605 Sierra Rose Drive Suite #4
Reno, NV 89511

Dear: ____ Date: _____/_____/_____

Thank you for choosing Nevada Pain and Spine Specialists to assist you with your pain management. We appreciate your trust in us and look forward to the opportunity to work with you and your primary care provider and physician.

Please keep in mind this appointment is for an initial CONSULTATION/EVALUATION ONLY. Prescription medications **MAY NOT be prescribed at this appointment.** It is very important that you continue medication management with your primary care provider or physician.

Your New Patient Consultation is on: _____/_____/_____ at _____: _____am/pm

with Dr. ________________________.

** If for any reason, you have to cancel and/or reschedule your appointment; please notify us at least 24 hours in advance. If you “NO SHOW” twice as a new patient to the practice, we will not reschedule your consultation without payment in full in advance

OFFICE HOURS:	Monday – Friday	7:30 AM – 5:00 PM (Lunch 12:00 – 1:00)
	Phone: 775-689-5410	Fax: 775-689-5431 ATTN: Julie F. or Ruth

Please bring the following to your appointment:

✓All current medication bottles
✓Completed Registration Form
✓If relevant, X-Ray and/or MRI films
✓Driver’s License or another Photo Identification.
✓Current Health Insurance Card(s)
✓Current Prescription Card
✓Co-payment (if required by your insurance)

__**Completed New Patient Packet and MSQS Packet must be returned 48 hours PRIOR to your scheduled appointment**__

If you have any questions, or need assistance of any kind, please call anyone of our schedulers:

- Julie M. (Dr. Steven Berman): 775-398-1547
- Tina W. (Dr. Kenneth Pitman): 775-398-1542

PATIENT FINANCIAL RESPONSIBILITY FORM:

INSURANCE:

As a courtesy, Nevada Pain & Spine Specialists will file all claims to your insurance carriers for services provided. In order to extend this courtesy, we need a picture ID and your current insurance card(s), and the information in the attached forms.

- Many procedures that we perform require pre-determination and pre-authorization from your insurance carrier and may take 2-4 weeks to obtain.
- If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician.
- Insurance coverage varies widely; we strongly recommend that you become familiar with your policy and the benefits, restrictions and non-covered services that are specific to your plan.
- If any changes in your insurance coverage or benefits occur while being treated at Nevada Pain & Spine Specialists, you are responsible to notify us immediately.
- Co-pays are due at time of service
- Patients are responsible for co-pays, coinsurance, deductibles and all other costs not covered by insurance or Medicare.
- Parent/ guardian is responsible for co-pays, coinsurance, deductibles and all other costs not covered by insurance or Medicare, if patient is a minor.

WORKER'S COMPENSATION:

If you are being seen for a work-related injury, you need to complete the information in the attached forms.

AUTO ACCIDENT:

If you are being seen for an injury related to an auto accident, you need to complete the information required in the attached forms.

CASH/SELF PAY:

If you are not covered by health insurance or Medicare, we expect payment in full at the time of service. We do offer a **20% discount for payment in full at time of service**. If you are unable to pay in full, our staff is happy to discuss/arrange payment options prior to your visit.

PATIENT FINANCIAL RESPONSIBILITY:

I have read the foregoing and I understand that I am responsible for the charges not covered by insurance or Medicare, and that all charges are due and payable within 30 days. If I am a Medicare patient, I am only responsible for the deductible, coinsurance and non-covered services. If I am unable to pay in full within 30 days, I am to contact the Billing Department for financial arrangements at 775-747-5050 Ext: 111. My account will be considered delinquent after 90 days. I will be discharged as a patient from Nevada Pain and Spine Specialists.

