PRIMed
Pain Institute

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name: | Date of Birth: | Age: | Sex: |
| Address: (City, State, Zip) | | | |
| Billing Address: | SSN: | Marital St.atus: | |
| Primary Phone #: | Work Phone #: | Secondary Phone #: | |
| Email: | Employment: Full/Part/None | Employer: | |
| Referring Physician: | Primary Care Physician: | | |
| How did you hear about us? (Referring doctor, friend, family, self referral, internet, magazine, newspaper, advertisement other) | | | |

## EMERGENCY CONTACT INFORMATION

| | |
|---|---|
| Emergency Contact Name: | Cell Phone#: |
| Relationship: | Home Phone #-: |

## INSURANCE INFORMATION

| | |
|---|---|
| Primary Insurance:<br>Copay: | Secondary Insurance:<br>Copay: |
| Certificate#/Policy ID: | Certificate #: |
| Group Number: | Group Number |
| Subscriber Name: | Subscriber Name: |
| Subscriber DOB/Relationship: | Subscriber DOB: |

Please circle the best option listed that describes your race and ethnicity.

| | | |
|---|---|---|
| Race:<br>Asian, Native Hawaiian, Other pacific Islander, Black/African American, American Indian/Alaska Native, White, More than 1 race | Ethnicity:<br>Hispanic/Latino,<br>Not Hispanic/Latino, unreported/refuse to report | Primary Language: |

**Authorization To Pay Benefits To Physician:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my provider when they accept assignment.

**Authorization To Release Medical Information:** I hereby authorize my Provider to release any information necessary for my course of treatment.

**I certify that the above information is correct as of the date signed.**

_____ _____

Signed (patient of parent if minor) Date

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Date: _____ Referral Source: _____
**NAME:** _____ Date of Birth: _____ Age: _____
Name patient prefers to be called: _____ Primary Care Physician: _____
Primary Language: _____

## PAIN HISTORY

When did your pain first begin (date)? _____
In what part of your body did the pain begin? _____
Under what circumstances did the pain begin?

- ☐ Accident at work
- ☐ Accident at home
- ☐ Following Surgery
- ☐ Pain just began
- ☐ At work, but not an accident
- ☐ Auto Accident
- ☐ Following an illness
- ☐ Other: _____

Briefly describe the circumstance(s) you checked: _____
_____
_____

Are you in litigation because of your pain or injury? ☐ Yes ☐ No

Expectations from the Pain Clinic: _____
_____

## PAIN INTENSITY

Please mark your pain level at present time

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | Moderate | | | | | Worst Possible |

Which of the following best describes your usual level of pain?

__Mild __Uncomfortable __Distressing/Severe __Very Severe __Unbearable

Please rate your pain intensity on a scale from 0=no pain to 10= excruciating, worst pain possible.

Write the number in the spaces below:

A. Describes your pain at its worst: _____
B. Describes your pain at its least: _____
C. Describes your pain on the average: _____

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## QUALITY OF PAIN

Please describe your pain. (check all that apply)

| | | |
|---|---|---|
| ☐ Pricking | ☐ Throbbing | ☐ Dull |
| ☐ Aching | ☐ Sharp/Stabbing | ☐ Pulling |
| ☐ Burning | ☐ Numbness/Tingling | ☐ Shooting |
| ☐ Gnawing | ☐ Other: _____ | |

Please check what makes your pain feel:

***Worse***

- ☐ Walking
- ☐ Lifting
- ☐ Bending
- ☐ Lying
- ☐ Weather/Temp changes
- ☐ Standing
- ☐ Sitting
- ☐ Other: _____

***Better***

- ☐ Heat
- ☐ Ice
- ☐ Rest
- ☐ Lying
- ☐ Weather/Temp changes
- ☐ Standing
- ☐ Sitting
- ☐ Medication:
- ☐ Other: _____

## LIFESTYLE CHANGES

During the past month how much did pain interfere with the following activities? (Circle the number for each of the questions that best describes your situation.)

| | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|---|
| Going to work | 1 | 2 | 3 | 4 | 5 |
| Performing household chores | 1 | 2 | 3 | 4 | 5 |
| Yard work or shopping | 1 | 2 | 3 | 4 | 5 |
| Socializing with friends | 1 | 2 | 3 | 4 | 5 |
| Recreation & Hobbies | 1 | 2 | 3 | 4 | 5 |
| Having sexual relations | 1 | 2 | 3 | 4 | 5 |
| Physical exercise | 1 | 2 | 3 | 4 | 5 |
| Sleep | 1 | 2 | 3 | 4 | 5 |
| Appetite | 1 | 2 | 3 | 4 | 5 |

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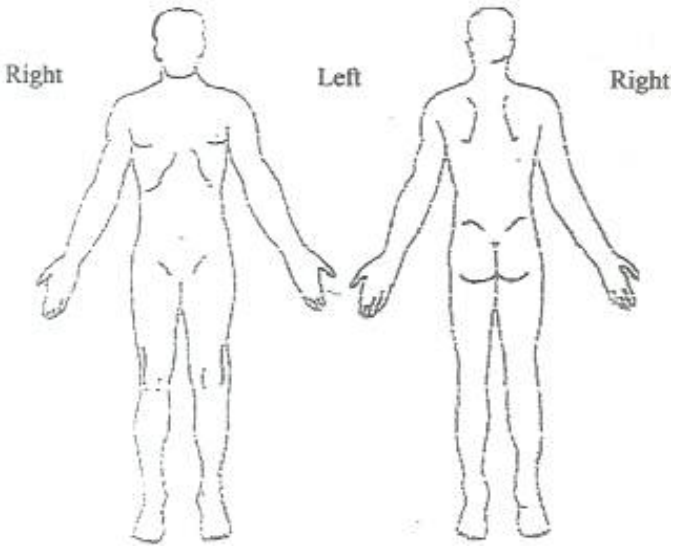
**PAIN DIAGRAM**

Please mark the location(s) of your pain on the diagrams with an "x". If whole areas are painful, please shade in the painful area.




**PRIOR TREATMENTS**

| (Check all that apply) | Helpful | Not Helpful |
|---|---|---|
| ☐ Surgery | ☐ | ☐ |
| ☐ Nerve Blocks | ☐ | ☐ |
| ☐ TENS/MENS | ☐ | ☐ |
| ☐ Physical Therapy | ☐ | ☐ |
| ☐ Occupational Therapy | ☐ | ☐ |
| ☐ Biofeedback/Relaxation Therapy | ☐ | ☐ |
| ☐ Psychological Support | ☐ | ☐ |
| ☐ Other: _____ | ☐ | ☐ |

**PSYCHOSOCIAL/PSYCHOLOGICAL**

Residence: ☐ Live Alone ☐ Live with: _____Steps to climb (#):_____

Significant other: _____ Relationship:_____

Do you take care of other family members (parents, children): ☐ Yes ☐ No

Do you have caps, false teeth, or contact lenses? ☐ No ☐ Yes, Please specify: _____

Previous/Current Occupation: _____

Are you currently working? ☐ Yes ☐ No If no, why not? _____

Tobacco use? ☐ No ☐ In the Past, Year Quit_____, Per Day: ____ #years: _____

☐ Yes, Per Day: ____ #years: _____

Recreational drug use? ☐ Yes ☐ No

Alcohol use? ☐ No ☐ Yes, How much Beer/Wine/Liquor per week: _____

During the past month have you been tense or anxious?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

During the past month have you been depressed or discouraged?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

During the past month have you been irritable and upset?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

When you are in pain, how often is your husband/wife/other family supportive or encouraging?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

When you are in pain, how often is your husband/wife/other family ignore you or become angry?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

## FAMILY HISTORY

(Specify whom if applicable) ☐ Adopted

☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Cancer _____

☐ Diabetes _____ ☐ Alzheimer's _____ ☐ Migraine _____

☐ Mental Illness _____ ☐ Stroke _____ ☐ Other _____

## MEDICAL HISTORY

Do you now have or have you ever had any of the following medical conditions?

