Central Arizona Pain Institute
Interventional Spine & Pain Management
2100 Centerpointe West Drive
Prescott, AZ 86301
Phone: 928.717.0788 www.centralazpain.com Fax: 928.717.0748

ACKNOWLEDGEMENT & RECEIPT OF PRACTICE CONSENT FORMS

Please place your initials to the left of each item, signifying your receipt and willingness to adhere to each of the items.

_____ 1. General Office Information

_____ 2. Acknowledgement of Receipt of Privacy Practices

_____ 3. HIPAA Consent Form

_____ 4. Assignment and Release of Information

_____ 5. Verification of Authenticity for Pain Management

_____ 6. Financial Responsibility Form

_____ 7. Consent for Chronic Opioid Therapy (American Academy of Pain Medicine)

_____ 8. Medicare and/or Medicaid (AHCCCS) Authorization (if applicable)

_____ _____
Patient Signature Date

_____
Patient Name (Please Print)

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian or minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient