IZZY PAIN AND WELLNESS

GODWIN IZUEGBUNAM, MD
BOARD CERTIFIED

8910 N. 43rd Ave Suite 104
Glendale, AZ 85302
Phone: 602-595-2986
Fax: 602-595-3041

PATIENT REGISTRATION

Personal Information: Today's Date: ___________________

Patient First Name: ____________________________M.I. ________Last Name: _____________________________
DOB:___________________ Age: _______Last SSN #: ____________________ Email: _______________________
Address: ____
Street Apt# City/State/Zip
Cell Phone: ____________________Home Phone: _________________Work Phone: ________________________

Gender: M F Language: ENG___ Other: _________________ Marital Status: S M W D O

Race/Ethnicity: __ White __ Black/African American __ American Indian__ Alaska Native__ Asian__ Native Hawaiian /Pacific Islander __Hispanic/ Latino __Other: ____________________

Occupation: ________________________________ Retired: ____YES _____NO From: ____________________

Employer Name: ____Phone Number:______________________
Address:____City/State/Zip:___________________________________

Primary Care Physician:
Name:____Phone:__________________________________
Address:____
Street Suite# City/State/Zip

Psychiatric Care:
Name:____Phone:____________________________________
Address:____
Street Suite# City/State/Zip

Cardiologist Care:
Name: ____ Phone:____________________________________
Address:____
Street Suite# City/State/Zip

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Financial Responsible Party Information

Responsible Party Name: ________________________________ Relationship to patient: __________________

DOB: ______________________________ Age: ________ Social Security #: ___________________________

Emergency Contact Name: _____________________________Phone Number: __________________________
Relationship to patient: ____

Insurance Information:

Primary Insurance: _______________________________ Address: _____________________________________

Policy #: _______________________________Group #: ____

Policy Holder Name: _____________________________ DOB: _________ Relationship to patient: __________

Secondary Insurance: _____________________________ Address: _____________________________________

Policy #: ____ Group #_____________________________________

Policy Holder Name: ______________________________ DOB: _________ Relationship to patient: __________

Advanced Directives

Do you have a living will? _______ YES ______ NO Current copy provided ______ YES ______ NO

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PATIENT RESPONSIBILITY – INSURANCE DISCLAIMER

Patient Responsibility - Insurance Disclaimer Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. We suggest to all patients that they contact their insurance to confirm that these services are covered.

Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductible you have yet to cover. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our clinic.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Patient Name (Print): ____DOB________________________

Signature: ________________________________

Date: ____________________________________

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Chronic Opioid Administrative Agreement

I ___________________________________ understand that there are risks associated with taking Opioids for an extended period of time. These risks include: dependence, addiction, changes in personality, sleep changes, bowel and bladder changes, changes in sexual desire or performance, changes in appetite and weight, possible changes in coordination which may interfere with driving, operating machinery, or even death, especially if medication is not taken as prescribed.

Sudden discontinuance of opioids can lead to rebound pain, and other withdrawal symptoms. These included: agitation, sweating, diarrhea, muscle cramps, hypertension, chest pain, and a general state of being uncomfortable. I have been informed not to stop my medication suddenly or change the dose. Other medications can increase the risk of opioids, especially medication that depress the central nervous system: such as tranquilizers, muscle relaxants, ant-seizure medications, and other medications, even cold and allergy pills. Recreational and social practices such as: smoking or alcohol use can profoundly affect the risk of opioids. I agree to inform Dr. Izuegbunam of these social habits. To minimize these risks, I agree to come in for regular visits, exactly as determined, to obtain labs, x-rays, and consultations when requested or recommended. Specifically, if I am asked to have a urine screen, serum and drug level determinations, or pulse oximetry done, it will be done immediately.

I understand and agree that I must **NOT** obtain opioid medications from any other physicians. This includes emergency rooms, physicians and dentists. I also agree to obtain any prescribed opioid **ONLY** from:

Pharmacy Name: ______________________________________ Pharmacy telephone number___________

Pharmacy located at: ____

I understand that if my medication or prescription for said is stolen, lost, destroyed, rendered unusable or used before the next month supply is due, IT WILL NOT BE REFILLED UNTIL THE REFILL DUE DATE. I also understand that if there is a request from the pharmacy or Medical board for additional information it will be promptly provided, as per this agreement. Failure to abide by this agreement will-result in you being discharged from this practice and will need to find another source of care.

____ ____________________________

Patient signature Date

____ ____________________________

Physician / Witness Signature Date

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URINE ANALYSIS AGREEMENT

Patients are required to participate in a random Urine Analysis testing, this means if you are selected to provide Urine sample you are advised to do so. Failure to give a Urine sample will result in your IMMEDIATE DISCHARGE FROM OUR PRACTICE!!!