| | | | | | | |
|---|---|---|---|---|---|---|
| General: | ☐ None | ☐ Weight Loss | ☐ Fever | | | |
| HEENT: | ☐ None | ☐ Headache | ☐ Migraines | ☐ Blurred Vision | ☐ Double Vision | |
| | | ☐ Glaucoma | ☐ Sinusitis | ☐ Other | | |
| Cardiovascular: | ☐ None | ☐ Hypertension | ☐ Chest Pain | ☐ Palpitations | ☐ Shortness of Breath | |
| | | ☐ Heart Attack | ☐ Murmur | ☐ Pacemaker | ☐ Mitral Valve Prolapse | |
| | | ☐ Circulation Problems | | ☐ Other | | |
| Respiratory: | ☐ None | ☐ COPD | ☐ Asthma | ☐ Cough | | |
| GI: | ☐ None | ☐ Ulcers | ☐ Hiatal Hernia | ☐ Irritable Bowel | ☐ GI Bleeding | |
| GU: | ☐ None | ☐ Renal Failure | | | | |
| Blood: | ☐ None | ☐ Transfusions | ☐ Fatigue | ☐ Bleeding Disorder | | |
| Endocrine: | ☐ None | ☐ Diabetes | ☐ Thyroid Disorder | | | |
| Infectious: | ☐ None | ☐ HIV | ☐ Hepatitis | ☐ Herpes Zoster/Shingles | | |
| Neuropsychiatry: | ☐ None | ☐ Blackouts/Falls | ☐ Seizure Disorder | ☐ Weakness | ☐ Other | |
| Musculoskeletal: | ☐ None | ☐ Osteoarthritis | ☐ Rheumatoid Arthritis | ☐ Osteoporosis | | |
| Neoplastic: | ☐ None | ☐ Cancer (specify): _____ | | ☐ Radiation Therapy | | |

| Surgeries | Date | Surgeries | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you have any medical implanted in your body? ☐ No ☐ Yes, Specify: _____

**ALLERGIES**

☐ None
☐ Penicillin ☐ Sulfa ☐ Latex ☐ Codeine
☐ Shell Fish ☐ Iodine ☐ Contrast Dye
☐ Other: _____

| Current Medications | Dose | Frequency | Date Started | Effective (Pain Meds) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are you currently taking ***COUMADIN, PLAVIX*** or any other ***BLOOD THINNERS***?
☐ Yes ☐ No

Are you afraid of becoming addicted to your medications? ☐ Yes ☐ No

**DIAGNOSTIC TESTS**

| | Date |
|---|---|
| MRI | _____ |
| CT | _____ |
| X-Ray | _____ |
| EMG | _____ |
| Other | _____ |

PRIMed Pain Institute

**STATE OF NEVADA**

**COMMUNICABLE DISEASE / TUBERCULOSIS SCREENING QUESTIONNAIRE**

| | | | |
|---|---|---|---|
| **COMMUNICABLE DISEASE SCREENING** | | | |
| **Are you experiencing any of the following symptoms?** | | | |
| ○ Yes | ○ No | 1. Sore throat | |
| ○ Yes | ○ No | 2. Rash / sores on skin | |
| ○ Yes | ○ No | 3. Cold sore | |
| ○ Yes | ○ No | 4. Fever and rash | |
| ○ Yes | ○ No | 5. Fever and respiratory symptoms – cough, runny nose | |
| ○ Yes | ○ No | 6. Drainage from eyes, ears | |
| ○ Yes | ○ No | 7. Skin lesion, cyst, boil | |
| ○ Yes | ○ No | 8. Nausea, vomiting | |
| ○ Yes | ○ No | 9. Diarrhea | |
| ○ Yes | ○ No | 10. Cough lasting more than three weeks | |
| ○ Yes | ○ No | 11. Swollen glands | |
| ○ Yes | ○ No | 12. Non healing wound | |
| ○ Yes | ○ No | 13. Returned from travel in another country within the last month | |
| **Have you ever been told by a physician or other health care provider that you have any of the following conditions?** | | | |
| ○ Yes | ○ No | 14. Hepatitis A, B, or C | |
| ○ Yes | ○ No | 15. Tuberculosis | |
| ○ Yes | ○ No | 16. HIV / AIDS | |
| **TUBERCULOSIS (TB) SCREENING** | | | |
| **Are you experiencing any of the following symptoms?** | | | |
| ○ Yes | ○ No | 17. Persistent coughing | |
| ○ Yes | ○ No | 18. Coughing up blood | |
| ○ Yes | ○ No | 19. Night sweats | |
| ○ Yes | ○ No | 20. Unexplained tiredness | |
| ○ Yes | ○ No | 21. Fever recurring | |
| ○ Yes | ○ No | 22. Unexplained weight loss | |
| ○ Yes | ○ No | 23. Positive for TB – either skin test or blood test | |
| ○ Yes | ○ No | 24. Have you ever been told by a health care provider that you have had active TB? | |
| ○ Yes | ○ No | 25. Have you ever cared for or lived with anyone diagnosed with active TB? | |
| ○ Yes | ○ No | 26. Have you worked or volunteered in a setting where TB may be more common, e.g., homeless shelter, nursing home, group home, prison? | |
| | | | |
| **I acknowledge that the above information is true and correct to the best of my knowledge.** | | | |
| **SIGNATURE** – *Patient Completing Form:* | | **Date Signed** *(MM/DD/YYYY):* | |
| _____ | | _____ | |

