SHAM M. VENGURLEKAR, MD, PC.
7010 E. CHAUNCEY LANE, SUITE #215
PHOENIX, AZ 85054

Patient Demographics

Please complete this form in its entirety by providing the requested information. All requested information is necessary to provide you complete care and missing information will cause delays. Please remember to notify our offices to report any changes to the information being provided (e.g. insurance company, phone number, address, primary care physician, etc.).

Last Name	First Name	Middle Initial	Today's Date / /

Date of Birth / /	Age	Sex M / F	Name of Spouse

Arizona Address	City	Zip	Marital Status S M W D Sep

Permanent Address (if different from above)	City	Zip	Social Security Number - -

Home Phone Number ( ) -	Cell Phone Number ( ) -	Email Address

Name of Employer	Work Phone Number	Occupation

Primary Insurer (If not the Primary Insurance Holder) Name		Address (if different than above)
Phone Number	Date of Birth	Social Security Number

Emergency Contact:	Phone Number:

Name of Referring Physician	Address	Phone Number Fax Number

Name of Primary Care Physician (If different from Referring Physician)	Address	Phone Number Fax Number

Name of Primary Insurance Company	Name of Secondary Insurance Company

Patient/Responsible Party Name: ______________________
Patient/Responsible Party Signature: ______________________ Date: __________

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Sham M. Vengurlekar, M.D., P.C.
Center for Minimally Invasive Interventions
for Complex Spinal, Sports, Joint, Accident Pain,
PRP and Regenerative Cells Therapy.

Office Use Only

Height_______ **Weight**_______ **Blood Pressure** _______ **Temp** _______

SpO2 _______ **RR** _________ **Pulse** _______

Patient's Name: ____________________________ Date of Birth: ____________

Referring Physician: ___________________ Today's Date: ___________

Dear Patient;

I place a lot of emphasis on the details of your symptoms of pain and other aspects of your medical history. This form will help me to arrive at an accurate diagnosis and formulating the appropriate interventional pain therapies tailored to your needs.

Please pay close attention to the following items, which you need to fill out completely and accurately. If there are any blanks, it will delay your appointment.

ESTABLISHED PATIENT CONSULTATION

1. Date of onset pain_________ 2. Location of primary pain________________
3. Nature of pain _______________________ (e.g.: sharp, stabbing, stinging, etc)
4. Continuous or intermittent? ___________________
5. Did you have a fall, injury, or accident prior to the onset of pain? No [ ] Yes [ ]
   If yes, what date? __________ Briefly describe: ______________________________

____

6. Intensity of pain:

No pain 0 1 2 3 4 5 6 7 8 9 10**Severe Pain**

7. Activities that increase your pain:

Sitting________ Walking Standing______ Coughing/Sneezing__________
Bending_______ Sports activities_ Lying down__________

8. List activities that relieve your pain (excluding medications):

Sitting________ Lying down __________ Ice/Heat______ Other______________

9. Sleep Pattern:

Unchanged [ ] Interference with sleep [ ]

a) How many hours of sleep do you get?______

10. Ability to pursue activities/occupation?_______________________________

11. List any drug, food, or environmental allergies and type of reaction: (ex: penicillin, sulfa, itching, rash)

____

____

____

12. **Current Medication**: (list **ALL** pain medications & dosages)

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

13. List **ALL** medications that you have taken in the **past** to control your pain and mark in the () what type of relief you received: e.g.: (**R**) relief (**SR**) some relief (**NR**) no relief

__________( ) __________( ) __________( ) __________( )
__________( ) __________( ) __________( ) __________( )

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Patient's Initials______

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Patient's Name________________________

14. List any medications you are taking for **other** medical disorders (also include herbal/supplements/over the counter medications):

________________ ________________ ________________
________________ ________________ ________________

15. **Other Treatment:** Please write in the ( ) whether your symptoms were:
(**W**) Worsened (**I**) Improved (**U**) Unchanged
a) Chiropractic ( ) b) Acupuncture ( ) c) Massage ( )
d) Epidural blocks ( ) e) Trigger point injection ( )
f) Physical Therapy ( )

16. Tests performed for **current condition** by another physician/facility
X-rays ( ) CT Scans ( )
MRI Scans ( ) EMG/nerve conduction studies ( )
Labs ( ) Other ( )

17. List any **new** medical conditions and/or surgical history **within the last six months** (list **all** medical problems, e.g.: Asthma, high blood pressure, heart disorders, cardiac workup, Appendectomy, Hernia surgery, Hysterectomy, Breast implants)

