SOBARZO MD
PAIN MANAGEMENT
21820 Kingsland Blvd. Suite 101A, Katy, Texas 77450
P: 281.766.0854 • F: 281.768.4376 • Info@SobarzoMD.com
www.SobarzoMD.com

NEW PATIENT PAIN ASSESSMENT FORM

Patient Name: ______________________ DOB: ______________ Age: ________

Welcome to our office. Our goal is to provide you with the best possible medical care in a timely manner. Please help us by completing this questionnaire:

MEDICAL HISTORY (check all that apply):

______AIDS
______Attention Deficit
______Anemia
______Anxiety
______Asthma
______Bleeding Disorder
______Cancer: ______________
______Cholesterol – **High/Low**
______Chronic Back Pain
______Congestive Heart Failure
______Coronary Artery Disease
______Depression
______Diabetes
______Diverticulitis
______Emphysema
______GI Bleed
______Gout
______Heart Attack
______Hepatitis – **A / B / C**
______High Blood Pressure
______HIV
______**Hyper/Hypo** Thyroid
______Irregular Heart Beat
______ Irritable Bowel Syndrome
______Kidney Failure
______Liver Problems
______Lupus
______Migraines
______Neurological Disorder
______Poor Circulation
______Pulmonary Embolism
______Reflux
______Rheumatoid Arthritis
______Seizures
______Sexual Dysfunction
______Skin Rash/Ulcers/Lesions
______Sleep Apnea
______Stroke
______Meningitis
______**OTHER** ______________
______**NONE**

SURGICAL HISTORY

1. Have you had spinal surgeries? ☐ CERVICAL (Neck) ☐ THORACIC (Mid-Back) ☐ LUMBAR (Low Back) If so, what type? ______________________
2. Have you had Facet/Epidural Steroid Injections? ☐ CERVICAL(Neck) ☐ THORACIC(Mid-Back) ☐ LUMBAR
   If so, last injection date? ______________________
3. Do you have a **STENT, PACEMAKER, PORT** or any other **implantable device**? ☐ Yes ☐ No
   If so, what type?______________________

ALL OTHER SURGERIES (check all that apply):

_____Abdominal Surgery
_____Amputation
_____AV Fistula Creation
_____AV Graft
_____Aortic Valve Replacement
_____Appendectomy
_____Beast Surgery
_____Bronchoscopy
_____CABG
_____Carotid Endarterectomy
_____Carpal Tunnel
_____Cataract Extraction
_____Cholecystectomy
_____Colon Resection
_____Craniotomy
_____Gastric Bypass
_____Hemorrhoidectomy
_____Hip Replacement
_____Knee Arthroscopy
_____Knee Replacement
_____Kyphoplasty
_____Lumpectomy
_____Mastectomy
_____Mitral Valve Replacement
_____Nephrectomy Native
_____Para Thyroidectomy
_____Pneumonectomy
_____Prostatectomy
_____PTCA
_____RA-F Bypass
_____Rotator Cuff Repair
_____TURP+
_____TAH w/ BSO
_____Hysterectomy
_____Tonsillectomy
_____Tunneled Dialysis Catheter
_____UPPP
_____Vertebroplasty
_____**OTHER:**______________

Anesthesia Problems: ☐ Yes ☐ No Surgical Complications: ☐ Yes ☐ No Post-OP Complications: ☐ Yes ☐ No

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FAMILY HISTORY (check all that apply):

______Alcoholism
______Anemia
______Angina
______Arthritis
______Anesthesia Complications
______Anxiety
______Asthma
______Birth Defects
______Blood Clots
______Blood Transfusions

______Bowel Disease
______Cancer: ____________________
______Cholesterol **High / Low**
______Depression
______Diabetes
______Growth Development
______Headaches
______Heart Disease
______Thyroid Disease
______Suicide Attempt

______Melanoma
______Migraines
______Osteoporosis
______Psychiatric Care
______Seizures
______Severe Allergies
______Stroke
______Hypertension
______Liver Disease
______Weight Disorder

PAIN HISTORY:

1. What is your chief complaint for today's visit? ______________________________
2. How did the problem begin?: ◻ WORK ◻ INJURY ◻ MOTOR VEHICLE ACCIDENT ◻ OTHER
   Brief explanation: ______________________________
3. How often do you have pain and how long does it last?______________________________
4. Pain is worse WHEN I?______________________________
5. Pain is better WHEN I?______________________________
6. Difficulty sleeping? ◻ YES ◻ N0
7. Problems with daily activities (personal hygiene, housekeeping, walking, grocery shopping, etc)? ◻ YES ◻ N0
8. On a scale of 0 to 10 (0=pain free and 10=very painful), pain level right now? __________ 9. How would you describe your pain? ◻ Dull ◻ Aching ◻ Throbbing ◻ Sharp ◻ Burning
10. Please check below all that applies and write body part:
   ◻ Numbness - Where? ______________________________
   ◻ Tingling - Where? ______________________________
   ◻ Weakness - Where? ______________________________
   ◻ Coldness - Where? ______________________________
   ◻ Muscle Spasms/Cramps - Where? ______________________________
   ◻ Changes on Skin Color - Where? ______________________________

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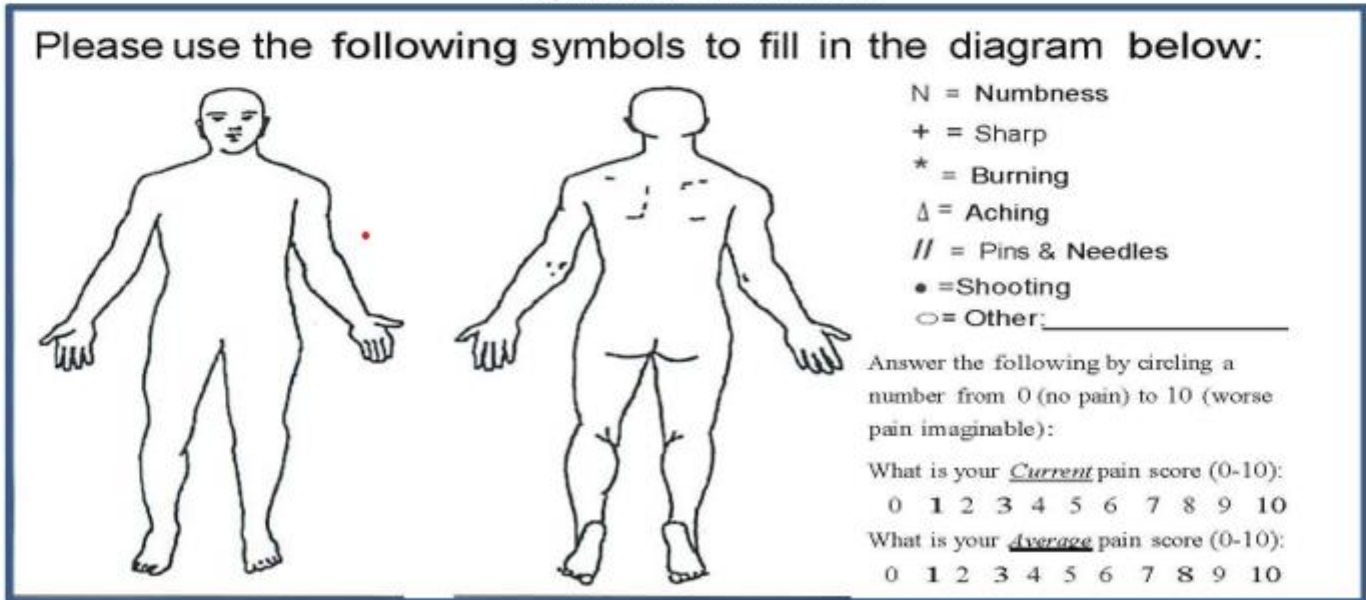
CURRENT PAIN DETAILS



PAIN TREATMENT HISTORY:

1. First medical care date for current problem? ____
2. Please list the names of all doctors you have seen for **this** condition:
   - Doctor ______________________ Specialty______________ Phone ______________
   - Doctor ______________________ Specialty______________ Phone ______________
   - Doctor ______________________ Specialty______________ Phone ______________
   - Doctor ______________________ Specialty______________ Phone ______________
   - Doctor ______________________ Specialty______________ Phone ______________
3. What studies were done?
   □ EMG Physician: ________________ Most recent date ________________
   □ MRI Most recent date ____________________
   □ CT scan/Myelogram Most recent date ____________________
   □ X-RAY Most recent date ____________________
   □ DEXA SCAN Most recent date ____________________
4. Treatments performed:
   □ Physical Therapy (circle) US, Ten Unit, Massage, Core Strengthening Exercise Program
   Any Relief? ____
   □ Chiropractic Manipulation How long? ________________________
   □ Injections IN office _____ Out Patient Procedure _____
   □ Psychotherapy/Counseling Results ___________________________
5. **<u>Allergies</u>** to medication? □ No □ Yes - Please List: ____
   ____
6. Allergies other than medications? □ No □ Yes - Please List:
   ____
7. Please list all of the medications including any over the counter medications, diet supplements, blood thinning medications (Asa, Ecotrin), all herbal (Mai huang, St John's wart), and NSAIDS (Motrin, Ibuprofen, Aleve) medications:

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PLEASE LIST ALL INFORMATION REQUESTED

Medication	Dosage	Frequency	Prescribing Physician

- Please be advised, if you have any heart conditions or if you are on Plavix, Coumadin,etc, we will require a written approval from your prescribing physician for discontinuation of these medications prior to scheduling any procedures.
- Please be advised, if you are a diabetic, your blood sugar may increase following steroid injections. Please also note that you need to monitor your blood sugar closely following procedures and may need assistance at home for 24 hours after injections. Contact your prescribing physician prior to your procedure for specific instructions.

8. Height ____________________ Weight ______________________
9. Have you been **prescribed or use any type of OXYGEN** in the past 12 months? If so, explain usage: _________________
10. Have you ever seen a psychologist or psychiatrist? □ Yes □ No
11. Do you smoke? □ Yes □ No How may cigarettes per day? ____________________
12. If you are a former smoker, when did you quit? _____________________________
13. Do you drink alcohol? □ Yes □ No
14. Do you use recreational drugs? □ Yes □ No
15. Have you ever had a problem with substance abuse? □ Yes □ No
16. Are you currently working? □ Yes □ No If not, why? ____
17. Please, briefly describe your job duties: ____

Patient Name: ____ DOB: __________________________

REVIEW OF SYSTEMS (check all that apply to you NOW)

GENERAL	EYES	EARS, NOSE, THROAT	CARDIOVASCULAR	RESPIRATORY
□ fever	□ blurring	□ earache	□ chest pains	□ cough
□ chills	□ diplopia (double vision)	□ ear discharge	□ palpitations	□ dyspnea (difficulty breathing)
□ sweats	□ irritation	□ tinnitus	□ syncope (fainting)	□ excessive sputum
□ anorexia	□ discharge	□ decreased hearing	□ dyspnea on exertion (difficulty breathing)	□ hemoptysis (coughing up blood)
□ fatigue / weakness	□ vision loss	□ nasal congestion	□ orthopnea (difficulty breathing lying flat)	□ wheezing
□ malaise (discomfort)	□ eye pain	□ nosebleeds	□ PND (Paroxysmal Nocturnal Dyspnoea)	□ pleurisy

□ weight loss	□ photophobia	□ sore throat	□ peripheral edema	
□ weight gain		□ hoarseness		
□ sleep disorder				

GASTROINTESTINAL	**GENITOURINARY**	**MUSCULOSKELETAL**	**DERM / SKIN**	**NEUROLOGICAL**
□ nausea	□ dysuria (painful urinating)	□ back pain	□ rash	□ paralysis
□ vomiting	□ hematuria (blood in urine)	□ neck pain	□ itching	□ paresthesias (burning or prickling in hands, arms, legs, feet, etc)
□ diarrhea	□ discharge	□ joint pain	□ dryness	□ seizures
□ constipation	□ urinary frequency	□ joint swelling	□ suspicious lesions	□ tremors
□ change in bowel habits	□ urinary hesitancy	□ muscle cramps		□ vertigo
□ abdominal pain	□ nocturia (excessive urination at night)	□ muscle weakness		□ transient blindness
□ melena (black, tarry stools)	□ incontinence	□ stiffness		□ frequent falls
□ hematochezia (vomiting of blood)	□ genital sores	□ arthritis		□ frequent headaches
□ jaundice	□ decreased libido	□ sciatica		□ difficulty walking
□ gas / bloating	□ erectile dysfunction	□ restless legs		
□ indigestion / heartburn		□ leg pain at night		
□ dysphagia (difficulty swallowing)		□ leg pain with exertion		
□ odynophagia (painful swallowing)				

