PRE-TREATMENT PREPARATION

Welcome to my practice. Below are some simple instructions for you to follow before you come to each appointment. I perform several treatments and procedures – trigger point injections, PRP/Stem Cell procedure, epidural.

It is very important that before you come to our office for **ANY** treatment you **MUST EAT**. Have a full meal an hour before your appointment. A meal/snack of carbs, protein and juice works best.

Examples: (**CARBS ARE BEST**)

Breakfast: Pancakes with syrup, oatmeal and juice, cereal with juice, donuts and juice. You can add a protein with any of these as well.

Lunch: a sandwich with meat and bread, burger, chips or fry's, and juice or soda.

A power bar, yogurt, fruit alone or a high protein meal is not an appropriate meal before treatment. The juice is to keep your blood sugar up so you do not get light headed during treatment.

POST-TREATMENT

If you are sore after trigger point injections, or any procedure, use ice for 15-20 minutes every 2 hours as needed.

DO NOT put ice directly on the skin. Use a light weight towel with your ice bag.

DO NOT ice for more than 20 minutes at a time.

DO NOT use heat at any time after treatment.

Eric Cerre, NMD
1600 W. Chandler Blvd. Suite 100
Chandler AZ 85224
P-480.821.8686 F-480.821.290

Welcome to my practice. Please complete the following information.

PERSONAL INFORMATION:

NAME:_____Age____DOB_____Sex:____M_____F

ADDRESS:_____CITY:_____STATE:___ZIP:_____

PHONE:_____HOME PHONE:_____EMAIL:_____

DRIVERS LICENSE:_____SSN#_____MARITAL STATUS:___S___M___D___W

EMPLOYER:_____WORK #_____

EMERGENCY CONTACT:_____PHONE#_____

PRESENT SYMTOMS/COMPLAINTS:_____

REFERRED BY:_____

CURRENT MEDICATIONS:

List your current medications, strength, dosage per day, doctor who prescribed medication. List additional meds on back.

1._____
2._____
3._____

ALLERGIES: medicine, chemical, food, tape, perfume etc. NO KNOW ALLERGIES ____

1._____
2._____
3._____

SURGICAL HISTORY: List type of surgery and date.

1._____2._____
3._____4._____

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 2 YEARS: List date, where you had the imaging, part of body imaged.

X-RAYS_____

MRI:_____

CT SCAN:_____

OTHER: (EKG, EMG, etc.):_____

Extraordinary Pain Relief
by Dr. Eric Cerre, NMD

Review of Systems: Check all that apply past and present

Patient Name:_____ **Date:**_____

General
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Color changes
- ☐ Hair and nail changes

Head
- ☐ Headache
- ☐ Head injury
- ☐ Neck Pain

Ears
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Eyes
- ☐ Vision Loss/ Changes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam

Nose
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

Neck
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

Respiratory
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

Urinary
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

Vascular
- ☐ Calf pain with walking
- ☐ Leg cramping

Musculoskeletal
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Hematologic
- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine
- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

Psychiatric
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

1600 W. Chandler Blvd. Suite 100,
Chandler, AZ 85224

Office: 480.821.8686
Fax: 480 821 2903

Dr. Eric K. Cerre, NMD
1600 W. Chandler Blvd. Suite 100
Chandler, Az. 85224
(480) 821-8686
(480) 821-2903-Fax

DISCLOSURE OF POTENTIAL RISKS OF TRIGGER POINT INJECTIONS

As with most procedures, there are potential risks. Listed below are some of the possible risks from Trigger point injections **but is not all inclusive** due to the individuality of each person. Every effort is made to reduce the possibility of any type of reaction.

1. Depending on the location of the trigger point, there is the possibility of puncturing body cavities such as the lung, abdomen, pelvic cavity, and corresponding blood vessels and nerves.
2. Possible infection of bruising at the injection site.
3. Possible reaction to medications used in the procedure.
4. Possible infiltration of medications into areas beside the intended injection site.

Trigger point injections is not a covered procedure under most health insurances. As a patient, I have been advised and understand the potential risks.

Patient Signature:_____

Doctor Signature:_____

Date:_____

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Dr. Eric Cerre, NMD
1600 W. Chandler Blvd. Suite 100
Chandler, Arizona 85224
Ph (480) 821-8686
Fax (480) 821-2903

Consent For Evaluation and Treatment

By signing this document, I authorize evaluation and treatment with Dr. Eric Cerre, a Naturopathic Medical Physician, and hereby understand, consent, and agree to the following:

1. I have been informed that Eric Cerre is a Naturopathic physician licensed to practice Naturopathic medicine in the State of Arizona (Lic. 09-1159). I understand that I will be treated with Naturopathic treatment modalities including but not limited to the following:
    - Consult and Exam
    - Trigger Point Injection
    - Decompression
    - PRP/Stem Cell
    - Minor Surgery
    - P-Shot/O-Shot
    - Hormone Therapy
    - Medication (Pain Management)

2. Information developed as part of the evaluation/treatment is confidential but may be released to those parties as required by laws such as:
    - In medical emergencies involving danger to self or to others;
    - Upon presentation, or reasonable suspicion of abandonment/neglect or physical/sexual abuse of a child or elder;
    - A court order;
    - Insurance billing claim requirements;
    - Upon receipt of properly executed consent form;
    - And where otherwise legally required.

