9920 West Cheyenne Ave., Ste. 110, Las Vegas, NV 89129
9065 S. Pecos Rd., Ste. 230, Henderson, NV 89074
501 S. Rancho Dr., Ste. G-44, Las Vegas, NV 89106

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

Dear Patient,

It is important that you arrive on time to your appointment to meet with the physician. You will be rescheduled if you do not arrive on time.

Please print out and complete all of this paperwork prior to your appointment and bring it with you. Also bring the following:

- **All of your pertinent medical records (unless the referring doctor has already faxed them to our office)**
- **MRI, X-Ray or CT-scans films**
- **Picture identification**
- **Health insurance card**
- **All medication prescription bottles you are currently taking.**
- **Come prepared to pay your co-pay or deductible when you check in to our office. You are responsible for the co-pays as required by your insurance company. Copays are collected at check-in before you are seen.**

Please understand that if your paperwork is not complete or if you are not on time for your appointment, you may be rescheduled.

For directions to our office, please visit our website at **painfreenevada.com**.

If you have any questions, feel free to contact our office at **(702) 316-2281.**

Sincerely,

Innovative Pain Care Center

Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

REGISTRATION FORM

PATIENT INFORMATION

Date	Referring Physician			
☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last Name	First Name		MI
Birth Date	Age	SS#	Gender ☐ M ☐ F	

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Street Address

City	State	Zip

Phone	Cell

Preferred means of contact ☐ Call ☐ Text ☐ Email:

May we leave a voice mail? ☐ Yes ☐ No

Can we leave a message with family member/someone else? ☐ Yes ☐ No

EMPLOYMENT INFORMATION

Employer	Cell

Street Address

City	State	Zip

INSURANCE INFORMATION

Primary Insurance	Policy Start Date	
Member/Policy#	Group Name/Number	
Policyholder’s Name	SS#	DOB
Policyholder’s Employer	Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Secondary Insurance	Policy Start Date	
Member/Policy#	Group Name/Number	
Policyholder’s Name	SS#	DOB
Policyholder’s Employer	Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other	

IN CASE OF EMERGENCY

Name	Relation to Patient	Phone

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

ASSIGNMENT AND RELEASE

I understand that any and all fees incurred for medical treatment are my total and ultimate responsibility, regardless of any insurance I may have. It is ultimately my responsibility to know the guidelines of my insurance coverage. In the event that my insurance does not provide benefits or provides reduced benefits and/or I do not provide my insurance company needed information in a timely manner, I will be financially responsible to pay up to the agreed upon fee schedule.

I agree to pay for all services rendered. If a collection agency's services are required, I further agree to pay collection agency fees (35%) and interest at the rate of 1.5% monthly or 18% annually until the debt is paid. I further agree to pay for all legal fees, court costs and reasonable attorney fees associated with collecting any outstanding debt. There will be a $75.00 fee (per incident) added to my bill for redeposit or returned checks.

I, the undersigned, assign directly to **Innovative Pain Care Center**, medical benefits, if any, from my insurance carrier that would otherwise be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and/or further medical treatments. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________________ ______________________

Patient or Responsible Party Signature **Date**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

NOTE: ALL SECTIONS MUST BE COMPLETED PRIOR TO SEEING THE PHYSICIAN. PLEASE WRITE YOUR NAME ON EACH PAGE IN THE SPACE PROVIDED.

Patient Name ____ Date ________________

DOB ______________ Age _______ Occupation ______________________________________

INITIAL PAIN ASSESSMENT

Answering the following questions will help your physician better understand and treat your pain.

Are you currently on WORKER'S COMPENSATION? ☐ Yes ☐ No

Is your condition related to a MOTOR VEHICLE ACCIDENT (MVA)? ☐ Yes ☐ No

Is your condition related to any OTHER ACCIDENT/INJURY? ☐ Yes ☐ No

Do you have an attorney for any legal issues regarding your condition? ☐ Yes ☐ No

Are your medical expenses currently on an attorney lien? ☐ Yes ☐ No

Do you have any disability claim regarding your pain problem? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No ☐ N/A

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current job and is this a physically demanding job or sedentary?

____

If not employed, then what is your work status?

☐ Unemployed ☐ Retired ☐ Disabled ☐ Homemaker

Since what date ___________________________________

Chief Complaint (The reason you are here):

____

____

Please check one: ☐ Right Handed ☐ Left Handed

When your pain started (Date) ________________ (If work related this will be your date of injury or accident.)

What do you think caused your pain? How did your pain start? ________________________________

____

Has your pain increased, decreased, or stayed the same in severity since it started?

____

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

Check all the words that describe your pain.

☐ Aching ☐ Burning ☐ Sharp ☐ Pins/Needles ☐ Stabbing ☐ Penetrating
☐ Throbbing ☐ Numbness ☐ Pressure ☐ Shooting ☐ Gnawing ☐ Tiring
☐ Tender ☐ Nagging ☐ Intermittent ☐ Continuous ☐ Others: ________________

CERVICAL (neck, shoulder or arm pain)

Do you have pain in your neck, shoulder(s) or arms? ☐ Yes ☐ No

If so, how does the pain in your arms compare to the pain in your neck? Check the phrase that applies.

