Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Medical History

Patient Name:_____, _____ _____ DOB:_____ SS#:_____
(Last) (First) (MI)

Sex: ☐ Male ☐ Female Self Pay? ☐ Yes ☐ No Insurance? ☐ Yes ☐ No

Mailing/Home Address:_____

Phone Number: (Home)_____ (Cell)_____ (E-mail)_____

☐ OK to leave a voicemail ☐ DO NOT leave a voicemail

Your current employment status:
☐ Retired ☐ Employed ☐ Unemployed ☐ Other
☐ Student ☐ Disabled

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced

I authorize disclosure of Information regarding my billing, condition, treatment, and prognosis to the following individual(s) and use the following as an emergency contact.

Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

Preferred Pharmacy:_____ Phone: _____
Address: _____

Primary Care Provider:_____Phone: _____
Address: _____

Do you want a summary of your visit sent to your PCP or any other Provider? Yes ☐ No ☐

Other/Referring Provider:_____ Phone:_____Address:_____

Instructions for Release of Personal Health Records: I, _____ acknowledge that I have received a copy of Valley of the Sun Institute for Pain Management Privacy Practices. I give permission to Valley of the Sun Institute for Pain Management to communicate messages regarding: Appointments, Referrals to another Physician, Lab results, X-rays, and other tests.

Regarding above messages you may communicate with:

_____

_____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Please indicate if you have ever had any Medical history/Surgery related to each of the following. *You may only mark if the answer is YES.*

1. Eyes (Cataracts, Glaucoma, Lasik)	Yes	No	16. Kidneys or Bladder	Yes	No
2. Ears, Nose, Sinus, Tonsil	Yes	No	17. Appendix	Yes	No
3. Tonsillectomy	Yes	No	18. Hernia	Yes	No
4. Thyroid or Parathyroid glands	Yes	No	19. Diabetes	Yes	No
5. Lungs	Yes	No	20. Bones, Joints or Muscles	Yes	No
6. Heart Disease	Yes	No	21. Back, Neck or Spine	Yes	No
7. Coronary (heart), Arteries (angina)	Yes	No	22. Brain	Yes	No
8. Arteries	Yes	No	23. Stroke or TIA	Yes	No
9. Veins or blood clot in the veins	Yes	No	24. Skin	Yes	No
10. High Blood Pressure	Yes	No	25. Cosmetic or Plastic Surgery	Yes	No
11. High Cholesterol or Triglyceride	Yes	No	26. Males Only: Prostate, Penis, Testes,	Yes	No
12. Esophagus or Stomach (ulcer)	Yes	No	27. Females Only: Uterus, Ovaries, Tubes	Yes	No
13. Bowel (Small & Large Intestine)	Yes	No	28. Cancer	Yes	No
14. Colonoscopy	Yes	No	29. Blood Transfusion	Yes	No
15. Liver or Gallbladder	Yes	No	30. Other, Describe:		

If surgical procedure, please describe the type and date: _____

_____

_____

Social History

Allergies to Medication/Other: ☐ Yes ☐ No ☐ No Known Allergies

If Yes, please describe what type including the reactions: _____

_____

Smoking Status: ☐ Never ☐ Former ☐ Every Day Amount per Day:_____

How much Alcohol do you consume in a week? ☐ None ☐ 1-2 drinks ☐ 3-4 drinks ☐ More than 5

Do you use THC? ☐ Yes ☐ No

Please list any illicit drug use: _____

Please list any Prescribed and Over the Counter medications. Including dosages and how often:

_____

_____

_____

Family History: ☐ Mother ☐ Father ☐ Grandparents ☐ Siblings

Any known chronic diseases, i.e. Hypertension, Heart Disease, Diabetes, Cancer, etc._____

_____

_____

Patient Name:_____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Current Concerns

Do you now or have you had any problems related to the following systems? If you have any medical concerns/questions you may discuss it with your physician at the time of service and leave it blank.

Constitutional
___Weight Gain
___Chills
___Fever within the last month
___Night Sweats
___Enlarged Glands (Lymph Nodes)
___Feel you are at risk for HIV or Aids
___Other_____.