_______________________________ _____________________________ Date: _____/_____/_____

Patient Name (Printed) Patient Signature

FORMS:

Completion of any forms requested by patient by our physicians requires an office visit. We may not complete all forms as it may be more appropriate for your primary care provider and/or surgeon to complete. Please let us know what type of form you are requesting to be completed when you call to schedule an appointment. Our staff will determine if we can complete the form, if so they will schedule the appropriate time with your physician. **The charge for completing the form(s) ranges from $25.00 to $200.00. The amount is due at the time of your appointment.**

PHARMACY REFILLS:

Nevada Pain and Spine Specialists has an onsite dispensary for your prescription needs, for the convenience of our patients. If you choose to use a pharmacy, have them fax a refill request to 775-786-4031. Refill requests will NOT be authorized on Fridays or after hours; neither the staff nor the physicians will authorize these requests. **We do NOT do early refills without an appointment. The provider will only provide enough medications until your regularly scheduled appointment.**

Demographics:

Please fill in the following:

Name: Today's Date: Social Security Number:

Date of Birth: Age: Sex:

Address City State:

Home Phone: Work Phone: Cell Phone:

Employment Status: Employer Name:

Occupation/ Title:

Address: City: State: Zip:

Emergency Contact: Relationship: Phone:

Insurance information:

PRIMARY insurance company's name: ____

Insurance Address: City: State: Zip:

Name of Insured: Date of birth: Relationship to insured:

Insurance ID number: Group Number:

SECONDARY insurance company's name: ____

Insurance Address: City: State: Zip:

Insurance ID number: Group Number:

ACCIDENT/INJURY INFORMATION

Patient Name: _________________________ DOB: _____/_____/_____ Date: _____/_____/_____

Date of Injury: _____/_____/_____ Body Part(s): __________________________________

WORK RELATED INJURY: Claim Number: _____________________________________

Name of Employer at time of injury: ____

Employer City: ________________________ State: __________

Name of Adjuster: ___________________________________

Address: ____

Phone Number: _____-_____-_____ Fax Number: _____-_____-_____

Name of Case Manager ____

Phone Number: _____-_____-_____ Fax Number: _____-_____-_____

Name of Attorney (if applicable) ____

Phone Number: _____-_____-_____ Fax Number: _____-_____-_____

WE REQUIRE A COPY OF YOUR C4

AUTO RELATED INJURY: Claim Number: _____________________________________

Name of Insurance Company: ____

Address: ____

Phone Number: _____-_____-_____ Fax Number: _____-_____-_____

MEDICARE PATIENTS

(These questions are required by Medicare)

Is Medicare Primary?

I request that payment if authorized Medicare/Other insurance company benefits be made either to me or on my behalf to Nevada Pain & Spine Specialists for any serviced furnished me by that part who accepts assignments/ physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/ Other Insurance Company claim.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of HCDA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

In Medicare/Other insurance assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

Is Medicare Secondary?

If you checked yes, please check any boxes below that apply to you:

- You are older than age 65? _____ YES _____ NO
- You or your spouse is actively employed and covered by a group health plan?
  _____ YES _____ NO
- Your primary coverage is through your employer or spouse's? _____ YES _____ NO
- Does this employer have over 100 employees? _____ YES _____ NO
- Is your condition related to an accident or injury?
  - If yes, date of injury: _____/_____/_____
    - Type of injury (please circle one): Auto / Work / Other
- Are you disabled?
  - Date you became eligible for disability: _____/_____/_____
  - Reason: _____ ESRD _____ OTHER

Patient Signature:______________________________________ Date: _____/______/_____

Patient Name: ____________________ D.O.B: ___/___/___ Date: ___/___/___

What pain problem are you seeing us for?:

____

Draw the location of your pain on the diagram below. Use the the symbols below to show where your pain occurs and how it feels. Circle the words that coordinate with your symptoms.