3. Treatment is individualized to specific needs and may result in emotional and physical discomfort through the treatment, healing and recovery process.
4. Nothing should be constructed here-in that there's a perfect remedy or treatment for those disease stats considered terminal or incurable.
5. You have the right to withdraw from this agreement at anytime.

Patient Name_____ Signature_____ Date _____

Guardian Name_____ Signature_____ Date _____

Doctor Name Dr. Eric Cerre, NMD Signature_____ Date _____

07/15

Eric Cerre, NMD
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Chandler AZ 85224
P- 480.821.8686 F- 480.821.2903

Notice of Privacy Practices for Protected Health Information

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.

This Office is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not disclose your health information except as described in this Notice.

This Office is permitted by federal privacy laws to make uses and disclosures of your protected health information for purposes of treatment, payment, and healthcare operations. Protected health information is the information that we create and obtain in providing services to you.

Examples of uses of your health information for treatment purposes:

1. The medical history and treatment information we obtain will be recorded in a health record/chart.
2. During the course of your treatment, Dr. Cerre may determine that he will need to consult with another specialist and will share that information with such specialist and obtain his/her input.
3. Some health information will be shared with healthcare facilities in order to schedule procedures.

Examples of uses of your health information for payment purposes:

1. We will submit a written or electronic request for payment to your insurance company (automobile or health) or attorney. The information released will include: name, address, insurance identification, and other identifiable personal information. It will also include diagnoses, procedures, and supplies used.
2. Your insurance company (automobile or health) may request additional information regarding your medical care before authorizing payment of your claim.

Examples of the use of your health information for healthcare operations:

1. We may need to use your healthcare information is assist us in such functions as credentialing, medical transcription, or medical review. We will share the minimal information necessary to complete these processes.

For release of health information not related to treatment, payment and our healthcare operations, a signed AUTHORIZATION form will be required.

Examples of disclosure of your health information not related to treatment, payment or our healthcare operations:

1. Releasing your healthcare information to another physician.
2. Completion of disability benefits applications.

We require that protected patient information be kept out of patient traffic areas.

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Patient Receipt for Notice of Privacy Practices For Protected Health Information

Patient's Name:_____DOB:_____

Please check one:
____I have reviewed, **but choose not to receive a copy** of Dr. Cerre's Notice of Privacy Practices for Protected Health Information.

____I have reviewed and received a copy of Dr. Cerre's Notice of Privacy Practices for Protected Health Information.

Release Of Your Health Information

Who may receive information regarding your Protected Health Information? Check all that apply.

Spouse:___Y___N Name:_____DOB:_____

Children:___Y___N Name:_____DOB:_____
Name:_____DOB:_____

Attorney:___Y___N Name:_____

Other: Name:_____

May we leave messages regarding appointments and other health information on your voice mail on the number listed on our forms?___Y___N

I understand this authorization may be changed or revoked at any time by submitting a written notification to Dr. Eric Cerre.

My signature below acknowledges that I have read this Notice of our Privacy Practices.

Patient
Signature:_____Date:_____

CANCELLATIONS, MISSED APPOINTMENTS AND PRESCRIPTION POLICY

Our goal at Extraordinary Pain Relief, is to provide quality medical care in a timely manner. Our office provided 30 to 60 minute appointments for our patients to better care for your medical needs. Missed appointments may deny other patients from receiving care during that time slot. Therefore, we have implemented a cancellation and missed appointment policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

CANCELLATION OF AN APPOINTMENT:

In order to be respectful of the medical needs of other patients and our office, please be courteous and call our office promptly if you are unable to attend your appointment. This time will be reallocated to other patients who are in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require that you **call at least 24 hours in advance**.

To cancel your appointment, please call our office at 480.821.8686 **at least 24 hours prior** to your scheduled appointment. If you do not reach our office staff, please leave a detailed message on the voice mail. Please leave your phone number so we can contact you to reschedule your appointment. Late cancellations will be considered as a "no-show".

NO-SHOW POLICY:

A no-show is a missed appointment without a 24 hour notice. No-shows inconvenience other patients who may need access to medical care in a timely manner. Failure to present at the time of a scheduled appointment without adequate notice will be recorded in the patient's chart as a no-show.

FEE FOR MISSED APPOINTMENTS:

Missed appointments and no-shows will result in a $50 charge to the patient and must be paid prior to your next appointment. Any further no-shows or cancelled appointments may result in the dismissal from this practice. We do understand there are times when a 24 hour notice is not possible. Emergency cancellations or missed appointments will be evaluated on an individual basis.

PRESCRIPTIONS:

Prescription refills for a controlled medication always requires an office visit. If you are on a non-controlled medication that has refills you must call the pharmacy for refill of your medication. You will be required to have an appointment with our office on a regular basis to monitor your health and medical needs. Please plan your appointment with our office a week before your non-controlled prescription is gone to insure you will not have a lapse in your medication. Control medication appointments can be filled only 3 to 4 days before your prescription runs out (Per Arizona State Law) We recommend you make your next month's appointment early to insure you will not have a lapse in your medication.

Any lab tests or imaging that is requested by our office must be done before your next appointment. If the testing is not done your prescriptions will not be refilled until the testing is completed.

We DO NOT prescribe the following: Percocet, Oxycodone, Dilaudid, Methadone.

I have read the above policies completely. I agree to all of the terms and understand that if I violate this policy it may result in the termination of my doctor/patient relationship.

NAME PRINT:_____

SIGNATURE:_____ DATE:_____

07/2016