



**Denis G. Patterson, DO**  
Board Certified Pain Medicine  
Board Certified Physical Medicine & Rehabilitation

5578 Longley Lane  
Reno, NV 89511

**Ali Nairizi, MD, MS**  
Board Certified Pain Medicine  
Diplomate of the American Board of Anesthesiology

2385 E. Prater Way, #204  
Sparks, Nevada 89434

tele 775.284.8650  
fax 775.284.8654  
[www.nvadvancedpain.com](http://www.nvadvancedpain.com)

**Appointment Location:** \_\_\_\_\_

**Appointment Date :** \_\_\_\_\_

**Check in time:** \_\_\_\_\_  
**(If you check in late, your appointment may need to be rescheduled)**

Welcome to Nevada Advanced Pain Specialists!

We are committed to providing a comprehensive multi-disciplinary approach for each individual's pain complaints to ensure you receive the most appropriate care.

Every individual is evaluated for the root cause of their pain – not just a “quick fix” approach to only provide symptomatic relief. We employ a methodical and physical medicine oriented approach that includes analysis of biomechanics, joint motion, as well as skeletal, nerve and muscle tissues. Only the latest diagnostic tools and technologies are used by the professionals at Nevada Advanced Pain Specialists to make accurate assessments including: EMG/Nerve testing, MRIs, x-rays, bone scans, and diagnostic pain injections.

The most important information comes from you – the patient. Our providers will spend time asking questions and listening to you. We understand that your personal experiences with your pain represent some of the most important data available to us for accurate diagnosis and effective treatment.

Once an accurate diagnosis is reached, we will employ various modalities, physical therapy, medication management, and appropriate interventional techniques to treat your pain.

When pain is treated properly, the net result is a more active lifestyle, which will lead to a healthier, happier you!

Sincerely,

Denis G. Patterson, DO  
Medical Director – Nevada Advanced Pain Specialists



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## **Please Bring and Complete the Following to Your Appointment**

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1. Driver's License/Photo ID
2. Health Insurance Card(s)
3. **Completed** forms from this packet
4. Radiographic Imaging (x-rays, CTs, and/or MRIs) films and reports if you have them available.
5. Any important previous medical records
6. A list of your current medications, when they were last filled, and the name of the provider who prescribed them to you.
7. **Payment is due at the time of service -IF YOU ARE UNABLE TO PAY AT THE TIME OF YOUR APPOINTMENT, YOU WILL HAVE TO RESCHEDULE.**

**It is the responsibility of the patient to make sure that all of the above materials are completed and provided to our office at the time of the appointment. If any of the information is not available or incomplete, your appointment may need to be rescheduled.**

Our main fax number is (775) 284-8654. Should you need to reschedule your appointment, please call us at your earliest convenience at (775) 284-8650.

We look forward to seeing you soon,  
The Staff of Nevada Advanced Pain Specialists