Is your pain located on (circle one): LEFT RIGHT BILATERAL

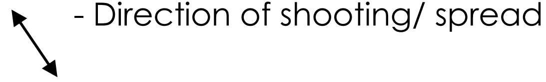
X - Stabbing, Sharp, Cutting

△ - Pressure, Squeezing, Throbbing

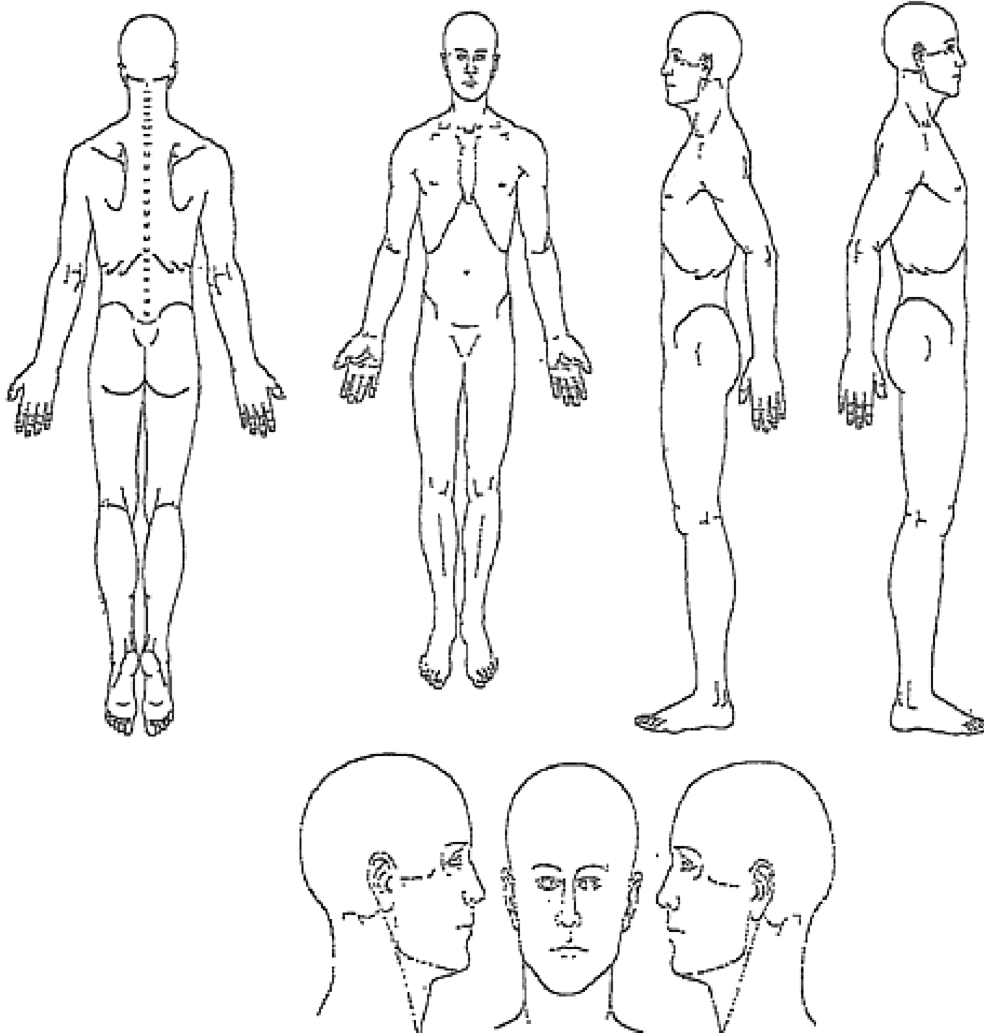
⬯ - Dull, Aching

B - Burning, Hot

- Tingling, Pins and Needles



- Direction of shooting/ spread



History of Present Illness:

What problem are you seeing us for? ____

Who referred you to us? ____

Please list current treating physicians/ providers: Include name and city

____

Who is your Primary Care Provider? ____

When did your pain start? ______________________________

What do you think caused your pain?

____

Please select the responses that apply to your pain:

☐ started suddenly ☐ started gradually ☐ has stayed the same

☐ has worsened rapidly ☐ has worsened gradually ☐ has slowly improved

☐ has happened before ☐ has never happened before

Pain Scale: 0= NO PAIN 10= WORST PAIN POSSIBLE

At **best**, how severe is your pain on a scale of 0-10? _______

At **worst**, how severe is your pain on a scale of 0-10?_________

On **average**, how severe is your pain on a scale of 0-10?________

What is an **acceptable** level of pain on a scale of 0-10? ________

How often do you experience your pain problem?

☐ Steady or constant ☐ Brief or momentary ☐ Comes and goes ☐ Never changes

Pain problem occurs:

☐ Daily ☐ Weekly ☐ Monthly ☐ Less Often

Pain problem is worse during:

☐ Mornings ☐ Afternoons ☐ Evenings ☐ Bedtime ☐ N/A Pain is the same all the time

Describe your pain:

☐ dull ☐ sharp ☐ aching
☐ pounding ☐ throbbing ☐ cramping
☐ burning ☐ tingling ☐ electrical
☐ shooting ☐ numbing ☐ pins/needles

What worsens your pain:

☐ sitting ☐ bending ☐ lifting
☐ twisting ☐ coughing/sneezing ☐ standing
☐ walking ☐ reaching ☐ exercise
☐ certain positions ☐ stress ☐ damp/cold
☐ heat ☐ light touch ☐ certain foods
☐ other ☐ none

If other, please explain ______________________________

What helps your pain:

☐ sitting ☐ heat ☐ quiet ☐ER Visits
☐ standing ☐ stretching ☐ relaxation ☐ injections
☐ reclining ☐ massage ☐ exercise ☐ medications
☐ other ☐ none

If other, please explain ______________________________

Symptoms associated with your pain:

☐ numbness ☐ weakness ☐ swelling
☐ stiffness ☐ cramps ☐ weight loss
☐ fever ☐ chills ☐ sweats
☐ fatigue ☐ skin changes ☐ hair changes
☐ nail changes ☐ rashes ☐ skin coolness
☐ bowel problems ☐ bladder problems ☐ paralysis
☐ balance problems ☐ depression ☐ anxiety
☐ insomnia ☐ suicidal ☐ none

Your pain interferes with:

☐ work ☐ sleep ☐ personal care
☐ sexual relations ☐ driving ☐ yard work
☐ light work ☐ heavy work ☐ using the bathroom

☐ walking short distances ☐ walking long distances ☐ shopping
☐ other ☐ none

If other, please explain ____

Past non-surgical treatments you have had (how helpful?):

	N/A	No Help	Some Help	Much Help	Worse
Epidural blocks	☐	☐	☐	☐	☐
Trigger point injections	☐	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐	☐
Massage	☐	☐	☐	☐	☐
TENS/ Electrical Stimulation	☐	☐	☐	☐	☐
Psychological counseling	☐	☐	☐	☐	☐
Hypnosis	☐	☐	☐	☐	☐
Nutritional/ Herbal therapy	☐	☐	☐	☐	☐
Pain/ Rehab program	☐	☐	☐	☐	☐

If other, please explain ____

Surgeries/Pain Treatment:

List all surgeries you have had to treat **your pain**: Please include date, surgical procedure:

____

____

____

What studies have been performed to evaluate your pain:

☐ MRI ☐ CT
☐ X-Rays ☐ EMG
☐ Discogram ☐ Ultrasound
☐ Disability/ Impairment Rating ☐ Psychological Testing
☐ Other ☐ None

Where did you have your previous studies performed? ______________________________

Your current pain treatment plan can be described as:
☐ Poor ☐ Fair ☐ Adequate ☐ Good ☐ No Treatment

Review of Systems:

General: ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

Skin: ☐ Excessive Sweating ☐ Rash ☐ Pigmentation ☐ Change In Hair Growth Or Loss ☐ Nail Changes ☐ Skin Color Changes ☐ Bruising

HEENT: ☐ Visual Loss ☐ Hearing Loss ☐ Glaucoma ☐ Nose Bleed ☐ Hoarseness

Respiratory: ☐ Bloody Sputum ☐ Cough ☐ Wheezing ☐ Shortness Of Breath

Cardiovascular: ☐ Chest Pain ☐ Fainting ☐ Swelling Of Extremities ☐ Irregular Heart Beat

Gastrointestinal: ☐ Abdominal Pain ☐ Constipation ☐ Nausea ☐ Vomiting ☐ Stool Incontinence

Genitourinary: ☐ Urinary Infections ☐ Kidney Stones ☐ Blood In Urine ☐ Incontinence

Musculoskeletal: ☐ Joint Pain ☐ Muscle Weakness ☐ Fractures ☐ Muscle Pain ☐ Muscle Cramps ☐ Joint Swelling

Neurological: ☐ Trouble Walking ☐ Balance Problems ☐ Headaches

Cancer: please specify which type, where, and indicate if you received surgery, chemotherapy, radiation therapy, or hormone therapy:

____

____

Medical History:

Current PAIN medications (include strength/dosage/frequency), write N/A (none) if not taking any:

____

____

____.

Please list any previous PAIN medications and indicate why they were discontinued:

____

____

____.

How long have you been taking prescription pain medication(s)?__________Years/Months

Please list all other medications you are currently taking (include strength/dosage/ frequency):

____

____

____

Do you have any allergies and/ or medication allergies? If yes, please list: ____________________

____

List other SURGERIES and HOSPITALIZATIONS, please include approximate dates:

____

____

Please list any other medical conditions:

- ☐ Heart Attack
- ☐ Hypertension
- ☐ COPD
- ☐ Diabetes Type II
- ☐ Stroke
- ☐ Migraine Headaches
- ☐ Low Thyroid
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Fibromyalgia
- ☐ None
- ☐ Heart Failure
- ☐ High Cholesterol
- ☐ Diabetes Type I
- ☐ Asthma
- ☐ Peripheral Vascular Disease
- ☐ High Thyroid
- ☐ Chronic Bronchitis
- ☐ Seizure Disorder
- ☐ Hepatitis
- ☐ Rheumatoid Arthritis
- ☐ Other/ Cancer: ____________

Tobacco/Alcohol/ Drugs:

Do you smoke? If yes, how often? ______________________________

Do you drink alcohol? If yes, how often?

____

Do you use any illicit substances? If yes, which substances? How often?

____

Psychiatric History:

Have you previously experienced any mental/psychiatric condition such as?

☐Depression ☐Anxiety ☐ Bipolar Disorder

☐Alcoholism ☐Post Traumatic Stress Disorder ☐ Schizophrenia

☐Childhood Trauma/ Abuse ☐Suicidal Ideation/ Attempt ☐ None

If yes to any of these conditions, please explain:

____

____

Have you ever struggled with or received treatment for substance addiction/abuse, if yes please indicate facility name:

____

Have you ever used alcohol or illicit substances to control your pain?

____

Are you under the care of a mental health provider? If yes, please list the name and phone number of your current provider:

____

Family History:

Please list any medical problems that run in your family? Write "N/A" if you do not have any that apply:

____

____

Social History:

Birthplace (City/ State): _______________________

Marital Status: __________________________

Children? If so, how many/ ages? __________________

Who do you currently live with? __________________

Occupational History:

Current work status: _________________________________

Please describe your current occupation: (if you are not working, write N/A)

____

What is your highest level of education completed? ______________________

ONLY COMPLETE THIS SECTION IF THIS IS A WORK-RELATED/WORK COMP INJURY

What body part is/are covered? ______________________________

Who was your employer? ______________________________

How long had you been working there? ______________________________

What was your job? ______________________________

How long has it been since you last worked? ______________________________

What type of work had you previously performed? ______________________________

HIPAA

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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. "Protected Health Information" 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 protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services 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 protected health information 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, your protected health information 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 protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk 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 protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Mary Wells	775-689-5410	N/A
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Provided By HCSI– Revised March 2013

HIPAA

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices and understand my rights contained in the notice.

Patient Name (printed): ____

Patient Signature: ____

Date: _____/_____/_____

Witness Name (printed): ____

Witness Signature: ____

Date: _____/_____/_____

Acknowledgement and Consent to Discuss Treatment

Patient Name: ______________________________ D.O.B.: ____/____/____
(Please Print)

I have read **The Notice of Privacy Practices** and understand my rights contained in the notice.

By way of signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the **Privacy Notice**.

I also authorize and give permission for representatives of NPSS to discuss information regarding appointments, medication treatment, information regarding medications, test/lab results, insurance and billing with:

____________________________ (Relationship) ____________________________

____________________________ (Relationship) ____________________________

____________________________ (Relationship) ____________________________

Do we have permission to:

Leave a message on your home phone or cell phone answering machine?

☐ YES ☐ NO

Leave a message at your place of employment?

☐ YES ☐ NO

Discuss your medical condition with any member of your household?

☐ YES ☐ NO

______________________________ ____/____/____
Patient Signature Date

______________________________ ____/____/____
NPSS Representative Date

REVISED 02.09.2017