MEDICATION LIST

Please include all prescribed meds, over the counter medication, vitamins, herbals, and supplements taken. This list will be updated at each visit.

Patient Name:_____ **DOB:**_____ **Date:**_____

DATE	MEDICATION/DOSE	FREQUENCY TAKEN	DISCONTINUED

Pharmacy Name: _____

Location: _____

Phone: _____ **Fax:**_____

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Physician Assistant Certified

NEVADA SPINE CLINIC
CENTER FOR SPINE AND SPECIAL SURGERY
7140 Smoke Ranch Rd. Ste. 150 Las Vegas, NV 89128
8930 W. Sunset Rd. Ste 350 Las Vegas, NV 89148
3175 St. Rose Pkwy. #121 Henderson, NV 89052
TEL: (702)320-8111

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Physical Medicine Rehabilitation
Pain Management

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AUTHORIZATION TO REQUEST MEDICAL RECORDS

Patient:_____ Date of Birth:_____ Date:_____
(please print)

Address:_____

THIS IS TO AUTHORIZE:

Nevada Spine Clinic
7140 Smoke Ranch Road Las Vegas NV 89128

TO REQUEST INFORMATION FROM:

_____
(Name of Doctor, Insurance Co., or Individual)

Address:_____ City:_____

State:_____ Zip:_____ Phone No:_____ Fax:_____

(CHECK RECORDS TO BE REQUESTED)

[ ]All Medical Records [ ]Operative Reports [ ]NCV/EMG Reports [ ]Xray/MRI Reports

[ ]Lab Work [ ]Office Notes [ ]OTHER

I REALIZE THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION

_____ _____
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

OFFICE PERSONNEL REQUESTING: _____

PLEASE FAX TO: (702)_____

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PATIENT INFORMATION

Name:_____ Date:____/____/____
(Last) (First) (M.I.)

Single/Married/Other_____ Gender: M / F DOB:___/___/___ Age:____ Social Security#:____-____-_____

Ethnicity: Hispanic Non- Hispanic Race:_____ Preferred Language:_____

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

Phone:(____)____-_____ (____)____-_____ (____)____-_____ _____
(Home) (Cell) (Work) (Email Address)

Employer:_____ _____
(Name) (Address)

Referring Physician:_____ _____
(Name) (Address)

Emergency Contact:_____ _____ (____)____-_____ (____)____-_____
(Name) (relationship to you) (Home Phone) (Cell)

Insurance information:(if applicable)

Primary Insurance:_____ Secondary Insurance:_____
Policy Holder:_____ Policy Holder:_____
Subscriber Name:_____ Subscriber Name:_____
Date of Birth:_____ Date of Birth:_____
Social Security #:_____ Social Security:_____
Effective Date:_____ Effective Date:_____
ID#_____ ID#_____
Group#_____ Group#_____

Personal Injury Cases(LIEN) (if applicable)

Attorney Information:_____ _____
(Name) (Phone #)
Address:_____ Date of Injury:_____

**Our standard policy requires us to bill your health insurance unless you, the patient, specifically request by signature below, not to do so.

I, **DO NOT** want my health insurance billed: _____ ___/___/____
(Signature) (Date)
Please be advised that if you later decided to bill Health Insurance it will be billed from that time and date only.

Work Comp Information(if applicable):

Claim Adjuster or Case Manager Name:_____
Employer Receiving Worker's Compensation from:_____
Phone:(____)____-_____ Fax:(____)____-_____
Claim #:_____ Date of Injury:_____
Your Signature:_____ Date:_____

Name_____ DOB_____ Date_____

Are you: Married____ Single____ Children: Y / N How many_____ Dominant Hand: R / L

Do you use tobacco (smoke/chew)? Y / N If yes, how much and for how many years?_____

Do you drink alcohol? Y / N If yes, how many drinks per day/week:_____

Do you or have you used recreational drugs? Y / N Which ones?_____

Do you receive disability compensation of any kind?_____ What kind?_____

What is your occupation?_____

What is your employment status now?(circle) Full-Time Retired Student Unemployed Unable to work due to pain/injury

Height:_____ Weight:_____ Have you experience any sudden weight loss or gain?_____

Are you or could you be PREGNANT/NURSING?_____ Date of last period_____

Do you have any ALLERGIES (IE: medication, latex gloves, tape?) NO__ YES__, Please list them_____

_____

PRIOR MEDICAL HISTORY (list ALL previous illness type and date):_____

_____

_____

_____

_____

PRIOR SURGICAL HISTORY (list previous surgeries, type and date):_____

_____

_____

_____

_____

List previous SERIOUS INJURIES (i.e. fractures with date)_____

_____

_____

Name_____ DOB____/____/_____ Date_____

Date of injury(**if applicable**)_____

How did the injury occur?(**if applicable**)_____

Where does it hurt?_____

Have you been treated for your present problem? Y / N When _____ By whom _____

Indicate which of the following you have tried for your pain and if it helped:

