Patient name: _____ Visit Date: _____

LAS VEGAS PAIN INSTITUTE & MEDICAL CENTER, LLC

INITIAL EVALUATION

HISTORY OF PRESENT ILLNESS:

CHIEF COMPLAINT (please indicate right, left, or both sides):

_____

_____

How did the pain first occur? (Brief summary and approximate date)

_____

_____

_____

Describe the quality of pain you are having (Please Circle)

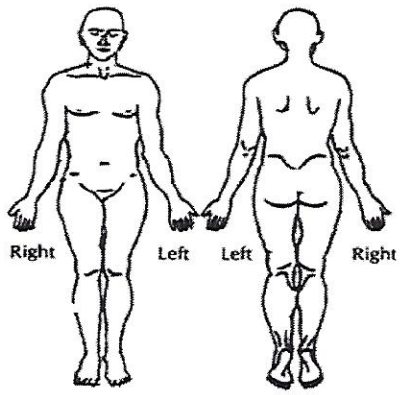
Constant	Electrical	Numbness
Intermittent	Tingling	Deep Ache
Dull Ache	Jabbing	Radiating
Burning	Knife like	Spasm

Describe the areas of discomfort (Use picture below to mark all areas of discomfort)

N = numbness	T = tingling	B = burning
A = ache	O = other	S = severe

Please rate your pain. (0 = no pain, 10 =excruciating)

Current pain: ____ Average pain: _____ Worst pain: ____ Best day: _____



Medical Assistant Initial: _____

Weight: _____ lbs

Height: _____

Blood Pressure: ____/_____

Heart Rate (HR): _____

Patient name: _____ **Visit Date:** _____

(mark all that applies for the following questions)

Timing of pain: □ all day □ in the morning □ in the afternoon □ in the evening □ at night □ at rest

Frequency of pain: □ daily □ weekly □ monthly □ yearly □ increasing □decreasing
□ unchanged

What triggers your pain: □ movements □ cold weather □ laying down □ standing □ sitting
□ bending □ activities

What helps with your pain: □ stretching □ laying down □ massage □ heat □ ice □ elevation □ rest
□ medications

Describe the severity of your pain during the past week:
□ None □ Mild □ Moderate □ Severe

Describe your limitations on daily activities:
□ None □ Moderate □ Unbearable

How often do you take medicine for pain relief:
□ Never □ Seldom □ fairly often □ regularly

What medicines do you take for pain? _____

_____

Current Medications: *(Write **ALL**, including over the counter medications and vitamins)*

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Drug Allergy (if not applicable, please mark □ **No Known Drug Allergies**)

	Allergen name	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Patient name: _____ **Visit Date:** _____

Medical History: *(diabetes, high blood pressure, cancer, thyroid, etc)*

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Surgical History (all types):

	TYPE	DATE
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Accidents/injuries history:

	TYPE	DATE
1.		
2.		
3.		
4.		

Family History *(Other than self, has anyone in your immediate family had any of the following?)*

		Who?	Living?	Deceased/age?
Cancer	□ Yes □ No			
Tuberculosis	□ Yes □ No			
Diabetes	□ Yes □ No			
Heart Attack	□ Yes □ No			
High Blood Pressure	□ Yes □ No			
Stroke	□ Yes □ No			
Seizure	□ Yes □ No			
Asthma/emphysema	□ Yes □ No			
Thyroid disease	□ Yes □ No			
Kidney disease	□ Yes □ No			
Bleeding disorders	□ Yes □ No			
Stomach/duodenal ulcer	□ Yes □ No			
Mental Illness	□ Yes □ No			
Suicide	□ Yes □ No			

Patient name: _____ **Visit Date:** _____

Social History

Marital Status: □ single □ married □ divorced □ separated □ widowed

How many children do you have? _____

Who lives with you? _____

Do you have any family or children that live locally? _____

Who accompanied you to this appointment? _____

Education level: *(check highest grade completed)*

□ Grade School □ High School □ College Degree

Employment: □ Student □ currently Employed □ Unemployed □ Retired □ Disabled (how long) _____

Tobacco history

Do you smoke: □ Yes □ No How many cigarettes per day? _____ How long? _____

If you quit smoking, when did you quit? _____

IV drug abuse? □ Yes □ No How much / how often / type _____

Alcohol History

How much alcohol do you drink on average?

