Patient Information

Your completed intake paperwork helps our Providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. If you have any questions or are unsure about how to complete any section of this form, inquire at our front desk or call **480-456-3703**

Patient Information

Your Name _____ Today's Date _____

Driver's License #/State _____ Social Security Number: ____

Date of Birth: _____ _____ Age: _____ Gender: ❑ Male ❑ Female

Street Address: _____ __ _

City/State/Zip: _____

Email: _____ _____

Physical Address Same as Mailing? ❑ Yes ❑ No If not, please list mailing address: _____

_____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Spanish ❑ Other _____

Referral

Who is your Primary Care Provider? _____

Were you referred to our clinic by another physician? If so, whom?

↳ If not, how did you hear about us? ❑ TV ❑ Radio ❑ Insurance Company ❑ Family ❑ Friend ❑ PCP

❑ www.3dintegratedmedical.com ❑ Facebook ❑ Twitter ❑ YouTube ❑ Other _____
Website _____ Social Status

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other

Preferred Pharmacy Information

Pharmacy Name: _____ Phone Number: _____ Street Address: _____ City/State/Zip:

Do you have a Prescription Drug ID card ? ❑Yes ❑No Member ID # _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____ Policy/I.D.

Number: _____ Group Number:

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other:

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____ Policy/I.D.

Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other:

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number:

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: _____

Agent Name: _____ State of Injury: _____

Phone number: _____ Fax number: _____Claim Number: _____

Date of initial injury: _____

Injury Claim

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ❑ Yes ❑No

I certify that the above information is accurate, complete and true. I give my consent for Arizona Pain to retrieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature: _____ Date: _____

3D Integrated Medical

Today's Date: _____

Your Name: _____ **Height:** ___ **Weight**: _____lbs.

Onset of Symptoms

Where is your worst area of pain located, please list one area? What is the main reason for today's visit?

_____

Does the pain radiate? if yes, where? _____

Please list additional areas of pain _____

Approximately when did this pain begin?

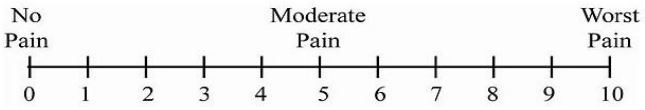
What caused your current pain episode?

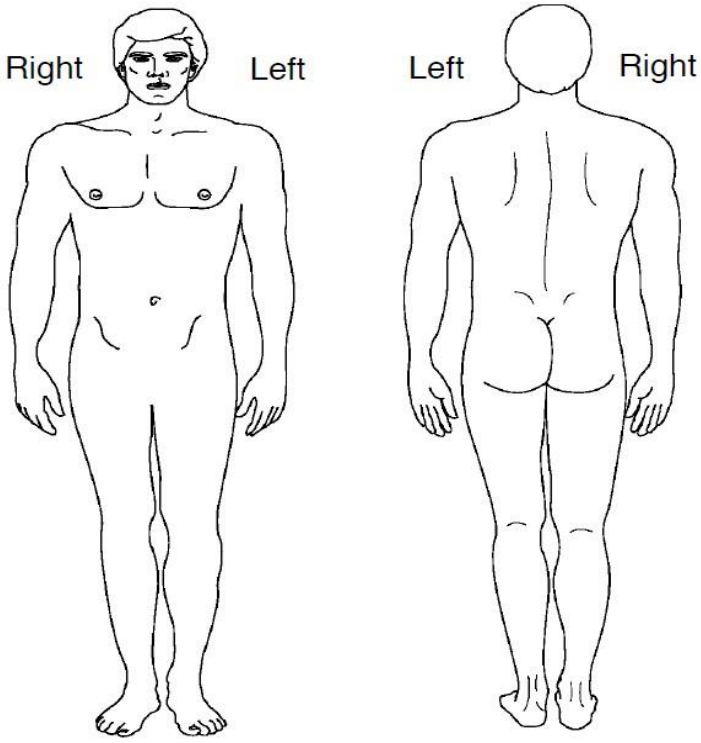
How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching





What is your current pain **right now**? _____

that best describe your symptoms:

Pain Description - Check all of the following that describe of your pain:

❑ Aching ❑ Numbness ❑ Spasming ❑ Throbbing
❑ Cramping ❑ Shock-like ❑ Squeezing ❑ Tingling/Pins & Needles
❑ Dull ❑ Shooting ❑ Stabbing/Sharp ❑ Tiring/Exhausting
❑ Hot/Burning

