*** REQUIRED BELOW**

Candyce D. Williams, M.D.

PATIENT INFORMATION

Primary Care Physician ____________________ **Phone #** ____________

***Patient Name** ____________________ Male / Female Marital status ________

***Address** ____________________ City ________ State ______ Zip ________

***Birth Date** ____________ Age ______ Social Security # ____________

***Primary Phone #** ____________ (Home/Cell) Secondary Phone # ____________ (Home/Cell)

***Is it ok to leave detailed message regarding appointments or results at all numbers provided? Yes No**

***Email address:** YES / NO If Yes: (Print clearly) ____________________

Race: (Circle) African American American Indian/Alaska Native Asian Caucasian Native Hawaiian /Pacific Islander Other

Ethnicity: (Circle) Hispanic or Latino Non Hispanic or Latino

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Are you currently in a skilled nursing facility or Hospice facility? Yes No

If yes, list facility Name: ____________________ Phone number: ____________

Employer ____________________ Work Phone ____________

Employer Address ____________________ City ________ State ______ Zip ________

Spouse's Name ____________________ Birth Date ________ Social Security # ________

Occupation ____________________ Work Phone ____________

Emergency Contact ____________________ Phone ____________ Relationship ________

Second Contact if Same as Home # ____________________ Phone ____________ Relationship ________

WORKMANS COMP INFORMATION

Insurance Company's Name ____________________ Date of Injury : ____________

Claim ID# ____________________ Employer: ____________

Claim Adjustor: ____________________ Phone # ____________

COMMERCIAL INSURANCE INFORMATION

Insurance Company's Name ____________________ Policyholder ____________

Policy ID# ____________________ Group# ____________

Employer ____________________ Policyholder SS# ____________ Date of Birth ________

I hereby authorize Candyce D. Williams, MD to furnish the above insurance company(s) all medical information necessary to process any appropriate claim.

I also authorize payment of medical benefits to Candyce D. Williams, MD. I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the standard rates and payment terms of this office. If it is deemed necessary, in the sole discretion of this office, to refer my account to a collection agency as a result of nonpayment, I agree to pay any collection cost incurred as a result of this action, including attorney's fees.

Patient and/ or guarantor agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

OUR OFFICE POLICY STATES THAT PAYMENT FOR SERVICES IS REQUIRED AT TIME OF VISIT.

***SIGNATURE OF FINANCIALLY RESPONSIBLE PERSON:** ____________________ **DATE:** ________

***PATIENT'S SIGNATURE:** ____________________ **DATE:** ________

PRIVACY NOTICE

***I,** ____________________ hereby acknowledge receipt of the Notice of Privacy Practices given to me. DATE: ________

Staff Witness seeking acknowledgment: ____________________ DATE: ________

Candyce D. Williams, M.D.

Name ______________________ Date of Birth ________________

Date ______________________ File # ________________

REVISED OSWESTRY DISABILITY

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and Is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing It.
- ☐ Washing and dressing increase the pain and I find It necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but It gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not Increase with distance.
- ☐ I cannot walk more than one mile without Increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because It Increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immediately.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well
- ☐ Because of pain, my normal night's steep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep Is reduced by less than 1/2
- ☐ Because of pain, my normal nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life Is normal, but Increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic Interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me ato seek alternative forms of travel.
- ☐ Extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow
- ☐ My pain is neither getting better nor getting worse.

Form by N Hudson-Cook, K Tomes-Nicholson, A Breen In Roland MO Jenner JR Eds Back Pain Manchester University Press 1989 187-204

Candyce D. Williams, M.D.