____
____
____

18. . System Review: (Circle all that apply)
a) **Cardiac**: chest pain/heart attack/high blood pressure/irregular heart beat/heart murmur/ shortness of breath
b) **Lungs:** cough / blood in sputum / asthma / bronchitis / valley fever / tuberculosis
c) **Neurological**: headaches / seizures / stroke / paralysis / dizziness / ringing in ears
d) **Skeletomuscular**: fibromyalgia / arthritis / lupus / connective tissue disorder
e) **Hormonal**: thyroid / sex hormones
f) **Metabolic**: diabetes / elevated cholesterol / elevated triglycerides
g) **Blood Disorder**: increased bleeding / thalassemia / hemophilia / Christmas disease / sickle cell disorder / phlebitis or clots in leg or lung
h) **Urinary**: burning / lack of continence / increased frequency / kidney stone / blood in urine / prostate problems / impotence
i) **Stomach/Bowel**: ulcer / acidity / constipation / diverticulitis / diarrhea / blood in stool

19. Past or current exposure to:
a) Tuberculosis [ ] b) Valley Fever (cocci) [ ]
c) Rheumatic fever [ ] d) Hepatis (jaundice) [ ]
e) AIDS [ ] f) Other____________

20. **HABITS – PLEASE NOTE ANY CHANGES** (if no change please put N/C)

a) Smoking: Yes [ ] No [ ]
b) Alcohol: Yes [ ] No [ ] If yes, how much ________________
c)Drugs:
Use of any street or recreational drugs________________________
Use of **prescription** drugs for recreation use____________________

21. **FAMILY HISTORY** – List any medical conditions and the family member(s) applicable:
(*ex: cardiac history, stroke, diabetes, asthma, infectious diseases, cancer, etc*)

____
____

22. Please provide your referral source: ____________________________
____

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Patient's Initials______

SHAM M. VENGURLEKAR, MD, PC
7010 E. CHAUNCEY LANE, SUITE #215
PHOENIX, AZ 85054

Medical Power of Attorney for Health Care Acknowledgment and Assignment

A Power of Attorney for Health Care allows you to name a health agent, someone who will make health decisions for you if you cannot. Your health care agent will ensure that your health care providers give you the care you wish to receive. You may also require that your health care agent communicate in any manner with you about any specific proposed health care.

Please check the appropriate box:

- ☐ I do not have a medical power of attorney and I'll make all health care decision for myself.
- ☐ I acknowledge and understand that **Advanced Directives will not be acknowledged.** It is our policy to institute all measures to preserve and promote life.
- ☐ I have a medical power of attorney (please attach medical power of attorney) and my Agent is as follows:

____
Agent's Full Name

____
Agent's Street Address

__________ __________ __________
City State Zip Code

________________ ________________
Agent's Daytime Phone Agent's Other Phone

____
Agent's Email Address

SIGNATURE

I understand the contents of this document and the effect of granting powers to my Agent.

____
Principal's Full Name

____
Principal's Signature

____
Date

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7010 E. CHAUNCEY LANE, SUITE #215
PHOENIX, AZ 85054

Authorization for the Release of Medical and/or Billing Information

Many of our patients allow a family member or a friend to request medical or billing information. Under the requirements of HIPAA, we are not permitted to release information to anyone but the patient without the patient's direct approval, in writing. Please take a moment to complete the below section if you'd like to approve the release of medical and/or billing information to someone other than yourself.

☐ **I DO NOT authorize the offices of Sham M Vengurlekar, MD to release my Medical and/or Billing Information.**

☐ **I authorize the offices of Sham M Vengurlekar, MD to release my Information as follows:**

Recipient Name: ____________________ Information: ☐ Medical Information ☐ Billing Information

Recipient Name: ____________________ Information: ☐ Medical Information ☐ Billing Information

Recipient Name: ____________________ Information: ☐ Medical Information ☐ Billing Information

Recipient Name: ____________________ Information: ☐ Medical Information ☐ Billing Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or request a copy of my record to review the information disclosed. I understand that the information being disclosed to any of the above recipient(s) is not protected information as the recipient may disclose the information to others.

Date: ____________________

Patient Name: ____________________

Patient Signature: ____________________

Revocation of Approval for the Release of Medical and/or Billing Information

I am revoking my approval for my personal information to be disclosed. I understand that no information will be given to the recipient unless another authorization is completed and signed by me.

☐ **I am revoking my approval for the above recipient(s) to receive my Medical and/or Billing Information.**

Date: ____________________

Patient Name: ____________________

Patient Signature: ____________________

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NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services (I/We) have prescribed are available elsewhere on a competitive basis.

1. DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

   - Scottsdale Spine and Joint, LLC: Center for minimally Invasive Interventions to treat complex spinal, sports, joint, and accident pain.
   - Cloud 9 Anesthesiology provides anesthesia services

2. ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS?