Pain Frequency

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is the pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

In the past three months have you developed any new:

❑ Balance Problems ❑ Bladder incontinence ❑ Bowel incontinence ❑ Chills

❑ Difficulty Walking ❑ Fevers ❑ Nausea ❑ Vomiting

❑ Numbness/Tingling? Please list where _____

❑ Weakness? Please list where: _____

❑ **I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

❑ MRI of the _____ Date: _____ Facility:

❑ X-ray of the _____ Date: _____ Facility:

❑ CT scan of the _____ Date: _____ Facility:

❑ EMG/NCV study of the _____ Date: _____ Facility:

❑ Ultrasound of the _____ Date: _____ Facility:

❑ Other diagnostic testing:

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History

Mark any of the following pain treatments you have undergone **prior** to today's visit:

❑ Chiropractic ❑ Physical Therapy ❑ Spine Surgery

❑ Epidural Steroid Injection: check all levels that apply ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Medial Branch Blocks or Facet Injections: check all levels that apply ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Radiofrequency Ablation: check all levels that apply ❑ Cervical ❑ Thoracic ❑ Lumbar

❑ Spinal Column Stimulator: check one ❑ Trial Only ❑ Permanent Implant

❑ Trigger Point Injections, where _____

❑ Other Treatments :

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Past surgical history Current Medications

Are you taking a **prescribed** **blood-thinner** medication? ❑Yes ❑No If yes, please check which one:

❑ Aggrenox ❑ Coumadin ❑ Effient ❑ Eliquis ❑ Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa ❑ Ticlid ❑ Warfarin ❑ Xarelto ❑ Other _____

Who prescribes your blood thinner medication? Please list the Doctor's name and phone number:

_____

Please list **ALL** medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Past Surgical History

Please indicate any surgical procedures you have had done in the past**, including the date, type, and any pertinent details.**

Abdominal Surgery:
❑ Gallbladder removal _____
❑ Appendectomy _____

Female Surgeries
❑ Caesarean section _____
❑ Hysterectomy _____
❑ Laparoscopy _____
❑ Ovarian _____

Heart Surgery
❑ Valve replacement _____
❑ Aneurysm repair _____
❑ Stent placement _____

Joint Surgery
❑ Shoulder _____
❑ Hip _____
❑ Knee _____

Spine / Back Surgery
❑ Discectomy (levels) _____
❑ Laminectomy _____
❑ Spinal fusion (levels) _____

Other Common Surgeries
❑ Hemorrhoid surgery _____
❑ Hernia repair _____
❑ Thyroidectomy _____
❑ Tonsillectomy _____
❑ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary):

_____
_____
_____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

Environmental Allergies

Are allergic to ❑ Iodine or ❑ Tape

Latex Allergy

Are you allergic to latex? ❑ Yes ❑ No

If yes: Do you require special medications or rescue measures to manage your latex allergy ❑ Yes ❑ No

Food Allergies

Are you allergic to shellfish? ❑ Yes ❑ No

Family History

Mark all appropriate diagnoses as they pertain to your **biological *MOTHER AND FATHER* only**.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems:

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

Drug Allergies

Do you have any allergies or reactions to medications? ❑ Yes ❑No

If yes, please list all medications you are allergic to and the reaction you have:

Medication Name **Allergic Reaction Type**

Past Medical History /Problem List

Mark the following conditions/diseases that you have been treated for in the **past**:

General Medical

❑ Cancer – Type
❑ Diabetes – Type
❑ HIV / AIDS

Gastrointestinal

❑ Bowel Incontinence
❑ Acid Reflux (GERD)
❑ Gastrointestinal Bleeding
❑ Constipation

Head/Eyes/Ears/Nose/Throat

❑ Glaucoma
❑ Headaches
❑ Head Injury
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Migraines

Cardiovascular / Hematologic

❑ Anemia/Bleeding Disorders
❑ Heart Attack
❑ High Blood Pressure
❑ Hypertension
❑ High Cholesterol
❑ Mitral Valve Prolapse
❑ Murmur
❑ Pacemaker/Defibrillator
❑ Poor Circulation
❑ Stroke
❑

Respiratory

❑ Asthma
❑ Bronchitis
❑ Emphysema / COPD
❑ Pneumonia
❑ Tuberculosis
❑ Valley Fever

