NEVADA COMPREHENSIVE PAIN CENTER

REGISTRATION FORM

PATIENT INFORMATION
Información del paciente

Patient's last name (Apellido) :	First(Nombre):	Middle (Segundo nombre):	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.
Birth date (Fecha de nacimiento) : / /	Age (Edad):	Social Security no. (Seguro Social):		

Marital status (circle one): Single / (Soltero/a) Married / (Casado/a) Divorced / (Divorciado/a) Separated / (Separado/a) Widowed (Viudo/a)	Sex: ❑ M ❑ F	Home phone (Teléfono): ( )	Cell phone (Cellular): ( )
Street address (Dirección):		Prefer means of contact (Prefieren medios de contacto): ❑ Call ❑ Text ❑ Email:	
City (Ciudad):	State (Estado) & ZIP Code (Código postal):	Primary Language:	Ethnicity:
Occupation (Ocupación):	Employer (Empleo):	Employer phone no.: (Telefono del empleo): ( )	
Referred to clinic by (Referido por):	❑ Dr.	❑ Other:	

IN CASE OF EMERGENCY
En caso de emergencia

Name (Nombre) :	Relationship to patient (relación al paciente):	Telephone number (Numero de teléfono):

INSURANCE INFORMATION
Información de su a seguranza

Insurance Company (Aseguranza):	Subscriber's name (Nombre del suscriptor):	Subscriber's SSN (Seguro social del suscriptor):	Birth date: (Fecha de nacimiento): / /
Policy number (Póliza):	Group number (Numero de grupo):	Patient's relationship to subscriber (Relación al paciente): ❑ Self ❑ Spouse ❑ Child ❑ Other:	
Occupation (Occupacion):	Employer (Empleo):	Employer phone no. (Telefono del empleo): ( )	
Name of secondary insurance (Segunda aseguranza):	Subscriber's name (Nombre del suscriptor):	Subscriber's SSN (Seguro social del suscriptor) :	Birth date: (Fecha de nacimiento) : / /
Policy number:		Group number:	

ATTORNEY INFORMATION
Información de su abogado0

Attorney's name (Nombre del abogado) :	Phone number (Numero de telefono):	Date of accident (Fecha del accidente) :

WORKERS COMP. INFORMATION
Compensación al trabajador

Workers comp name:	Adjusters name:	Phone number:	Date of injury:	Claim number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NVCPC or my insurance company to release any information required to process my claims.

Patient/Guardian signature (Firma del paciente o guardián) _____ Date (Fecha) _____

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PATIENT MEDICATION LIST

Provided by the patient

	Medication Name	Dose	Frequency (How Often)	Reason for Taking	Last Taken
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Patient Signature **Date**

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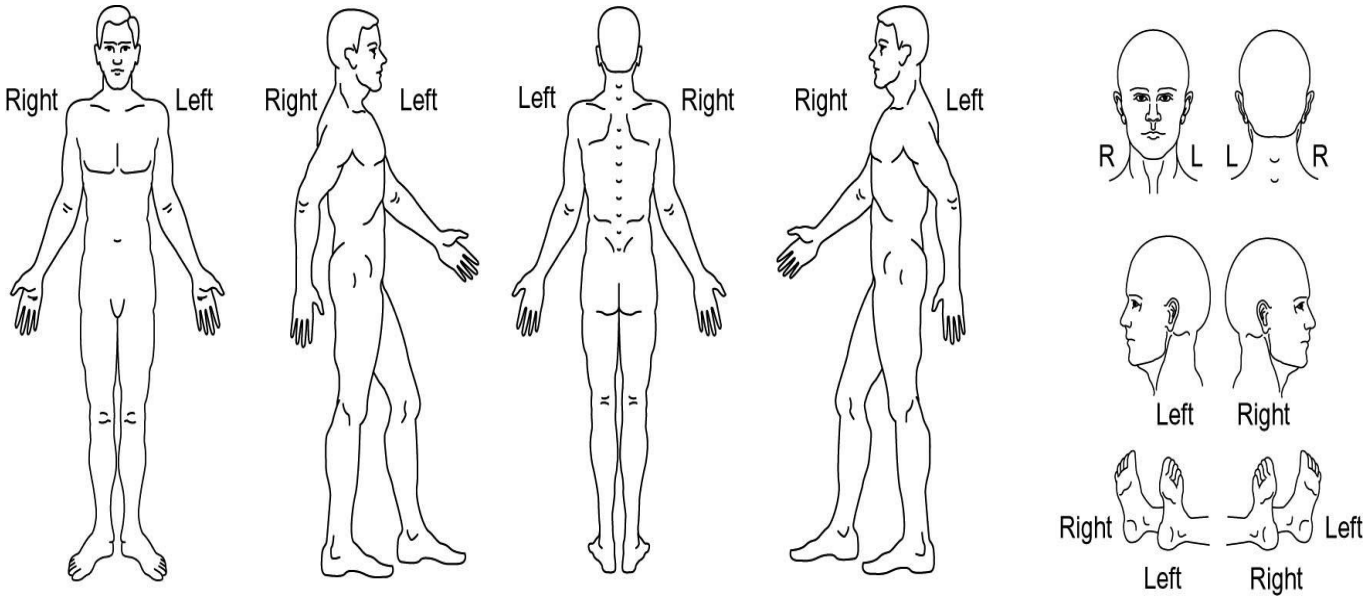
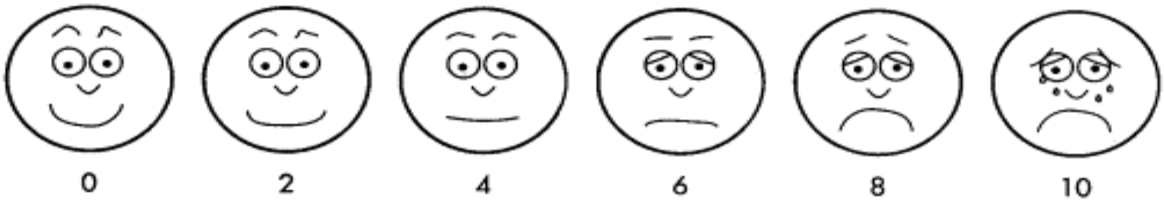
On the following diagram, Please indicate the area where you currently feel pain.