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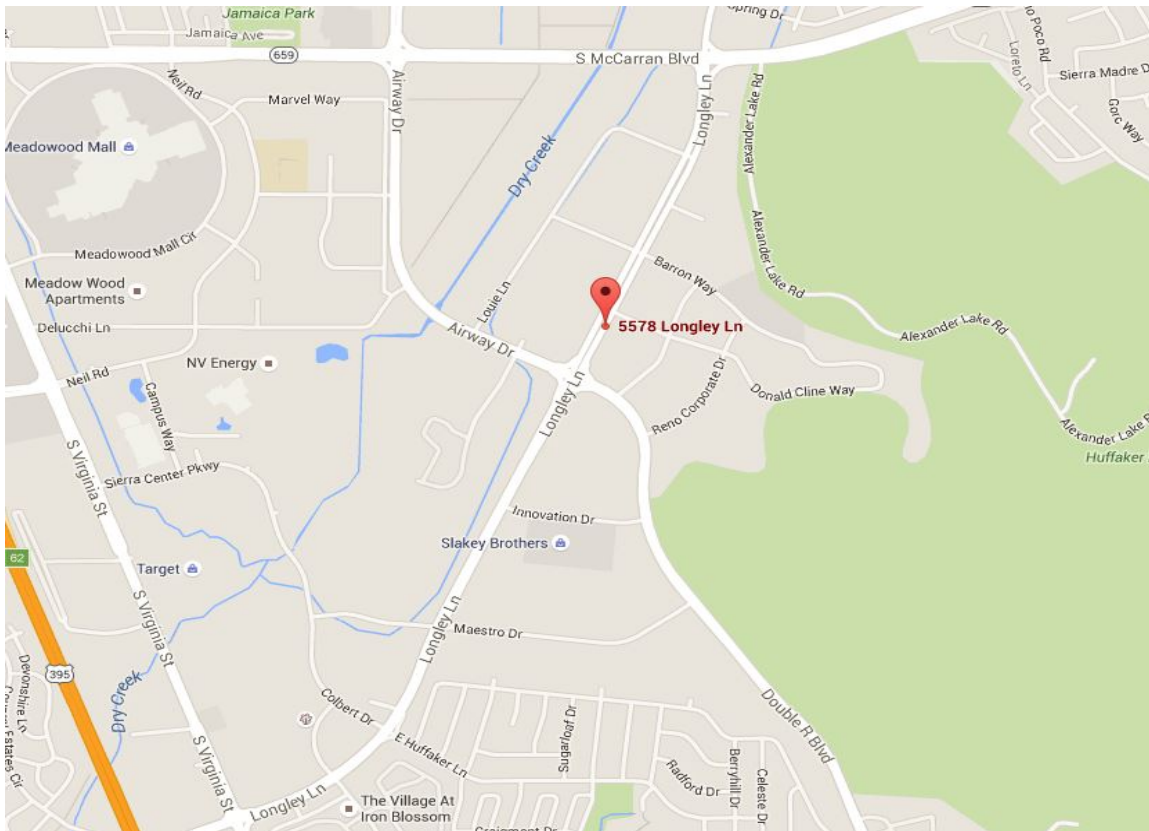
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### **RENO OFFICE DIRECTIONS:**

Heading **SOUTH** of I-580 take exit #64 Moana Ln  
Turn **LEFT** onto E Moana Ln  
E Moana becomes Airway Dr  
Turn **LEFT** onto Longley Ln  
Our office is to the **RIGHT**

Heading **NORTH** on I-580 take exit #61 S Virginia St  
Turn **RIGHT** onto S Virginia St  
Turn **RIGHT** onto Longley Ln  
Our office is to the **RIGHT**



**5578 Longley Lane, Reno NV. 89511**



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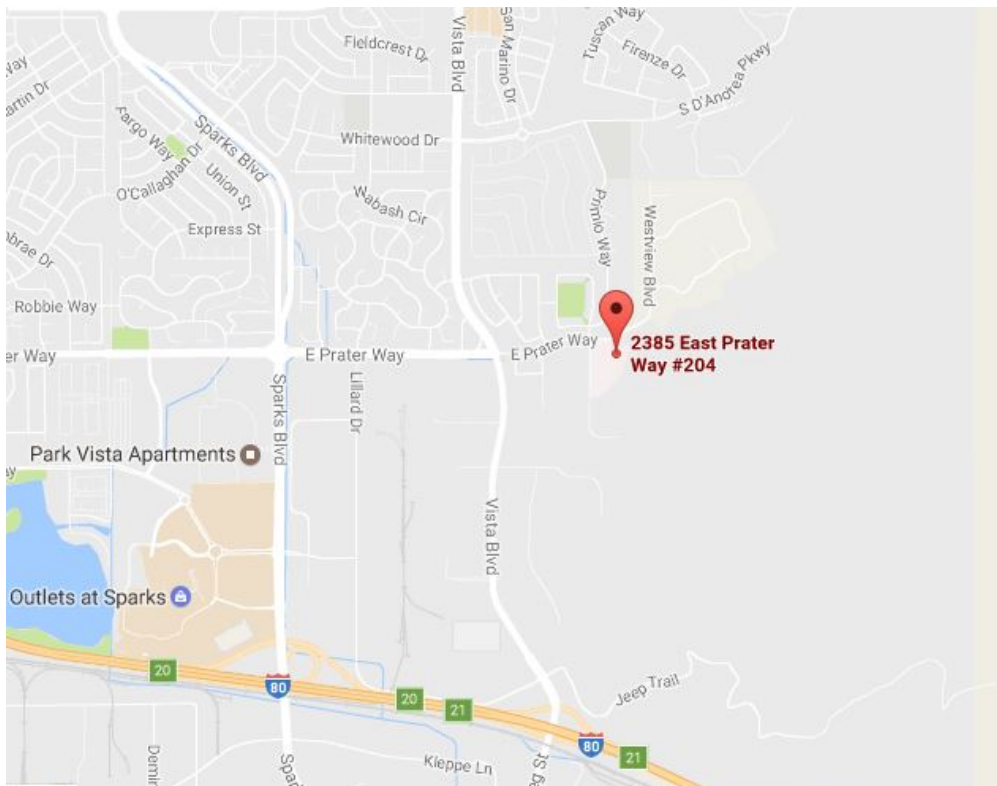
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### **SPARKS DIRECTIONS:**