PSYCHOLOGICAL	**ENDOCRINE**	**HEMATOLOGICAL/LYMPHATIC**	**ALLERGY / IMMUN**
□ depression	□ cold intolerance	□ abnormal bruising	□ urticarial (hives)
□ anxiety	□ heat intolerance	□ bleeding	□ allergic rash
□ memory loss	□ polydipsia (excessive thirst)	□ enlarged lymph nodes	□ hay fever
□ suicidal ideation	□ polyphagia (excessive hunger)		□ recurrent infections
□ hallucinations	□ polyuria (excessive amount of urine production)		
□ paranoia	□ unusual weight change		
□ phobia			
□ confusion			

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MEDICATION/OPIOID CONTRACT

I ______________________________ agree to the following guidelines as part of my treatment for chronic pain management with a provider from Sobarzo MD Pain Management/Arturo Sobarzo MD, PLLC:

- If I have a chronic pain problem, it may require the prescription of opioid pain medications to increase my quality of life by increasing my function and reducing my pain perception. I understand that Opioid medications can also be prescribe for short term, temporary, acute pain problems. The risks, side effects, and benefits of the medication have been discussed with me in detail in the event that chronic opioid therapy is indicated. I agree to the policies set forth by Sobarzo MD Pain Management/Arturo Sobarzo MD PLLC in accordance to the federal and state guidelines, for toxicology monitoring and diagnostic testing needed to evaluate the risks associated with opioid treatment.
- I understand that the use of the opioids in pain management is an acceptable practice, however, there is a potential for habit formation and in some instances, may result in addiction.
- If I am treated with opioid medications, I agree to take the medications only as prescribed and I will not accept a prescription for an opioid based, controlled substance, from another physician, without approval from my provider. An exception to this would be in an emergency situation, where I will notify ER Providers of my opioid contract with this office.
- I will use only one pharmacy to obtain prescribed controlled substances and any changes to this must be discussed with the provider prior to any changes. The pharmacy will be in the greater Houston area associated with the office I am being treated in, not out of the state of Texas. I give full consent for my provider and pharmacist to exchange information in writing or verbally. I also understand that changing pharmacies regularly is considered by the state and federal government as high-risk behavior for drug aberrancy, and I will comply with the office policy for toxicology testing when doing so.
- I understand that opioids are not effective long term, as single therapy, due to tolerance and dependency. An opioid prescription will be used in conjuncture a with multi-modal therapeutic plan, focused on interventional treatment options. If I am prescribed opioids, the goal is to continuously reduce and/or taper me off of them. To do so, I will meet the provider regularly to assess my progress. If the provider does not feel that opioid therapy is medically indicated, then they are not obligated to continue prescribing them.
- I am responsible for any lost, misplaced, stolen or miscounted medications from the pharmacy. The provider will not replace my medications or refill my medications early in the event that this occurs. I will not share my medications with anyone. A stolen medication will require a police report to be made and a notification to my provider within 48 hours of loss.
- I agree to participate in any medical or psychological assessments recommended by my provider for assessment for dependency, aberrancy or worsening of any comorbid conditions. I also understand that I will comply with Urine Drug Testing Policies of the office, including random sampling and pill counts. Failure to show up at the allocated time for random testing would forfeit my next prescription.
- The use of illegal drugs can lead to immediate discontinuation of opioid therapy and possible dismissal from the practice. If toxicology testing is indicated, I will follow the protocols for this testing as well as be responsible for any financial costs, if not covered by my insurance.

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- I understand that at every visit I will bring all prescription medications with me in their original containers on every appointment even if the bottle is empty. Failure may result in the rescheduling of my appointment.
- Failure to comply with ordered procedures or test may result in the discontinuation of medications.

I understand that my provider may stop prescribing the medications listed if:

- I do not show any improvement in pain or my activity has not improved.
- I develop rapid tolerance or loss of improvement from the treatment.
- I develop significant side effects from the medication.
- The clinic finds that I have broken any part of this agreement.
- My toxicology diagnostic testing reveals I am not following the recommended dosages for my prescriptions or the testing reveals I have used illegal or street drugs.
- My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from receiving further care from this clinic following guidelines set forth by the Texas State Medical Boards.

SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOD MEDICATIONS:

There are potential adverse effects that may occur while working and taking opioid medications. These adverse effects could potentially be dangerous and cause safety risks. These include delayed reaction time, impaired judgement, drowsiness, and physical addiction. Any of these may impair your ability to drive or operate heavy machinery. These adverse effects tend to diminish over time.