I ______________________________________ well aware that if I am chosen to give a Urine sample, I understand that I am required to participate, and my failure to do so will result in my IMMEDIATE DISCHARGE FROM IZZY PAIN MANAGEMENT.

I ______________________________________ have read and understand the following conditions above.

Signature: ______________________________________

Date: ______________________________________

CANCELLATIONS / NO SHOW / LATE FEE AGREEMENT

Due to the increasing amount of last-minute cancellations and appointment no-shows and late arrival, we are now implementing a new policy. **EFFECTIVE IMMEDIATELY,** the following charges will be applied to **ALL** patients who do not arrive to their scheduled appointed time and date. This includes cancellations **(less than 48 hours' notice)** and also patients who arrive more than 15 minutes late to their appointment.

Please note: No show/cancellation and late fee **WILL NOT** be covered by insurance!

****Initial visit:** Cancellation/No show - $ 50.00

****All Procedures:** Cancellation/No show - $50.00

****Follow up appt:** Cancellation/No show/ Late Fee - $35.00

** **Multiple** "NO-SHOW" appointments and or cancellations **may also be cause for termination.**

Please respect our new policy and understand that the appointment time reserved for you could have been spent with another much-needed patient.

Patient Name (Print) :____

Signature:__________________________ Date: ____________________________

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Lost Prescriptions / Lost Medication Bottles

Due to regulations by the Arizona Board of Pain Management, the Drug Enforcement Agency, and the Arizona State Medical Board, Dr. Izuegbunam cannot and will not **RE-WRITE** prescriptions and/or medications. It is your responsibility, and only you have the power to control this.

Post-Dated Prescription:

To prevent misunderstanding regarding post-dated prescriptions, we feel the need to offer some clarifications.

What are they?

A post-dated prescription is given to patients usually because they are being seen before there next refill date on the last prescription Dr. Izzy has given them. We all know by now that Izzy Pain and Wellness only schedules to see patient on **TUESDAY** and **FR IDAY**, so more than likely you are going to be given a prescription for your meds before they need to be filled which is called "Post-Dated".

What do I tell the pharmacy?

Nothing, they are Pharmaceutical experts and know how to handle the situation. If under their own discretion they feel the need to call our office to verify the date on the prescription, we will be happy to oblige them, however, you are not to go to your pharmacy and ask for refills before the date written on the prescription. We will not allow them to do so.

What do I do if I ran out of my medications, and I'm given a post – dated script?

Dr. Izuegbunam always writes prescriptions to last 30 days, he also informs every patient to take their medication as directed, if you follow the directions for your medication then you won't be out.

Izzy Pain And Wellness stresses to every patient how important it is to take your medicine only how it is written on the bottle; If you choose to take the medication more than what is directed, then it is your responsibility to deal with the consequences.

What if I am in pain, Should I go to my PCP Doctor to get a prescription to last me until the date on the Post-Dated script?

Being under Pain Management, patients are only to be prescribed Pain Medicine by that physician. The only exception is if you have a Chronic Illness (Example: Lupus, Sickle Cell, Cancer.) **PLEASE NOTE: Unless otherwise being treated by a physician for an illness, Dr. Izuegbunam is notified of, no patient are to receive pain medication from another doctor.**

What do I do if I am in pain, and cannot wait for the date on the Post-Dated script?

We advise patients to go to the Emergency Room if they are experiencing unbearable pain!

You are not to go to the emergency room to get your medication filled unless you are in severe pain.

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REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		

Eyes:	☐ Recent Visual changes

Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	

Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		

Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath

Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia

Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness
	☐ Joint Swelling	☐ muscle spasms	☐ Neck Pain

Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		

Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☐ Numbness/Tingling		☐ Seizures

Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	☐ Thoughts of Harming Others

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst? ☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night
☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present
☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_______________ The Best It Gets_______________ The Worst It Gets_______________

Mark the effect each of the following have on your pain level

	Increases	Decreases	No Change in my pain
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

____

____

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other ____________

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1)	____________	____________	____________
2)	____________	____________	____________
3)	____________	____________	____________
4)	____________	____________	____________
5)	____________	____________	____________

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1)	____________	____________
2)	____________	____________
3)	____________	____________

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis ☐Cancer ☐Diabetes ☐Headaches/Migraines ☐High Blood Pressure

☐Kidney Problems ☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

Alcohol Use:

☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☐Never

☐ Daily use of alcohol

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? ________ ☐ How many years? ________ ☐ Quit Date: ________

Illegal Drug Use:

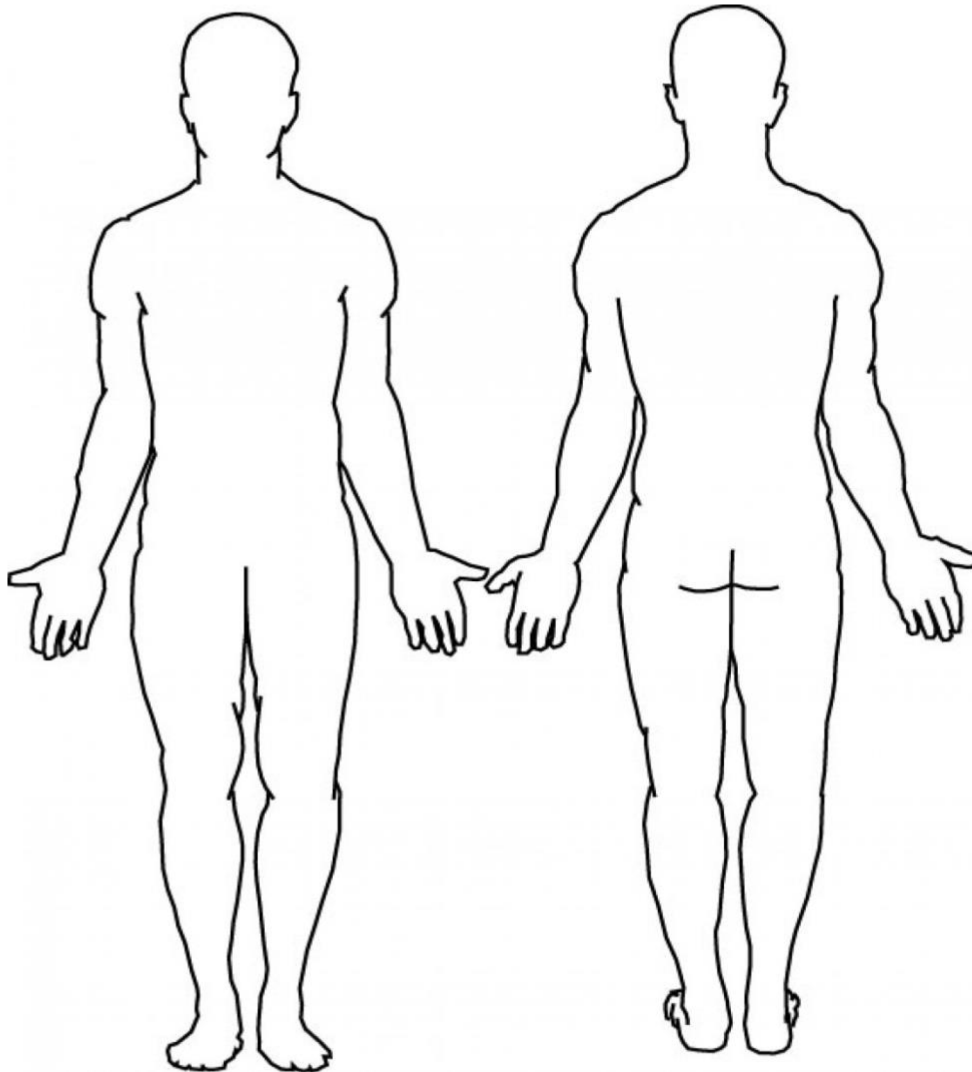
☐ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ N

Where is your pain? Mark the area on your body where you feel the sensations described below using the appropriate symbol. Mark the areas of radiation including all affected areas. To complete the picture, please draw in your face.

Aching	Numbness	Pins and Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	x x x x	/ / / /



RIGHT LEFT LEFT RIGHT

FRONT BACK

Please mark with an X on the body form where the pain is worst now.

Rate your pain in scale of 1 to 10, 10 being the worst. ____

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CLARIFICATION OF CONSENT

There have been many discussions during patient sessions that have identified some practices that may need clarification. Please review the clarifications below and feel free to bring any concerns to your provider during your upcoming appointment.

1. Medications sent by Izzy pain management are sent as a 30-day supply of medication. Medication filled prior to the 30 days is done so as a courtesy from the pharmacy. This courtesy does not change the amount of medication we prescribe.

2. No call- no shows, late arrivals or late cancellations jeopardize timely refills. We attempt in every way to see you prior to your fill date. Please call our office at 602-595-2986 a minimum of 24 hours prior to your appointment for any changes.

3. Transportation to your appointment is your responsibility as the patient. Transportation issues resulting in late arrival is documented and may lead to late fee charges. We recommend arranging transportation one month prior if utilizing an insurance funded transport service.

4. Transportation following your appointment is your responsibility. Front desk phones are NOT available for this. Please understand that these phones must remain available for our staff to coordinate appointments, reach insurance etc.

5. Confirming stock of medication is your responsibility. This is not the responsibility of our staff. This has been done so previously as a courtesy. We understand that this is not always known prior to your appointment and may not be known until you arrive at the pharmacy. We are happy to accommodate sending prescriptions to another pharmacy.

We thank you for your time in reviewing this information. If you have any questions, please address them with your provider during your next appointment. We look forward to seeing you.

Patient signature: ____

Date: ______________________________________