Heading East on I-80 exit #21 for Vista Blvd  
Turn left onto Vista Blvd.– heading NORTH. Continue on Vista Blvd. for about a mile.  
Turn right onto E. Prater Way and continue east for about .4 miles.  
Our office is on the right, located on the second floor of the Northern Nevada Medical Center Medical Office Building

Heading West on I-80 exit #21 for Vista Blvd  
Turn right onto Vista Blvd.– heading NORTH. Continue on Vista Blvd. for about a mile.  
Turn right onto E. Prater Way and continue east for about .4 miles.  
Our office is on the right, located on the second floor of the Northern Nevada Medical Center Medical Office Building

**2385 E. Prater Way, Suite 204, Sparks NV  
89434**





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**In order to bill your insurance company, you MUST complete all requested information.  
Demographic information: (Please Print)**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_ / \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ / \_\_\_\_\_  
Email Address: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Preferred Method of Contact: \_\_\_\_\_ Race: \_\_\_\_\_

Language Preference if not English: \_\_\_\_\_

Ethnicity: Hispanic or Latino \_\_\_ Not Hispanic or Latino \_\_\_ Decline \_\_\_

Employer: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_ / \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Individual you would like us to contact and give permission to contact in case of an emergency:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ / \_\_\_\_\_

---

**INSURANCE INFORMATION:**

**Primary Insurance**

Insurance Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ / \_\_\_\_\_  
Name of Insured (if different than patient): \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Relationship to Patient: \_\_\_\_\_ ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

**Secondary Insurance**

Insurance Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ / \_\_\_\_\_  
Name of Insured (if different than patient): \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Relationship to Patient: \_\_\_\_\_ ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

**WORKERS COMPENSATION:**

Insurance Company \_\_\_\_\_ Date of Injury \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ / \_\_\_\_\_  
Claim # \_\_\_\_\_ Case Manager \_\_\_\_\_  
Employer at time of injury \_\_\_\_\_ State \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Reason for appointment:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:**

**Past Surgical History:**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family History:**

\* Please provide us with any medical conditions that family members have

|                     | <b>Condition</b> | <b>Age</b> | <b>Deceased? (Y/N)</b> |
|---------------------|------------------|------------|------------------------|
| <b>Grandfather:</b> | _____            | _____      | _____                  |
| <b>Grandmother:</b> | _____            | _____      | _____                  |
| <b>Father:</b>      | _____            | _____      | _____                  |
| <b>Mother:</b>      | _____            | _____      | _____                  |
| <b>Brother:</b>     | _____            | _____      | _____                  |
| <b>Sister:</b>      | _____            | _____      | _____                  |