The pain in my **arm(s)** is ☐ **worse than** ☐ **the same as** ☐ **less than** the pain in my neck.

Please divide your cervical pain for a total of 100%: Neck Pain ____% Arm Pain ____%

LUMBAR (back, hip or leg pain)

Do you have pain in your back, hip(s) or leg(s)? ☐ Yes ☐ No

If so, how does the pain in your legs compare to the pain in your back? Check the phrase that applies.

The pain in my **leg(s)** is ☐ **worse than** ☐ **the same as** ☐ **less than** the pain in my back.

Please divide your lumbar pain for a total of 100%: Back Pain ____% Leg Pain ____%

****Please clarify your pain level, whether it is for the neck or back****

Check the number that best describes your pain **ON AVERAGE**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

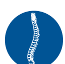
Check the number that best describes your pain **AT ITS WORST**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

Check the number that best describes your pain **AT ITS BEST**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

____ ______________________
Patient Name **Date**



Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

Check the most appropriate answer for each **daily function**. Only check one answer for each question.

How long can you **sit**?	☐ < 15 min	☐ 15-30 min	☐ 30-45 min	☐ 1-2 hrs	☐ 2-4 hrs	☐ > 4 hours
How long can you **stand**?	☐ < 15 min	☐ 15-30 min	☐ 30-45 min	☐ 1-2 hrs	☐ 2-4 hrs	☐ > 4 hours
How long can you **ride in a car**?	☐ < 15 min	☐ 15-30 min	☐ 30-45 min	☐ 1-2 hrs	☐ 2-4 hrs	☐ > 4 hours
How far can you **walk**?	☐ < 1 block	☐ 1 block	☐ 1-2 blocks	☐ 2-3 blocks	☐ 3-4 blocks	☐ > 4 blocks
How much **weight can you lift without pain**?	☐ < 5 lbs	☐ 5-10 lbs	☐ 10-20 lbs	☐ 20-40 lbs	☐ 40-60 lbs	☐ > 60 lbs

Check the things that make your pain feel worse. Check all that apply.

☐ Walking ☐ Standing ☐ Sitting ☐ Lying Down ☐ Lifting ☐ Other _______________

What sorts of things make your pain feel better? Check all that apply.

☐ Heat ☐ Cold ☐ Sitting ☐ Lying down ☐ Medicine ☐ Other _______________

Check the numbers below that best describe how pain has interfered with your daily functioning.

Mildly Moderately Severely

General Activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Normal Work Routine

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

GOAL: What activities would you like to return to that are currently limited by pain? _____________

____

LOCATION OF PAIN

In the diagram below, shade in the area(s) where you feel pain. “X” the areas that hurt the most.

Right Left Right Left Right Left

______________________________ ______________

Patient Name **Date**

Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

PATIENT HISTORY

Have you tried Physical, Chiropractic, Massage, or Acupuncture therapy? ☐ Yes ☐ No

If yes, Please list dates and results:

____

____

____

PREVIOUS PAIN RELATED SURGERY/TREATMENTS

What pain treatments have you received in the past? (For example, pain medications, back surgery, epidural steroid injections, etc). If the exact date is not known, list the approximate month/year. **DO NOT** include current medications here. Circle the number next to the treatment to signify the amount of pain relief provided.

Previous Treatment or Medication	Treatment Date(s)	No Relief										Complete Relief
		0	1	2	3	4	5	6	7	8	9	10
		0	1	2	3	4	5	6	7	8	9	10
		0	1	2	3	4	5	6	7	8	9	10

CURRENT MEDICATIONS

Pharmacy Name ______________________ Phone Number ______________

Pharmacy Address ______________________________________

1. List all current **PAIN MEDICATIONS** (opioids, narcotics, muscle relaxants, anti-depressants, anti-convulsants, anti-inflammatories and sleeping aids.) Include dosage in mg and # of times taken per day & the doctor who is prescribing the medication.

MEDICATION	DOSAGE (mg)	AMOUNT / DAY	WHO PRESCRIBED

2. List all other current medications including dosage in mg and # of times taken per day & the doctor who is prescribing the medication. Use a separate sheet of paper if necessary.

MEDICATION	DOSAGE (mg)	AMOUNT / DAY	WHO PRESCRIBED

______________________________ ______________________

Patient Name **Date**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

ARE YOU CURRENTLY TAKING ANY BLOOD THINNING MEDICATIONS? ☐ Yes ☐ No

If Yes, name of blood thinning medication ______________________________
(Warfarin, Aspirin, Xarelto, Coumadin, etc.)

Have you had X-Rays, CT Scans, MRI's, or Nerve Testing? If so, please list the test, the date it was performed along with the location, if known:

____

____

____

____

ALLERGIES TO MEDICATIONS

Do you have any allergies to medications? ☐ Yes ☐ No

If "yes", list any allergies to medications and what reaction happens:

MEDICATION	REACTION

SURGICAL HISTORY (UNRELATED TO PAIN)

List all prior surgeries unrelated to your pain. If the exact date is not known, list the approximate month/year.

