

21st Century Pain & Sports Medicine, Inc.

21st Century Pain & Sports Medicine, Inc.

Mark Starr, MD (H)

10565 N. Tatum Blvd, Suite B-115

Paradise Valley, AZ 85253

(480) 607-6503 Fax: (480) 607-6533

PLEASE READ, INITIAL, AND RETURN ALONG WITH YOUR NEW PATIENT FORMS ON THE DAY OF YOUR APPOINTMENT.

Please do NOT wear any perfumes, colognes, or fragrances to our office. Many patients are very chemically sensitive. _____

Office visit is \$300 per hour. The visit may take up to 1½ to 2 hours. We will charge accordingly. This does NOT include supplements. _____

We do NOT take any insurance. _____

Please expect to spend about 2 ½ to 3 hours at our office. _____

Blood work is welcome but not necessary. If you have any blood work from the past 6 months, you are welcome to bring that along with you. _____

If you want to get blood work done through your insurance, this is a list of what we need with our prices.

CBC – Complete Blood Count - \$20

CMP – Complete Metabolic Panel - \$20

Ferritin – Menstrating women only -\$20

TPO – Thyroid Peroxidase Antibodies -\$35

Thyroglobulin antibodies -\$36

Thyroid Panel - \$150

EKG – (for patients over the age of 40) - \$50

Bone Density Scan – (DEXA is the best) Not available in our office

Men only – Testosterone, Estradiol, SHBG -\$100 total

Please bring in at least 1 week worth of basal body temperature readings. As a suggestion, you may use a Geratherm thermometer. Take reading first thing in the morning in the arm pit. Please do not use digital. _____

Dr. Starr uses kinesiology in his practice to help obtain and build your treatment plan.

Please give us 48 hours notice for cancellation or appointment changes or you will be charged \$50.00. _____

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Patient Information

Date: _____

Patient's Full Name: _____
(Last) (First) (Middle) (Sex) (Date of Birth)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Alt Phone: _____

Email: _____

Do we have your permission to notify you of clinic-related matters via this email address? Y N

If patient is a minor, give parent or guardian's name: _____

Whom may we thank for referring you to our office? _____

Previous Physician: _____

Financially Responsible Party Information

Name: _____
(Last) (First) (Middle) (Marital Status)

Address: _____
(Street) (City) (State) (Zip)

How long have you lived at this address: _____ Home Phone _____

SSN: _____ Date of Birth: _____ Relationship to Patient _____

Employer: _____ Employer Phone: _____

Emergency Contact Information

Name: _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____ Relationship: _____

I HEARBY AUTHORIZE 21st Century Pain & Sports Medicine, Inc. and staff to release to my insurance company, employer, or whomever entity I consent, any information acquired in the course of my examination or treatment, including physical, mental, information on HIV, drug use, alcohol use, and this consent does not limit any information contained in my medical records. I hold 21st Century Pain & Sports Medicine, Inc. harmless from any damage that may result from such a release of information. I also hereby authorize payment directly to 21st Century Pain & Muscle Sports, Inc. of the surgical and/or medical benefits, if any other otherwise payable to me for his services.

21st Century Pain & Sports Medicine, Inc.

Signature (Parent/Guardian Signature, if minor) _____

Major Symptoms

A. Tell us what are your **major symptoms** or **problems** for which you have come to us.

Treatment Received

B. Tell us about the treatment you have received for the problems you have mentioned above, such as the physicians consulted, investigations, and the test that you had (including x rays, CT scans, blood tests), and current prescriptions or over-the-counter medicines, etc.

Allergies

C. Please list all known allergies: _____

Medications

D. List all medications you are taking including herbal remedies, vitamins and supplements:

<u>Name</u>	<u>Dosage</u>	<u>What are you taking if for?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the Counter

E. Please list any aspirin products or blood thinners that you are currently taking? (Aspirin, Excedrin, Alka Seltzer, Coumadin):

Surgical History

F. Please list surgical history:

Dental

G. Please list dental surgeries and number of amalgams?

For Both Men and Women

H. Please answer the following:

Have you ever taken a lot of antibiotics in your lifetime, including childhood: Yes No

Please note: Taking a lot of antibiotics is defined as taking antibiotics more than 2-3 times in a given year, or taken them continuously for a month for any condition, such as acne, urinary tract infection, sinus or bronchial infection, etc...

