Nevada Advanced Pain Specialists
Center for Injury Rehabilitation

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

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

5578 Longley Lane
Reno, NV 89511

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

tele 775.284.8650
fax 775.284.8654
www.nvadvancedpain.com

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

Patient Name: _____ Birth Date: ____/____/____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ /_____ Cell Phone: (____) _____ /_____

Social Security #: _____ Email Address: _____

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: _____

Primary Care Physician: _____ Phone: (____) _____ /_____

Emergency Contact: _____ 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 _____

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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

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Physical Therapy Cancellation Policy

To gain the most benefit from our office and to ensure that other patients receive the highest level of care, it is essential to keep all of your scheduled appointments. Due to the fact that we spend so much one-on-one time with our patients, to be fair to the therapist it is important that you maintain your scheduled appointment time.

If you cancel an appointment **within 24 hours of your appointment time a cancellation fee of $50 each visit may be charged to you prior to your next appointment.** Insurance companies do not cover this fee. There are exceptions for emergencies.

We appreciate your understanding in this manner. We strive to provide the best quality care for our patients.

Acknowledgement of Cancellation Policy

I have read and understand the Physical Therapy Cancellation Policy.

_____ _____

Patient Name | Patient Signature and Date

_____ _____

Signature of office personnel | Date

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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

_____ This authorization shall remain in force and effective until (9) nine months after my death
Inital or_____ (date) at which time this authorization expires.

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

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

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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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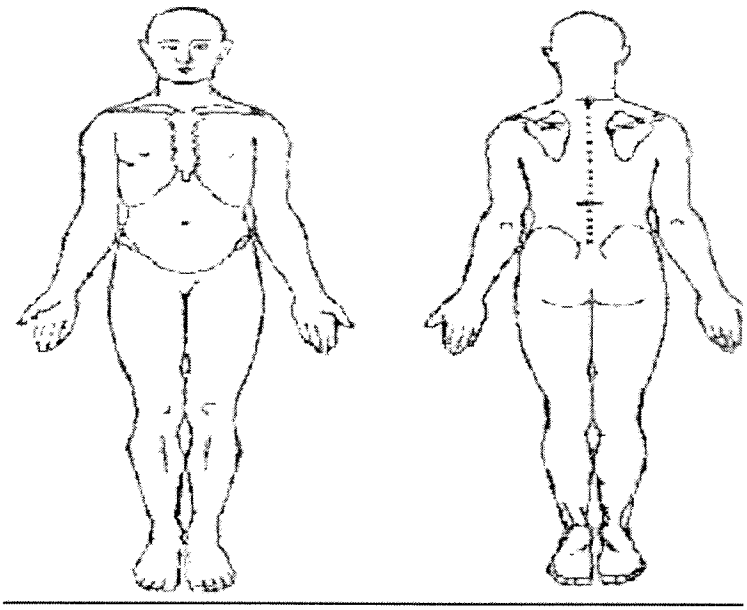
Patient's name_____ Date_____ Age_____ Gender M / F

Referred by_____

Please mark where your pain is:



Please Circle Yes or No

Unexplained Weight Loss	Y N
Fatigue/Fever	Y N
Nausea/Vomiting	Y N
Dizziness	Y N
Ringing in the ears	Y N
Fainting spells	Y N
Bowel/bladder problems	Y N
Night pain	Y N
Changed by position?	Y N
Headaches	Y N

Reason for therapy_____

How did your injury occur_____

Pain Location_____

Average pain level 0 1 2 3 4 5 6 7 8 9 10

Aggravating Factors_____

Pain level at its worst 0 1 2 3 4 5 6 7 8 9 10

Alleviating Factors_____

Pain level at its best 0 1 2 3 4 5 6 7 8 9 10

Description of pain_____ Getting Better Y/N

How long have you had your symptoms?_____

Occupation_____

Duties_____

Difficulty with activities_____

Goals for physical therapy_____

Hobbies_____

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Living Environment (House/apt, how many stories etc)_____

Family members that live with you _____

Do you smoke?_____Smoke Pack/day_____Alcohol Drinks/day_____Pregnant_____months

What other treatment have you had for this problem?_____

Do you exercise? If so, what type and how often?_____

Past Medical History_____

History of cancer?_____ Diabetes?_____

List any surgeries_____

Medications_____

_____Helping Y /N

Physical Therapy No Show Policy

Should you need to cancel your appointment, you must call and notify us prior to your scheduled appointment time.

If you fail to do so, you will be charged a fee of $50.00 and we will not be able to schedule any future appointments with you until the fee is paid.

If you miss three appointments without notifying us, we will no longer be able to see you as a patient.

Patient Signature:_____ Date: _____

Staff Signature: _____ Date: _____

Thank you,

Jamie Pribyl and Staff