SURGERY	DATE

______________________________ ______________________________
Patient Name **Date**

Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

DOMESTIC HISTORY / INFO

Parents: Is your Father still living? ☐ Yes ☐ No Is your Mother still living? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If so, how much per day? ________________

Do you drink alcohol? ☐ Yes ☐ No If so, how much per week? ________________

Have your ever had a substances abuse or addiction problem? ☐ Yes ☐ No

MEDICAL HISTORY

Please place an "✓" if you or a family member currently have or have a history of the following conditions: Please list other family members as appropriate in the space provided (e.g. "brother", "uncle").

Condition	Self	Father	Mother	Other Family	List Other Family Member
Diabetes	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
Heart - Mitral Valve Prolapse	☐	☐	☐	☐	
Palpitations, Irregular or Fast Heart Beat	☐	☐	☐	☐	
Other Heart Disease ________	☐	☐	☐	☐	
Chest Pain	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
Emphysema	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
Sickle Cell Illness	☐	☐	☐	☐	
Other Blood Disease/Problem	☐	☐	☐	☐	
Kidney Disease or Trouble	☐	☐	☐	☐	
Jaundice or Hepatitis (A, B or C) *(Specify)* ________	☐	☐	☐	☐	
Other Liver Disease	☐	☐	☐	☐	
Gallbladder Trouble	☐	☐	☐	☐	
Meningitis	☐	☐	☐	☐	
Thyroid Trouble	☐	☐	☐	☐	
Cancer - of ________	☐	☐	☐	☐	
Other Serious Illness not mentioned *(Shingles, MS, etc.)*	☐	☐	☐	☐	
Explain:					

________________________ ________________________

Patient Name **Date**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

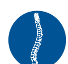
PAIN MANAGEMENT QUESTIONNAIRES

The following are some questions given to all patients at **Innovative Pain Care Center** who are on or being considered for opioids for their pain. There are 3 sections to complete. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Section 1 of 3: OPIOID RISK TOOL
Please complete one column according to your gender and check the number in the column if your answer is "yes".

Mark each box that applies	Female	Male
Family History of Substance Abuse		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Rx Drugs	☐ 4	☐ 4
Personal History of Substance Abuse		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Rx Drugs	☐ 5	☐ 5
Age between 16-45 years	☐ 1	☐ 1
History of preadolescent sexual abuse	☐ 3	☐ 0
Psychological Disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals		

Patient Signature **Patient Name** **Date**



Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

Name ____________________________ **Date of Birth** _______________ **Today's Date** _______________

SECTION 2 of 3: PATIENT HEALTH QUESTIONNAIRES - 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
Moving or speaking so slowly that other people have noticed? Or, the opposite: being so fidgety or restless that you've been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE CODING 0 + ________ + _________ + _________

Total Score ____________________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

Name ____________________________ **Date of Birth** _______________ **Today's Date** _______________

The following are some questions given to all patients at **Innovative Pain Care Center** who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

(Use "✓ " to indicate your answer)

SECTION 3 of 3: SOAPP-R	Never	Seldom	Sometimes	Often	Very Often
How often do you have mood swings?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt a need for higher doses of medication to treat your pain?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt impatient with your doctors?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt that things are just too overwhelming that you can't handle them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often is there tension in the home?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you counted pain pills to see how many are remaining?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been concerned that people will judge you for taking pain medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often do you feel bored?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you taken more pain medication than you were supposed to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you worried about being left alone?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt a craving for medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others expressed concern over your use of medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have any of your close friends had a problem with alcohol or drugs?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others told you that you had a bad temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Innovative
Pain
Care
Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

Name ____________________________ **Date of Birth** _______________ **Today's Date** _______________

Cont. Section 3 of 3: SOAPP-R	Never	Seldom	Sometimes	Often	Very Often
How often have you felt consumed by the need to get pain medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you run out of pain medication early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others kept you from getting what you deserve?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often, in your lifetime, have you had legal problems or been arrested?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you attended an AA or NA meeting?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been in an argument that was so out of control that someone got hurt?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been sexually abused?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others suggested that you have a drug or alcohol problem?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you had to borrow pain medications from your family or friends?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been treated for an alcohol or drug problem?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

SOAPP Score _________________

Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

CONTROLLED SUBSTANCE QUESTIONNAIRE

Questions	Yes	No	N/A
Have you ever used a controlled substance in a way other than prescribed?	☐	☐	☐
Have you ever diverted a controlled substance to another person?	☐	☐	☐
Have you ever taken a controlled substance that did not have the desired effect?	☐	☐	☐
Are you currently using any drugs, including alcohol or marijuana?	☐	☐	☐
Are you using any drugs that may negatively interact with a controlled substance?	☐	☐	☐
Are you using any drugs that were not prescribed by a practitioner that is treating you?	☐	☐	☐
Have you ever attempted to obtain an early refill of a controlled substance?	☐	☐	☐
Have you ever made a claim that a controlled substance was lost or stolen?	☐	☐	☐
Have you ever been questioned about your pharmacy report or PMP report?	☐	☐	☐
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	☐	☐	☐
Have you ever been accused of inappropriate behavior or intoxication?	☐	☐	☐
Have you ever increased the dose or frequency of meds without telling your provider?	☐	☐	☐
Have you ever had difficulty with stopping the use of a controlled substance?	☐	☐	☐
Have you ever demanded to be prescribed a controlled substance?	☐	☐	☐
Have you ever refused to cooperate with any medical testing or examinations?	☐	☐	☐
Have you ever had a history of substance abuse of any kind?	☐	☐	☐
Has there been any change in your health that might affect your medications?	☐	☐	☐
Have you misused or become addicted to a drug, or failed to comply with instructions?	☐	☐	☐
Are there any other factors that your practitioner should consider before prescribing?	☐	☐	☐

