1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Patient Application for Treatment

Name____ **Nickname** ______________________________________

DOB: _________________ Age _________ **Gender (check one) ❑ Male ❑ Female ❑ Unspecified**

Address____ **City/State** ________________________ **Zip Code** ________________

Cell Phone____ **Home Phone** ____

Email ____

How did you hear about us? ❑Patient Referral__________________________❑ Dr. Referral _____________________________________

❑ Law Firm________________________________❑ Google ❑ Webpage ❑ Yelp ❑ Event ❑ Radio

❑ Other ___________________________________

What is the best way to contact you? (Check one) ❑ Email ❑ Cell Phone ❑ Home Phone

I would prefer appointment reminder notifications by (check one) ❑ Text ❑ Email

Marital Status (check one) ❑ Single ❑ Married ❑ Other Do you have Children? ❑ Yes ❑ No How Many ___________________

Employment Status (check one) ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑Self Employed

Occupation________________________________**Employer**___________________________________**Phone**________________________

Emergency Contact ____**Phone#**____

Do you have insurance? ❑ Yes❑ No Insurance Name______________________**ID #** _________________**SSN**____________________

Race (check one)

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian	❑ Samoan
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Philipino	❑ Other
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian	❑ Choose not to specify

Primary Care Physician _____________________________**Address** ____________________________________**Phone** ______________

Would you like our physicians to communicate your condition & course of care with your PCP? ❑ Yes ❑ No

When was your last Physical examination? _________________________________

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Have you ever been referred to a specialist? ❑ Yes ❑ No If yes, describe: ____

Have you ever had chiropractic care? ❑ Yes ❑ No

Has anyone in your family received chiropractic care? ❑ Yes ❑ No

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Alcohol: ❑ None ❑ Yes: How many drinks/day __________**frequency/week** ___________**What kind**___________________

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What is YOUR goal for treatment?

____

1. **Chief Complaint** ______________________________ **When did it start?** ____________________ **Gradual/Sudden**

Circle the current pain level of your complaint?
1 2 3 4 5 6 7 8 9 10
Mild **Severe**

Circle the percentage of the day you experience the complaint?
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worse? (1-10) ____________

2. **Chief Complaint** ____________________________ **When did it start?** _____________________ **Gradual/Sudden**

Circle the current pain level of your complaint?
1 2 3 4 5 6 7 8 9 10
Mild **Severe**

Circle the percentage of the day you experience the complaint?
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worse? (1-10) ____________

3. **Chief Complaint** ____________________________ **When did it start?** ______________________ **Gradual/Sudden**

Circle the current pain level of your complaint?
1 2 3 4 5 6 7 8 9 10
Mild **Severe**

Circle the percentage of the day you experience the complaint?
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worse? (1-10) ____________

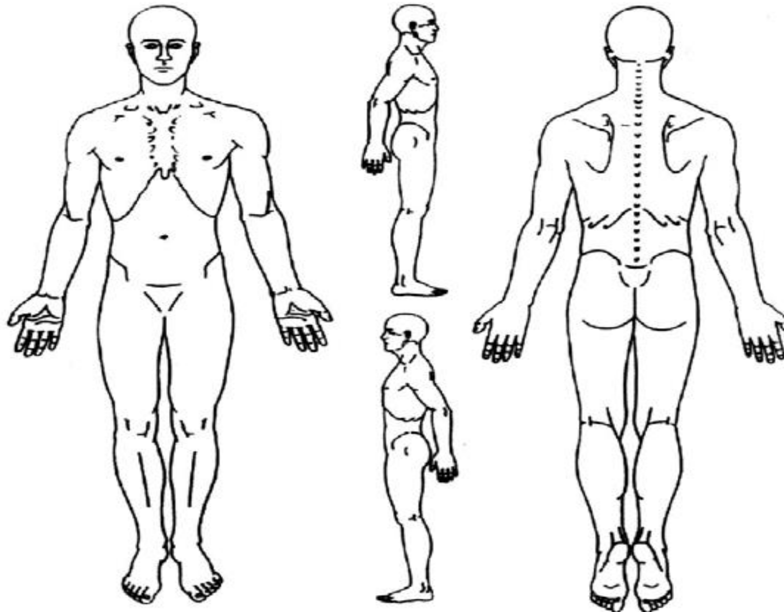
What job activities are you unable to do? ____

When do you feel it most? □ **AM** □ **PM** **When present, how long does the complaint last?** __________ **Mins** ________ **Hrs**

What makes it feel better? ____________________________ **What makes it feel worse?** ______________________________

Using the letters below, please show where you are experiencing all of your current complaints:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Do you currently have pain and/or difficulty performing any of the following activities?