□ None □ ____ drinks per day □ ____ per week □ ___ per month

What radiology services have you had in the last year?

	Body Part	Location (where)	Date (year)
MRI	_____	_____	_____
Cat scan	_____	_____	_____
X-ray	_____	_____	_____
Bone scan	_____	_____	_____
Ultra Sound	_____	_____	_____

Gastrointestinal

How is your appetite? □ Good □ Fair □ Poor

How are your bowel movements? □ Good □ Fair □ Poor

Diarrhea? □ Yes □ No

Constipation? □ Yes □ No

Do you use laxatives? □ Yes □ No

Any bowel or bladder incontinence (uncontrolled)? □ Yes □ No

Patient name: _____ **Visit Date:** _____

Psychiatric

Do you consider yourself: □ Tense □ Nervous □ Depressed □ Suicidal □ none

How many hours of sleep do you get each night? _____

Have you had emotional disturbances in the past? □ Yes □ No

Have you been physically abused? □ Yes □ No If yes, when? _____

Are you under the care of a psychologist? □ Yes □ No If yes, who? _____

Review of Systems: *mark all that applies (If yes, please note date of occurrence)*

		Date			***Date***
Heart Attack	□ Yes □ No		Joint Tenderness / Swelling	□ Yes □ No	
Coronary Artery Disease	□ Yes □ No		Gout	□ Yes □ No	
Heart Valve Problems	□ Yes □ No		Osteoporosis	□ Yes □ No	
High Blood Pressure	□ Yes □ No		Musculoskeletal Trauma	□ Yes □ No	
Irregular Heart Beat	□ Yes □ No		Anemia	□ Yes □ No	
Blood Clot	□ Yes □ No		Bruise Easily	□ Yes □ No	
Stroke	□ Yes □ No		Blood Thinners	□ Yes □ No	
Seizures	□ Yes □ No		Glaucoma / Eye Disease	□ Yes □ No	
Emphysema	□ Yes □ No		Hepatitis (type)	□ Yes □ No	
Asthma	□ Yes □ No		Chronic / Recurrent Infections	□ Yes □ No	
Arthritis	□ Yes □ No		Painful/difficult urination	□ Yes □ No	
Diabetes	□ Yes □ No		Change in Appetite	□ Yes □ No	
Thyroid Condition	□ Yes □ No		Weight loss / gain	□ Yes □ No	
Cancer	□ Yes □ No		Weakness / Fatigue	□ Yes □ No	
Gastrointestinal ulcers	□ Yes □ No		Changes in Coordination	□ Yes □ No	
Acid indigestion/reflux	□ Yes □ No		Drug / Alcohol Use	□ Yes □ No	
Change in bowel habits	□ Yes □ No		Emotional Disturbances	□ Yes □ No	
Hearing Loss	□ Yes □ No		Difficulty sleeping	□ Yes □ No	
Headaches	□ Yes □ No		Nausea	□ Yes □ No	
			Vomiting	□ Yes □ No	

Patient name: _____ **Visit Date:** _____

PHYSICAL THERAPY QUESTIONARE

1. Have you **ever** had physical therapy before? □ Yes □ No
2. Have you had physical therapy prior to or within our facility **this year**?

   □ Yes □ No If yes, name of outside facility: _____
3. Have you ever had **home health** physical therapy? If yes, when? _____
   how long? _____ name of home health? _____
4. Do you exercise regularly □ Yes □ No
5. How often do you exercise? □ None □ Daily □ ____ times a week
6. What type of exercise? □ walking □ running □ other _____
7. Do you have any of the following problems with exercise? □ chest pain □ dizziness
   □ nausea □ shortness of breath