**Social History:**

**Smoker:** No \_\_\_ Yes \_\_\_ If yes, # of packs per day \_\_\_

**Alcohol:** No \_\_\_ Yes \_\_\_ If yes, average # of drinks per day \_\_\_

**History of drug addiction:** No \_\_\_ Yes \_\_\_

**Place of Birth:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_

**Children:** No \_\_\_ Yes \_\_\_ If yes, how many \_\_\_\_\_

**Education:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Medications:**

**Medication Allergies:** \_\_\_\_\_

| <b>Medication</b> | <b>Strength</b> | <b>Dosage</b> |
|-------------------|-----------------|---------------|
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |
| _____             | _____           | _____         |

## Review of Systems:

\* Mark all that apply to your current condition

### General:

Fever  Weight loss  Fatigue  Special diet

### Eyes:

Visual loss  Double vision  Injury  Glasses

Inflammation  Glaucoma

### Ears:

Deafness  Ringing  Dizziness  Pain in ears

Discharge from ears

### Nose:

Nose bleeds  Obstruction  Discharge from nose

### Mouth:

Soreness mouth or tongue  Toothache

### Throat:

Hoarseness  Sore Throat  Voice changes

### Cardiovascular:

Palpitations  Rapid heart rate  Irregular heart beat

Chest pain  Shortness of breath  Leg swelling

Leg pains while walking  High blood pressure

### Respiratory:

Shortness of breath  Wheezing  Cough  Bloody sputum

Night sweats  History of pleurisy  Tuberculosis

Pneumonia  Asthma

### Gastrointestinal:

Nausea  Abdominal pain  Vomiting  Vomiting blood

Jaundice  Change in bowel habits  History of ulcer

Weight loss

### Genitourinary:

Urinary tract infection  Painful urination  Kidney Stones

Incontinence  Blood in urine  Prostate cancer

Difficulty stopping and starting urine stream

### Musculoskeletal:

History of fractures  Dislocations  Sprains  Neck pain

Arthritis  Muscle pain  Stiffness  Mid-back pain

Muscle weakness  Night cramps  Joint Swelling

Low back pain



**Integumentary (skin):** \_\_\_Abnormal sweating \_\_\_Itching \_\_\_Rash  
\_\_\_Sores that do not heal \_\_\_Easy bruising

**Neurological:** \_\_\_Disturbance to smell \_\_\_Facial numbness \_\_\_Difficulty chewing  
\_\_\_Facial weakness \_\_\_Taste disturbance \_\_\_Hearing difficulty  
\_\_\_Balance problems \_\_\_Speech difficulty \_\_\_Headaches  
\_\_\_Swallowing difficulties \_\_\_Paraplegic history  
\_\_\_Loss of consciousness \_\_\_Pain going down arm  
\_\_\_Pain going down leg \_\_\_Involuntary movement  
\_\_\_Seizures/epilepsy \_\_\_Gait difficulty \_\_\_Coordination issues  
\_\_\_Numbness, tingling or burning \_\_\_Urinary control problems  
\_\_\_Prior head injury or skull fracture

**Psychiatric:** \_\_\_Nervous breakdown \_\_\_Hallucinations \_\_\_Depression

**Endocrine:** \_\_\_Diabetes \_\_\_Abnormal growth \_\_\_Enlarged head, feet, hands  
\_\_\_Unusual hair growth \_\_\_Abnormal change in skin color  
\_\_\_Thyroid or goiter problems \_\_\_Dryness of hair or skin  
\_\_\_Heat intolerance \_\_\_Cold intolerance \_\_\_Excessive thirst  
\_\_\_Excessive urination

**Blood & Lymph Systems:** \_\_\_Anemia \_\_\_Swollen lymph nodes \_\_\_Abnormal bleeding  
\_\_\_Family history of bleeding disorder

**Allergy and Immune System:** \_\_\_Migraine \_\_\_Food Allergies \_\_\_AIDS  
\_\_\_ Immune system disorder

**Women:** Are you currently pregnant or think you may be pregnant? No \_\_\_ Yes \_\_\_

**PATIENT NAME (please print):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

What percentage of your pain is (please have the total add to 100%):