Genitourinary
___Change in stream
___Blood in urine

___Bathroom use at night

___Other_____.

Eyes
___Double Vision
___Glaucoma
___Cataracts
___Other_____.

Musculoskeletal
___Bone Pain
___Muscle Pain
___Joint Pain
___Other_____.

Ears/Nose/Throat
___Hearing Changes
___Sore Throat
___Sinus Problems
___Other_____.
Do you wear dentures
___No ___Yes

Integumentary (Skin)
___Rash
___Lumps or Bump
___Mole, Skin Tags
___Other_____.

Cardiovascular
___"Blacked out" or lost consciousness
___Chest Pain or Pressure
___Rapid or Irregular Heartbeat
___Known difficulty with a heart valve
___Swelling in Legs, Ankles or Feet
___Pain in the Calves of legs when walking
___Varices Treatment (Sclerotherapy, Banding)
___Other_____.

Neurological
___Tremors
___Dizzy
___Numbness/Tingling
___Significant Headache
___Seizures
___Slurred Speech
___Difficulty moving and arm or leg
___Other_____.

Psychological
___Do you feel Anxious
___Do you feel Depressed
___Are you often Unhappy
___Difficulty falling asleep
___Difficulty staying asleep
___Sleep apnea or disruptive snoring
___Weight gain or loss more than 10 lbs

Respiratory
___Wheezing
___Frequent Coughs
___Shortness of Breath
___Awakening at night w/shortness of breath
___Other_____.

Endocrine
___Excessive Thirst
___Too Hot/Cold
___Tired/Sluggish
___Other_____.

Gastrointestinal
___Stomach/Abdominal Pain
___Nausea/Vomiting
___Indigestion/Heartburn
___Difficulty with Swallowing
___Other_____.

Hematologic/Lymphatic
___Swollen Glands
___Bruising
___Lumps or Bumps
___Other_____.

Allergic/Immunologic
___Hay Fever
___Other_____.

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Pre-Evaluation Questionnaire

1.) Status: If this is NOT your first visit; please tell us how you are doing? ___ Better ___ Same __ Worse

2.) Pain Level: Please circle the number that best describes your level of pain: 1 2 3 4 5 6 7 8 9 10

3.) Emotional Status: Please select the face that most describes how you feel today: 

4.) Injection/Manipulation Response: How long did it last/help you? _____

How often does your chronic pain limit your ability to perform the following activities?

Physical Activities Lower Body

- Walking ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Climbing Stairs ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Kneeling/Bending ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing

Physical Activities Upper Body

- Carrying Groceries/Packages ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Reaching for something up high ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Turning your head ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing

Personal/Household Care

- Bathing/Dressing ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Getting in/out of bed/chair ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Performing Housework ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing

Work

- Concentrating on your job ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Working with your hands ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Performing tasks at work ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing

Social Activities

- Visiting with family/friends ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Getting out of the house ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Pursuing hobbies/recreation ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing
- Sleep ___ Able to do ___ Somewhat ___ A Lot ___ Keeps me from doing

On a typical night, does pain affect your ability to sleep? ___ Yes ___ No

Because of my pain, I get _____ % less sleep than usual: (choose from statements below)

A. 25% less sleep B. 50% less sleep C. 75% less sleep D. No sleep at all

Patient Name: _____

Patient Signature:_____ **Date:** _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