ADVERSE EFFECTS OF MIXING OPIOID MEDICATIONS:

These adverse effects may worsen when mixing opioid medications with other medications, including alcohol.

- Feeling of Anxiety
- Confusion
- Dizziness
- Drowsiness
- Slowed/Difficult Breath
- Constipation
- Nausea/Vomiting
- Impaired Judgment
- Slow Heart Rate
- Excessive Sweating
- Difficulty Urinating
- Physical/Psych Dependence

RISKS:

Abruptly stopping a medication may lead to withdrawal symptoms. The symptoms below may be harmful if you are being treated with other co-morbid conditions. Please DO NOT stop medications without the supervision of your provider.

- Runny Nose
- Diarrhea
- Rapid Heart Rate
- Drowsiness
- Sweating
- Nervousness
- Vomiting
- Abdominal Cramps
- Shakes and Chills
- Difficulty Sleeping for Several Days

I have read the above MEDICATION/OPIOID CONTRACT. By signing this contract, I affirm that I have read, understand, and accept all terms of the contract and appropriate opportunity was allocated to me by the provider to answer any and all questions that I may have prior to prescribing opioids.

Patient Signature:____Date:___________________________

Provider Signature: ____ Date:___________________________

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Code of Conduct

We are glad that you have chosen Sobarzo M.D. Pain Management/Arturo Sobarzo MD PLLC as your new pain management provider. Our providers strive to improve your quality of life through medication management and Interventional pain therapies.

Listed below are reasons our group may consider as grounds for patient termination from the practice. This are inclusive, but not limited to the following:

- ✓ Disruptive, uncooperative, or disrespectful behavior towards our staff either in-person or via telephone conversation (Please Note: this will include relatives and non-relatives of the patient)
- ✓ Repeated No Shows, Cancellations, and Late arrivals. Patients are required to provide notification to office staff 24-hours prior to the scheduled appointment of any reason they are not able to keep the original appointment date or time.
- ✓ Refusing to adhere to your provider's plan of care.
- ✓ Violating your medication and controlled substances agreement.
- ✓ Failure to pay for services rendered. (Please Note: for any questions regarding outstanding balances, call the billing department at 832-952-0432 for assistance.)
- ✓ You, the patient, terminates the relationship with Arturo Sobarzo, M.D., a provider of Sobarzo M.D. Pain Management

Message Regarding Social Media Reviews/Postings:

You have the right to publish reviews via social media (Facebook, Yelp, Google, etc...) regarding your experience with Arturo Sobarzo M.D. Pain Management. However, if a negative review is published before allowing us to rectify or resolve the situation, you grant us permission to review and/or request the negative comment to be removed from the site.

Violation of these policies may be considered for patient termination at your provider's discretion.

Patient Signature:____Date:___________________________

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Legal Assignment of Benefits and Designation of Authorized Representative

Patient Name: ____

DOB: ____________________________

Social Security Number: ____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider group, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider group, to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or other insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient Signature:____Date:____________________________

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Medical Records Release Form)

Patient Name: ______________________________ **Address:**______________________________
Date of Birth: ________________**Telephone:** ______________________**Social Security#:** ____________

Reason of Record Request:

□ Continuation of Care	□ Billing or Claims	□ Disability Determination	□ Other
□ Transferring Care	□ Insurance	□ School	
□ Personal Use	□ Legal Purposes	□ Employment	________________

I hereby authorize Sobarzo MD Pain Management/Arturo Sobarzo MD, PLLC, to
RELEASE MY HEALTH INFORMATION TO:

____
(Person or Organization)

____
(Street Address or PO Box)

____
(City, State, Zip)

______________________ ______________________
(Telephone Number) (Fax Number)

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want released/disclosed. If all health information is to be released/disclosed, then check ONLY the first box.