Patient's Signature ____________ Patient Name ____________ Date ____________

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

NECK PAIN AND DISABILITY QUESTIONNAIRE

Rate the severity of your pain by checking a number: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (WASHING, DRESSING, ETC.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ I am slow and careful because it is painful for me to look after myself.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weight without extra pain.
- ☐ I can lift heavy weight but it causes extra pain.
- ☐ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like a table.
- ☐ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I cannot lift any weight due to neck pain.

SECTION 4 - READING

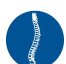
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight neck pain.
- ☐ I can read as much as I want to with moderate neck pain.
- ☐ I cannot read as much as I want to due to moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.

SECTION 5 - HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that occur infrequently.
- ☐ I have moderate headaches that occur infrequently.
- ☐ I have frequent moderate headaches.
- ☐ I have frequent severe headaches.
- ☐ I have severe headaches all the time.

SECTION 6 - CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.



P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

SECTION 7- WORK

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can barely do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 - DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all.

SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed. (less than 1hour sleepless)
- ☐ My sleep is mildly disturbed. (1hour sleepless)
- ☐ My sleep is moderately disturbed. (2 to 3 hours sleepless)
- ☐ My sleep is greatly disturbed. (4 to 5 hours sleepless)
- ☐ My sleep is completely disturbed. (6 to 7 hours sleepless)

SECTION 10 - RECREATION

- ☐ I am able to engage in all recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ I am able to engage in most, but not all of my usual recreation activities.
- ☐ I am able to engage in a few of my usual recreation activities.
- ☐ I can hardly do any recreation activities.
- ☐ I cannot do any recreation activities due to neck pain.

____________________	____________________	____________________
Patient Signature	**Patient Name**	**Date**

FOR OFFICE USE ONLY

____________ x2 =	____________________	____________________
Total Points	**Disability Percentage**	**Rating Scale**

Innovative
Pain
Care
Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (WASHING, DRESSING, ETC.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. On a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - WALKING

- ☐ Pain doesn’t prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1mile.
- ☐ Pain prevents me from walking more than 1/2mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7- SLEEPING

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SEX LIFE (IF APPLICABLE)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 - SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sport.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 - TRAVELLING

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to receive treatments.

Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

PRESCRIPTION MEDICATION AGREEMENT FOR CONTROLLED SUBSTANCE THERAPY FOR PAIN

Nevada law requires a patient to enter into a "Prescription Medication Agreement" if a controlled substance is to be continued for more than 30 days for treatment of pain. I understand that this agreement will be updated every 365 days, or if there is a change to my treatment plan. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities that my practitioner has made me aware of. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please sign below to indicate your understanding of all parts of this document.)

1. I understand my overall treatment plan and I understand the goals of the treatment of pain, including the appropriate use of a controlled substance.

- I have discussed my treatment plan with my practitioner, **Innovative Pain Care Center**: **Dr. Daniel Burkhead**, **Dr. Ho Dzung**, **Dr. Willis Wu**, **Dr. Ryan West**, **Michael Eastman, PA-C**, **Michael Scott, PA-C**, **Neil Jones, PA-C**, and I have a good understanding of the overall treatment plan and goals of treatment. My practitioner has discussed possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that continuation of a controlled substance for more than 30 days may provide some benefit for the treatment of my pain. I may be continued on controlled substance(s); including opioids.
- I understand that part of the goals of my pain management therapy may likely include attempts to minimize or discontinue the use of controlled substances. There may be various reasons that my practitioner will recommend tapering or discontinuation of a controlled substance. Some of these reasons may include, but are not limited to: a reduction of pain symptoms by other means, the presence or development of side effects, any signs of misuse, abuse, diversion, or addiction, refusal to comply with diagnostic studies or other aspects of the treatment plan, attempts to obtain medication from another provider, use of illicit drugs or other medications that may interact with the controlled substance, or any other reason that my practitioner may deem it in my best interest to reduce or discontinue the controlled substance.
- I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner. I will keep the medication safe, secure, and out of the reach of children and I will dispose of unused medication appropriately.
- I understand that controlled substances can cause certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing, and possibly fatal overdose. Due to this risk of fatal overdose, the antidote naloxone (Narcan®) is available, without a prescription, at pharmacies.

- I understand that while taking these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.
- I understand the risks and benefits associated with the use of controlled substances for the treatment of pain for greater than 30 days, including the risk of abuse, misuse, tolerance, dependence, and addiction.