Pain Clinic/Anesthesiologist_____ Anti-inflammatory/Anti-Depressant_____

Trigger Point Injections_____ Epidural Steroid Injection_____

Chiropractic Therapy_____ Physical Therapy_____

How long are you able to sit/stand comfortably?_____

How far are you able to walk?_____

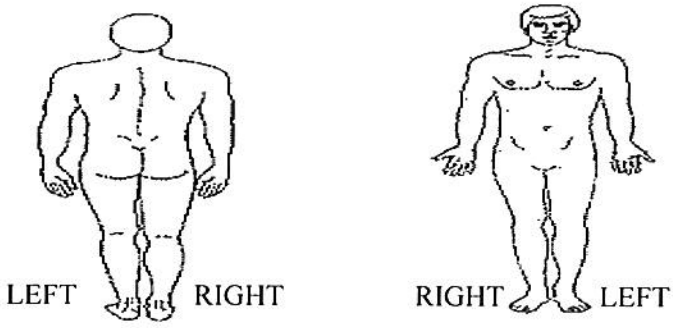
Circle the words that describe your pains:

ACHING	SHARP	PENETRATING	THROBBING	GNAWING
TENDER	NAGGING	SHOOTING	BURNING	UNBEARABLE
NUMBNESS	STABBING	OCCASIONAL	MISERABLE	CONTINUOUS

Severity of your pain. Mark the point on the line between 0 (no pain) and 10 (worst pain) which best describes how severe your pain is:

0 1 2 3 4 5 6 7 8 9 10

Please mark the area of your pain on the diagram below



At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its least: 0 1 2 3 4 5 6 7 8 9 10

Name:_____ DOB_____ Date:_____

****Please check all that apply ("Family" applies to parents, brothers & sisters)**

Condition	You	Family
Cardiovascular		
Anemia	____	____
Blood Clots	____	____
Heart Attack	____	____
Murmur/Palpitations	____	____
High Blood Pressure	____	____
Pacemaker	____	____
Ear, Nose, Throat		
Deafness	____	____
Deviated Septum	____	____
Earaches	____	____
Hay Fever/Allergies	____	____
Loss of Hearing	____	____
Nosebleeds	____	____
Sinus Infections	____	____
Sinus Problems	____	____
Wear Dentures	____	____
Wear Hearing Aid	____	____
Endocrine		
Diabetes	____	____
Thyroid Problem	____	____
Eyes		
Blindness	____	____
Cataracts	____	____
Dilated Pupil	____	____
Eye Injury		____
Glaucoma	____	____
Corrective Lenses	____	____
Eye Prosthesis	____	____
Skin		
Psoriasis	____	____
Other _____		

Condition	You	Family
Genitourinary		
Blood in Urine	____	____
Kidney Stone	____	____
Loss of Bladder Control	____	____
Menstrual Problems*(Female)*	____	____
Sexual Problems	____	____
Bladder Problems	____	____
Testicular Pain *(Male)*	____	____
Hepatitis	____	____
HIV/AIDS	____	____
Low Blood Sugar	____	____
Sickle Cell	____	____
Musculoskeletal		
Fibromyalgia	____	____
Gout	____	____
Lupus	____	____
Joint Pain	____	____
Muscle Pain	____	____
Cramps	____	____
Osteoarthritis	____	____
Rheumatoid Arthritis	____	____
Trouble Walking	____	____
Osteoporosis	____	____
Gastrointestinal		
Abdominal bleeding	____	____
Colitis	____	____
Gallbladder disease	____	____
Hemorrhoids	____	____
Indigestion	____	____
Jaundice	____	____
Loss of bowel movement	____	____

Condition	You	Family
Neurological		
Multiple Sclerosis	____	____
Alzheimer's disease	____	____
Brain Disorder	____	____
Seizures/Epilepsy	____	____
Dizziness	____	____
Fainting Spells	____	____
Headaches	____	____
Neuritis	____	____
Paralysis	____	____
Stroke	____	____
Side Effected L / R		
Psychiatric		
Confusion	____	____
Memory Loss	____	____
Depression	____	____
Insomnia	____	____
Respiratory		
Asthma	____	____
Bronchitis	____	____
Chronic Cough	____	____
Coughing Blood	____	____
Emphysema	____	____
Pain with Breathing	____	____
Pneumonia	____	____
Shortness of Breath	____	____
Tuberculosis	____	____
Women		
Are you pregnant now?	Y	N
Last Menstrual Cycle	_____	
Postmenopausal	Y	N
How many years?	_____	

***** IF <u>NONE</u> APPLY, PLEASE SIGN & DATE HERE:_____**

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DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name:______________________________ DOB______________ DATE___________

WE WILL NOT COMMUNICATE TO ANYONE WITHOUT A WRITTEN AUTHORIZATION FROM YOU UNLESS IT IS IN REGARDS TO THE CONTINUITY OF TREATMENT.