PRIMed Pain Institute

Date _____

Patient Name _____

# OPIOID RISK TOOL

| | | Mark each box that applies | Item Score If Female | Item Score If Male |
|---|---|---|---|---|
| **1. Family History of Substance Abuse** | Alcohol | [ ] | 1 | 3 |
| | Illegal Drugs | [ ] | 2 | 3 |
| | Prescription Drugs | [ ] | 4 | 4 |
| **2. Personal History of Substance Abuse** | Alcohol | [ ] | 3 | 3 |
| | Illegal Drugs | [ ] | 4 | 4 |
| | Prescription Drugs | [ ] | 5 | 5 |
| **3. Age** (Mark box if 16 – 45) | | [ ] | 1 | 1 |
| **4. History of Preadolescent Sexual Abuse** | | [ ] | 3 | 0 |
| **5. Psychological Disease** | Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia | [ ] | 2 | 2 |
| | Depression | [ ] | 1 | 1 |
| | **TOTAL** | | _____ | _____ |

**Total Score Risk Category**
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.

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# CONSENT FOR OPIOID THERAPY

Providers at PriMMed are prescribing opioid medication to me for treatment of _____.

I am being started on opioids because other modalities have failed.

I am aware that the use of opioids has certain side effects associated with it. These include:

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Vomiting
- Sleepiness or drowsiness
- Aggravation of depression
- Itching
- Dizziness
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – overdose can stop your breathing and lead to death
- Dry mouth, which can lead to loss of teeth

**These side effects may be made worse if you mix opioids with other drugs, including alcohol.**

I am aware that the use of opioids has certain safety risks associated with it. These include:

- Slowing of reflexes or reaction time
- Clouded judgment, Drowsiness
- Physical dependence
- Tolerance to analgesia
- Addiction
- Possibility that the medication will not provide substantial pain relief
- The danger associated with the use of opioids while operating heavy equipment or driving

**These effects may be made worse if you mix opioids with other drugs, including alcohol.**

I have been made aware of alternative therapies available which do not involve opioids. Other treatments discussed include:

☐ Physical Therapy
☐ Non-opioid Medications
☐ _____
☐ Acupuncture
☐ Interventional Procedures

I will inform my doctor about all other medications and treatments that I am receiving.

I will not engage in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for themselves.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that there is a chance of becoming addicted to my pain medicine. I am aware that the development of addiction has been reported in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal consequence of using opioids for a long period of time. I

understand that physical dependence is different than addiction. I am aware physical dependence means that if my pain medications use is markedly decreased or stopped, I will experience withdrawal symptoms. Withdrawal symptoms include:

- Runny nose
- Yawning
- Large pupils
- Goose bumps
- Abdominal pain and cramping
- Diarrhea
- Irritability/Nervousness
- Body aches/Flu-like symptoms
- Rapid heart rate
- Difficulty sleeping for several days
- Sweating

I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that I can also develop psychological dependence on opioids. This means it is possible that stopping the drug will cause me to miss or crave it.

I am aware that tolerance to opioids means that I may require more medication to get the same amount of pain relief. With tolerance, increasing the doses of opioids may not help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my provider to choose another form of treatment.

(**With Male Patients**) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my provider may check my blood to see if my testosterone level is normal.

(**With Female Patients**) If I plan to become pregnant or believe that I have become pregnant while taking opioids, I will immediately call my obstetrician and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent on opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on opioids and there is always the possibility that my child will have a birth defect while I am taking an opioid.