2. **It is my responsibility to maintain compliance with my treatment plan.**

- I will keep, and be on time for, all scheduled appointments with my practitioner.
- I understand that prescriptions will only be provided scheduled office visits, and it is my responsibility to make sure that I have scheduled an appointment for refills (typically 30 days in advance). I understand that a minimum of a 5-7day notice may be necessary to get in for an appointment for medication refills. I will not call between appointments, at night, or on weekends to attempt to obtain refills.
- I understand that my medication is my responsibility and if it is lost or stolen, the medication will not be replaced until my next appointment and may not replaced at all.
- I will treat the office staff respectfully at all times and I may be subject to discharge from the clinic if I am disrespectful to staff or disruptive to the care of others.
- If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

3. **It is my responsibility to communicate important information to my practitioner.**

- I agree to inform my practitioner if I have ever taken a controlled substance in the past, and if it provided the intended effect. I will also inform my practitioner if I am ever given a prescription for a controlled substance by another provider, prior to filling or taking that medication.
- I will inform my practitioner if I use alcohol, marijuana, or any other illicit drugs.
- I will inform my practitioner if I have ever been treated for side effects or complications relating to the use of controlled substances.
- If I or anyone in my family has had problems with mental illness or with abuse or misuse of alcohol or other drugs, I will inform my practitioner, as this may put me at greater risk of developing an addiction. I will also inform my practitioner of any change in my health status, any new medications that have been prescribed, or any other circumstances which may impact my usage of a controlled substance.

4. **I understand that I am strictly prohibited from sharing the controlled substance with anyone or giving or selling the medication to any other person.**

5. **I understand that, as part of my treatment monitoring, periodic body fluid testing (urine, blood, saliva, etc.) may be required at the discretion of my practitioner. I will consent to such monitoring when deemed necessary by my practitioner.**

- I agree to come in to the clinic for such monitoring and testing within 24 hours of being contacted

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

by the office, and if I refuse or am unable to do so, then my treatment with controlled substances may be discontinued, at the discretion of the practitioner.

- I agree to bring any and all vials of my current medications to the office within 24 hours of being contacted, in order to have my practitioner perform a pill count.

6. **I agree to sign a release form to let my practitioner obtain records from other clinics and speak to other practitioners about my current or prior medical care.**

- It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.
- I will keep up to date with any bills from the office, and I will inform the office of any change in my health insurance or payment method. I agree to pay the copayment or coinsurance fees required by my insurer at the time of service.
- I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Medical, Dental, or Nursing Boards.

7. **I agree to fill all of my prescription from only one pharmacy. My pharmacy is:**

Pharmacy Name ____________________ Phone Number ____________________

Pharmacy Address ____

8. **I understand that Nevada state law requires me to provide a listing of every state in which I have previously resided, or had a prescription for a controlled substance filled. Below is a listing of such states:**

____________________ ____________________

____________________ ____________________

____________________ ____________________

9. **I understand that if I violate any part of this agreement, then I may be denied prescriptions for controlled substances and I may be discharged from the clinic.**

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree to abide by the rules of the Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment of my pain condition.

____________________	____________________	____________________
Patient Signature	**Patient Name**	**Date**
____________________	____________________	____________________
Parent/Guardian Signatue	**Parent/Guardian Name**	**Date**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

WRITTEN INFORMED CONSENT FOR CONTROLLED SUBSTANCE THERAPY FOR PAIN

Nevada law requires a patient's informed consent before a controlled substance can be initially prescribed to treat the patient's pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities that my practitioner has made me aware of. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please sign below to indicate your understanding of all parts of this document.)

1. **It is my responsibility to maintain compliance with my practitioner's treatment plan. This includes the responsibility of using the controlled substance properly, as prescribed, and taking the medication as directed.**

- I have discussed my treatment plan with my practitioner, **Innovative Pain Care Center**: **Dr. Daniel Burkhead**, **Dr. Ho Dzung**, **Dr. Wills Wu**, **Dr. Ryan West**, **Michael Eastman, PA-C**, **Michael Scott, PA-C**, **Neil Jones, PA-C** and I have a good understanding of the overall treatment plan and goals of treatment. I may be given prescriptions for controlled substances; including opioids. My practitioner has discussed specific risks and benefits of these drugs as well as possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that a controlled substance may provide some benefit for the treatment of my pain.
- I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.
- When I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.
- I understand my practitioner's protocol for addressing any requests for refills.
- If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

2. **It is my responsibility to understand the risks and benefits of using a controlled substance, including the possibility of addiction.**

- There are potential risks and benefits associated with the use of controlled substances for the treatment of pain and I understand these risks and benefits regarding the medication that I've been prescribed.
- I may experience certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing.
- Controlled substances also include a risk of tolerance, where my body may become accustomed to the original dosage of medication and this may require increased dosages to obtain the same effect. This is a situation that must be discussed with my practitioner, if it arises.
- I understand that I may become physically dependent on these controlled substances, creating a situation where I may experience withdrawal symptoms if I abruptly stop the medication. Withdrawal symptoms present as flu-like symptoms, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety, and sleep disruption.

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

- I understand that there is a risk of addiction to controlled substances. If I cannot control my usage of the medication then I may be referred for addiction treatment.
- I understand controlled substances carry a risk of fatal overdose. If too much of the medication is taken, or if the medication is combined with other medications that may alter my level of consciousness (including alcohol and marijuana) this risk is increased.
- Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone (Narcan®) is available, without a prescription, and I can obtain this medication from a pharmacist at any time.
- I have been made aware that there are controlled substances designed to deter abuse available to me and are risks and benefits associated with those drugs.

