



7220 S Cimarron Rd. Suite 270 Las Vegas, NV 89113

Tel: (702) 912-4100

Fax: (702) 912-4101

www.nvpaincare.com

URGENT INFORMATION: PLEASE READ

Dear Patient:

I write to inform you of a new law that may impact your next physician visit. As most people are aware, there has been an epidemic of deaths due to narcotic pain medications both in the USA and Nevada. To change this, the Nevada legislature and Governor Brian Sandoval signed Assembly Bill 474 which will add several new regulations into effect starting January 1. Because of these laws, and the penalties which physicians face if they don't comply, patients who get pain medications for both acute and chronic pain may notice some changes in their care and will alter patient care as it relates to the prescribing of controlled substances.

Here are some of the changes you may experience under this new law:

First off, before anyone is prescribed an initial narcotic pain medication for any reason, your physician will need to run a report on you checking the state database to look up your history of using controlled medications. Your physician will also need to have you sign an informed consent form that should include information on risks of taking narcotics, proper use of the medication and other options to control your pain. Finally, your physician will also need to evaluate your risk of addiction or dependency. Initial prescriptions for acute pain can only be prescribed for 14 days. If you require pain medications for more than 30 days, your doctor will need to then have you sign a Prescription Medication Agreement. The agreement should include the goals of using your controlled medication and discuss other rules your physician will have for your prescription medications. Rules will likely include using a single pharmacy, no sharing of your medications with others and use of other prescribed controlled substances, marijuana and illegal drugs amongst others. In our practice, we've been starting to gear up for these laws. In some cases, this is helping us re-evaluate many patients, including getting additional testing and referring patients to specialists to discuss alternative treatment options. While the focus of these laws has been on narcotic pain medications, many of these new regulations also apply to other controlled prescriptions. These include medications such as Xanax, valium, and stimulants for ADHD (Adderall, Ritalin). If you are a patient on these medications, you will likely have to work with your doctor on many of these same agreements and risk of abuse assessments. Your provider may also require you to submit to screenings and other diagnostic tests.



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These new mandated requirements have been put in place to provide guidance to health care providers, to inform and empower you the patient to take an active role in your treatment, and to reduce the opioid epidemic in Nevada.

We appreciate your patience with us as we work through implementation of this new law. During this process, we are committed to continuing to provide you with the best possible patient care.

If you have any questions about these new requirements or our practices policies and procedures, please contact us at 702-912-4100, talk to us at your appointment, or visit prescribe365.nv.gov.

Sincerely,

Nevada Pain Care



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective Date: August 28, 2020

The Practice of Nevada Pain Care is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using your Health Information for Treatment Purposes:

- Our medical assistant obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information about the medical care we provided to you.

Example of Using Your Health Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.



NOTICE OF PRIVACY PRACTICES

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI (“the Notice”);
- Receive Notification of a breach of your unsecured PHI
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out of pocket.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record.
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice.
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law
- Notify you following a breach of your unsecured PHI
- Provide you with a notice (‘Notice’) describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice
- Notify you if we cannot accommodate a request restriction or request, and
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.



NOTICE OF PRIVACY PRACTICES

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgement, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.



NOTICE OF PRIVACY PRACTICES

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, replacements.

Workers Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with law relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer such as in needing FMLA paperwork.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises, and € in other limited emergency circumstances where we need to report a crime.



NOTICE OF PRIVACY PRACTICES

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceedings as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")



NOTICE OF PRIVACY PRACTICES

To Request Information, exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practices Privacy Officer at 702-912-4100, or in writing to us at:

Nevada Pain Care
ATTN: Privacy Officer
7220 S Cimarron Rd, Suite 270
Las Vegas, NV 89113

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.
- We cannot, and will not, retaliate against you for filing a complaint with.



NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

Print Name

Patient (or Patient Representative*) Signature

Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.



Welcome!

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (702) 912-4100 if you have any questions or are unsure how to complete any section of this form.