**Tips for managing medications:**

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side affects you may be having
- Use of a medication box that is already divided into the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time

I have read this form and understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient signature _____ Date _____

Witness to above _____ Date _____

# CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. These drugs have potential for abuse or diversion, thus strict accountability is required. The long-term use of opioids, benzodiazepines, and barbiturates is controversial because of the uncertainty regarding their long-term efficacy.

This agreement relates to my use of controlled substances for chronic pain prescribed by a provider at PRIMMED Pain Institute. I have been informed and understand the policies regarding the use of controlled substances that are followed by the staff at PRIMMED Pain Institute. I understand that I will be provided controlled substances while actively participating in this program only if I adhere to the following conditions:

(**Initial every item**)

1. I will use the substances only as directed by the PRIMMED providers. _____
2. I will not receive replacement medications for any medications which I have lost or have been stolen. _____
3. I will receive controlled substances only from the PRIMMED. Information that I have received controlled substances outside the PRIMMED Clinic will lead to discontinuation of treatment. _____
4. I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out. _____
5. I agree to schedule and keep scheduled follow-up appointments with my provider at PRIMMED at recommended intervals. I understand that failure to keep appointments may lead to discontinuation of treatment. _____
6. If it appears to the provider that there are no significant benefits to my daily function or any improvement in my quality of life from the controlled substance, I will gradually reduce my medication as directed by the prescribing provider. _____
7. I will not use any illegal controlled substances, including cocaine, heroin, etc. _____
8. I agree to partake in urine and blood screens to detect the use of non-prescribed medications (including "street" drugs) at any time. _____
9. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy and behavioral medicine strategies. I also recognize that my active involvement in the management of my pain is extremely important. I agree to actively participate in all aspects of the Pain Management Program to maximize functioning and improve coping with my condition. _____

(OVER)

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10. I am responsible for keeping track of the amount of medication left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications. * _____
11. I agree to use one pharmacy for filling all my prescriptions except in case of emergency.
12. I will participate in the monthly prescription program if my provider deems it appropriate. ** _____
13. If I violate any of the above conditions, my obtaining prescriptions and/or treatment at PRIMMED may be terminated. _____
14. If the violation involves obtaining controlled substances or any prescription for my pain condition from another individual or if I engage in any illegal activity such as altering a prescription, I understand that the incident may be reported by my provider to other physicians caring for me, local medical facilities, pharmacies and other authorities such as the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the situation. _____
15. I will not share, sell, or trade my medications with anyone. _____

***MEDICATION REFILL INFORMATION:***

A. **Advance notice of <u>2-3 business days</u> is required for refills of prescriptions.**
B. Requests for scheduled refills must be telephoned only during regular office hours Monday - Friday (9:00 a.m. - 5:00 p.m.). Refills will not be made at night, on holidays, or on weekends.
C. Controlled substances such as opioids and benzodiazepines **WILL NOT** be telephoned in to a pharmacy. You must make an appointment to be seen.

***MONTHLY PRESCRIPTION PROGRAM:***

A. I will be given a thirty (30) day supply each month.

**THIS AGREEMENT WILL SUPERSEDE ALL OTHER AGREEMENTS.**

**BY SIGNING BELOW, I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE ABOVE AGREEMENT. I HAVE RECEIVED A COPY OF THIS FOR MY OWN RECORDS.**

| | |
|---|---|
| _____ | _____ |
| **Patient** | **Date** |
| _____ | _____ |
| **Physician/Provider** | **Date** |
| _____ | _____ |
| **Witness** | **Date** |

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I have received the following documents and have been provided an opportunity to review them. If I have any questions I can call (702)798-0111 and speak to an office representative.

- **Office Policies**
- **Insurance/Billing Policy**
- **Statement of Confidentiality & Record of Disclosures**
- **Notice of Privacy Policies**

**Patient Name:** _____
**Printed**

**Patient Signature:** _____ **Date:** _____

**Witnessed by:** _____ **Date:** _____

PRIMed Pain Institute

# OFFICE POLICIES

## 1. Appointments

- **Patients must call 3 business days prior to scheduling their office visit**
- **Patients that arrive 15 minutes after scheduled appointment will be rescheduled to a later appointment time or date.**
- **Cancellation of appointments must be done at least 24 hours prior to appointment time.**
- **Follow-up noncompliance: repeated cancellations or 3 "no-show" incidents will result in an evaluation with management and provider regarding continued care at our clinic.**