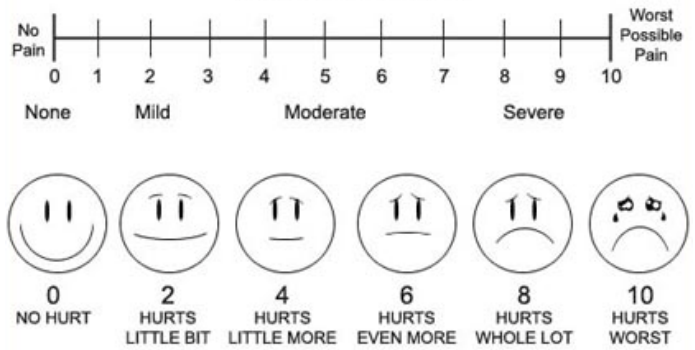
Neck pain \_\_\_% Arm Pain \_\_\_% Back Pain \_\_\_% Leg Pain \_\_\_% Head Pain \_\_\_% Hip Pain \_\_\_%

What is your overall functionality (on a scale from 0%-100%): 0% = Completely Limited / 100% = Fully Functional

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

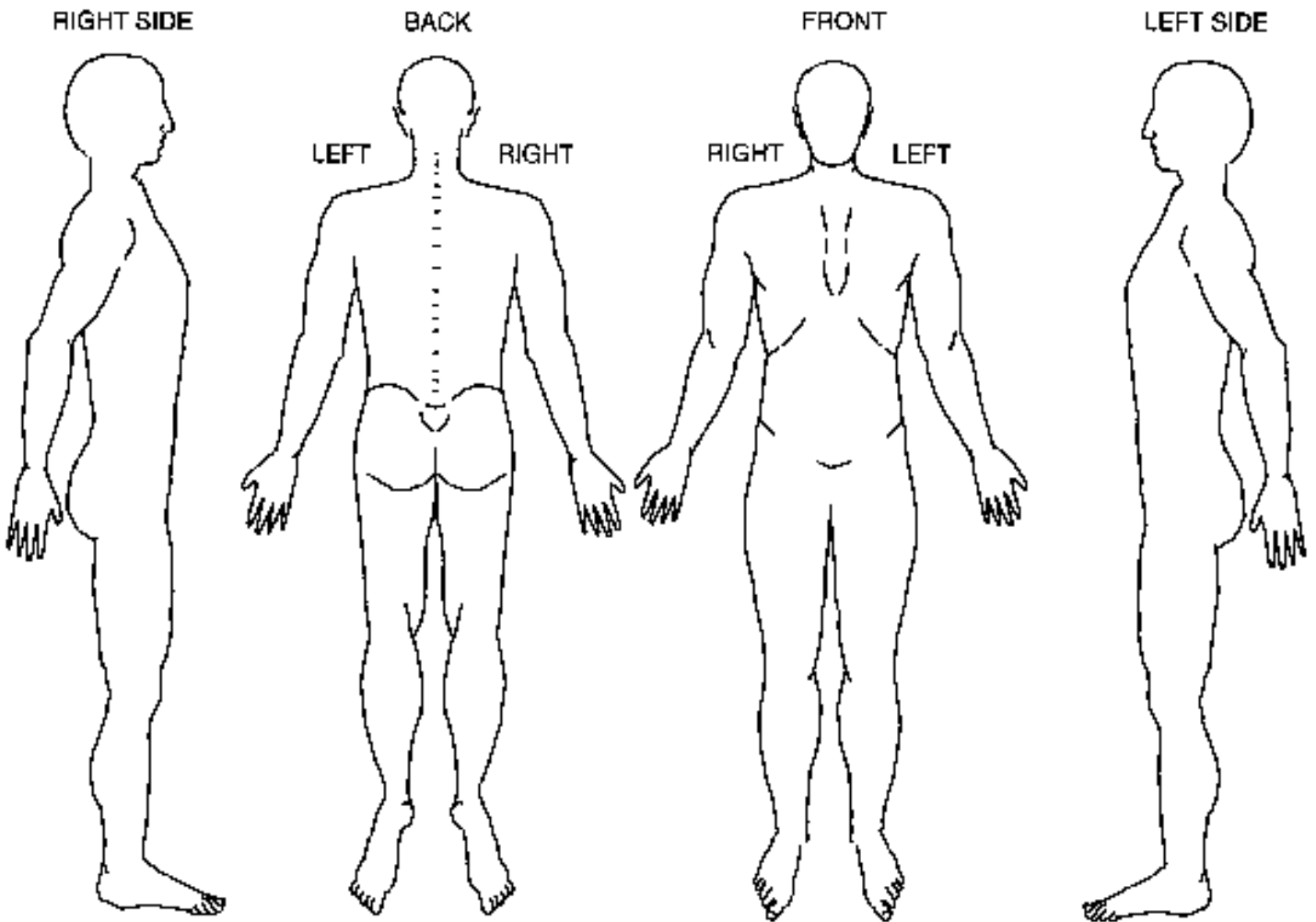
Please describe the type of pain or sensation you are currently experiencing: (check all that apply)