New Patient Intake Paperwork

Patient Information

Today's Date _____ Social Security Number: _____

Your Name: _____ Driver's License # / State: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Street Address: _____ Apt# _____

City/State/Zip: _____

Email: _____

Physical Address Same as Mailing? ☐ Yes ☐ No If not, please list mailing address: _____

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Work

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Work

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Race: ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Decline to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Report

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your primary insurance _____

Insurance policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance _____

Insurance policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Claim Number: _____ Date of initial injury: _____

State of Injury: _____ Employer Name: _____

Employer Address: _____

Workers Comp Company: _____

Claims Manager Name: _____ Phone number: _____

Injury Claim

Is your pain the result of a Motor Vehicle Accident or Personal Injury? (legal term describing injury sustained to your person by negligence of another) ☐ No ☐ Yes If yes, you will be asked to complete a separate form.

I certify that the above information is accurate, complete and true.

Patient Signature: _____ Date: _____

CLINICAL INFORMATION

Your Name: _____ Today's Date _____

Height: _____ Weight: _____ lbs

Referral

Were you referred to our clinic by another physician? If so, whom? _____

↳ If not, how did you hear about us? ☐ PCP ☐ Insurance Company ☐ Family ☐ Friend

☐ Other Website _____

Physicians

Primary Care Physician: _____ Phone: _____

Address: _____

Cardiologist: _____ Phone: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Pain Description

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free

1 – Very minor annoyance, occasional minor twinges

2 – Minor annoyance, occasional strong twinges

3 – Annoying enough to be distracting

4 – Can be ignored if you are really involved in your work/task, but still distracting

5 – Cannot be ignored for more than 30 minutes

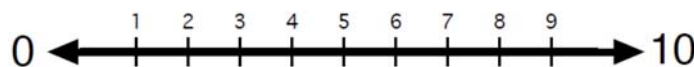
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities

7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort

8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.

9 – Unable to speak, crying out or moaning uncontrollably, near delirium

10 – Unconscious, pain makes you pass out



_____ What number on the pain scale (0-10) best describes your pain **right now**?

_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

_____ What number on the pain scale (0-10) best describes your **average pain over the last month**?

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

How did that pain begin? _____

How did that pain episode begin? ☐ Gradually ☐ Suddenly

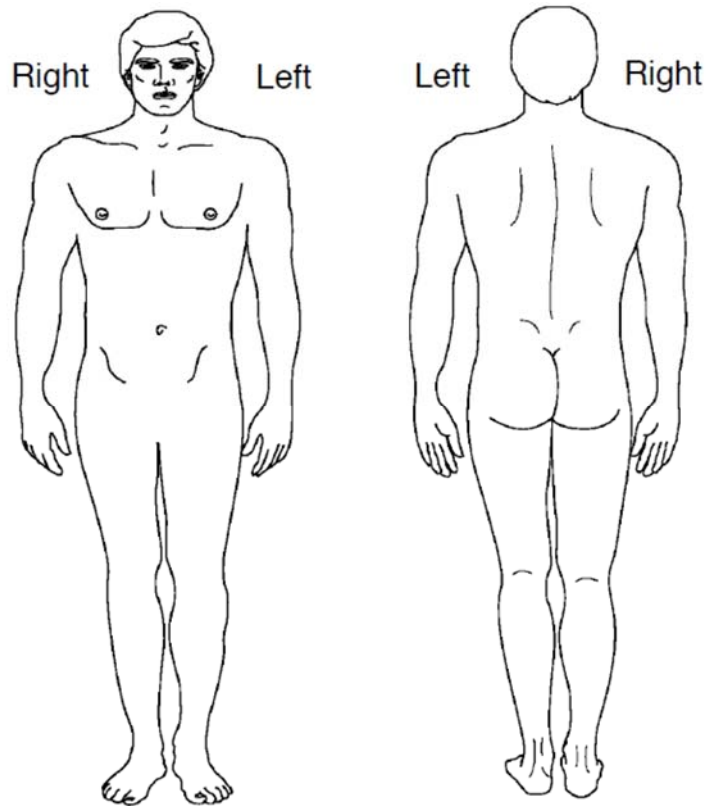
What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