   X Yes ___ No

   If yes, which ones: Minimally Invasive Interventions to treat complex spinal, sports, joint, and accident pain.

3. The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file; you will receive a copy.

ACKNOWLEDGEMENT: (I/We) have read this "Notice to Patients" form, and (I/We) understand the disclosures that it contains.

Date this_____ Day of_____________, 20___

____
Signature of Patient or Guardian

Rev. 3/05 LM
Retrieved from https://www.azmd.gov/Forms/Files/201707111248_b0eb145622eb4216ae91ba7c418a7687.pdf

7010 E Chauncey Lane, Suite #215
Phoenix, AZ 85054
(480) 314-2288 – T
(480) 314-1113 – F

Patient Out-of-Network Notice

Thank you for choosing Dr. Vengurlekar as your health care provider. Please take a moment to review the below partners providing your treatment and services. Dr. Sham Vengurlekar, MD, Scottsdale Spine and Joint, LLC, and Med Scope are each an individual provider and services will be billed to your insurance company separately. In and out-of-network (OON) benefits will be used to determine coverage.

- Dr. Vengurlekar is providing your professional services and is contracted with Medicare, Humana, Healthnet, BC/BS United Health Care, and Cigna. All other plans may be out-of-network. Please verify contract status with Health Plan.
- Dr. Vengurlekar uses Scottsdale Spine and Joint as the preferred facility. Scottsdale Spine and Joint is not participating as an in-network provider and out-of-network benefits must be utilized for services offered by Provider.
- Dr. Vengurlekar has partnered with Med Scope as the practices preferred lab. Med Scope is out-of-network for many insurance plans.
- Anesthesia services for Scottsdale Spine and Joint are provided by Cloud 9 Anesthesiology Associates, LLC. Cloud 9 is an out-of-network Provider.

Your services will be billed to your insurance company. Once the insurance company has processed your medical claim, you will receive an Explanation of Benefits (EOB) along with a check for payment. **The EOB is not a bill.** Instead, it is a document that shows how your health insurance company processed the health insurance claim based on your health care benefits. If you receive a check, please endorse to the practice and forward to our offices at 7010 E Chauncey, Suite 215, Phoenix, AZ 85054. As a reminder, you're responsible for all charges and failure to pay for services provided may result in additional action to secure payment.

I acknowledge receipt of the above information and understand that Dr. Vengurlekar has partnered with the above companies to provide services. I further understand that the listed partners may provide additional information regarding contracted services.

Patient Name (please print) ______________________ Date ____________

Patient Signature ______________________

7010 E Chauncey Lane, Suite #215
Phoenix, AZ 85054

(480) 314-2288 – T
(480) 314-1113 – F

PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Privacy is an important aspect of the care you receive. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information. Pursuant to HIPAA requirements, a copy of our Patient Privacy Practices is posted in the lobby and has been made available to all patients. Any concerns regarding patient privacy may be addressed to:

Dr. Owen Owens
Privacy & Security Officer
7010 E Chauncey Lane, Suite #215
Phoenix, AZ 85054
Telephone: (480) 314-2288

This letter is to acknowledge receipt of our Patient Privacy Practices.

Date: ______________________

Patient Name: ____

Patient Signature: ______________________________________

PATIENT RIGHTS & RESPONSIBILITY ACKNOWLEDGEMENT

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights and Responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician and the facility caring for the patient. Patients shall have the posted rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems. **A copy of our patient rights and responsibilities is available upon request.**

PATIENT SATISFACTION

Assessment of patient and family satisfaction is most important to us. A patient satisfaction evaluation is provided to all patients via email. Additionally, every attempt will be made to contact each patient following a procedure to inquire about the patient's wellbeing and address any concerns the patient may have regarding ongoing care and after-care instructions. **Patients are encouraged to call the Center directly to speak to a staff member regarding any questions, or concerns resulting from care, or treatment.** Patients may contact the Medical Director, or the Administrator at (480)314-0822.

VOICING COMPLAINTS

It is our goal to provide each patient with quality care and treatment plans that directly support healing in a safe & supportive environment. However, should the need arise, complaints may be directed to the Medical Director or the Administrator at (480) 314-0822. In the event the Medical Director, or Administrator haven't addressed the concern, the Arizona Department of Health Services may be contacted as follows: Arizona Department of Health Services, Attn: William Alcock, Bureau Chief, Medical Facilities Licensing, 150 N 18th Avenue, Phoenix, AZ 85007, or (602) 364-3030.

SIGNATURE

I acknowledge that I've been made aware of my rights and responsibilities as a patient of Dr. Sham Vengurlekar.

____

Patient's Full Name

____

Patient's Signature

____

Date