I hereby authorize the disclosure of my health information to the following persons:

➢ ______________________________ ______________ ______________
NAME RELATIONSHIP TO YOU TELEPHONE #

MARK WHICH INFORMATION YOU WOULD LIKE US TO RELEASE:

___ANY & ALL INFORMATION ___PRE-PROCEDURE INSTRUCTIONS ONLY ___APPOINTMENT INFORMATION ONLY

➢ ______________________________ ______________ ______________
NAME RELATIONSHIP TO YOU TELEPHONE #

MARK WHICH INFORMATION YOU WOULD LIKE US TO RELEASE:

___ANY & ALL INFORMATION ___PRE-PROCEDURE INSTRUCTIONS ONLY ___APPOINTMENT INFORMATION ONLY

➢ ______________________________ ______________ ______________
NAME RELATIONSHIP TO YOU TELEPHONE #

MARK WHICH INFORMATION YOU WOULD LIKE US TO RELEASE:

___ANY & ALL INFORMATION ___PRE-PROCEDURE INSTRUCTIONS ONLY ___APPOINTMENT INFORMATION ONLY

➢ ______________________________ ______________ ______________
NAME RELATIONSHIP TO YOU TELEPHONE #

MARK WHICH INFORMATION YOU WOULD LIKE US TO RELEASE:

___ANY & ALL INFORMATION ___PRE-PROCEDURE INSTRUCTIONS ONLY ___APPOINTMENT INFORMATION ONLY

This authorization will remain in effect until I send a written revocation. The extent of this disclosure is for written and verbal correspondence between the physician and the individual or institution listed above. A release of medical records is a separate form.

______________________________ ______________________________
Patient Signature(Parent or Guardian if Patient is a minor) Date:

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NEVADA SPINE CLINIC

MEDICATION POLICY

If you are prescribed medication during your treatment, there are several guidelines you must follow:

1. **The medications given to you should be taken as prescribed by your doctor. The medications may not be used for any other purposes than which they were given to you. These medications may not be given or sold to any other individual. Patients may be asked to perform a urine/serum drug test at any time.**

2. **You will be given a specific amount of medication to last a specific length of time. You must keep track of your medications to make sure you do not run out before the specific time. It is your responsibility to have follow-up appointments scheduled far enough in advance so that you do not run out of your medication.**

3. **Requests for medication refills will only be considered during regular office hours listed below:**
   Monday – Thursday 9:00 a.m. to 5:00 p.m.
   No refills will be given after hours, weekends or holidays. All refill requests must be received by Thursday to be refilled for the weekend.

4. **Requests for medication refills should be called to your pharmacy who will, in turn, call our office. Please allow 48 hours for this procedure. No refills of medications will be given if you have not been seen for 3 months. Your refill will need to be reviewed by your physician and may not be refilled until you have been seen again. It is your responsibility to make a follow-up appointment with your doctor. This will be strictly enforced.**

5. **If you call for medication or refills outside regular office hours, you will be instructed to go to the emergency room. There, you will be evaluated by an emergency room physician who will decide whether or not to refill your medication. Emergency Department Policy regarding medication refills is typically very strict and there is no guarantee that you will get your refill. If the Emergency Department is busy, you may be required to wait a long period of time to be seen.**

6. **While in the care of NSC, all pain medications will be given at our doctor's discretion. Do not seek pain medication from any other physicians. Breaking these rules will be grounds for termination of your treatment.**

7. **Telephone requests for prescription renewals are accepted only during regular business hours. In some instances there is a 48 to 72 hour waiting period before prescriptions will be refilled, so call for your refills accordingly. We are very cautious about refilling your medications too early, so follow your instructions carefully.**

_____ _____

(PRINT) Patient Name **Date of Birth**

_____ _____

Patient signature(Parent or Guardian if patient is a minor) **Date**

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AUTHORIZATION/ASSIGNMENTS/CONSENTS

PLEASE READ THE FOLLOWING CAREFULLY. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK FOR AN EXPLANATION FROM OUT OFFICE MANAGEMENTI

- Office hours are from 8:00 am to 5:00 pm Monday through Friday. All routine telephone calls to the office should be made during these hours.

  Patient Initial:_____

- I hereby authorize and request Nevada Spine Clinic to release my complete medical records (including x-rays) when referring to other facilities concerning my medical treatment.