- "N"** = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Pain Description - Check all of the following that describe of your pain:

- | | | | |
|--------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Numbness | <input type="checkbox"/> Spasming | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling/Pins & Needles |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing/Sharp | <input type="checkbox"/> Tiring/Exhausting |
| <input type="checkbox"/> Hot/Burning | | | |

Pain Frequency

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Enjoyment of Life | <input type="checkbox"/> Normal Work | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> General Activity | <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Mood | <input type="checkbox"/> Relationships with People | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> My goal is to resume normal activities | | |

In the past three months have you developed any new:

- | | | | |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Bladder incontinence | <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Fevers | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Numbness/Tingling – Where? _____ | | <input type="checkbox"/> Weakness – Where? _____ | |

☐ I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

- ☐ MRI of the _____ Date: _____ Facility: _____
- ☐ X-ray of the _____ Date: _____ Facility: _____
- ☐ CT scan of the _____ Date: _____ Facility: _____
- ☐ EMG/NCV study of the _____ Date: _____ Facility: _____
- ☐ Ultrasound of the _____ Date: _____ Facility: _____
- ☐ Other diagnostic testing: _____

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

- ☐ Chiropractic ☐ Physical Therapy ☐ Psychological Therapy ☐ Podiatrist Treatment (foot)
- ☐ Discogram – (circle all areas that apply) Neck / Mid-Back / Low-Back
- ☐ Epidural Steroid Injection – (circle all areas that apply) Neck / Mid-Back / Low-Back
- ☐ Joint Injection – Joint(s) _____
- ☐ Medial Branch Blocks or Facet Injections – (circle all areas that apply) Neck / Mid-Back / Low-Back
- ☐ Nerve Blocks – Area/Nerve(s) _____
- ☐ Radiofrequency Ablation – (circle all areas that apply) Neck / Mid-Back / Low-Back
- ☐ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant
- ☐ Spine Surgery
- ☐ Trigger Point Injection – Area of Body? _____
- ☐ Vertebroplasty / Kyphoplasty – Level(s) _____
- ☐ Other: _____

☐ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐ No

Have you experienced an allergic reaction to anesthesia? ☐ Yes ☐ No (Do not complete section below)

Which type of anesthesia did you react adversely to? Please check all that apply.

- ☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

- ☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

- ☐ Gallbladder removal _____
- ☐ Appendectomy _____
- ☐ Other _____

Female Surgeries

- ☐ Caesarean section _____
- ☐ Hysterectomy _____
- ☐ Laparoscopy _____
- ☐ Ovarian _____
- ☐ Other _____

Heart Surgery

- ☐ Valve replacement _____
- ☐ Aneurysm repair _____
- ☐ Stent placement _____
- ☐ Other _____

Joint Surgery

- ☐ Shoulder _____
- ☐ Hip _____
- ☐ Knee _____

Spine / Back Surgery

- ☐ Discectomy (levels) _____
- ☐ Laminectomy _____
- ☐ Spinal fusion (levels) _____

Other Common Surgeries

- ☐ Hemorrhoid surgery _____
- ☐ Hernia repair _____
- ☐ Thyroidectomy _____
- ☐ Tonsillectomy _____
- ☐ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary): _____

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE

Current Medications

Are you taking a prescribed **blood-thinner** medication? ☐ Yes ☐ No If yes, please check which one:

- ☐ Aggrenox ☐ Coumadin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pletal ☐ Pradaxa
- ☐ Ticlid ☐ Warfarin ☐ Xarelto ☐ Other _____

Please list **ALL** medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name

Allergic Reaction Type

Please check if you are allergic to ☐ Iodine or ☐ Tape Are you allergic to shellfish? ☐ Yes ☐ No

***Are you allergic to latex?** ☐ Yes ☐ No If yes, you will be asked to complete a separate questionnaire

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other medical problems: _____

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY

☐ I AM ADOPTED (No Medical History Available)