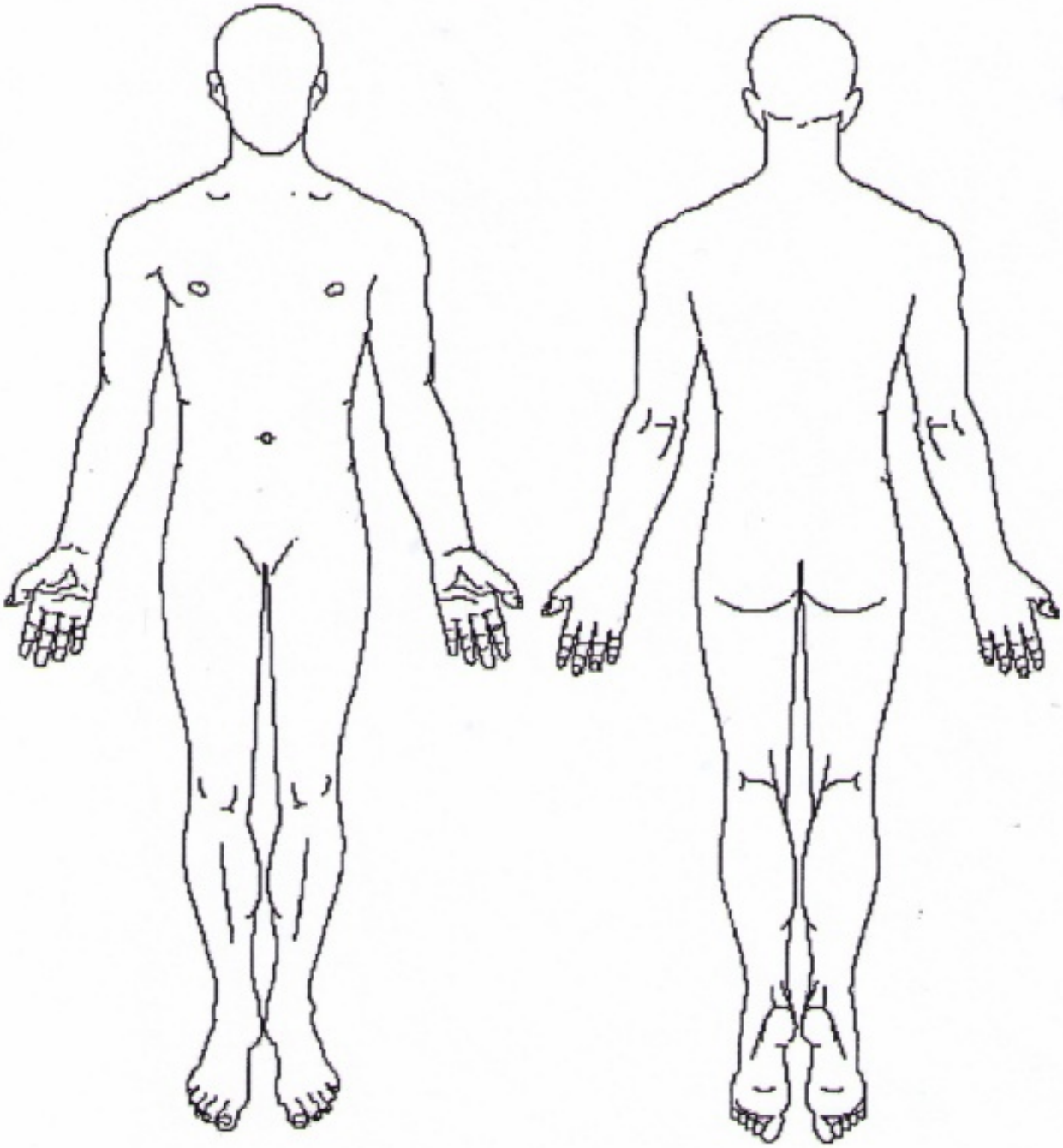
PAIN DRAWING

Patient Name: _____ Date: _____

Attending Dr.: _____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing



Patient Signature: _____

Date: _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

SF-12 Questionnaire

Patient Name _____

In general, would you say your health is:

___Excellent (1)
___Very Good (2)
___Good (3)
___Fair (4)
___Poor (5)

Does your health limit you in these activities? If so, how much?

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

___Yes, limited a lot (3)
___Yes, limited a little (2)
___No, not limited at all (1)

Climbing several flights of stairs

___Yes, limited a lot (3)
___Yes, limited a little (2)
___No, not limited at all (1)

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health?