Las Vegas Pain Institute & Medical Center

Las Vegas Office	Centennial Office	Henderson Office	Nellis Office	Sahara Office	Blue Diamond
3835 S. Jones Blvd. Las Vegas, NV 89103 89139	7175 N. Durango Dr. Las Vegas, NV 89149	2705 Horizon Ridge Henderson, NV 89052	1900 N. Nellis Blvd Las Vegas, NV 89115	1050 E. Sahara Rd Las Vegas, NV 89104	8828 Mohawk St. Las Vegas, NV
F: (702) 880-4197	F: (702) 645-4003	F: (702) 492-4719	F: (702) 531-6440	F:(702) 736-1530	F:(702) 586-6728

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PATIENT INFORMATION:

FIRST NAME: _____ LAST NAME: _____

DOB: ____ / ____ /_____ AGE: _____ MARITAL STATUS: _____ SEX: ☐ M ☐ F

SSN: _____ - _____ - _____ HOME #: _____ CELL #: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER TELEPHONE: _____

SPOUSE INFORMATION:

FIRST NAME: _____ LAST NAME: _____

DOB: ____ / ____ /_____ AGE: _____ MARITAL STATUS: _____ SEX: ☐ M ☐ F

SSN: _____ - _____ - _____ HOME #: _____ CELL #: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER TELEPHONE: _____

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PRIMARY INSURANCE:_____ ID:_____

SUBSCRIBER:_____ SS#:_____

SECONDARY INSURANCE:_____ ID:_____

SUBSCRIBER:_____ SS#:_____

TERTIARY INSURANCE:_____ ID:_____

SUBSCRIBER:_____ SS#:_____

EMERGENCY CONTACT NAME:_____

HOME #:_____ CELL #:_____

RELATIONSHIP:_____ ABLE TO MAKE MEDICAL DECISIONS? YES / NO

EMERGENCY CONTACT NAME (2):_____

HOME #:_____ CELL #:_____

RELATIONSHIP:_____ ABLE TO MAKE MEDICAL DECISIONS? YES / NO

PRIMARY CARE PHYSICIAN NAME:_____

PRIMARY CARE ADDRESS:_____

TEL:_____ FAX:_____

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LAS VEGAS INSTITUTE & MEDICAL CENTER OPIOID TREAMENT AGREEMENT

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

1. I understand that I have the following responsibilities:

a. I will take medications only at the dose and frequency prescribed.
b. I will not increase or change medications without the approval of this doctor or his/her colleagues.
c. I will actively participate in return-to-work efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
d. I will not request opioids or any other pain medicine from physicians other than from this doctor.
e. I will inform this doctor of all other medications that I am taking.
f. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement.
g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
h. I agree to participate in psychiatric or psychological assessments, if necessary.
i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following: consultation with an addiction specialist, individual counseling, and inpatient or outpatient treatment

Patient Name (Print) **Date**

Patient Signature **Date**

For the doctor: Keep signed originals in the patient file; give a photocopy to the patient. Renew at least every year.

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MEDICAL RECORDS RELEASE

I, _____ , give permission to release all medical records to Las Vegas Pain Institute & Medical Center.
(Print Name)

_____ _____ _____
Patient's Signature DOB Date

Please fax them to: □ Las Vegas Office □ Henderson Office
□ Nellis Office □ Centennial Office
□ Sahara Office □ Blue Diamond Office

□ Patient in office – **Please rush.**

□ Patient's appointment date and time is _____. *Thank you.*

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PRIVACY NOTICE

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 Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

A "Privacy Notice" is available upon request for your review; just ask the front office staff.

INSURANCE AUTHORIZATION & ASSIGNMENT/FINANCIAL STATEMENT

I hereby authorize Las Vegas Pain Institute to be my treating providers and to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Las Vegas Pain Institute all payments for medical services rendered to me or my dependants. I understand that I am responsible for any amount not covered by insurance.

I understand that all co-pays, deductibles or co-insurance is due at the time of service, no exceptions, unless prior arrangements have been made. I am responsible for providing Las Vegas Pain Institute with correct insurance information. Las Vegas Pain Institute will bill my insurance as a courtesy to me and if my insurance does not pay within 90 days from my dates of service(s), I am aware that I will be billed for the balance and held responsible for the amount in full. I also understand that if I do not satisfy my financial obligation and have an outstanding balance with the clinic, further services to me by Las Vegas Pain Institute will be withheld under such financial obligation is met.