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No If so, are you currently pregnant? ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar school ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Current Alcoholism ☐ Daily Limited Alcohol Use ☐ History of Alcoholism
☐ Never Drinks Alcohol ☐ Social Alcohol Use

Tobacco Use: ☐ Current Tobacco User ☐ Former Tobacco User ☐ Never Used Tobacco

Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs (Which: _____)

☐ Currently Using Someone Else's Prescription Medications

☐ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No (Which: _____)

Past Medical History

Mark the following conditions/diseases that you have been **treated** for in the past:

☐ No Past Medical History

General Medical

☐ Cancer – Type _____ ☐ Diabetes – Type _____ ☐ HIV / AIDS

Head/Eyes/Ears/Nose/Throat

☐ Glaucoma ☐ Headaches ☐ Head Injury ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Migraines

Cardiovascular / Hematologic

☐ Anemia ☐ Bleeding Disorders ☐ Coronary Artery Disease ☐ Heart Attack ☐ High Blood Pressure
☐ High Cholesterol ☐ Mitral Valve Prolapse ☐ Murmur ☐ Pacemaker/Defibrillator ☐ Phlebitis
☐ Poor Circulation ☐ Stroke

Respiratory

☐ Asthma ☐ Bronchitis ☐ Emphysema / COPD ☐ Pneumonia ☐ Tuberculosis ☐ Valley Fever

Gastrointestinal

☐ Bowel Incontinence ☐ Acid Reflux (GERD) ☐ Gastrointestinal Bleeding ☐ Constipation

Musculoskeletal

☐ Amputation ☐ Bursitis ☐ Carpal Tunnel Syndrome ☐ Chronic Low Back Pain ☐ Chronic Neck Pain
☐ Chronic Joint Pain ☐ Fibromyalgia ☐ Joint Injury ☐ Osteoarthritis ☐ Osteoporosis
☐ Phantom Limb Pain ☐ Rheumatoid arthritis ☐ Tennis Elbow ☐ Vertebral Compression Fracture

Genitourinary/Nephrology

☐ Bladder Infection(s) ☐ Dialysis ☐ Kidney Infection(s) ☐ Kidney Stones ☐ Urinary Incontinence

Hepatic

☐ Hepatitis A (active / inactive / unsure)
☐ Hepatitis B (active / inactive / unsure)
☐ Hepatitis C (active / inactive / unsure)

Neuropsychological

☐ Alcohol Abuse ☐ Alzheimer Disease ☐ Bipolar Disorder ☐ Depression ☐ Epilepsy
☐ Prescription Drug Abuse ☐ Multiple Sclerosis ☐ Paralysis ☐ Peripheral Neuropathy ☐ Schizophrenia
☐ Seizures ☐ Reflex Sympathetic Dystrophy/CRPS
☐ Other Diagnosed Conditions:

Fall Risk Assessment

Have you fallen in the last year?

☐ Yes ☐ No When was the last time you fell? _____

Do you have a fear of falling that interferes with your daily activities?

☐ Yes ☐ No

Do you use an assistive device to help you walk?

☐ Yes ☐ No If yes, what do you use? _____

Review of Systems

Mark the following symptoms that you **currently suffer from**. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Chills | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Unexplained Weight Gain | <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Weakness | | |

Eyes:

- ☐ Recent Visual Changes

Ears/Nose/Throat/Neck:

- | | | |
|--|---|--|
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Earaches | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Recurrent Sore Throats | <input type="checkbox"/> Ringing in the Ears |
| | | <input type="checkbox"/> Sinus Problems |

Cardiovascular:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Shortness of Breath During Sleep | <input type="checkbox"/> Swelling in the Feet | <input type="checkbox"/> Lightheadedness |

Respiratory:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Shortness of Breath on Exertion/Effort | <input type="checkbox"/> Shortness of Breath at Rest | |

Gastrointestinal:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Coffee Ground Appearance in Vomit | <input type="checkbox"/> Dark and Tarry Stools | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Vomiting | |

Musculoskeletal:

- | | | |
|---|--|--|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Stiffness |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Neck Pain |

Genitourinary/Nephrology:

- | | |
|---|--|
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Decreased Urine Flow/Frequency/Volume |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Flank Pain |
| | <input type="checkbox"/> Painful Urination |
| | <input type="checkbox"/> Pelvic Pressure |

Neurological:

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Instability When Walking | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Seizures |
| | | <input type="checkbox"/> Tremors |

Psychiatric:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Feeling Anxious | <input type="checkbox"/> Stress Problems |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Suicidal Planning | |

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Nevada Pain Care and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Nevada Compassionate Pain Care to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Nevada Pain Care's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Nevada Pain Care to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Nevada Pain Care to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Nevada Pain Care will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Ally Clinical Diagnostics my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due.

Patient Name: _____

Date: _____

Patient Signature: _____



Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

APPOINTMENTS

1. **Copayments**-Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, Nevada Pain Care reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.
2. **Procedure Prepayment**- Nevada Pain Care collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment you may request a refund according to our refund policy below. We reserve the right to reschedule your procedure until prepayment has been made.
3. **Missed Appointments and Late Arrivals**- If you are more than 20 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a \$25 charge. These charges are your responsibility and will not be billed to any insurance carrier. After 3 missed appointments you will be discharged from the clinic.

INSURANCE PAYMENTS

4. **Financial Responsibility**- Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
5. **Coverage Changes and Timely Submission**- It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Nevada Pain Care must submit a claim on your behalf to your insurer. If Nevada Pain Care is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
6. **Self-Pay**- If you do not have health insurance, or if your health insurance will not pay for services rendered by Nevada Pain Care, you are considered a self-pay patient. Your charges will be on our current self-pay fee schedule. Self-pay patients are expected to make payment in full at the time of service.

BENEFIT AND AUTHORIZATION

7. **Insurance Plan Participation**- We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and coinsurances.

8. **Referrals-** Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Nevada Pain Care, it is your responsibility to be aware of this fact, and to obtain this referral.
9. **Prior Authorization and Non-Covered Services-** Nevada Pain Care may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that service provided to you are covered benefits and authorized by your insurer. Nevada Compassionate Pain Care, as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
10. **Out of Network Payments-** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Nevada Pain Care, immediately.

ACCOUNT BALANCES AND PAYMENTS

11. **Reassignment of Balances-** If your insurance company does not pay within a reasonable time; we may transfer the balance to your sole responsibility. Please follow up with your insurance to resolve non-payment issues. Balances are due within 30 days of receiving a statement.
12. **Collection of Unpaid Accounts-** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Nevada Pain Care reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Nevada Pain Care for any expenses we incur to collect on your account, including reasonable attorney's fees and collection costs.
13. **Returned Checks-** Returned checks will be subject to a \$38 returned check fee.
14. **Refunds-** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: PBS, ATTN: Nevada Pain Care Billing Dept, 7250 Peak Dr #100, Las Vegas, NV 89128.
15. **Statements** – Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.
16. **Past due balance-** all balances are due before the end of the year.

Agreement and Assignment of Benefits

I have read and understand the financial policy of Nevada Pain Care, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Nevada Pain Care. I understand that I am financially responsible for all services I receive from Nevada Pain Care. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Signed: _____ Date: _____



Patient Authorization for Use and Disclosure of Protected Health Information

Nevada Pain Care takes your privacy seriously. We will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Nevada Pain Care to release your medical records to parties indicated.

Your Name: _____ Date of Birth: _____

Authorized Parties

By signing below, I authorize Nevada Pain Care, its agents and employees ("Provider"), to use and/or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party	Relationship
_____	_____
_____	_____
_____	_____

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Entire Medical Record (including copies) | <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Drug Testing |
| <input type="checkbox"/> Diagnosis/Treatment | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Claims Payment | | |

Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV related diseases and communicable disease related information.