Activity		
Walking	**Y**	**N**
Standing	**Y**	**N**
Running	**Y**	**N**
Sleeping	**Y**	**N**
Driving	**Y**	**N**
Personal Grooming	**Y**	**N**
Sitting	**Y**	**N**
Kneeling	**Y**	**N**
Exercising	**Y**	**N**
Bending	**Y**	**N**
Lifting Objects	**Y**	**N**
Lifting Children	**Y**	**N**
Housework	**Y**	**N**

1. **Have you ever had tests for your present condition? ❑ MRI ❑ X-ray ❑ CT ❑ Other**
2. **Do you have a pacemaker? ❑ Yes ❑ No**
3. **Have you ever lost work due to your condition(s)? ❑ Yes ❑ No If Yes, dates?** _________________

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem (s)?

(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)

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Current medications, including dosage if known: **If there are no current medications, check here: ❑**

1) ______________________ **5)** ______________________
2) ______________________ **6)** ______________________
3) ______________________ **7)** ______________________

List any known allergies you have had to any medications, foods or environment:

1) ______________________ **3)** ______________________
2) ______________________ **4)** ______________________

Past Medical History:

❑Head Aches/Migraines
❑Stroke
❑Seizures
❑Pneumonia
❑Diabetes (Type 1 or Type 2)
❑Thyroid Disease (Low or High)
❑Glaucoma
❑Macular Degeneration
❑Hearing Loss
❑High Blood Pressure
❑Blood Clots
❑Pulm Emboli (lung clots)
❑DVT (leg clots)
❑Heart Burn, Reflux
❑Stomach Ulcers
❑Heart Disease
❑Coronary Disease
❑MI/heart attacks
❑Congestive Heart Failure
❑Atrial Fibrillation
❑Angina (Chest pain)
❑Valve Disorder
❑High Cholesterol
❑Gastrointestinal Bleeding
❑Hepatitis (A, B, C)
❑HIV / AIDS
❑Chronic Wounds
❑Cancer (type)
❑Urinary Tract Infections
❑Incontinence
❑Kidney Stones
❑COPD (Emphysema, Bronchitis)
❑Asthma
❑Depression
❑Anxiety
❑Fibromyalgia
❑Chronic Fatigue Syndrome
❑Arthritis
❑Gout
❑Osteoporosis

Past Surgical History (indicate date if known)

❑ None
❑ Cataracts/LASIK______________________
❑ Tonsillectomy______________________
❑ Thyroidectomy______________________
❑ Coronary Bypass______________________
❑ Cardiac Stents______________________
❑ Pacemaker______________________
❑ Heart Valve______________________
❑ Gall Bladder______________________
❑ Appendectomy______________________
❑ Hysterectomy ______________________
❑ Bowel/Stomach Resection___________
❑ Bariatric surgery___________________
❑ Hernia____________________________
❑ Spinal Surgery_____________________
❑ Tubal Ligation_____________________
❑ Bladder surgery____________________
❑ Prostate surgery/resection_____________
❑ C-Section_________________________
❑ Orthopedic/joints___________________
❑ Other ____________________________

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FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. **Please state (P) for Patient or (F) for family**