## 2. Prescriptions

- **Please arrange to pick up any prescription refills 3 business days after your request has been submitted**
  - Such refills may be retrieved by an immediate family member over the age of 18, with valid I.D.
- **Prescription requests WILL NOT be refilled early**
- **Prescription documents can be obtained from our office between the hours of 9am-3pm**

## 3. Standard Operating Protocols

- **You are required to be evaluated by a provider in order to obtain a medical leave form.**
  - Allow 7-10 days for processing
- **All patient phone calls are important to us. Each message/concern will be addressed within 24hrs.**
- **Co-pays and deductibles MUST be paid at time of service.**
- **Please respect others by keeping cell phone conversations in the waiting room to a minimum.**

PRIMed Pain Institute

## ***PRIVACY DISCLOSURE***

*Our office staff strives to protect your rights and privacy regarding your medical records. Please be advised that your medical records will be released to insurance companies for payment of services, as well as any other medical agency or health care provider involved in your treatment and care.*

*Information that may be disclosed include: physician notes, diagnostic testing, surgical procedures, diagnosis, medication lists, correspondence, insurance information, and patient identification information.*

**Patient Signature:** _____ **Date:** _____

**Witnessed by:** _____ **Date:** _____

## TO ALL PATIENTS: INSURANCE/BILLING POLICY

This office will bill your primary and secondary insurance carriers as a courtesy to you, our patient. Please be aware that any discrepancies you may feel are in the payments from your insurance companies are between you, the patient, and the insurance carrier – not this office. Full and final responsibility for the expenses incurred in this office fall ultimately with you, the patient. Prior authorization will be obtained from your insurance carrier, but be advised that prior authorization does not guarantee payment from your insurance carrier. It is the sole responsibility of the patient to ensure that payment is made, and we appreciate your follow up with your insurance company to respond to our billing in a timely manner. Should 60 days pass without payment from your insurance carrier, the responsibility for payment in full will be transferred to you – the patient.

In addition, should your treatment at this office require injections and the use of other surgical centers, be advised that you will receive separate billings as the surgical center and doctor's office are two entirely separate entities. Should you have any questions regarding your doctor's bill the number to call for a billing representative is (877) 386-9728.

**Patient Signature:** _____ **Date:** _____

**Witnessed by:** _____ **Date:** _____

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# STATEMENT OF CONFIDENTIALITY

I understand that I am to consider all information regarding patient care and welfare, including the presence of other patients at PriMMed as privileged and confidential information.

I am committed to protect the privacy of other patients and will not release information of a confidential nature to other individuals.

I agree and acknowledge that I will be under the supervision and direction of PriMMed's staff at all times when I am in the office. I agree to abide by and comply with all directives given to me by such staff.

I agree and acknowledge that I am at PriMMed at my own risk and release the staff of said entity from any liability or claims related to my presence.

**Patient Signature:** _____ **Date:** _____

**Witnessed by:** _____ **Date:** _____

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# PATIENT RECORD OF DISCLOSURES

*In general, the HIPPA privacy rule gives individuals the right to request a restriction on users and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the home address.*

## I wish to be contacted in the following manner (check all that apply):

__ Home/work telephone_____

__ Please leave a message with detailed information

__ Leave a message with call back number only

__ Mail to my home/work/office

**Patient Signature:** _____ **Date:** _____

**Witnessed by:** _____ **Date:** _____

# NOTICE OF PRIVACY PRACTICES

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

### 1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you

about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

## 2. OUR LEGAL DUTY

**The Law Requires Us To:**

a. Keep your medical information private.
b. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
c. Follow the terms of the notice that is now in effect.

**We Have The Right To:**

a. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
b. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

**Notice of Change to Privacy Practices**

Before we make any important changes in our policy practices, we will change this notice and make the new notice available upon request.

## 3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by requesting it in writing.

- **For Treatment:** We may use your personal medical information to provide you with medical treatment or services. This information may be shared with doctors, nurses, technicians, medical students, or other healthcare professionals involved with your care. We may also share your medical information with healthcare providers to assist them in treating you.
- **For Payment:** We may use and disclose your medical information for payment purposes.
- **For Healthcare Operations:** We may use and disclose your medical information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditations, certificates, licenses and credentials we need to serve you.