Accomplished less than you would like

___Yes (2)
___No (1)

Were limited in the type of work or other activities

___Yes (2)
___No (1)

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your emotional health? (Such as feeling depressed or anxious)

Accomplished less than you would like

___Yes (2)
___No (1)

Didn't do work or other activities as carefully as usual

___Yes (2)
___No (1)

Patient Signature _____ **Date** _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

CAGE and CAGE-AID Questionnaire

Patient Name _____

(With questions regarding drug use, includes illegal drugs as well as the use of prescription drugs other than prescribed)

Do you drink alcohol? Yes No

Have you ever experimented with drugs? Yes No

In the last 3 months, have you felt you should cut down or stop drinking/using drugs? Yes No

In the last 3 months, has anyone annoyed you or gotten on your nerves by telling you to stop drinking or using drugs?

Yes No

In the last 3 months have you felt guilty or bad about how much you drink or use drugs? Yes No

In the last 3 months, have you been waking up wanting to have an alcoholic drink or use drugs? Yes No

Do relatives/friends worry or complain about your alcohol consumption? Yes No

Have you been physically, sexually, or emotionally abused? Yes No

During the past 4 weeks, how much did pain interfere with your work? (including work both inside/outside the house)

___Not at all (1)
___A little bit (2)
___Moderately (3)
___Quite a bit (4)
___Extremely (5)

Do you have a lot of energy?

___All of the time (1)
___Most of the time (2)
___Some of the time (3)
___A little bit of the time (4)
___None of the time (5)

Have you felt downhearted and blue?

___Not at all (1)
___A little bit (2)
___Moderately (3)
___Quite a bit (4)
___Extremely (5)

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities? (Like visiting with friends, relatives, etc.)

___Not at all (1)
___A little bit (2)
___Moderately (3)
___Quite a bit (4)
___Extremely (5)

Patient Name _____

Patient Signature _____ **Date** _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

INFORMATION FOR NEW PATIENTS BEING SEEN FOR PAIN MANAGEMENT

1. It is your responsibility to obtain and have your referring provider send your most recent medical records concerning your medical problem(s) PRIOR to being seen.

2. If you are from out of state or a cash pay patient, we require a $100.00 deposit, which will be non-refundable should you not show up for your appointment. This deposit will be applied towards your co-pay or your bill at the first appointment.

3. If your first New Patient Appointment is missed due to non-essential circumstances (i.e. COVID-19, hospitalization, etc.) and efforts are not made prior to your appointment to cancel or reschedule, we will require a $250.00 prepayment before we will schedule a new appointment.

4. We require names, phone numbers and addresses for your current treating physicians. We have the right to send office notes to your Primary Care Physician, Referring Physician, or another physician as deemed necessary.

5. We recommend that you bring any available imaging (CT, X-ray, MRI, US, etc.) and the reports to your first appointment. You can obtain both images and reports from imaging facility. We do not keep actual images on-site; you will be taking them with you after your appointment.

6. Bring all your current medications with you. If you prefer to bring a list please make sure that the medication name, dosage, and frequency are noted, i.e., Aspirin 81mg 1x a day. Include over the counter medications and supplements.

7. We reserve the right to refuse service and treatment. If this occurs, any co-pay paid for the same date of service will be refunded. This does NOT apply once you have been seen.

8. If you are seen on an initial exam, we are not required to accept you as a patient for treatment in the office. You will, however, still be responsible for your bill.

9. We may NOT prescribe narcotic medications on your first visit. It is your responsibility to make sure that you have enough medication until we can prescribe them for you.

10. If we are considering the prescription of narcotic medications, a urine drug screen will be required. This must be done at the same visit.

11. Once we prescribe the controlled medications, a controlled substance agreement form will need to be filled out. You WILL need your pharmacy phone number.

12. If you are a patient that has a family member or other person taking care of you, we must have a signed Power of Attorney on file to share information with that individual.

13. Dr. Farrell, may at times, refer a patient to Lab Express or to AZTMJ, both facilities are owned and operated by family members. Dr. Farrell does not have ownership, any financial interests nor does she receive any monetary compensation from either of the above-mentioned entities.