- Aching       Shooting       Throbbing
- Cramps         Stabbing         Swelling
- Dull             Stiffness         Burning
- Numbness       Sharp             Tingling



Other, please describe: \_\_\_\_\_

Please mark on the diagram the location of the pain:



**OFFICE USE ONLY:**  
 - / + UDS: \_\_\_\_\_ Room #: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Pulse: \_\_\_\_\_ O2: \_\_\_\_\_ Resp: \_\_\_\_\_ B/P: \_\_\_\_\_ / \_\_\_\_\_  
 Clinical info page 5 of 7

NAME: \_\_\_\_\_

**Nevada Advanced Pain Specialists Intake Sheet**

**Where do you have pain?** Check all that apply:

Neck    Middle back    Low back    Upper extremity    Lower extremity

**When did your pain begin?** \_\_\_\_\_

**Did your pain begin due to a traumatic event? Or did it come on gradually?** \_\_\_\_\_

**If it was due to trauma, what happened?** \_\_\_\_\_

**Is your pain getting better, worse, or staying the same?** \_\_\_\_\_

**Describe your pain:** Check all that apply:

Sharp shooting    Dull Achy    Burning    Throbbing    Stabbing    Other

**Does your pain radiate?**

**If yes, describe the path it takes:** \_\_\_\_\_

**Describe the radiating pain:** Check all that apply:

Sharp shooting    Dull Achy    Burning    Throbbing    Stabbing    Other

**Do you have any numbness or tingling anywhere?**

**If yes, where?** \_\_\_\_\_

**Do you have any weakness anywhere?**

**If yes, where?** \_\_\_\_\_

**What makes your pain better?** \_\_\_\_\_

**What makes your pain worse?** \_\_\_\_\_

**Have you tried ice, heat, or a TENS unit for your pain? Is so, which one(s) do you use and have they helped your pain?** \_\_\_\_\_

**What medications do you take for pain?** \_\_\_\_\_

**Have you tried others in the past?** \_\_\_\_\_

**Have you tried Physical Therapy?** \_\_\_\_\_

**If so, when did you last have PT and did it help?** \_\_\_\_\_

**Have you had any injections to treat your pain?** \_\_\_\_\_

**If so, what type of injections and did it help?** \_\_\_\_\_

**Have you had surgery to treat your pain in the past?** \_\_\_\_\_

**If so, what type of surgery and did it help?** \_\_\_\_\_

**Do you have any of the following? Check all that apply:**

History of cancer  Fevers/chills  Night sweats  Night Pain  Weight loss

Bowel/bladder incontinence



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## MEDICATION AGREEMENT & REFILL POLICY

As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. If Nevada Advanced Pain Specialists has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating Physicians, pharmacies, and hospitals.