3. **It is my responsibility to communicate important information to my practitioner.**
   If I or anyone in my family has had problems with mental illness or with abuse or misuse of alcohol or other drugs, I will inform my practitioner, as this may put me at greater risk of developing an addiction. I will also inform my practitioner of any change in my health status or any other circumstance which may impact my usage of medication.
4. **It is my responsibility to store and dispose of controlled substances in the appropriate manner.**
   Prescriptions for controlled substances should always be stored in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I may return the medications to a local pharmacy, a local police station, a "drug-take back day" station, or I may safely dispose of them by dissolving them in a "Dettera" bag, which may be available for purchase at a pharmacy.
5. **For Women (ages 15-45):** It is my responsibility to tell my practitioner if I am or have reason to believe that I am pregnant or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).
6. **For the Parent or Guardian of un-emancipated minor:** In addition to the above, there are risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person and I have an understanding about ways to detect such abuse, misuse or diversion.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I give my consent for the prescription of controlled substances to treat pain condition.

____________________	____________________	________________
Patient Signature	**Patient Name**	**Date**
Parent/Guardian Signature	**Parent/Guardian Name**	**Date**

Innovative
Pain
Care
Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

PATIENT CARE AGREEMENT & ACKNOWLEDGEMENT

OF RECEIPT OF INNOVATIVE PAIN CARE CENTER'S NOTICE OF PRIVACY PRACTICES

"Pursuant to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disability Act (ADA) of 1990 Innovative Pain Care Center does not discriminate in admissions, provisions of services, hiring and employment on the basis of race, color, national origin, sex, sexual orientation, gender identify, gender expression, religion, age or disability (including AIDS and related conditions)."

I look forward to working with you and hope that my staff and I can be successful in meeting your goals for your pain control. In striving to meet these goals, we all must adhere to certain standards.

(Please initial the statements below to acknowledge your understanding.)

_______ The Pain Center staff will treat you with respect and compassion, and we recognize that your time is important. In return, we ask that you respect our time by giving us at least 24 hours notice of cancellation of appointments. Failure to do so will incur a $75 fee for missed office visits and a $150 fee for missed procedures.

_______ Please note, patient co-pay, deductibles and co-insurance amounts are due at the time of service. Checks are not accepted at time of service.

_______ It is our policy that a $75 fee is assessed for any returned checks.

_______ In order to avoid any unnecessary charges billed to the patient, we ask that you update us immediately with any information on changes of insurance, address, name or phone number.

I appreciate the fact that you've entrusted us with your care and hope that you have a pleasant and productive visit.

Sincerely,

Daniel L. Burkhead, M.D.
And the Staff at Innovative Pain Care Center

My signature indicates that I acknowledge and accept the terms and conditions presented in this agreement and that I have received **Innovative Pain Care Center's** Notice of Privacy Practices.

Patient Name ____

Date ______________________ **Patient Signature** ______________________

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

NOTICE TO ALL PATIENTS REGARDING URINE TESTING

This office tests all patients randomly up to 12 times a year as part of our prescription monitoring program. As part of your narcotics agreement you have agreed to these tests. You should be prepared at every visit to provide a urine sample. If you are due for a urine screening, you will be asked prior to seeing your provider for the sample. If you are unable to provide a sample, you will be asked to wait in the waiting room until you are able to. If your test is inconsistent with your treatment plan, you may be required to provide a sample at every visit until you are in compliance. This is an additional charge to your office visit.

Urine tests for prescription monitoring are performed in two parts:

- **Part one** is an in office urine test. This test is billed by our office. If you have any questions about your out-of-pocket responsibility for the test, please contact our billing office.
- **Part two** are specific studies performed by a contracted out-sourced laboratory, test are performed based on medications that are taken, as well as dosages, height and weight of the patient and the results of the in-office testing. These are billed by a laboratory within the contracted net-work of your insurance plan. If you have any questions about the laboratory portion of these tests, please contact your contracted laboratory facility.

These tests:

- Prevent dangerous drug to drug interactions.
- Monitor compliance with your treatment plan.

I, ____, understand the above and agree to abide by the policies outlined in this agreement.

______________________________ ______________________________

Patient Signature **Date**

Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

HIPAA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Innovative Pain Care Center is committed to HIPAA regulations. Therefore each patient is required to sign a release. Patients may include companion(s) (family members, friends, etc.) accompanying them to their appointment, schedule or reschedule appointments. Listed individuals are approved to hear discussion regarding the patient's health information.

I authorize the following individuals to be involved in the discussion of my medical health information. I understand I am responsible for the release of information provided by **Innovative Pain Care Center** to the following:

Name:	**Relationship:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________ ______________________________

Patient Name **Date**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

Date ___________________________________

Dear Primary Care Provider / Referring Provider ____

This letter is intended to inform you of the ongoing pain management care of our mutual patient, _____________________________________.