□ Complete Medical Record-ALL	□ Operative Reports	□ Psychological Records	□ Physician Orders
□ Last 6 months of Active Treatment	□ Imaging Reports	□ Lab Results	□ Office Visits____________

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:
I do ____ (OR) do not _____consent to release information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol/drug abuse and/or HIV testing/results, or such disclosure shall be limited to the following specific types of information: ____

EFFECTIVE TIME PERIOD: This authorization expires within (6) months from the date signed. If you wish to have the authorization expire before (6) months, please indicate the date of expiration:______________________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named as the RECEIPENT of the medical records and to Sobarzo MD Pain Management/Arturo Sobarzo MD I understand that prior actions taken in reliance on the authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. It is further understood that the information is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

____ ______________________
Signature of Patient or Legal Representative* Date

** Legal Representative must submit copies of a legal document supporting assignment of this authority.*

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OFFICE AND FINANCIAL POLICIES

Initial:_____ **Insurance**: If a referral from your primary care physician is required for your visit, it is your responsibility to obtain it. As a courtesy, we will attempt to obtain it on your behalf, but failure to obtain the referral would require you to reschedule your appointment, unless you choose to be seen as a self-pay patient. If you confirmed your visit with our office and arrive with no referral, a rescheduling fee (also termed "No Show Fee") may be applied because your allocated time slot was confirmed with your acknowledgement of responsibility for obtaining a referral.

Initial:_____ **Forms Surcharge (at the discretion of your physician)**: Disabled Parking Applications, and Private Disability Insurance forms (No Charge). $50.00: Family Medical Leave Act forms, Bad Check Fees, and Credit Card Deferment forms. $150-300 (depending on complexity) for dictated letter describing medical care and limitations.

Initial:_____ **Check In and Financial Policy:** Please bring your insurance card and photo ID. You are required to notify our office when your insurance policy changes. Please be prepared to pay any co-payments or co-insurances or past due balances, which we will notify you through our online portal or communication with the billing company. In the event that your plan determines a service to be "not covered", you will be responsible for the entire charge.

Initial:____ **No Shows, Late Cancellations, Procedural Cancellation and Late Arrivals:** We ask that you give us a courtesy call 24 hours in advance if you must cancel your office appointment. We will attempt to confirm your visit 24-48 hours prior to the visit. No-showing for a confirmed appointment/procedure or canceling within the 24 hour period will result in a $50 charge to your account. Arriving 15 mins past your arrival time may require a rescheduling of your appointment, so as not to inconvenience other patients. Over 30 mins late will automatically cancel your appointment for rescheduling. All late fees are subject to provider discretion.

Initial:_____ **Refill Requests:** Please allow 48 hours to process all prescription refill requests. Therefore, schedule a medication refill visit >48 hours to completion of prescribed controlled substances. Prescription refill requests will not be accepted after hours or on weekends. No exceptions.

Initial:_____ **Minors:** Guardian(s) accompanying patients that are minors are responsible for any financial responsibilities as well as providing current insurance information for the minor.

Initial:_____ **Medical Records**: Please note that Sobarzo MD Pain Management/Arturo Sobarzo MD PLLC will work as quickly as possible to fulfill all medical records requests. All urgent requests/copies of your medical records can be made available upon request at a normal charge of $25.00 for the first 20 pages and $0.50 per page thereafter. A medical records release must be completed and submitted to request a copy of your records.

Initial:_____ **Office Based Procedures**: Office based procedure visits are not early medication refill visits and may require a copay. The medication refill visit will need to be scheduled on a separate visit date.

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I have read, understand and agree to the above office and financial policies. I agree to be bound by its terms. I hereby attest that I have provided current and accurate demographic and insurance information. In addition, I authorize release of information necessary for insurance filing and precertification by signing this statement. I am herein authorizing payment of medical benefits to my provider when an assigned claim is filed.

Patient Signature:____Date:___________________________

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Notice of Privacy Practices Acknowledgment

I, ___________________________, acknowledge that Sobarzo MD Pain Management/Arturo Sobarzo M.D. PLLC, provided me with a copy (upon request) of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

____ ____________

Patient Signature Date

HIPAA Disclosure

A) I hereby give consent to release my personal health information either verbally or in writing to persons of my choosing, for purposes of obtaining treatment and/ or for payment of medical services.

Name	Relationship to Patient
_____________________________________	_________________________
_____________________________________	_________________________

B) I hereby give consent for Sobarzo MD Pain Management/Arturo Sobarzo M.D. PLLC personnel to leave messages with my household members, my answering machine and/or my voicemail.

*If declining, please write N/A and sign below. Please note that you have the right to revoke this authorization, at any time by providing written notice to the office the revocation will take place on the date of the written notice and cannot be applied to prior disclosures.

Patient Signature:____Date:____________________________