Numbness ++++++ Pins & Needles: OOOOOOO Burning: XXXXXXXX



Choose the face that best describes how you feel!



0	2	4	6	8	10
No Pain	**Can be Ignored**	**Interferes with tasks**	**Interferes with concentration**	**Interferes with basic needs**	**Bed rest required**

PATIENT SIGNATURE:_____ **DATE:**_____

NEVADA COMPREHENSIVE
PAIN CENTER

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient,

Thank you for choosing Nevada Comprehensive Pain Center for your health care needs.

Payment for services is due at the time services are rendered. We accept cash, Mastercard, Visa, and Discover. We will submit an insurance claim on your behalf. Please notify our office immediately if your insurance information changes.

- All copays are due at the time of service and must be paid by cash, credit or debit. No checks will be accepted for copays.
- Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Our relationship is with you.
- You have the right to waive your insurance at any time. If you do not inform us of your insurance carrier information at the time of service, you are voluntarily waiving your right to use your insurance, and will be responsible for the fees incurred.
- You are responsible to know your insurance benefits. We can assist you in finding sources for this information.
- We will release any requested medical records or documents to your insurance carrier if required.
- Our office will attempt to collect fees from your insurance carrier. If your carrier denies payment, these fees will be transferred to you.
- ANY RETURNED CHECKS WILL BE SUBJECT TO A $25 FEE.
- Financial arrangements can be made through our administrator.
- You are responsible for any collection fees, legal fees, or court costs.
- All office visits are subject to a $25 “No show” fee unless cancelled within 48 hours prior to the appointment date. This fee is not billable to any insurance or attorney and is payable prior to any future visits.

If you have any questions or concerns, please ask our staff.

By signing this form you acknowledge that you have read and accept this agreement.

_____ _____

Patient Signature DATE

NEVADA COMPREHENSIVE
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"HIPAA"-Privacy Authorization Form

Authorization for use or disclosure of Protected Health Information

Patients Name: _____ Date of Birth: _____

I authorize the following individual(s) to obtain my personal/medical information:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand and agree to the NVCPC Notice of Privacy Practices which describes how my protected medical information may be used and disclosed, and may be given a copy if requested.

_____	_____
Patient or representative Signature	Date

This authorization will expire one year from the date of signing.

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PAIN CENTER
INSURANCE • WORKER'S COMP • PERSONAL INJURY
702.476.9999 WWW.NVCPC.COM

Fax: 702-946-5022 Email: MedicalRecords@nvcpc.com

HIPAA Compliant Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City/State/Zip Code: _____

This Authorization allows Nevada Comprehensive Pain Center to:

☐ **Send** copies of your medical record to the provider/person/facility below.

☐ **Receive** copies of your medical record from the provider/person/facility below. Fax: _____

Name of Provider/Person/Facility: _____ Phone: _____

Address: _____ City/State/Zip: _____

Purpose of Request: Healthcare Appointment and Coordination of Care

Information to be Released:

□ Initial Consultation Note □ Most Recent Office Visit Note(s) □ Radiology Reports: _____

□ Procedure Note(s) □ Dates of Service: From: _____ to _____ □ Other: _____

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans, or health care clearinghouses, which must follow federal standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights with Respect to this Authorization:
1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above-named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for the duration that I am an active patient. To initiate revocation of this authorization, I must submit this in writing to NVCPC. 3) I understand that a digital replication of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by federal law. 5) I understand that I have the right to refuse to sign this authorization, I am signing this authorization voluntarily, and that treatment, payment, or eligibility for benefits may not be conditioned on obtaining this authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of; Alcohol, Drug Abuse and/Psychiatric records, Sexually Transmitted Disease(s), and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to obtain copies of my health information, by contacting the Compliance/Privacy Officer.

Expiration Date: This authorization is valid while under active treatment, and will expire upon discharge from the practice, or the following date _____.

I have reviewed and understand the content of this authorization form. By signing this authorization, I am confirming it accurately reflects my permission.

Signature of Patient or Legal Representative: _____ **Date**: _____

Witness: _____ **Date** _____

If not signed by patient, select authorized authority (provide documentation):
□ Parent of Minor Child □ Power of Attorney □ Representative of Custodial Adult □ Other: _____