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

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

NEVADA ADVANCED PAIN SPECIALISTS
CENTER FOR INJURY REHABILITATION

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Please Bring and Complete the Following to Your Appointment

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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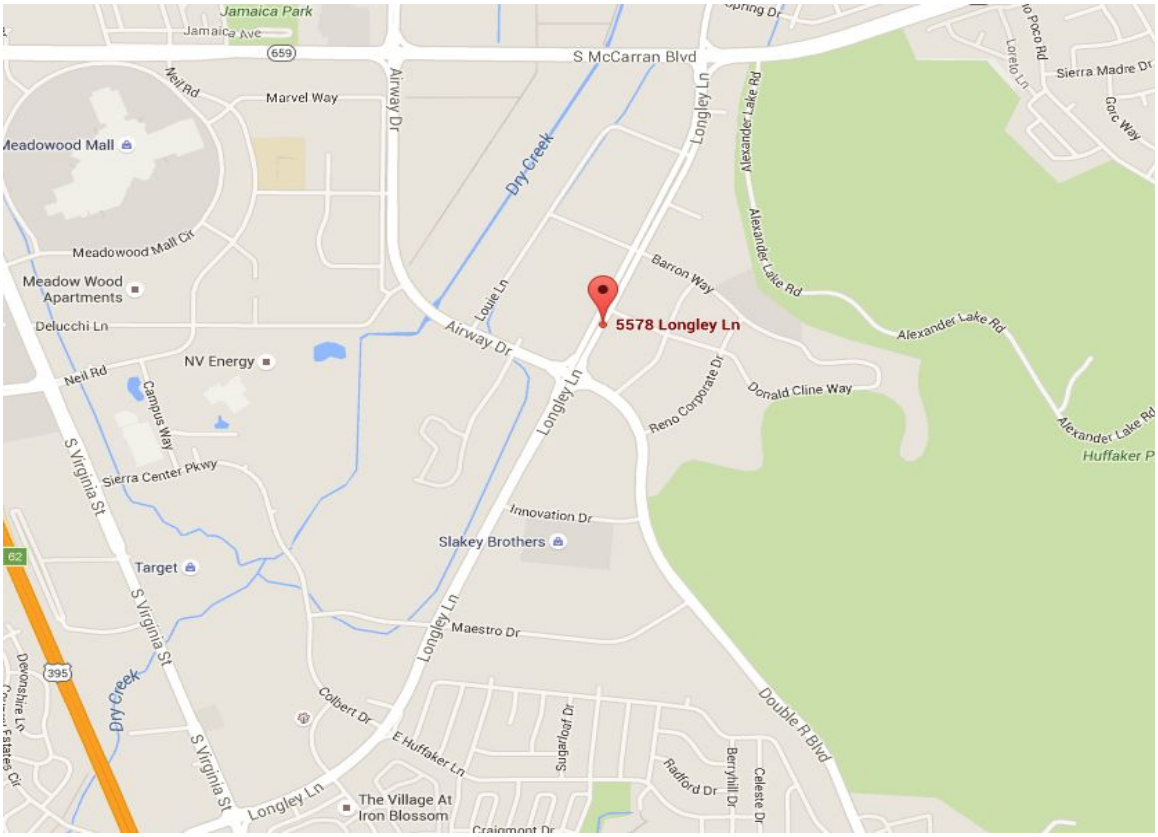
RENO OFFICE DIRECTIONS:

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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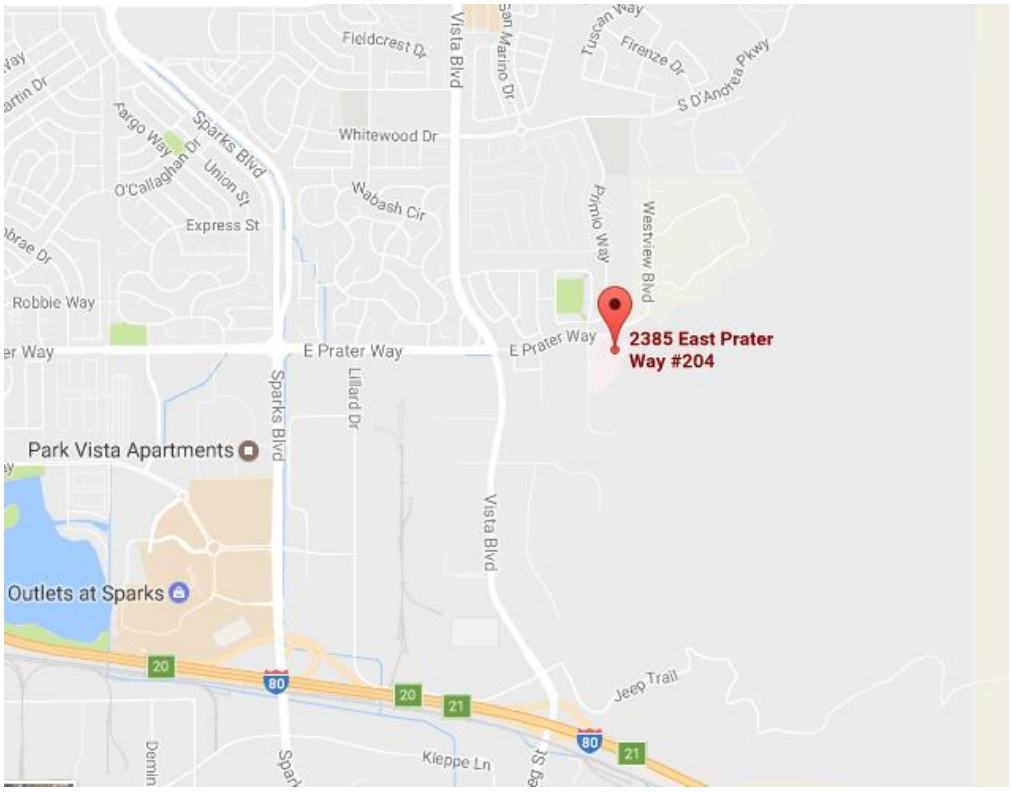
SPARKS DIRECTIONS:

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

	Condition	Age	Deceased? (Y/N)
Grandfather:	_____	____	_____
Grandmother:	_____	____	_____
Father:	_____	____	_____
Mother:	_____	____	_____
Brother:	_____	____	_____
Sister:	_____	____	_____

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: _____

Medication	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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%):

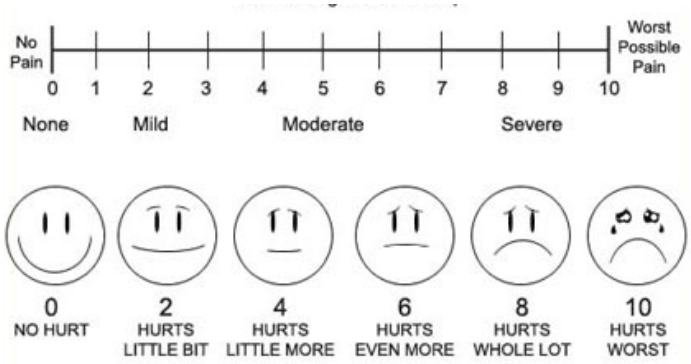
Neck pain ____% Arm Pain ____% Back Pain ____% Leg Pain ____% Head Pain ____% Hip Pain ____%