This patient has been continuing treatment in our chronic pain management clinic. The treatment plan may consist of a combination of physical modalities, medication management, and interventional procedures, possibly including steroid injections. The rationale for continuation of these treatments involves the patient's preference to avoid surgery. If repeat steroid injections are employed, they will be repeated only if the patient has had a recurrence of pain in the same location that was previously relived with similar steroid injections for at least 3 months. It is our judgment that the benefits of additional steroid injections outweigh the risks of repeated steroid administration.

Please do not hesitate to contact our clinic with any questions.

Sincerely,

Innovative Pain Care Center

Dr. Daniel Burkhead, MD | Dr. Ho Dzung, MD | Dr. Willis Wu, MD | Dr. Ryan West, DO

Please provide our office with your Primary Care Physician Information or Referring Doctor Information if you do not have a Primary Care Physician. New Insurance Guidelines require us to inform your primary care physician or referring physician of ongoing treatment.

Primary Care Physician / Referring Physician Information:

Name ____

Phone ____________________________________ Fax ____

HIPAA PRIVACY AUTHORIZATION RELEASE

I authorize Innovative Pain Care Center to release information to my medical provider listed above.

_____________________________________ _____________________________________

Patient Name **Patient Signature**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

NOTICE OF PRIVACY PRACTICES

AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

We must provide you with the following important information:

- How we may use and disclose your protected health information (PHI)
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your personal information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices as permitted by law. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past or that we may create or maintain in the future. Our practice will post a copy of our current Notice in a visible location at all times, and you may request a copy of our most current Notice at any time.

A. USES AND DISCLOSURES OF PHI

The following section describes different ways that we use and disclose your health information. For each kind of use or disclosure, we will explain the meaning and give an example. Not every use or disclosure will be listed; however, we have listed all of 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 submitting the revocation to us in writing.

1. Treatment: We may use and disclose medical information in the course of your treatment in order to provide, coordinate, or manage your healthcare and any related services. This may include other providers, pharmacies or others who assist in your care, such as your spouse, children, parents or caretaker.

Example: Medical information may be sent to another provider of medical care that you have been referred to by our office for further treatment or testing. You will be informed by your provider or other office personnel of such a referral prior to any disclosure of information. Only the minimum necessary information will be provided.

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

2. Payment: We may use and disclose your PHI, including records, to obtain payment for services and products you may receive from us. This may include activities associated with authorization of services, eligibility and coverage or obtain payment by your health insurance plan or other third parties which are responsible for such payment or information.

Example: Treatment details or medical records may be provided to your health insurer to determine if your insurer will cover your treatment or to obtain payment for services previously rendered.

3. Health Care Operations: We may use and disclose your PHI to ensure accurate and appropriate business operations. These activities include, but are not limited to, quality assessment activities, employee review activities, or licensing.

Example: A sign-in sheet may be used at the registration desk where you will be asked to sign your name. Your name may be called in the waiting room when it is time for the provider to see you. We may also use and disclose your PHI to contact you to remind you of your appointment.

"Business associates" perform various activities (e.g. transcription or answering services) for us. We will share your PHI with business associates whenever appropriate. A written contract with the business associate will outline the terms that will protect the privacy of your PHI.

4. Disclosures Required by Law: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

5. Release of Information to Family/Friends: Our practice may release your PHI to a friend or family member that is involved in your care or who assists in taking care of you.

Example: A patient, including a parent or guardian of a minor, may ask that a family member go to the pharmacy and pick up a prescription. In this example, that family member may have access to the patient's medical information.

B. ADDITIONAL USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to all or part of your PHI being used or disclosed for these purposes. If you are not able to agree or object, the provider will, using professional judgment, determine whether the use is in your best interest. In any event, only the PHI that is relevant to your health care will be disclosed.

1. Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your provider will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your provider is required by law to treat you and the provider has attempted to obtain your consent but is unable, he or she may still use your PHI to treat you.

2. Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify or that may be responsible for your care, your PHI that directly relates to that person's involvement in your health care. If you are unable to object to such a disclosure, we may disclose such information if we determine that it is in your best interest. We may use or disclose your PHI to an authorized public or private entity to assist and coordinate uses and disclosures to family or other individuals involved in your health care.

3. Communication Barriers: We may use and disclose your PHI if your provider attempts to obtain your consent but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to under the circumstances.

C. ADDITIONAL USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

1. Public Health: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority (ies) regarding the potential abuse or neglect of an adult patient, including domestic violence. However, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight: We may use or disclose PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Required by Law: We may use or disclose PHI to the extent required by law. The use or disclosure will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

4. Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to a court or administrative order, discovery request, subpoena, or other lawful process by another third party involved in the dispute.

5. Law Enforcement: We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes including:

- legal processes and otherwise required by law
- limited information requests for identification and location purposes
- pertaining to victims of crime
- suspicion that death has occurred as a result of criminal conduct
- in the event that a crime occurs on the premises of the practice, and
- medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

6. Abuse or Neglect: We may disclose your PHI to a public health authority, government entity or agency authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

7. Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for other duties authorized by law. We may also disclose information to a funeral director, as authorized by law, in order to permit the director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

8. Food and Drug Administration: We may disclose your PHI to a Food and Drug Administration authorized person or company to report adverse events, product defects or Problems; biologic product deviations; track products; to enable product recalls; to make repairs or replacements; or, to conduct post marketing surveillance, as required.