❑ Alcoholism	**(P or F)**	❑ High Blood Pressure	**(P or F)**	❑ Stroke	**(P or F)**
❑ Anemia	**(P or F)**	❑ Kidney Disease	**(P or F)**	❑ Suicide Attempt	**(P or F)**
❑ Asthma	**(P or F)**	❑ Liver Disease	**(P or F)**	❑ Thyroid Disease	**(P or F)**
❑ Cancer/Tumor	**(P or F)**	❑ Hepatitis	**(P or F)**	❑ Tuberculosis, TB	**(P or F)**
❑ Diabetes	**(P or F)**	❑ Lung Disease	**(P or F)**	❑ Ulcers	**(P or F)**
❑ Drug Abuse	**(P or F)**	❑ Mental Illness	**(P or F)**	❑ Venereal Disease	**(P or F)**
❑ Depression	**(P or F)**	❑ Osteoarthritis	**(P or F)**	❑ High Cholesterol	**(P or F)**
❑ Epilepsy/Seizures	**(P or F)**	❑ Osteoporosis	**(P or F)**	❑ HIV or Other Immune Disease	**(P or F)**
❑ Glaucoma	**(P or F)**	❑ Phlebitis	**(P or F)**	❑ Other ________________	
❑ Heart Disease	**(P or F)**	❑ Rheumatic Arthritis	**(P or F)**		

Please check any conditions that you have now or have had in the past

GENERAL
- ❑ Weight Loss / Gain
- ❑ Fatigue
- ❑ Fever

EYES
- ❑ Glasses/Contacts
- ❑ Eye Pain
- ❑ Double Vision
- ❑ Cataracts

EAR, NOSE, THROAT
- ❑ Difficulty Hearing
- ❑ Ringing in Ears
- ❑ Vertigo/Dizziness
- ❑ Sinus Trouble
- ❑ Nasal Stiffness
- ❑ Frequent Sore Throat

CARDIOVASCULAR
- ❑ Heart Murmur
- ❑ Chest Pains
- ❑ Palpitations
- ❑ Fainting Spells
- ❑ Shortness of Breath
- ❑ Difficulty Lying Flat
- ❑ Swelling Ankles

ENDOCRINE
- ❑ Loss of Hair
- ❑ Heat/Cold Intolerance

RESPIRATORY
- ❑ Coughing
- ❑ Coughing Blood
- ❑ Wheezing

GASTROINTESTINAL
- ❑ Heartburn/Reflux
- ❑ Nausea/Vomiting
- ❑ Constipation
- ❑ Change in BMs
- ❑ Diarrhea
- ❑ Jaundice
- ❑ Abdominal Pain
- ❑ Black/Bloody BM

GENITOURINARY
- ❑ Painful Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Erectile Dysfunction
- ❑ Abnormal Discharge
- ❑ Bladder Leakage

ALLERGIES
- ❑Food
- ❑ Environmental
- ❑ Medication
- ❑ Hives/Eczema
- ❑ Hay fever

PYSCHIATRIC
- ❑ Anxiety/Depression
- ❑ Mood Swings

HEMATOLOGY
- ❑ Easy Bruising
- ❑ Bleeding Gums
- ❑ Enlarged Glands

MUSCULOSKELETAL
- ❑ Joint Pain/Swelling
- ❑ Stiffness
- ❑ Numbness in toes/fingers
- ❑ Weakness in hands, feet, arm or legs
- ❑ Muscle Pain
- ❑ Loss of muscle Strength
- ❑ Back Pain

SKIN
- ❑ Rash/Sores
- ❑ Itching/Burning
- ❑ Lesions

NEUROLOGICAL
- ❑ Headaches
- ❑ Tremors
- ❑ Memory Loss

FEMALES ONLY

Date of Last Mammogram __________
Normal Abnormal
Date of Last Pap__________
Normal Abnormal
Date of Last Period_____________
Are you pregnant? Y / N

Patient Signature: ____________________________**/Print Name:**__________________________

Date: _______________ **Dr. Initials** ________

Staff Use Only: **Height:** ____inches **Weight:** __________ pounds **BP:** ________ /_____

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Welcome to LifeQuest

At LifeQuest Physical Medicine and Rehab, we strive to meet our patient's needs. Our patient's health comes first at all times. We are always pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our any questions you may have regarding our fees or your responsibility in complying with our financial policy and/ or procedures.

