writing of any address changes within 7 days of making them. Until you do, all communications sent to your phone, e-mail or common address you last gave us will be deemed received by you if sent to one of those by us.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Whether you have an attorney or not your will be responsible for the entire balance at time of settlement.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral or pre-authorization may result in a lower payment from the insurance company and more patient fees. This does not include any, personal injury, workers comp, or any claims that are not basic insurance claims.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires referral/prior authorization, you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a lower payment from insurance and higher payment from you.

Fair Treatment OF US: You agree that you will not disparage us in any way, written, visual, voice or oral, whether or not you believe it as a "truth," except as may be incidental as part of a genuine and good faith substantive dispute filed by you against us confidentially with us under the Amicable Resolution of Dispute process, below, and, if it fails for any reasons, then only before the appropriate licensure board or the Courts. This prohibition unconditionally includes publishing any disparagement of us in any other place, means or forum. It includes publishing in other places or forms that reference complaints you may have filed with the foregoing permitted forums. This includes disparagements placed by you in a newspaper, tweets, platforms, blog, social media of any kind, auto, visual, or a complaint site. It includes any other media or publication or circulation method, including any media of any form on the internet. The prohibition includes the acts of any person or entity acting under your engagement or control. You promise to be fair with us, make any complaints you feel you may have in the proper ways set forth under the Amicable Resolution of Disputes below and allowed, above, and acknowledge that disparagement of us goes beyond making a reasonable request for relief in a proper forum, above, and is instead an actionable damage to us immediately committed by the publication, alone. In any alleged dispute with us not regarding payment for services, you agree that you will remit all payments due prior to proceeding with the Amicable Resolution of Disputes paragraph, below.

Amicable Resolution of Disputes: If you believe you have a dispute with us, you must give us written notice of it with any evidence supporting it within 30 days of your discovery of the dispute, otherwise it is barred. If the dispute cannot be amicable resolved

Date: _____ **Initial** _____

between you and us by this communication process, you then agree to exclusively submit the matter to mediation before Mediator, who qualified in the area of the dispute who is a Member of the National Academy of Distinguished Neutrals, Arizona Chapter. Each of us will remit half the fees charged by the Mediator to try to resolve this dispute. Only after that Mediation, if the dispute is not resolved, then any unresolved dispute may then go on to any of the proper forums listed, above.

LAB RESULTS: We will attempt to contact you by phone with your lab results with 5-7 business days. If you have not received your lab results within 5-7 business days you are responsible to contact this office (602-996-6668) to obtain your lab results.

Acceptance of This Agreement: Our services and your rights and duties are governed by this agreement. The terms of it can be accepted by you in either of two ways: First, you can sign it or, second, you can accept it by seeking our professional services after receiving a copy of it—your act of going forward with services being deemed an acceptance of its terms just as through you signed it. We can give assure you have a copy of it in one of three ways: By handing it to you in our offices, or by e-mail to you, or by mailing it to you and noting then in our records that we have provided you a copy by one of the foregoing means. It will apply then to any services thereafter. For new or ongoing patients, the terms apply to services rendered after any of the foregoing acceptance or transmission steps.

Patient's name: _____

Responsible party: _____

Signature: _____ Date: _____

Witness: _____ Date: _____