*Please initial next to each line item.*

- \_\_\_ 1 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 participation in the management of my pain is essential. I agree to actively participate in all aspects of my treatment plan to maximize functioning and improve coping with my condition.
- \_\_\_ 2 If it appears to the provider that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as directed by the prescribing provider.
- \_\_\_ 3 I agree to follow the dosing schedule prescribed to me by my Physician, P.A. or APN.
- \_\_\_ 4 I agree to **never** share my medications with others nor will I sell or exchange my medication for any reason.
- \_\_\_ 5 I agree to always keep my medications safeguarded and within my control.
- \_\_\_ 6 I agree to notify Nevada Advanced Pain Specialists if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medication. Before any new medication can be prescribed, I must bring the unused medication to the Nevada Advanced Pain Specialists office for disposal.
- \_\_\_ 7 I agree that if I receive narcotic medications from Nevada Advanced Pain Specialists I am **not** allowed to receive the same type of medications from another Physician (including the emergency room or clinic) without the express consent or consultation with Nevada Advanced Pain Specialists.
- \_\_\_ 8 I agree to use only one pharmacy for my pain-related medications unless extenuating circumstances prevent this from being possible. In this event, I will notify Nevada Advanced Pain Specialists of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.
- \_\_\_ 9 I will count my pills that I receive from the pharmacy and will ensure that the proper amount is received. I understand that my Physician will not cover me for any shortage of medication. Any shortage found must immediately be discussed with the pharmacy upon receipt of the filled prescription.
- \_\_\_ 10 I understand that medication refills involving narcotic pain medication will require a scheduled office visit with my prescribing Physician at Nevada Advanced Pain Specialists. **Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased over the telephone.**
- \_\_\_ 11 I agree to **keep all scheduled appointments. I understand no medications will be given for cancelled or no-show appointments.** I agree also to be prompt to my appointments and understand that if I am more than **15 minutes** late I will have to reschedule.
- \_\_\_ 12 I understand that medication refills cannot be made after hours or on the weekend. The Nevada Advanced Pain Specialists refill hours are 8:00am – 2:00pm. Calls after 2:00pm will be addressed the following business day.
- \_\_\_ 13 I agree to bring my medications from any other Physician's office to Nevada Advanced Pain Specialists for my office appointments.
- \_\_\_ 14 I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
- \_\_\_ 15 I understand that I am solely responsible for the safekeeping of my medication and I must treat my medications as I would my money or valuable possession. **The Nevada Advanced Pain Specialists Physician will under no circumstances replace LOST or STOLEN prescriptions or medications.**
- \_\_\_ 16 I understand that my treatment at Nevada Advanced Pain Specialists may legally require a monthly visit so that my doctor can properly evaluate my progress, and/or adjust appropriate narcotic pain medications every 30 (thirty) days.
- \_\_\_ 17 I understand that abusive behavior or harassment toward any of the Nevada Advanced Pain Specialists staff will not be tolerated. Harassment includes, but is not limited to, more than 2 (two) phone calls to the office in one business day.

- \_\_\_ **18** I will not show up at the Nevada Advanced Pain Specialists office unannounced seeking medication refills.
- \_\_\_ **19** Medication refills will be made only as often as it is directed on the label. No early refills will be authorized.
- \_\_\_ **20 I will not use "street" or illegal drugs.**
- \_\_\_ **21** I agree to random drug screen tests to verify that I am only using drugs consistent with this agreement. If a test is requested and I leave the office without providing one, I understand I forfeit access to future narcotic prescriptions from Nevada Advanced Pain Specialists.
- \_\_\_ **22** I understand that if I do not adhere to any item on this agreement it will result in a mandatory referral to a Behavioral Health Specialist.
- \_\_\_ **23** I understand that a forged or falsified prescription will result in the immediate dismissal from Nevada Advanced Pain Specialists and possibly criminal proceedings as required by law.
- \_\_\_ **24** I understand that if I do not follow this medication agreement, I may be dismissed from Nevada Advanced Pain Specialists, at their discretion.
- \_\_\_ **25** This contract will become part of my permanent medical record.