Name ______________________ Date of Birth ______________

Date ______________________ File # ______________

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing
T = Tingling (Pins & Needles)
C = Cramping

On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

No Pain ______________________ Unbearable Pain:

Rate the pain at its **best** in the past week:

No Pain ______________________ Unbearable Pain

Rate your **average** pain in the past week:

No Pain ______________________ Unbearable Pain:

Rate your **worst** pain in the past week:

No Pain ______________________ Unbearable Pain

Candyce D. Williams, M.D.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Patient Name: ________________________________ **Date of Birth:** ____________

Please select one of the following:

1. ☐ I do not authorize Candyce D. Williams, MD to use/or disclose my protected health information to anyone other than myself.

OR

2. ☐ I hereby authorize Candyce D. Williams, MD to use and/or disclose the protected health information described below to ________________

____

[Name of Individual (i.e. Family member, significant other, child, parent)]

If authorization is permitted please complete the following:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. ☐ I hereby **authorize the release of my complete health record with the exception of the following information**:

- ☐ Mental health records
- ☐ Communicable diseases (Including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ________________

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until: Indefinitely or _____/_____/_____, at which time this authorization expires. [Circle or insert Date]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the 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.

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

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

________________________________ ________________________

Signature of Patient or Personal Representative — Date

________________________________ ________________________

Print Name of Patient or Personal Representative — Relationship to Patient

Candyce D. Williams, M.D.
DIPLOMATE AMERICAN BOARD
OF PHYSICAL MEDICNE AND REHABILITATION
INTERNAL MEDICINE
SPINAL CORD INJURY

Financial Agreement

Patient Name: ______________________________ **Date of Birth:** ____________

MEDICAL INSURANCE: HMO, PPO, Medicare, etc. The PATIENT portion (co-pay, deductable, account balance, etc.) is due at THE TIME OF THE VISIT. It is the PATIENT'S responsibility to verify benefits with their insurance company prior to their visit. It is the PATIENT'S responsibility to obtain the referral form from their PCP. If you fail to obtain referral and changes are denied by your insurance carrier you will be responsible for the charges.

INDUSTRIAL INJURY: Payment for the INITIAL and subsequent visits (while the claim is open) is pre-authorized and covered by the carrier. The PATIENT is responsible for payment if treatment is rendered after the claim becomes INVALID OR CLOSED.

NO INSURANCE COVERAGE: Full Payment is due at the time of service, unless PRIOR ARRANGMENTS have been made. We will bill Out-of-Network Insurances as a courtesy.

NO SHOW/LATE CANCELLATION: A $50.00 fee will apply if a PATIENT misses any testing appointments (Nuclear, echo, etc) with "LESS THAN" a 24 HOUR NOTICE.

Returned checks: A $35.00 charge will applied to your account in the event of a returned check.

I hereby authorize Candyce D. Williams, M.D. to furnish the insurance company(s) on file all medical information necessary to process any appropriate claim.
I also authorize payment of medical benefits to Candyce D. Williams, M.D I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the standard rates and payment terms of this office. If it is deemed necessary, in the sole discretion of this office, to refer my account to a collection agency as a result of nonpayment, I agree to pay any collection cost incurred as a result of this action, including attorney's fees.

Patient and/ or guarantor agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

OUR OFFICE POLICY STATES THAT PAYMENT FOR SERVICES IS REQUIRED AT TIME OF VISIT.

I understand and agree to the above policies:

______________________________ ______________________________
Signature of Patient or Personal Representative Date

______________________________ ______________________________
Print Name of Patient or Personal Representative Relationship to Patient

Candyce D. Williams, M.D.

DIPLOMATE AMERICAN BOARD OF PHYSICAL MEDICNE AND REHABILITATION INTERNAL MEDICINE SPINAL CORD INJURY

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to Pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For Example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to access the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Other Uses an Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission to the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries or event.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibilities for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: if you are a member of the armed forces, we may release information as required to military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign and authorization to disclose information, you may later revoke that authorization to stop any future uses or disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses or disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You must ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe the information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances when we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post a new Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also sent a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Privacy Officer
340 E Palm Lane, Suite 175
Phoenix, AZ 85004
602-386-1100

Effective date: April 14, 2013
Modified: April 18, 2013

COPY FOR PATIENT