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%

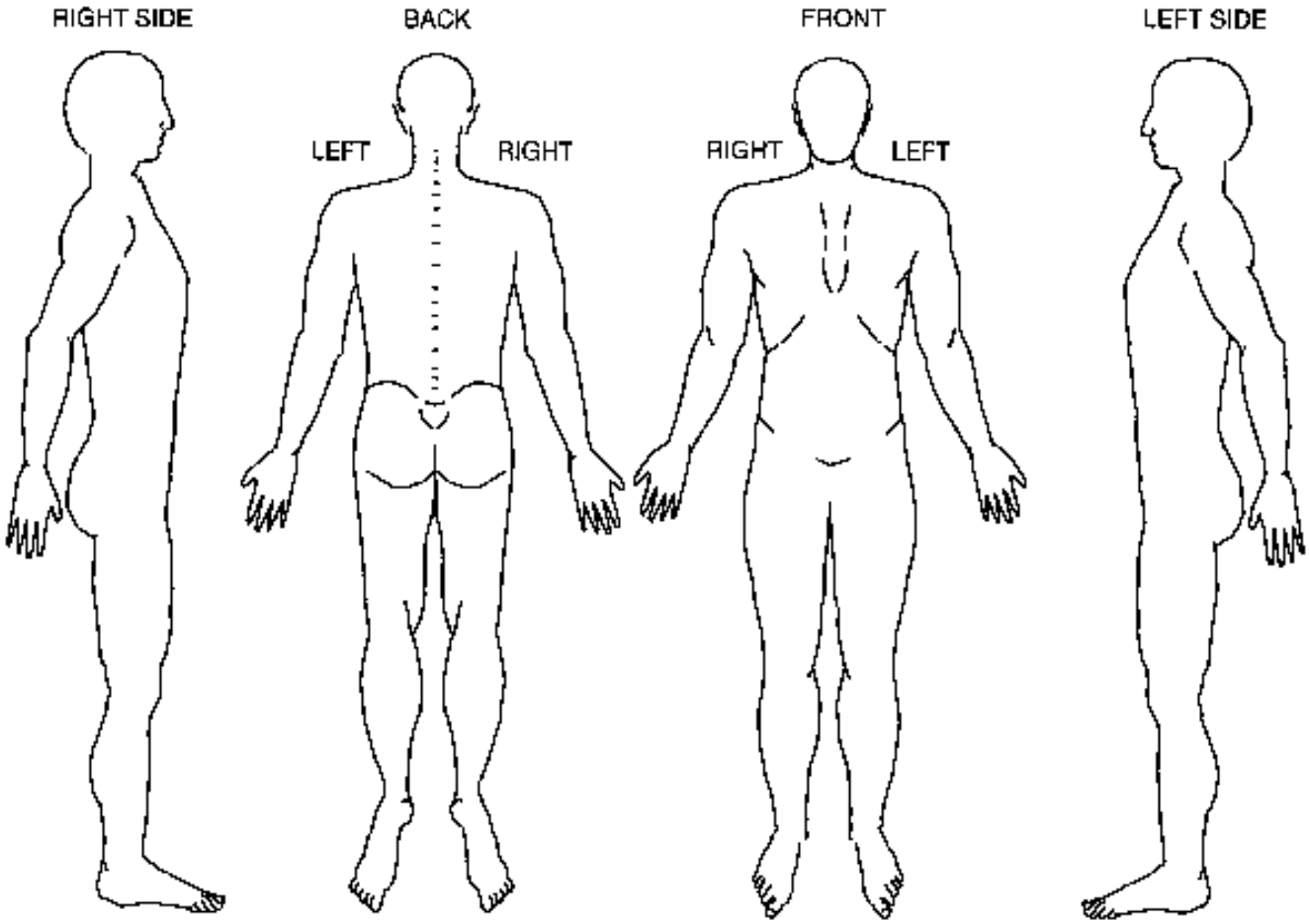
Please describe the type of pain or sensation you are currently experiencing: (check all that apply)

- ☐ 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:



NAME: _____

OFFICE USE ONLY:

– / + UDS: _____ Room #: _____ HT:_____WT:_____Pulse: ____O2:____Resp:_____B/P:____/_____

Clinical info

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 understand that I can NOT consume alcoholic beverages while taking narcotic medications.**
___ **22** 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.
___ **23** 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.
___ **24** 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.
___ **25** I understand that if I do not follow this medication agreement, I may be dismissed from Nevada Advanced Pain Specialists, at their discretion.
___ **26** 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

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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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
Initial or_____ (date) at which time this authorization expires.

_____ I understand that information used or disclosed pursuant to this authorization may be disclosed
Initial 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