Musculoskeletal

❑ Amputation
❑ Bursitis
❑ Carpal Tunnel Syndrome
❑ Fibromyalgia ❑ Joint Injury
❑ Osteoarthritis ❑ Osteoporosis
❑ Phantom Limb Pain
❑ Rheumatoid arthritis
❑ Vertebral Compression Fracture

Genitourinary/Nephrology

❑ Bladder Infection(s)
❑ Dialysis
❑ Kidney Infection(s)
❑ Kidney Stones
❑ Urinary Incontinence

Hepatic

❑Hepatitis A – circle one
active inactive unsure
❑ Hepatitis B – circle one
active inactive unsure
❑ Hepatitis C – circle one
active inactive unsure

Neuropsychological

❑ Alzheimer Disease
❑ Bipolar Disorder
❑ Depression
❑ Epilepsy
❑ Multiple Sclerosis
❑ Paralysis
❑ Peripheral Neuropathy
❑ Schizophrenia
❑ CRPS/Reflex Sympathetic Dystrophy

❑ **Other Diagnosed Conditions:**

_____
_____
_____
_____
_____
_____

Immunization History

Have you received a pneumonia vaccination? ❑ Yes ❑No If **yes**, when? _____

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No If yes, are you currently pregnant? ❑ Yes ❑No

Alcohol Use:

❑ Current Alcoholism ❑ Daily Limited Alcohol

Drug Use:

❑ History of Alcoholism ❑ Never Drinks Alcohol

❑ Social Alcohol Use

Tobacco Use:

❑ Current Smoker/Tobacco User

❑ Former Smoker/Tobacco User

❑ Never Smoked or Used Tobacco

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Social History Continued: **Drug Use:**

❑ Denies Any Illegal Drug Use

❑ Currently Using Illegal Drugs, list: _____

❑ Currently Using Someone Else's Prescription Medications, list _____

❑ Formerly Used Illegal Drugs (not currently using); list _____

Have you ever abused narcotic or prescription medications? ❑ Yes ❑No Which ones: _____

_____

Are you working? ❑ Yes ❑ No ❑ Student ❑ Retired Are you on disability? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No If yes, how many days per week? _____ What type of exercise do you perform? ❑ Bicycle ❑ Cardio ❑ Strength ❑ Swimming ❑ Walking

Other _____

How much time do you exercise on the days that you do exercise? _____

Have you had two or more falls in the past year? ❑ Yes ❑ No

Pain Scale

INSTRUCTIONS: For each question, please indicate your response by circling a number from 0 to 10. Please answer all questions

YOUR PAIN:	**0 = No Pain**					**10 = Extreme Pain**					
During the *past week,* the **best** my pain has been is.....	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, the **worst** my pain has been is	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, my **average** pain has been.....	0	1	2	3	4	5	6	7	8	9	10
During the *past 3 months*, my **average** pain has been.....	0	1	2	3	4	5	6	7	8	9	10

YOUR FEELINGS: During the past week I have felt:	**0 = Strongly Disagree**						**10 = Strongly Agree**				
Afraid.....	0	1	2	3	4	5	6	7	8	9	10
Depressed	0	1	2	3	4	5	6	7	8	9	10
Tired	0	1	2	3	4	5	6	7	8	9	10
Anxious	0	1	2	3	4	5	6	7	8	9	10
Stressed.....	0	1	2	3	4	5	6	7	8	9	10

YOUR CLINICAL OUTCOMES: During the past week:	**0 = Strongly Disagree**						**10 = Strongly Agree**				
I had trouble sleeping	0	1	2	3	4	5	6	7	8	9	10
I had trouble feeling comfortable 0	1	2	3	4	5	6	7	8	9	10	
I was less independent	0	1	2	3	4	5	6	7	8	9	10
I was unable to work (or perform normal tasks).....	0	1	2	3	4	5	6	7	8	9	10
I needed to take more medication.....0	1	2	3	4	5	6	7	8	9	10	

YOUR ACTIVITIES: During the past week I was NOT able to:	**0 = Strongly Disagree**						**10 = Strongly Agree**				
Go to the store	0	1	2	3	4	5	6	7	8	9	10
Do chores in my home.....	0	1	2	3	4	5	6	7	8	9	10
Enjoy my friends and family	0	1	2	3	4	5	6	7	8	9	10
Exercise (including walking).....	0	1	2	3	4	5	6	7	8	9	10
Participate in my favorite hobbies.....	0	1	2	3	4	5	6	7	8	9	10

Review of Systems

Mark the following symptoms that you **currently** suffer from.