Have you ever taken cortisone or cortisone-type medications such as prednisone in your lifetime, either oral or injections? Yes No

Please give details: _____

Have you ever had rectal or jock itch? (110.3) Yes No

Number of times: _____

Have you ever had athlete's foot? (110.4) Yes No

Number of times: _____

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Symptoms

I. In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

- 0=Never or almost never have the symptoms
- 1=Occasionally have it, effect is not severe
- 2=Occasionally have it, effect is severe
- 3= Frequently have it, effect is not severe
- 4=Frequently have it, effect is severe

DIGESTIVE TRACT

Ever get constipated (564.0)	_____	Nausea (787.1)	_____
Ever get diarrhea or loose stool (558.9)	_____	Vomiting (787.03)	_____
Alternating between constipation or diarrhea	_____	Indigestion (536.8)	_____
Gas (787.3)	_____	Mucus in stool (792.1)	_____
Belching (787.3)	_____	Difficulty swallowing (787.2)	_____
Bloating in abdominal area (787.3)	_____	Poor appetite (783.0)	_____
Ever get abdominal pain (789.00)	_____	Excessive Thirst (783.5)	_____
Ever notice white, coated tongue (112.0)	_____	Get Hungry a lot (783.6)	_____
Heartburn (787.1)	_____	Hemorrhoids (455..6)	_____

HEAD, EMOTIONS, AND MIND

Headaches (787.0)	_____	Pressure in the head	_____
Migraine headaches (346.90)	_____	Cannot think clearly	_____
Ever get depressed for no good reason (311)	_____	Mood swings (296.99)	_____
Anxiety(300.00), fear(799.2),nervousness(799.2)	_____	Difficulty in making decision	_____
Become aggressive easily (301.3)	_____	Learning difficulties or	_____
Fly off the handle (312.0)	_____	Learning Disabilities (315.2)	_____
Reduction in memory (780.9)	_____	Hyperactivity (314.9)	_____
Reduction in concentration (314.00)	_____	Restless (792.2)	_____
Insomnia (780.52)	_____		

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Environmental History

J. Please answer the following regarding your environmental history:

1. Which of the following smells bother you, if any: circle all that apply

Tobacco smoke, smoke from wood burning or fireplace, newsprint, new fabric stores
Exhaust fumes, gasoline products, natural gas
Bleaches, detergents, soaps, rubbing alcohol, chlorinated water
Ammonia, odor of new carpeting, asphalt, tar, rubber, plastics
Moth balls, insect sprays, paints, varnishes, shellac, spray cans, furniture polish,
floor wax
Perfume/Colognes hair sprays, cosmetics
Food odors, alcohol, formaldehyde

In what way do these odors/chemicals bother you?

Cause eye, ear, nose, or throat symptoms
Cause bronchial or chest symptoms
Cause skin rashes

Do foods bother you or disagree with you, including alcohol? Yes No

Explain:

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Please circle all that apply:

Yourself

Your Family (please state Whom)

History of Thyroid Problems	_____	_____
Heart Disease	_____	_____
Palpitations	_____	_____
Insomnia	_____	_____
Emphysema	_____	_____
Fatigue	_____	_____
Dry Skin/Eczema/Psoriasis	_____	_____
Depression	_____	_____
Pain	_____	_____
Weakness	_____	_____
Constipation	_____	_____
Menstrual Problems	_____	_____
Hysterectomy	_____	_____
Miscarriages/Birth Problems	_____	_____
Headaches	_____	_____
High Blood Pressure	_____	_____
Recurrent Infections (Sinus, Ear, Bladder)	_____	_____
Diabetes/Hypoglycemia	_____	_____
Digestive Problems	_____	_____
Autoimmune Disorders	_____	_____
Allergies	_____	_____
TMJ – Teeth Clenching	_____	_____
Hair Loss? Dry Hair	_____	_____
Brittle Nails	_____	_____
Weight Gain/Loss	_____	_____
Birth Defects	_____	_____
ADHD/ADD	_____	_____
Cold Hands/Feet	_____	_____
Problem Swallowing	_____	_____
Emotional/Mental Problems	_____	_____
Decreased Concentration	_____	_____
Drug or Alcohol Abuse	_____	_____
Multiple Sclerosis	_____	_____
Lupus	_____	_____
Arthritis	_____	_____
Sexual Dysfunction	_____	_____

