NEVADA PAIN CARE
Care You Can Believe In

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, 2018. 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

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 y our 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 (please circle): Male Female Prefer to not specify

Street Address: _____

City/State/Zip: _____

Email: _____

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

_____

_____

Preferred Phone: _____ Please circle: Home Mobile Work

Secondary Phone: _____ Please circle: Home Mobile Work

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Please circle: Home Mobile Work

Martial Status (please circle): Married Single Divorced Widowed Other: _____

Race (please circle): American Indian or Alaskan Indian Asian or Pacific Islander Black White

Decline to Report

Ethnicity (please circle): Hispanic Non-Hispanic Decline to Report

Primary Language (please circle): English Spanish Other: _____

Primary Insurance Plan

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

Policy/ID Number: _____ Group Number: _____

Complete this section if you ARE NOT the policy holder for your primary insurance:

Insurance Policy Holder (please circle): Self Spouse Child Other: _____

Policy Holder Name: _____ Policy Holder Gender: _____

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any applies)

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

Policy/ID Number: _____ Group Number: _____

Complete this section if you ARE NOT the policy holder for your primary insurance:

Insurance Policy Holder (please circle): Self Spouse Child Other: _____

Policy Holder Name: _____ Policy Holder Gender: _____

Date of Birth: _____ Social Security Number: _____

Physicians

Primary Care Physician: _____ Phone: _____

Address: _____

Cardiologist: _____ Phone: _____

Address: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

Address: _____

_____

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

Patient Signature: _____ Date: _____

CLINICAL INFORMATION

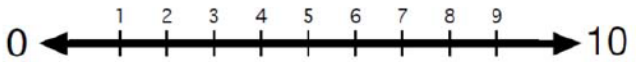
Your Name: _____

Height: _____ Weight: _____ lbs

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? _____

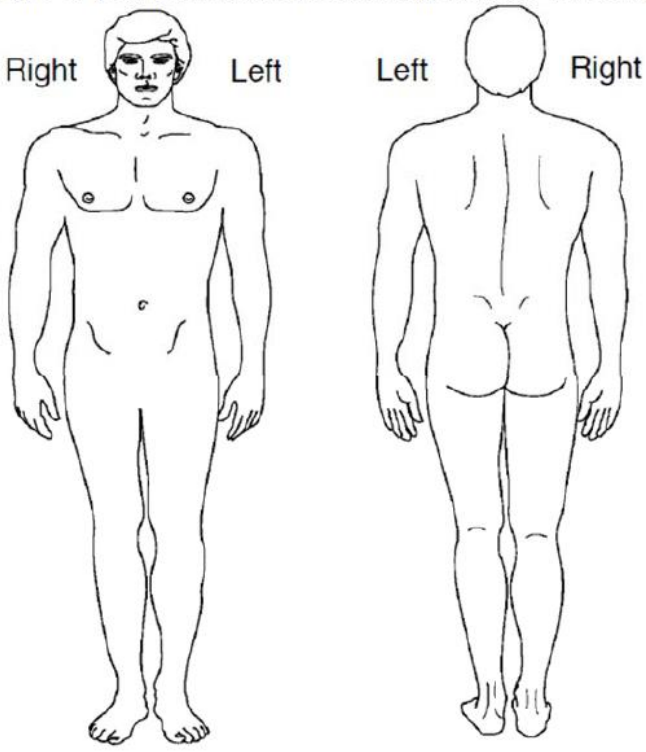
How did that pain begin? _____

_____

How did that pain episode begin? Please circle one: Gradually Suddenly

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 your pain:

- ❑ Aching
- ❑ Cramping
- ❑ Dull
- ❑ Hot/Burning
- ❑ Numbness
- ❑ Shock-like
- ❑ Shooting
- ❑ Spasming
- ❑ Squeezing
- ❑ Stabbing/Sharp
- ❑ Throbbing
- ❑ Tingling/Pins & Needles
- ❑ Tiring/Exhausting

Pain Frequency

What word best describes the frequency of your pain (please circle one): Constant Intermittent

What is your pain at its worst (please circle): Mornings During the Day Evenings Middle of the Night

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

- ❑ Enjoyment of Life
- ❑ General Activity
- ❑ Mood
- ❑ My goal is to resume normal activities
- ❑ Normal Work
- ❑ Recreational Activities
- ❑ Relationships with People
- ❑ Sleep
- ❑ Walking
- ❑ Other: _____