Note: Diagnosed conditions/diseases should be noted under Past Medical History above.

Constitutional:

- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Easy Bruising
- ❑ Excessive Sweating
- ❑ Excessive Thirst
- ❑ Fatigue
- ❑ Fevers
- ❑ Low Sex Drive
- ❑ Night Sweats
- ❑ Unexplained Weight Gain
- ❑ Unexplained Weight Loss
- ❑ Weakness

Eyes:

- ❑ Recent Visual Changes

Ears/Nose/Throat/Neck:

- ❑ Difficulty Hearing
- ❑ Earaches
- ❑ Hayfever/Allergies
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

Cardiovascular/Respiratory:

- ❑ Chest Pain
- ❑ Cough
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Lightheadedness
- ❑ Shortness of Breath During Exertion
- ❑ Shortness of Breath During Rest
- ❑ Swelling in the Feet
- ❑ Wheezing

Gastrointestinal:

- ❑ Abdominal Cramps
- ❑ Acid Reflux
- ❑ Constipation
- ❑ Coffee Ground Appearance in Vomit
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Hernia
- ❑ Vomiting

Genitourinary/Nephrology

- ❑ Blood in Urine
- ❑ Decreased Urine in Flow, Frequency or Volume
- ❑ Erectile Dysfunction
- ❑ Flank Pain
- ❑ Painful Urination
- ❑ Pelvic Pressure

Musculoskeletal:

- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Muscle Spasms
- ❑ Neck Pain

Neurological:

- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling
- ❑ Seizures

Psychiatric:

- ❑ Anxiety/Stress
- ❑ Depressed Mood
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize **3D Integrated Medical**, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Arizona Pain to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review **3D Integrated Medical** Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the **3D Integrated Medical** to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize **3D Integrated Medical** to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that **3D Integrated Medical** will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested**. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency and attorney fees will increase the balance you owe.

Signed:_____ Date: _____

Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

APPOINTMENTS

1. Copayments. Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

2. Procedure Prepayment. Collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until prepayment has been made.

3. Missed Appointments and Late Arrivals. If you are more than 15 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a charge. Missed procedure, MRI or EMG appointments are subject to a charge.
   These charges are your responsibility and will not be billed to any insurance carrier.

INSURANCE PAYMENTS

4. Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

5. Coverage Changes and Timely Submission. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which must submit a claim on your behalf to your insurer. If is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

6. Self-Pay. If you do not have health insurance, or if your health insurance will not pay for services rendered by, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

7. Insurance Plan Participation. We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

8. Referrals. Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by, it is your responsibility to be aware of this fact, and to obtain this referral.

9. Prior Authorization and Non-Covered Services. May provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services

provided to you are covered benefits and authorized by your insurer. As a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

10. Out of Network Payments. If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to, immediately.

ACCOUNT BALANCES AND PAYMENTS

11. Reassignment of Balances. If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

12. Collection of Unpaid Accounts. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.

13. Returned Checks. Returned checks will be subject to a returned check fee.

14. Refunds. Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to:

15. Statements. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

Agreement and Assignment of Benefits

I have read and understand the financial policy of 3D Integrated Medical, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to. I understand that I am financially responsible for all services I receive from. This financial policy is binding up on you and your estate, executors and/or administrators, if applicable.

Signed: _____ Date: _____

Patient Authorization for Use and Disclosure of Protected Health Information

We take your privacy seriously. We will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes to release your medical records to parties indicated.

Your Name: _____ **Date of Birth:** _____

Authorized Parties

By signing below, I authorize (3D Integrated Medical), its agents and employees ("Provider"), to use and/or disclose any and all of my protected health information of any kind and description to the following party or parties
("Recipients")

Party	**Relationship**

Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may redisclose the records and that the records may no longer be protected by the Federal privacy regulation.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Right of Refusal

I acknowledge that I have had the opportunity to review 3D Integrated Medical Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at 3D Integrated Medical. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization. My written revocation must be submitted to the privacy office whose address is listed below:

3D Integrated Medical
2135 E. Southern Ave.
Tempe, AZ 85282
480-456-3703

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below. For one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

Signature

Signed by: _____ _____

Signature of Patient or Legal Guardian Today's Date

_____

Relationship to Patient