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Name _____ **DOB** _____

PLEASE INITIAL ALL

If the provider finds it appropriate to prescribe any controlled substances, we ask that all of our patients adhere to the following policy:

_____ I understand the purpose of this agreement is to prevent misunderstandings about certain medications I will be taking for pain management. This is to help you and your provider comply with the law regarding controlled pain medication.

_____ I understand that if I break the agreement, the provider will stop prescribing me pain medication.

_____ I will not use any illegal substances, and I will not increase or decrease my medication dosage. If I feel that adjustments are required, I agree to contact the prescribing provider.

_____ I will not share my medication with anyone, and I will not take another person's medication.

_____ I will not receive any controlled pain medication from other providers, and I will only use one pharmacy (for purpose of verifying controlled pain medications) unless extenuating circumstances require me to fill medications at another pharmacy.

_____ I understand that it is my responsibility to safeguard my medication. Should they be lost, stolen, destroyed, or if they are used up early, the medication(s) will under no circumstances be refilled.

_____ I agree not to sell, lend, or in any way give my medication to any other person.

_____ I agree not to drink alcohol or to use other mood-altering drugs while I am taking controlled pain medications.

_____ I understand that there may be risks associated with the use of controlled pain medication including but not limited to dependence, addiction, changes in personality, sleep pattern disturbance, respiratory depression, bowel or bladder dysfunction, change of appetite, possible weight gain or loss, change of coordination (may interfere with driving, operating machinery, and fine motor movement), and risk of death.

_____ I agree to report any changes in my mental status and any other possible pain mediation side effects to my prescribing provider.

_____ I agree to submit to testing on an as needed basis to monitor for medication complications and compliance with recommended treatment.

_____ I understand that sudden discontinuation of pain medication can lead to rebound pain, withdrawal symptoms, seizures, and other symptoms. I have been informed not to stop any controlled pain medication suddenly unless directed by a pain management provider.

_____I agree to allow my pain management provider to review any of my past medical or psychological records.

_____ VOSIP will not accept any patient over 200 morphine milliequivalents (200 MME). These patients may need to go through a detox program and agree to be on a weaning/tapering program to less than 90 MME.

_____ Face-to-face evaluation required for initiation of opiate management. Opiate medications will not be prescribed during initial consultation/visit, a follow-up appointment is required.

_____ I have read and understand the above information. I agree and understand that noncompliance with the above will result in formal discharge with notification to my providers.

Patient Signature _____ **Date** _____

Physician Signature _____ **Date** _____

Witness _____ **Date** _____

Pharmacy Name / Phone Number _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Patient Consent and Agreement for "Off-Label" Medical Treatment

Reason for this consent and agreement

All prescription drugs in the United States have a label approved by the United States Food and Drug Administration. This label provides an indication and dosage for the drug, but neither the physician nor the patient is legally bound to follow these. Pain treatment is virtually impossible unless the physician prescribes one or more medications that are for an indication or dosage not listed on the drug label.

Consent and Agreement

The undersigned acknowledges that pain control cannot be achieved without "off-label" use of one or more drugs. The undersigned furthermore accepts all risks and complications that may occur from off-label use since the benefit of pain control cannot otherwise be achieved. The undersigned agrees to waive all liability against the physicians and the clinic who provide pain treatment.

Specific Off-Label uses

Any and all off-label drugs are covered by this consent including, but not limited to:

- Actiq ® for non-cancer pain
- The use of antidepressants, anti-epileptics, muscle relaxants, tranquilizers, and nutriceuticals for pain relief
- The administration of sustained release preparations of morphine and oxycodone used more frequently than every 12 hours
- Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary, published maximal dosage levels
- Topical use of morphine, methadone, naloxone, cartsoprodol, and ketamine

I _____, the undersigned to the above, release the physician and clinic of all liability for off-label use of drugs.

Patient Signature _____ **Date** _____

Dear Patient,

This notice is to let you know that if you receive an injection which includes: Cyanocobalamin (B-12), Marcaine, and/or Homeopathic medication, that these medications are not covered by insurance. We regret to inform you we will be charging all of our patients $20-$30 for these medications at time of service. We apologize for the inconvenience and thank you for your understanding.

