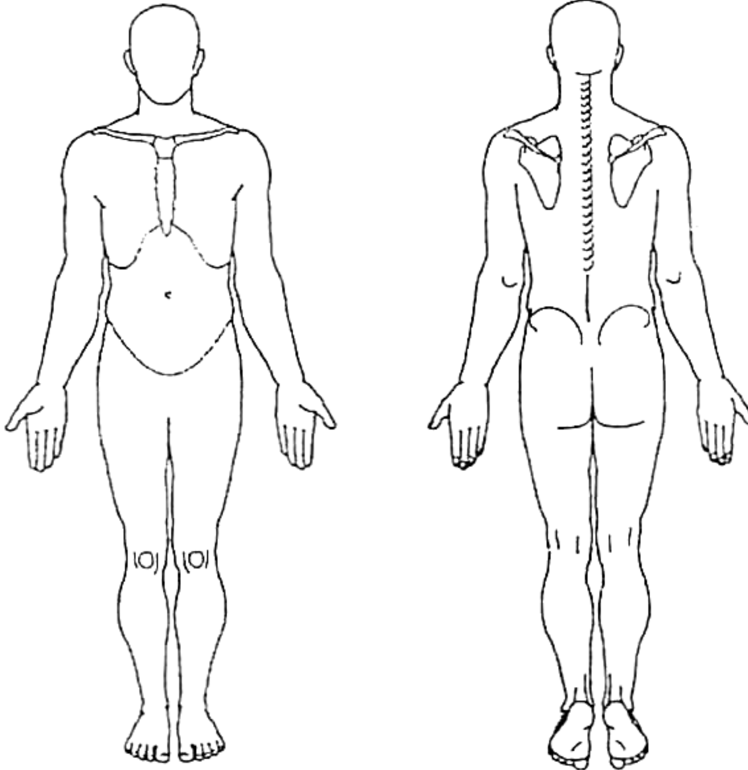
Southern Nevada Pain Center Health Form- Initial Consultation

Name: Date: Referring Physician:
Age:____ Ht:____ Weight:

What is your Chief Complaint?______________________

Please mark on the body diagram where your pain is:



When did the problem begin?_________________
Describe the circumstances related to the onset of pain (accident, injury, illness, surgery):
____
____
If the injury occurred at work, is this a **Worker's Comp** case? Yes No N/A

How is your pain today? "0" is no pain at all, "10" is the worst pain.
Today: 0 1 2 3 4 5 6 7 8 9 10
Daily Average: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain:

Aching	Stabbing	Tender	Nagging
Throbbing	Gnawing	Burning	Numb
Shooting	Sharp	Exhausting	Unbearable

Allergies: List all medications/foods you are allergic to, including reaction from the medication
____

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Medication: List all medication you are currently taking, **include dosage, frequency** and reason:
If you have a **complete** list that we can photocopy, you do not have to complete this section.

Name_______________ Dose:________________Frequency:_______________________________________
Name_______________ Dose:________________Frequency:_______________________________________
Name_______________ Dose:________________Frequency:_______________________________________
Name_______________ Dose:________________Frequency:_______________________________________
Name_______________ Dose:________________Frequency:_______________________________________
Name_______________ Dose:________________Frequency:_______________________________________

Failed Pain Medication: List all medication you have taken, which was ineffective or intolerable due to side effects:

____
____

Previous Therapies:		**Improved**	**No Change**	**Worse**
Physical Therapy	□	□	□	□
Occupational Therapy	□	□	□	□
Aquatic/Pool Therapy	□	□	□	□
Passive Modalities				
(heat, ice U/S, massage)	□	□	□	□
Mobilizations	□	□	□	□
Traction	□	□	□	□
Exercise/aerobic conditioning	□	□	□	□
TENs Unit	□	□	□	□
Chiropractic Services	□	□	□	□
Psychological counseling	□	□	□	□
(for pain management)				
Drug detoxification	□	□	□	□
Acupuncture	□	□	□	□
Bed rest	□	□	□	□
Biofeedback	□	□	□	□
or relaxation therapy				
Interventional Therapies:				
Trigger point injections	□	□	□	□
Epidural injections	□	□	□	□
Facet joint injections	□	□	□	□
Medical branch blocks	□	□	□	□
Selective nerve blocks	□	□	□	□
Spinal Cord stimulation	□	□	□	□
Intrathecal delivery system	□	□	□	□

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Medical History: Please list any medical condition (ie. Asthma, Hypertension, Heart Disease, Cancer)
____
____

Surgical History: List any surgeries or other conditions for which you were hospitalized:
____
____

Psych History: Please list any psychiatric or psychologic issues:
____
____

Social History:
Marital Status: Single Married Divorced Separated Widowed
Education Level: H.S College Vocational
Are you currently working?__________ Last day worked: __/__/____
What is your job title? ____________ Any Work Restrictions? _____________
Do you smoke cigarettes? __________ If yes, how much?
How much alcohol do you drink?__________________________
Do you use illegal substances? Yes No
Have you ever had a problem with substance abuse? Yes No
If yes, which substances were involved?____

Family History:
Is your Father alive? Yes No
What kind of medical problems did/does he have?___________
Is your Mother alive? Yes No
What kind of medical problems did/does she have?___________

Review of Systems: Do you now or have had any problems related to the following symptoms:
□Night Sweats □Fevers □Chills □Pain awakens you □Unexplained weight loss □Chest Pain
□Headaches □Visual Changes □Hearing Loss □Dizziness □Swelling in Legs □Shortness of Breath
□ Cough □Abdominal Pain □Nausea □Vomiting □Heartburn □Constipation □Diarrhea □Incontinence

PATIENT CONSENT FOR NARCOTIC TREATMENT

This is to verify that you are being treated by Southern Nevada Pain Center for an acute or chronic pain condition. In order for Southern Nevada Pain Center to appropriately take care of your pain needs, we require that you read and adhere to our narcotic contract. These policies are intended for the safety of our patients.

BY INITIALING I AGREE TO THE FOLLOWING:

___1. I will receive controlled substance prescriptions from only one physician or designated physician assistant, and one pharmacy when possible
___2. To prevent diversion of controlled substances (such as selling), Southern Nevada pain Center and its designee have the right to urine/serum medication levels screening whenever requested
___3. I certify that I have disclosed to my physician any past diagnoses or treatments of psychiatric conditions, drug or alcohol abuse
___4. I have never been involved in the sale, illegal possession or transport of controlled substances such as narcotic, sleeping pills, pain pills or illegal substances such as marijuana, cocaine, "crack cocaine", methamphetamines, "crystal meth", or heroin.
___5. I agree to allow the physicians and designees at Southern Nevada Pain to communicate with referring physicians, pharmacists and the Drug Enforcement Agency (DEA) regarding my medication.
___6. I certify that I am not pregnant (if applicable), and if I am pregnant, I will notify the physician or the health care provider immediately.
___7. I understand that lost, stolen, or misplaced prescriptions or medication will generally not be replaced. Certain circumstances may be considered, but proof of a police report must be provided and filed
___8. I agree to take my medication(s) as prescribed; I will not alter my dosage or timing of medications without consulting my physician or a provider at Southern Nevada Pain Center.
___9. I agree that while I am being treated with narcotic medication, I will abstain from alcohol use. I understand the dangers involved in consuming alcohol and narcotic medication. I also understand that the narcotic medication may cause drowsiness. If I feel really tired, or impaired, I will not operate a car or potentially dangerous machinery. Substance Abuse, which is defined as use of a controlled substance for non-therapeutic purposes; Addiction, which is defined as a psychological dependence characterized by compulsive use despite harm; Diversion, such as selling the controlled substance;
___10. I understand that any infarction or "break" of the normal routines established for the consumption of the prescriptions, or any suspicious deviation of the aforementioned will result in my being removed from medical treatment and care by the Southern Nevada Pain Center.
___11. I am aware and agree that I will need to make an appointment and be seen by a clinician to receive refills for all prescriptions for controlled substances.

I HAVE READ THIS FORM AND FREELY CONSENT TO PARTICIPATE

____ ____________________

PATIENT SIGNATURE Date

____
Witness Signature

NOTICE OF PRIVATE PRACTICES
SOUTHERN NEVADA PAIN CENTER
6950 WEST DESERT INN ROAD- SUITE 110
LAS VEGAS, NV 89117

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Understanding Your Health record/ Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and plan of future care or treatment. This information, often referred to as your health and medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the may health professionals who contribute to your care
- legal document describing the care you received
- means by which you or your third party payer can verify that services billed were actually provided
- tool for educating healthcare professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can asses an continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why other may access you health information
- make more informed decisions when authorizing disclosures to others

Your health Information Rights

Although you health records is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record a provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information a provided in 45 CFR 164.528
- request communication of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

<u>You have the right to inspect and copy your protected healthcare information</u>

This mean you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses to make decisions for you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have any questions about access to your medical records.

<u>You have a right to request a restriction of your protected health information</u>

You may request that any part of your 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 a specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your health protected information, your health protected information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your health protected information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your physician. You may request a restriction by completing the patient information restriction form.

<u>You have the right to request to receive confidential communications from us by alternative means or at a alternative location.</u>

We will accommodate reasonable request. We may also condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make request in writing to our Privacy Contact.

<u>You may have the right to have your physician amend your health protected information</u>

This means you may request an amendment of health protected information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

<u>You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.</u>

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made for you, for a facility directory, or family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

<u>You have the right to obtain a paper copy of this notice from us upon request even if you have agreed to accept the notice electronically.</u>

Our Responsibilities

Southern Nevada Pain Center is required to:

- maintain the privacy of your health information
- provide you with a notice as tour legal duties and privacy practices with respect to information we collect and maintain on you.
- abide by the terms of the notice
- notify you if we are unable to agree to a request restriction
- accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective from all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied.

We will not use or disclose your health information without your authorization, except as described in this notice.

For more information or to report a Problem

If you have questions or would like additional information, you may contact the privacy officer at 259-5550

If you believe your privacy rights have been violated, you can file a complaint with the privacy officer or with the secretary of Health and Human Services. There will be no retaliation for filling a complaint.

Examples of Disclosures for Treatment, Payment and health Operations

We will use your health information for treatment.

> For example: Information obtained by and nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.
>
> We will provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once your discharged from the hospital

We will use your health information for payment.

> For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use you health information for regular health operations.

> For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health records to assess the care and outcomes in your case and other like it. This information will then be used in a effort to continually improve quality and effectiveness of the healthcare and services we provide.

Business Associates: There may be services provided that are contracted with other business associates. Example- radiologist, pathologist, laboratory, transcriptionist. These persons may have access to some of your personal and health information, but are required as business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, 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 related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws related to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public

PATIENT RIGHTS

The Southern Nevada Pain Center has adopted the following policies concerning Patient's Rights, Responsibilities and Complaint Procedure.

1. Patients have the right to considerate and respectful care.
2. Patients have the right to know by name the physician responsible for coordinating their care. The patient also has the right to know the name of the person responsible for the procedures and/ or treatment provided.
3. Patients have the right to actively participate in decisions regarding medical care and to refuse treatment to the extent permitted by law.
4. Patients have the right to every consideration of their privacy concerning their own medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in the patient's care should have the permission of the patient to be present
5. Patients have the right to expect that all communications and records pertaining to their care should be treated confidential.
6. Patients have the right to expect that within its capacity, the Center should make reasonable response to the request of a patient for service.
7. Patients have the right to obtain information as to the relationship of the center to other health care institutions insofar as their care is concerned.
8. Patients have the right to be advised if the Center proposes to engage in or perform human experimentation affecting their care or treatment. Patients have the right to refuse to participate in such research projects
9. Patients have the right to examine and receive explanation of their bill regardless of source of payment. They also have the right to know the fees for specific services.
10. Patients have the right to know what Center rules and regulations apply to their conduct as a patient
11. Patients have the right to know what provisions the Center has for after hours or emergency care
12. Patients have the right to reasonable response to any request of service.
13. Patients have the right to be informed by the physician or a delegate of the physician of his/her continuing healthcare requirements following his/ her discharge from the Center.
14. Patients have the right to have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

NOTICE OF PRIVATE PRACTICES

SOUTHERN NEVADA PAIN CENTER
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LAS VEGAS, NV 89117

WRITTEN ACKNOWLEDGMENT

I acknowledge that I have received the Notice of Privacy Practices which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

I have also received a copy of the Patient's Bill of Rights.

I give authorization to leave a message on an Answering Machine or with anyone who answers at my phone number. These messages would only be about scheduled appointments or a request for to call the Center.

____________ YES ___________ NO

I also give authorization to the Center to speak with _______________________________________ on my behalf. And to answer any questions he/ she may ask regarding my care

I acknowledge being informed that my physician may have financial interest in Single Day Surgery Center, and if a procedure is scheduled , I may request the procedure be scheduled at a location other than Single Day Surgery Center.

____ ____________________________
Signature of Patient or Legal Representative Witness

____ ____________________________
Date Date

PATIENT INFORMATION

PATIENT NAME (LAST) (FIRST) (M.I)

ADDRESS

CITY STATE ZIP HOME PHONE

DATE OF BIRTH MARITAL STATUS SOCIAL SECURITY #

PATIENT EMPLOYER EMPLOYER ADDRESS

CITY STATE ZIP WORK PHONE

SPOUSE NAME DATE OF BIRTH SOCIAL SECURITY #

SPOUSE ADDRESS CITY STATE ZIP HOME NUMBER

SPOUSE EMPLOYER CITY STATE ZIP WORK NUMBER

PERSON TO CONTACT IN EMERGENCY HOME NUMBER WORK NUMBER RELATIONSHIP

INSURANCE INFORMATION

PRIAMRY INSURANCE PHONE

POLICY HOLDER NAME (LAST) (FIRST) RELATIONSHIP TO PATIENT

POLICY # OR SOCIAL SECURITY # GROUP # DATE OF INJURY

SECONDARY INSURANCE PHONE

POLICY HOLDER NAME (LAST) (FIRST) RELATIONSHIP TO PATIENT

POLICY # OR SOCIAL SECURITY # GROUP # DATE OF INJURY

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless or insurance coverage. A copy of the signature is as valid as the original.

PATIENT SIGNATURE ____ **DATE:** ______________