9. Military Activity and National Security: When appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate command authorities; (2) for purpose of determination by the Department of Veteran Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

10. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of this notice.

D. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications: You have the right to request that our practice communicate with you about your health related issues in particular manner or at a certain location. For example, you may ask that we contact you at home, but not leave a message on the answering machine. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact whose name is listed elsewhere in this Notice.

2. Request Restrictions of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations (TPO). You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must make your request in writing to the Privacy Contact listed elsewhere in this notice. You must include (a) the information you wish restricted; (b) whether you are requesting to limit our use, disclosure or both; and, (c) to whom you want the limits to apply.

Your provider is not required to agree to a restriction. If your provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If you provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

3. Inspect and Obtain Copy your PHI: This means you may inspect and obtain a copy of PHI about you that is contained in your medical record. A medical record includes medical, billing and any other records used for making decisions about you.

Under federal law, however, you may not inspect or receive copy the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed.

You may be required to submit your request in writing and a fee may be charged by the practice for the costs of copying, mailing, labor and supplies associated with your request.

4. Request Amendments to your PHI: This means you may request an amendment of PHI about you in your medical record for as long as we maintain it. The request must be in writing and submitted to the Privacy Contact listed elsewhere in this Notice. You must provide us with a reason that supports your request for an amendment. In certain cases, we may deny your request for an amendment. Including requests that are in our opinion are:

- accurate and complete;
- not part of the PHI kept by the practice;
- not part of the PHI which you would be permitted to inspect and copy; or are
- not created by our practice, unless the individual or entity who created the information is not available to amend the information.

If your request is denied, 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.

5. Request Accounting of Certain Disclosures of your PHI: This right applies to disclosures for purposes other than treatment, payment or healthcare operations (TPO) as described in this Notice. You have the right to specific information regarding these disclosures that occurred after April 14, 2003. This accounting is a list of certain non-routine disclosures our practice has made, if any, of your PHI for non-TPO purposes. Use of your PHI as a part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Contact listed elsewhere in this Notice and must state a time period, which may not be longer than six (6) years from the date of disclosure, and may not include dates prior to April 14, 2003.

The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period.

6. To Obtain a Paper Copy of this Notice: Upon request, even if you have agreed to accept this notice electronically, you have the right to obtain a paper copy.

7. Complaints/Questions: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint. For information about the complaint process, please contact the Privacy Contact listed elsewhere in this Notice.

E. PRIVACY CONTACT/QUESTIONS AND FURTHER INFORMATION

For questions regarding this notice and further information regarding any of its contents, you may contact our Privacy Officer located at **39920 W. Cheyenne #110 Las Vegas, NV 89129, (702) 316-2281 or by fax (702) 316-2272.**

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

ACKNOWLEDGEMENT OF RECEIPT

OF INNOVATIVE PAIN CARE CENTER'S NOTICE OF PRIVACY PRACTICES

I hereby acknowledge I have received a 6 page packet of **Innovative Pain Care Center's** Notice of Privacy Practices.

Patient Name ____

Date ______________________ **Patient Signature** ______________________

Innovative
Pain
Care
Center

P: (702) 316-2281
F: (702) 316-2272
PainFreeNevada.com

COVID-19 PANDEMIC TREATMENT CONSENT FORM

Name ____ **Date** ______________________

As with the transmission of any communicable disease like a cold or the flu, you may exposed to COVID-19, known as "Coronavirus," at any time or place. Be assured that we, at Innovative Pain Care Center, have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limits transmission of all diseases in our offices and we continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office just as you might be at your gym, grocery store, or favorite restaurant. "Social distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the medical evaluations and/or procedures that we provide, it may not be possible to maintain social distancing between the patients, medical providers, staff, and sometimes other patients, at all times.

COVID-19 virus has a long incubation period during which carries of the virus may not show symptoms and might still be highly contagious. It is impossible to determine who has the virus and who doesn't, given the current limitations in virus testing.

If you have been exposed to a communicable disease, you may spread the disease to the healthcare provider, staff, or other patients in the practice.

Although exposure to a communicable disease within our office is unlikely, by signing below, you accept the risk of possible exposure to disease within our office, and you consent to treatment here at our facility despite this possible risk.

You agree that if you begin to exhibit any symptoms of COVID-19, or if you are diagnosed with COVID-19 within a 30-day period either before or after you visit, you will contact our office immediately to report your illness or exposure so that we can take steps to limit the spread of this disease.

Your signature below provides attestation that the following statements are true:

- I have not felt hot or feverish in the past 14-21 days.
- I have not felt short of breath or had any difficulties breathing in the past 14-21 days.
- I have not developed a cough, sore throat, or runny nose within the past 14-21 days.
- I have not had any flu-like symptoms (gastrointestinal upset, headache, or fatigue) in the past 14-21 days.
- I have not experienced a loss of taste or smell in the past 14-21 days.
- I have not been in contact with any confirmed COVID-19 positive patient in the past 14-21 days.
- I have not traveled outside of the state of Nevada in the past 14-21 days.

I have read this form and I comprehend the information it contains. I agree with all of the above statements, and I understand the risks involved in being seen for a medical visit.

____

Patient Signature