**In addition to using and disclosing your medical information for treatment, payment, and healthcare operations, we may use and disclose medical information for the following purposes:**

- **Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, location in our facility, and your condition described in general terms.
- **Notification:** Medical information to notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of an emergency or if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.
- **Disaster Relief:** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.
- **Research in Limited Circumstances:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal established protocols to ensure the privacy of medical information.
- **Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties: we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
- **Specialized Government Functions:** Subject to certain requirements we may disclose or use health information for military personnel and veterans, for national security, and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
- **Court Orders/Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
- **Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug

Administration (FDA) for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the FDA. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting/spreading a disease or condition.

- **Victims of Abuse, Neglect, or Domestic Violence:** We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health, safety, or the health and safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
- **Workers' Compensation:** We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.
- **Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, criminal investigations, or proceedings, inspections, licensure, or disciplinary actions and other authorized activities.
- **Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances, some required by law, include: reporting of certain types of wounds, pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims or crimes at the request of a law enforcement official reporting death, crimes on our premises and crimes in emergencies.

## 4. YOUR INDIVIDUAL RIGHTS:

You can view or get copies of your medical information. You may also request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. The request must be in writing and the form is obtainable by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, there is $0.60 charge for each page, and postage will be added if you wish the copies to be mailed. Inquire with medical records for a full explanation of our fee structure.

You have the right to:

**a.** Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and healthcare operations and other specified exceptions.

**b.** Request that we place any additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).

**c.** Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

**d.** Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

**e.** If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to our office.

## QUESTIONS AND COMPLAINTS:

If you have any questions about this notice or if you feel we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIMed
Pain Institute

# CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other patients.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$25.00** cancellation fee. Procedure cancellations require 3 business day notice, without notification they will be subject to a **$100.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as "**NO-SHOW"**. Patients who "No-Show" two (2) or more times in a 12-month period, may be dismissed from the practice; thus they will be denied any future appointments. Patients will be subject to **a $25.00 fee for office appointment "No Show" and $100.00 procedure "No Show" fee.**

Patients who arrive more than 15 minutes beyond their scheduled arrival time will be charged a **$25.00 rescheduling fee for office appointments** and **$100.00 for procedure appointments**.

The "Cancellation" and "No Show" fees are the **sole responsibility** of the patient. This fee is **not covered** by insurance, and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but **only with management approval**.

Our practice firmly believes that good physician/patient relationship is based upon understanding and effective communication. Questions about cancellation and no-show fees should be directed to the Billing Department (702)798-0111 ext 107.

**Please sign that you *have read, understand and agree* to this Cancellation and No-Show Policy.**

**Patient Name (Please Print) _____ Date of birth_____**

_____ _____

**Signature** **Date**

PRIMed
Pain Institute

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

| I hereby authorize: | To release to: |
|---|---|
| PriMMed<br>5741 S. Fort Apache, Suite<br>Las Vegas, Nevada 89148<br>ph: (702) 798-0111<br>fax: (844) 247-3481 | _____<br>_____<br>_____<br>_____ |

| I hereby authorize: | To release to: |
|---|---|
| _____<br>_____<br>_____<br>_____<br>_____ | PriMMed<br>5741 S. Fort Apache, Suite 120<br>Las Vegas, NV 89148<br>ph: (702) 798-0111<br>fax: (844) 247-3481 |

I request and authorize the above-named health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released may include information regarding the following condition(s) which may be protected by Federal Law, Drug/Alcohol Abuse, Mental Health Problems, Sickle Cell Anemia, HIV/AIDS Infection, Sexually Transmitted Diseases.

INFORMATION TO BE RELEASED:

Dates of Service: _____

- o All chart records
- o Consultation(s)
- o Operative Report(s)
- o Pathology Report(s)
- o Radiology Report(s)
- o Laboratory Reports(s)
- o Billing Information
- o Other (specify)_____

FOR THE PURPOSE OF:

- o Further Medical Treatment
- o Moving/Relocation
- o At the request of the individual
- o Insurance claims
- o Attorney/Court Case
- o Change Physicians
- o Other (specify): _____

Confidential Notice: The documents accompanying this release contain confidential information belonging to the sender. This information is legally privileged and intended for the use of the individual named above, if you are not the intended recipient, please notify the sender and dispose of the information received. Use of this protected information by anyone other than the recipient is strictly prohibited. This request will expire 90 days from signature date.

_____ _____

**Signature of Applicant** **Date**