Diagnostic Tests and Imaging:

Mark all 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 OFR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History

Mark all 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
- ☐ Joint Injection: Joint(s): _____ Date(s): _____
- ☐ Medial Branch Blocks (MBBs) or Facet Injections - (circle all areas that apply): Neck Mid-Back Low-Back
- ☐ Nerve Blocks: Area/Nerve(s): _____
- ☐ Radiofrequency Ablation (RFAs) (circle all areas that apply): Neck Mid-Back Low-Back
- ☐ Spinal Cord Stimulator - (circle one): Trial 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)? – Please circle: YES NO

Have you experienced an allergic reaction to anesthesia? – Please circle: YES NO **(Do not complete section below)**

Which type of anesthesia did you react adversely to? Please circle all that apply:

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	Strok
Mother													
Father													

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? Please circle: Yes No

If so, are you currently pregnant? Please circle: Yes No

Highest level of education obtained? Please circle: Grammar School High School College Post-Graduate

Alcohol Use: (please circle) Daily Limited Alcohol Use History of Alcoholism

Never Drinks Alcohol Social Alcohol Use

Tobacco Use: (please circle) Current Tobacco User Former Tobacco User Never Used Tobacco

Drug Use: (please circle) 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: _____

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:

Review of Symptoms

Mark the following symptoms that you **currently suffer from**.
NOTE: *Diagnosed conditions/treatments should be noted under Past Medical History.*

Constitutional:
❑ Chills ❑ Difficulty Sleeping ❑ Easy Bruising
❑ Excessive Sweating ❑ Excessive Thirst ❑ Fatigue ❑ Fevers
❑ Insomnia ❑ Low Sex Drive ❑ Night Sweats ❑ Tremors
❑ Unexplained Weight Gain ❑ Unexplained Weight Loss ❑ Weakness

Eyes:
❑ Recent Visual Changes

Ears/Nose/Throat/Neck:
❑ Dental Problems ❑ Earaches ❑ Hearing Problems
❑ Nosebleeds ❑ Recurrent Sore Throats ❑ Ringing in the Ears ❑ Sinus Problems

Cardiovascular:
❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis
❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness
❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Respiratory:
❑ Cough ❑ Wheezing ❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort ❑ Shortness of Breath at Rest

Gastrointestinal:
❑ Abdominal Cramps ❑ Acid Reflux ❑ Constipation
❑ Coffee Ground Appearance in Vomit ❑ Dark and Tarry Stools ❑ Diarrhea
❑ Hernia ❑ Vomiting

Musculoskeletal:
❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness
❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Genitourinary/Nephrology:
❑ Blood in Urine ❑ Decreased Urine Flow/Frequency/Volume
❑ Erectile Dysfunction ❑ Flank Pain ❑ Painful Urination ❑ Pelvic Pressure

Neurological:
❑ Carpal Tunnel Syndrome ❑ Dizziness ❑ Headaches
❑ Instability When Walking ❑ Numbness/Tingling ❑ Seizures ❑ Tremors

Psychiatric:
❑ Depressed Mood ❑ Feeling Anxious ❑ Stress Problems
❑ Suicidal Thoughts ❑ 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 Pain Care to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that 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 Nevada Pain Care to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practice. This includes, but it not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Navea 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 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 the Laboratory 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 of 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: _____

NEVADA PAIN CARE
Care You Can Believe In

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 $50 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.

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, executers 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 _____

_____

_____

- ☐ Entire Medical Record (including copies)
- ☐ Diagnosis/Treatment
- ☐ Claims Payment
- ☐ Psychological Testing
- ☐ Appointment Information
- ☐ Drug Testing
- ☐ Medications

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

NEVADA PAIN CARE
Care You Can Believe In

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 & Rescheduling Policy

I understand that I will be charged a cancellation fee of $50 if I fail to give at least 24 hour notice prior to canceling my appointment.

I understand that I will be charged a no show fee of $50 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 rescheduling of appointments, 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, no show and rescheduling policy. I understand it is my responsibility to plan appointments accordingly.

_____ _____

Patient Signature Date

_____

Patient name (print)

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 $50.

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.

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

_____

Patient name (print)

_____

Patient Signature

_____

Date