Patient Signature _____ **Date** _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Billing and Financial Responsibility

Our office staff strives to schedule appointments in a professional, timely manner, in order to allow quality care for all our patients. When a patient does not keep the appointment reserved for them, this deprives another patient from receiving treatment in that reserved time slot. Therefore, it is the patients' responsibility to remember their own appointments. We ask that you call at least 24 hours before your appointment to cancel or reschedule. If it is after our office hours, please leave a voicemail message. Patients who call to cancel their appointments on the same day as the appointment will be charged a no-show fee. The no-show fee for a missed or late cancellation varies depending on the type of procedure/appointment. Please ask the front desk for cancellation fee details

Co-payments are due upon check in:

- Cash-pay or "boutique" services are to be paid at the time of service.
- Any additional payment arrangements need to be worked out in advance with management.
- Cash-pay patients, we require payment prior to being seen.

Lien/Personal Injury patients:

- There is a $100 Lien filing fee at start of care.
- See additional form for payment arrangements.

Worker's Compensation:

- Worker's Comp patients must have a list of approved codes for billing, case #, caseworker contact information, and award letter.

Insurances NOT currently accepted:

- In the case we do not carry your insurance, you may still have out of network benefits. Please check with your insurance company before scheduling an appointment.
- Should you require a copy of our contracted plans, please ask for it.

Lab work and other outside services:

- All lab work and other outside services are paid directly to those facilities. We do not quote their charges, nor do we collect from them.
- If a saliva test is performed in our office, there is a charge of $20 billed to the patient since insurance does not cover this test.

Patient Name _____

Patient Signature _____ **Date** _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

HIPAA Privacy Authorization Notice and Consent to Treat

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

A copy of the *Notice of Privacy Practices* has been made available for my review. I understand the office will use and disclose my protected health information to provide my medical care, receive payment for services provided to me, and to conduct its business.

I understand I have the right to revoke this authorization and any listed contacts, in writing at any time. I understand this revocation is not effective to this extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Patient consents and agrees to Valley of the Sun Institute for Pain Management, LLC and its Providers to assess, recommend, and treat conditions discussed. Patient Bill of Rights is available upon request.

Patient Name _____

Patient/Legal Guardian Signature _____ **Date** _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the patient's receipt of *Notice of Privacy Practices* but was unable to do so as documented below:

Date _____ Initials _____

Reason _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Patient Name _____ Location of Patient_____

Date of Birth _____ Date Consent Discussed_____

Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her ophthalmologist's
- office (or at a remote site) while the physician obtains test results and consults from healthcare
- practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to
- allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the
- equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal
- medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My ophthalmologist has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my ophthalmologist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Valley of the Sun Institute for Pain Management, PLLC to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Signature of Patient (or person authorized to sign for patient) Date

_____

If authorized signer, relationship to patient

_____ _____

Witness Date

I have been offered a copy of this consent form (patient's initials) _____

Valley of the Sun Institute for Pain Management

Dr. Estelle Farrell

Authorization for Release of Medical Records

Patient Name:_____ SSN:_____
Address:_____ DOB:_____
City, State, Zip:_____ Phone #: _____

I, _____, do hereby authorize the release of the following:

[ ] Discharge Summary	[ ] ECG/EEG/Cardiac Cath.	[ ] Operative Notes
[ ] Pathology Reports	[ ] Laboratory Reports	[ ] Radiology Reports
[ ] Emergency Reports	[ ] History & Physical	[ ] Progress Notes
[ ] ALL RECORDS	[ ] Other: _____	

FROM: _____ Phone:_____ Fax:_____

Address: _____

TO: _____ Phone:_____ Fax:_____

Address:_____

Dates of Service: _____

_____ I DO _____ I DO NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider, to whom this authorization is furnished may not condition its treatment of above-named patient on whether or not I sign this authorization.

_____ _____
Signature of Individual with Power of Attorney or Guardian Date