**MATERIAL RISK NOTICE**

There are risks with the use of narcotics. These include, but are not limited to:

1. **BRAIN:** Sleepiness, difficulty thinking, confusion, impaired balance
2. **LUNG:** Difficulty breathing, shortness of breath, wheezing, slowing of breathing rate
3. **STOMACH:** Nausea, vomiting and constipation can be severe
4. **SKIN:** Itching, rash
5. **URINARY:** Difficulty urinating
6. **ALLERGY:** Potential for allergic reaction
7. **DRUG INTERACTION(S):** Possibility of interaction with other medications. Can make the effect of both drugs stronger when taken together.
8. **TOLERANCE:** With long term use, an increasing amount of the same drug may be needed to achieve the same pain-relieving effect.
9. **PHYSICAL DEPENDENCE/WITHDRAWAL:** Physical dependence develops within 3-4 weeks when taking these drugs. If they are stopped abruptly, symptoms of withdrawal may occur. These include, but are not limited to: abdominal cramps, abnormal heart beat, nausea and vomiting, sweating, flu-like symptoms. These may be life-threatening. All controlled substances need to be slowly tapered under the direction of your Physician or facility.
10. **ADDICTION:** This refers to the abnormal behavior directed toward acquiring or using drugs in a non-medically necessary manner. People with a history of drug and/or alcohol abuse are at increased risk of developing an addiction.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accept these terms. No narcotic or otherwise habit-forming medications will be prescribed without the acceptance of this agreement,

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Pharmacy Telephone Number

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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## **Physicians' Information**

Please list the names, specialties, and phone numbers of your other healthcare providers:

**Physician Name**

**Specialty**

**Phone Number**

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Today's Date



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## KNOW YOUR INSURANCE PLAN

Your health insurance is based upon a contract between you and the insurance company, or in some cases, the insured party's employer and the insurance company. If your employer has selected your plan, it is customary for the employer to describe and discuss the benefits of the plan with the employee. It is the responsibility of the insurance company to provide supporting documentation (Plan Benefit Booklet) and the Enrollment Card of the insured.

It is the responsibility of the insured party who benefit from this plan, or who receives benefits from this insurance plan to know:

- The commencement date of the plan
- If there is an annual deductible, and how much
- Which hospital, laboratory, and radiology center the carrier is contracted with
- The amount of your co-payment

It is your responsibility to present the insurance card to the receptionist when checking in. It is also your responsibility to notify our office of any changes or termination of your plan.

The contract between the "Provider Service" (Physician) with any insurance company is:

- To provide quality medical care to the patients
- To submit the claim for service to the appropriate carrier in a timely fashion
- To give credit to the patient for any "contracted discount"
- To collect co-payments and other balances due from patient at time of service

If you ever have questions regarding your coverage, you will need to contact your employer or call the number listed on the back of your insurance card. Please refer to your Explanation of Benefits from your insurance company and your monthly statement from Nevada Advanced Pain Specialists.

We will bill services at the end of each work day. If you have provided information that is not accurate, we will be required to bill you directly. Changes made to your insurance information after the fact comes with a \$25.00 charge to you.

---

Signature

---

Date

\* Physicians in this practice may have a financial interest or relationship with companies that provide products, services or facilities used in your care. This does not affect the care or medical decision-making used in your treatment and details are available upon request.





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www.nvadvancedpain.com

## Authorization to Release Protected Health Information & Consent for Treatment

I authorize Nevada Advanced Pain Specialists to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. The administration and performance of all treatments includes but is not limited to, the use of prescribed medication, the performance of procedures, diagnostic imaging, and utilization of urine drug testing, all of which is considered medically necessary or advisable by the treating provider.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing, or claims payment or other purposes as I may direct. I authorize Nevada Advanced Pain Specialists to release protected health information to the following individual(s):

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Initial This authorization shall remain in force and effective until (9) nine months after my death or \_\_\_\_\_ (date) at which time this authorization expires.

\_\_\_\_\_  
Initial I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and Initial may no longer be protected by federal or state law.

\_\_\_\_\_  
Initial I understand that I have the right to revoke this authorization, in writing, at any time.