Limited Release of Medical Information: In the event that any insurance company, or other 3rd party, obligated to make payment to me or to LifeQuest Physical Medicine and Rehab for the charges made for the services, refuses to make such payment upon demand, I hereby assign, transfer, and convey to LifeQuest Physical Medicine and Rehab any and all cause of action that might exist in my favor against such company or person. I authorize LifeQuest Physical Medicine and Rehab to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

Collection/ Attorney Fees: I agree to pay all costs of collection agency, if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney fees or other such costs as the court determines proper.

Uninsured Patients: No patient will carry a personal cash balance. Payment is due when services are rendered. We gladly accept Visa, MC, American Express, Discover, check or cash. We also offer EFT services for payment plan agreements.

Insurance Patients: Our clinic provides billing for individual or group insurance policies, personal injury claims, authorized workers' compensation, and Medicare. All recommended professional services that are covered/ limited by the **out- of- network** portion of your health insurance and are rendered to you will be charged to your health insurance on your behalf. I understand that my health insurance is a contract between me, the insurance carrier, and the provider. I understand that I am ultimately responsible for any services rendered to me that are not covered by my insurance company. I agree to pay my portion of fees at the time treatment is rendered. If your current health insurance policy is terminated for any reason and there are dates of service that were rendered prior to termination, you will also be responsible for any remaining balance.

If you receive checks in the mail for services rendered by our office, it is your responsibility to bring the checks in immediately with any supporting documents. If you do not provide the checks and/or supporting documents, you will be responsible for the entire balance due for that date of service.

1. **General Consent to Treatments:** I hereby request and consent to the performance of the indicated procedures (or on the patient below, for whom I am legally responsible) by the Doctors of Chiropractic, Medical Doctors, Nurse Practitioners and/or Doctors of Physical Therapy and assistants who now or in the future work at this office or any other LifeQuest Physical Medicine and Rehab office. Including but not limited to any and all necessary ancillary diagnostic services I have agreed to and acknowledge to have done. I have had an opportunity to discuss with the Doctors practicing in this clinic and/or with the other office or clinic personnel the nature and purpose of the procedures indicated for me. I understand that the results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treatments, including but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and possible complications, and I wish to rely upon the Doctor to exercise judgment during the course of procedure which the Doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
2. **Informed Consent for Injection Therapies:** By signing, I authorize LifeQuest Physical Medicine and Rehab and staff to administer injections that my healthcare provider considers reasonable and necessary. I understand that all injection treatments are commonly, but not always, accompanied by risks, including, but not limited to, bruising, temporary increase in pain, inflammation, and temporary numbness. I also understand that more serious reaction may occur, including, but not limited to: infections, allergic reactions, prolonged numbness, weakness, paralysis, spinal headache from Dural puncture, lung puncture or death as a result of or related to injection treatment. I understand that there are various types of injections that are commonplace in the practice of pain management including but not limited to trigger point, intramuscular, intra-articular (joint), tendon, ligament, nerve blocks or other forms of injections.
3. **Right to refuse treatment:** I acknowledge that I have the opportunity to discuss the nature and purpose, alternative methods or treatments, the risks, potential complications and associated risks associated with any treatment or procedure recommended by a healthcare provider of my choice. I also understand that I retain the right to refuse any particular examination, diagnostic tests, procedure, treatment, therapy or medication recommended or considered medically necessary by my healthcare provider. I also understand that due to the nature of the practice of medicine, there is no guarantee as to the results of my evaluation and treatment to my satisfaction, and I understand I may ask any additional questions I may have at any time.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office, or any other LifeQuest Physical Medicine and Rehab clinics.

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Patient Bill of Rights and Responsibilities

To ensure the finest care possible, as a Patient receiving medical care or Durable Medical Equipment (DME) you should understand your role, rights and responsibilities involved in your own plan of care.