With respect to any communicable disease related information protected by State confidentiality rules and disclosed under this Authorization. Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Right of Refusal

I acknowledge that I have had the opportunity to review Nevada Pain Care Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Nevada Pain Care. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

Privacy Officer
7220 South Cimarron Rd.
Suite 270
Las Vegas, NV 89113

Expiration

This authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

Signature

Signed By: _____
Signature of Patient or Legal Guardian

Today's Date

Relationship to Patient



TELEPHONE CONTACT WITH PATIENTS

The Practice contacts Patients for a variety of reasons, including appointment reminders and providing test results. If you would like to restrict the way in which we contact you (e.g., do not leave a message on phone message machines or other recorders; do not provide information to others who may answer your phone (at your home or office), please inform a member of our reception desk staff and complete the following form:

PATIENT INSTRUCTIONS TO THE PRACTICE'S STAFF REGARDING TELEPHONE CONTACT:

Patient Name: _____

It is permissible to contact me at the telephone locations checked below:

_____ Home Telephone Number (____) _____ - _____

_____ Work Telephone Number (____) _____ - _____

_____ Mobile Telephone Number (____) _____ - _____

_____ Email _____

It is permissible to leave voice messages at the telephone locations checked below:

_____ Home Telephone Number

_____ Work Telephone Number

_____ Mobile Telephone number

_____ Sending Email Message

It is permissible to leave messages with other people who may answer the telephone numbers checked below:

_____ Home Telephone Number

_____ Work Telephone Number

_____ Mobile Telephone number

Patient Signature

Date



Mailing address: 7220 S Cimarron Rd, Ste 270
Las Vegas, NV 89113
Tel: (702) 912-4100
Fax: (702) 912-4101

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my health care provider *STEPHEN GEPHARDT, MD of NEVADA PAIN CARE* to obtain my health information during this term of this authorization from the recipient(s) that I have identified below.

Patient Name: _____ DOB: _____ SSN: _____

Recipient: I authorize my health care information to be obtained from the following recipient(s):

Physician/Practice/Facility, etc: _____

Address of Physician/Practice/Facility, etc: _____

Tel: _____ Fax: _____

Purpose: I authorize the release of my health information for the following specific purpose:

____ Continued Care ____ Insurance ____ Legal ____ Transfer ____ Personal

Other: _____

(Note: "at the request of the patient" is sufficient if the patient is initiating this authorization)

Information to be disclosed: I authorize the release of the following health information:

____ Chart note(s) ____ Diagnostic Testing report(s) ____ Procedure Report
____ Billing record ____ All records

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20_____.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Nevada Pain Care. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Nevada Pain Care Officer of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the Nevada Pain Care Officer of Compliance for answers to my questions about the privacy of my health information at 7220 S Cimarron Rd. #270, Las Vegas, NV 89113 or by telephone at (702) 912-4100.

Patient/Parent/Legal Guardian or Representative Signature

Legal Relationship

Date

Witness Signature

Date



Same Day Cancellation/ No Show Policy

I understand that I will be charged a cancellation fee of \$25 if I fail to give at least 24 hour notice prior to cancelling my appointment.

I understand that I will be charged a no show fee of \$25 if I fail to show for my appointment.

I understand that these charges will be my responsibility and my insurance carrier will not cover these charges.

I understand that repeated same day cancellations and missed appointments are disruptive to the optimal delivery of care and may result in discharge from Nevada Pain Care.

I understand Nevada Pain Care's appointment cancellation and no show policy. I understand it is my responsibility to plan appointments accordingly.

Patient name (print)

Patient Signature

Date



Late Policy

I understand that if I do not arrive to my appointment by the scheduled appointment time I will be re-scheduled to the next available appointment/provider.

I understand that it is my responsibility to notify Nevada Pain Care staff if I am unable to maintain the appropriate arrival time.

I understand that multiple late appointments will result in a same day re-schedule fee of \$25.

I understand that I am responsible for the charges incurred and my insurance carrier will not cover these charges.

I understand Nevada Pain Care's late policy. I understand it is my responsibility to plan appointments accordingly.

Patient name (print)

Patient Signature

Date