I also understand and agree that if my account must be referred to any third party collections, I will be responsible for any and all costs related to the collection action, including but not limited to, collection agency percentage fees, interest, court costs, and reasonable attorney fees.

IT IS YOUR RESPONSIBILITY AS THE PATIENT TO NOTIFY THE OFFICE OF ANY INSURANCE, PHONE, OR ADDRESS CHANGES IMMEDIATELY TO FACILITATE PROPER BILLING.

I understand the above information and am aware at anytime I may request a full copy of the Privacy Notice for Las Vegas Pain Institute & Medical Center, LLC

_____ _____

Patient Signature **Date**

_____

Patient Name (Please Print)

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APPOINTMENT DISCLOSURE

Due to the growing nature of our practice, we need to make sure that scheduled appointment times are honored. If we book an appointment time for you and you miss it, it takes the time away from someone who could have potentially scheduled in your place. The same applies to cancelling appointments less than 24 hours prior to your appointment time.

Because of this growing problem, we are going to implement a fee to try and minimize on the amount of wasted time and the potential space for another patient.

By signing below, I understand that Las Vegas Pain Institute & Medical Center, LLC, has a missed appointment and cancellation fee in effect. I understand that in the event I miss my appointment or cancel my appointment in less than **24** hours from my appointment time, I will be subject to a **$50.00** fee. I understand that if I am charged this fee, it will be due and payable upon my next appointment.

_____

Patient Name (Print)

_____ _____

Patient Signature Date

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DISCLOSURE AUTHORIZATION FOR INFORMATION REQUESTS

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA),
I _____, hereby authorize the following providers:

_____

_____

to disclose the following protected health information to **Las Vegas Pain Institute & Medical Center.**

- □ Medical history, including specific progress notes regarding any problems that would impact my consult, office visit, surgery or procedure progress or outcome.
- □ A list of allergies.
- □ Results of relevant diagnostic or laboratory tests.
- □ Other _____

This protected health information is being used by this institution for Pain Management treatment provided by Las Vegas Pain Institute & Medical Center. This authorization shall be in force and effective until _____.

I understand that, as set forth in Las Vegas Pain Institute Privacy Notice, I have the right to revoke this authorization, in writing, at anytime by sending the written notification to the above address.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that Las Vegas Pain Institute & Medical Center will not condition my treatment whether I provide authorization for the requested use or disclosure.

I understand that I have the right to

- Inspect or copy my protected health information (at a scheduled time) to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

_____ _____

Patient Signature or Representative Date

_____

Patient Name or Representative (Print)

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PAYMENT OF SERVICES FOR BLUE CROSS BLUE SHEILD MEMBERS:

This letter is to inform all members and patients that have Blue Cross and Blue Shield as their insurance carrier (regardless of it being primary, secondary, or tertiary), that payment of our services may be reimbursed directly to them because we are an out of network provider.

We are disclosing this information to you so that if you receive any payments from your insurance company BCBS for services rendered by our office, you are fully aware that they need to be directed to us for payment on your account. If this does not occur then we will have no choice but to pursue further action in collecting monies due to us.

By signing this notice you as the member/patient has read and understood all the information explained above and agree to submit all monies received by your insurance company for services rendered at Las Vegas Pain Institute & Medical Center, LLC to our office.

If you fail to comply with this notice you understand that you will be made responsible for the entire account balance that was billed to your insurance company. You also understand that if any fees (collection and/or legal) that are accrued because of your failure of compliance, it will also become your responsibility.

If you should have any further questions, please feel free to contact management (702) 880-4193.

Thank you,

Las Vegas Pain Institute & Medical Center, LLC

Patient Name (Print) _____ **Patient Signature** _____ **Date** _____

***If patient is a minor, or if patient is incapable of signing, please complete the following*:**

Guardian Name (Print) _____ Relationship _____ Signature _____

Date: _____