Informed Consent Form

I _____, acknowledge that Dr. Mark Starr and/or his professional medical staff have recommended to me, based on my symptoms and signs, that I may benefit from a clinical trial on hormone replacement therapy for my thyroid, adrenals, and/or sex hormones. I have been provided with additional information and resources to read and other options, conventional, alternative, and homeopathic have been offered to me as well. The risks and benefits have been explained to me as well as the reasons for using this approach that may vary from that of my conventional doctor or health care provider. Dr. Starr is licensed as a homeopathic physician and includes homeopathy in his integrated care plans.

I agree to undertake this therapy and to report to Dr. Mark Starr or his staff any reactions or adverse side effects I might have as well as benefits I experience. I have discussed conventional and traditionally accepted options and diagnosis and treatment with my other physician prior to visiting Dr. Mark Starr and the other providers at this Center. It is my informed decision that I accept the treatments as discussed with Dr. Mark Starr and his medical staff as an integrative and homeopathic approach to my medical care in lieu of or in conjunction with the other conventional options presented to me by my other physicians. I fully understand that any of these therapies may or may not give me appreciable benefits. I acknowledge that no guarantees or claims have been made to me regarding the efficacy or results of these therapies.

Patient Signature: _____

Parent or Spouse's Signature if Applicable: _____

Date: _____

Staff Signature: _____

Supplement Return Policy

To insure the optimum quality of our physician grade supplements, we apologize that we cannot accept returns on these items once they have been purchased and have left the office

- any opened supplements
- any oil supplements
- any softgels

All other unopened supplements may be returned within one week of purchase

*Please note: Some of the supplements Dr. Mark Starr prescribes can be purchased at health food stores or other locations. Dr. Mark Starr can only vouch for the quality and potency of the supplements that he offers through his office.

Patient's Initials: _____

Date: _____

Notice of Privacy Rights

Our Commitment to your privacy:

We are dedicated to maintaining the privacy of your health information. We maintain the confidentiality of your health information as required by law.

Agreements

I understand a record will be kept of the health services provided to me.

I understand that this record will be kept confidential and will not be released to others unless so directed by my representatives or myself or unless the law requires it.

I understand that my provider may discuss my case with clinic members and any students under their tutelage.

I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit.

I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my provider to the best of their ability will answer any questions I have.

Requirements

It is required by Federal Law to maintain the privacy of your Private Health Information (PHI) and to provide you with a Privacy Notice detailing NMSA/LT's legal duties and privacy practices with respect to your PHI.

Under the Privacy rule, it may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal Law.

It is required to abide by the terms of this Privacy Notice.

Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

Will distribute any revised Privacy Notice to you prior to implementation.

Will not retaliate against you for filing a complaint.

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To obtain more information about your privacy rights or if you have any questions you want answered about your privacy rights, as provided by Privacy Rule Section 164.520(b)2(vii), you must contact Naturopathic Medicine of Southern Arizona (NMSA)/Laser Therapeutics (LT) privacy officer. Include the following information:

Name: 21st Century Pain & Sports Medicine, Inc.

Address: 10565 N. Tatum Blvd. Suite B-115
Paradise Valley, AZ 85253

Telephone: 480-607-6503

Effective Date: June 3, 2008

Patient Acknowledgment

With this signature, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Please print your name: _____

Signature: _____

Date: _____