Patient Rights

- To select those who provide you with Medical, Chiropractic and DME services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap
- To be treated with friendliness, courtesy and respect by each and every individual representing our Clinic, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your medical care or DME services, without fear of discrimination or reprisal
- To request and receive complete and up- to- date information relative to your condition, treatment, alternative treatments, risk of treatment plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Clinic's policies, procedures and charges
- To request and receive data regarding treatment, services, or costs thereof, privately and with confidentially
- To be given information as it relates to the uses and disclosures of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To respect the rights of Clinic's personnel
- To notify your Physician with any potential side effects and/ or complications

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

______________________________	________________________
Patient/Legal Guardian Signature	**Date**
______________________________	________________________
Staff Signature	**Date**

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

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Health Care Information Authorization

At times, our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving LifeQuest Physical Medicine and Rehab authorization to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- ✓ **I may be contacted by** home, work, or cell phone.
- ✓ **Messages may be left** on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- ✓ **Also, I may be contact by postal mail or e-mail** to send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders. With my permission, my name and or photograph may be used for office events, bulletin board, newsletters or patient testimonials

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of ***LifeQuest Physical Medicine and Rehab*** The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Official.
This AUTHORIZATION is requested by ***LifeQuest Physical Medicine and Rehab*** for its own use/disclosure of protected health information. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, ***LifeQuest Physical Medicine and Rehab*** will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/ disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU IF REQUESTED **

PERSONAL REPRESENTATIVES (family members, attorneys, etc. I hereby authorize LifeQuest Physical Medicine and Rehab and its employee's permission to discuss, send and/or receive medical information to/with the following individuals:

We like to co-manage your case with your Primary Care Physician; do you authorize us to send notes or records to them? Y/N

If Yes, please provide us the following information: Primary Care Doctor ____________________Office Phone # ________________

My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of *LifeQuest Physical Medicine and Rehab's* Notice of Privacy Practices.

____	____
Patient Name Printed	**Personal Representative Name Printed**
____	____
Patient Signature	**Signature of Personal Representative**
____	____
Date	**Personal Representative Authority to act for Patient**

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LifeQuest
PHYSICAL MEDICINE AND REHAB

Office Policy, Procedures& Disclosures

Medical/Chiropractic Department:
(Please initial next to each item below)

_______I understand that there is a $25 charge for missed appointments without a 24 hour advance notice or a NO CALL NO SHOW for any appointment with the Medical Doctor, Physician Assistant, Nurse Practitioner or Chiropractic.

_______ I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance Policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
Patients are responsible for the payments of copays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
Patients may incur, and are responsible for the payment of additional charges at the discretion of LifeQuest Physical Medicine and Rehab. These charges may include but are not limited to (subject to change at any time)
_______I have been offered copies and reviewed LifeQuest Physical Medicine and Rehab's complaint procedures, emergency preparedness, home safety and equipment warranty procedures.
_______**Assignment of Benefits (AOB)-** I request that payment of authorized Medicare benefits be made to me or on my behalf to LifeQuest Physical Medicine and Rehab for durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the CMS-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

Massage Department:
(Please initial next to each item below)

_______I understand that there is a 24-hour cancellation policy for ALL massages, in place at LifeQuest Physical Medicine and Rehab.

_______ I understand that I lose the right to any free massages if I do not cancel 24 hours before the scheduled massage.

_______ I understand that I lose one massage from my package if I do not cancel 24 hours before the scheduled massage.

_______ I understand that I will be charged the $25.00 if I do not cancel 24 hours before the scheduled massage.

_______ I understand that I, not the insurance company, personal injury case, or workers compensation case, will be charged the value of the massage if I do not cancel 24 hours before the scheduled massage.

Miscellaneous:
(Please initial next to each item below)

_______ I understand that there is a $40 charge for forms completion by our Providers, including but not limited to disability and FMLA forms

MEDICARE PATIENTS ONLY:

______The products and/or services provided to you by LifeQuest Physical Medicine and Rehab are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request, we will furnish you a written copy of the standards.

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Disclosure:

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 nonroutine 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.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:
Valley Pain Intervention Center____
Laboratories: Insight Labs
ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS?
_X_ Yes ___ No
If yes, which ones:
Local Pain Centers and Laboratories: AZ Pain Treatment Centers, Lab Corp, Sonora Quest Labs

****

I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Disclosure Form:
Please sign/date below:

Printed Patient Name:_________________________________ **Date**: __________________________________

Signature of Patient: __________________________________ **Witness**:________________________________