  Patient Initial:_____

- I hereby assign to Nevada Spine Clinic all benefits for surgical and medical care payable under medical insurance policy and/or policies. I also authorize release of information from Nevada Spine Clinic to my insurance carrier for services billed.

  Patient Initial:_____

- I understand that I am financially responsible for all services rendered whether or not paid by my insurance. **Payment is expected at the time of service.** Visa, MasterCard, American Express and Discover are accept for my convenience. I understand that if my care is on a lien, it is my responsibility to notify Nevada Spine Clinic if there are any changes in my legal representation. There will be a charge of $25 for all returned checks.

  Patient Initial:_____

ORTHOPEDIC OR SPINAL EMERGENCIES USUALLY REQUIRE HOSPITAL ADMISSIONS. IF YOU SHOULD FIND YOURSELF IN THAT EMERGENCY SITUATION, PLEASE GO TO THE NEAREST HOSPITAL EMERGENCY ROOM. THE EMERGENCY ROOM STAFF WILL THEN CONTACT YOUR PHYSICIAN. PLEASE KEEP IN MIND THAT ON WEEKENDS THERE MAY BE OTHER DOCTORS COVERING YOUR DOCTORS PRACTICE AND THEREFORE, YOU MAY BE SEEN BY SOMEONE OTHER THAN YOUR DOCTOR.

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My Signature below acknowledges the following:

- I have received a copy & am aware of the Patient Bill of Rights; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.

- I have received a copy & am aware of this office's Notice of Privacy Practices, including the Private Health Inormation (PHI) designated at the time of visit. [**LAST TWO PAGES OF PACKET]**

I have read and fully understand the information that has been provided.

Signature of Patient/Representative:_____ DOB:_____ DATE:_____

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Patient Name:_____ DOB:_____ DATE:_____

INITIAL LEARNING ASSESSMENT

During your visit without organization, you will be presented with information that may be new to you. To aid in providing the best care possible, please answer the following questions. Then return this form to the front desk. Thank You.

How do you like to learn new things? Please check all that apply:

	Reading		Pictures/Diagrams
	Discussion		Hands On/Demonstration
	Videotapes		Self Study
	Audiotapes		Other_____

Factors that can affect learning:	YES	NO	Comments:
Do you speak English in your home?			If no, what language do you speak? Name of interpreter:
Can you read English?			
Can you write English?			
Do you hear well?			If no, do you utilize a hearing device? Yes No
Do you see well?			If no, do you utilize glasses or contacts? Yes No
Do you have any cultural or religious practice/beliefs that may affect your care or treatment?			If yes, please explain:

Other comments:

_____

_____

_____

_____

_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS I NFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Uses and disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of office that are involved in your care and treatment for the purpose of providing health care serviced to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your PHI, as necessary, to a home health agency that provides care to you. Another example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI medical school students that see patient at our office. In addition, we may use a sign-in sheet at the registration where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization, as required by law; Public Health issues; Communicable Diseases; Health Oversight: Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners funeral Directors, and Organ donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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NEVADA SPINE CLINIC

At the Nevada Spine Clinic, our patients have a right to:

- Considerate care that safeguards their personal dignity and respects their psychological, cultural, and spiritual values. NSC does not discriminate based on race, age, sex or ethnicity.
- Effective communication.
- Be involved in making decision and resolving dilemmas regarding their medical care, treatment, and services.
- Refuse medical care, treatment and services.
- Confidentiality, privacy, and security of their medical records.

Patients (and their families) of the Nevada Spine Clinic have a responsibility to:

- Follow the practice's rules and regulations concerning patient care and conduct.
- Be considerate and show respect to the practice's staff and propertt
- Promptly meet any financial obligation agreed to with the practice
- Provide to the best of his or her knowledge, accurate and complete information about their present conditiong, any unexpected changes in their condition, past medical history, medication (prescribed, a non-prescribed and herbal),
- Acknowledge when they do not understand a contemplated treatment course or care dicision,
- Ask questions when they do not understand what theyh ave been told or what they are expected to do,
- Follow the pre-operative and post-discharge care instructions
- Express any concerns they have about their ability to follow and comply with the proposed care plan or course of treatment, including anesthesia or operative requirements.
- The patient and family are responsible for the outcomes if they do no follow the prescribed care plan.

Nevada Spine Clinic has a responsibility to:

- Provide it's patients with the highest quality care utilizing the most up to date medical technology,
- Respect the needs of patients for confidentiality, privacy, and security.
- Address the needs of those with physical, vision, speech, hearing, language, and cognitive impairments.
- Receive, review and to the best of its ability, resolve complaints from patients and their families.

Please feel free to ask questions regarding your rights and responsibilities as a patient of Nevada Spine Clinic at any times.