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.					

Signature **Date**

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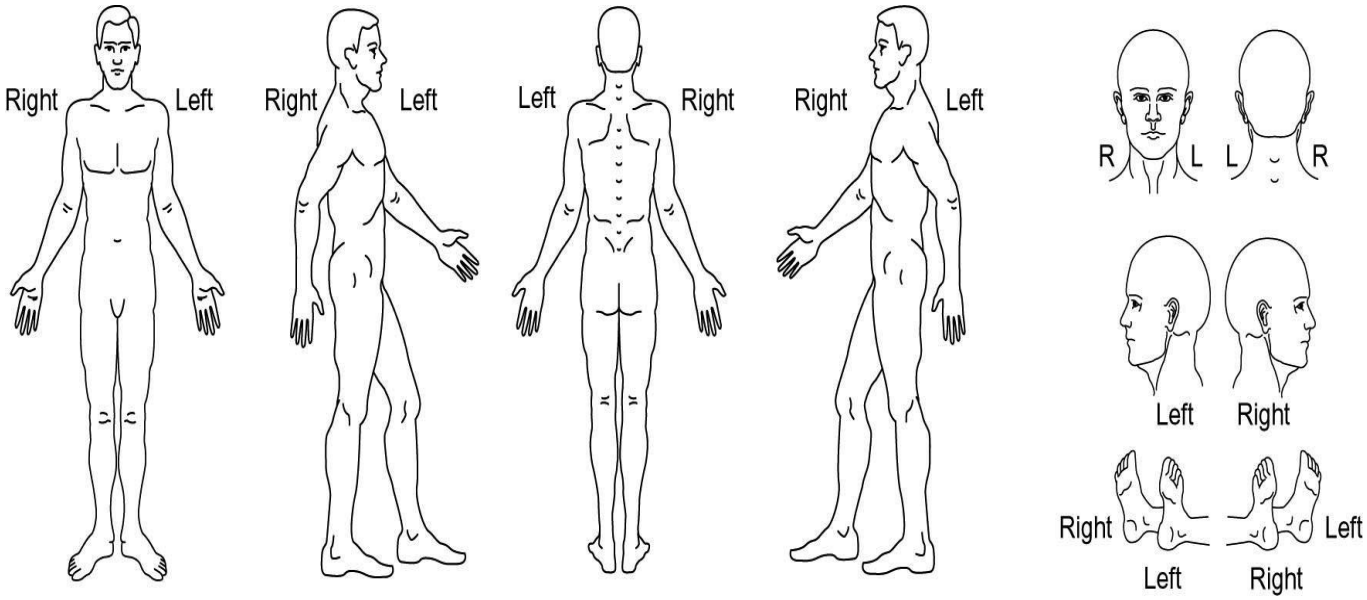
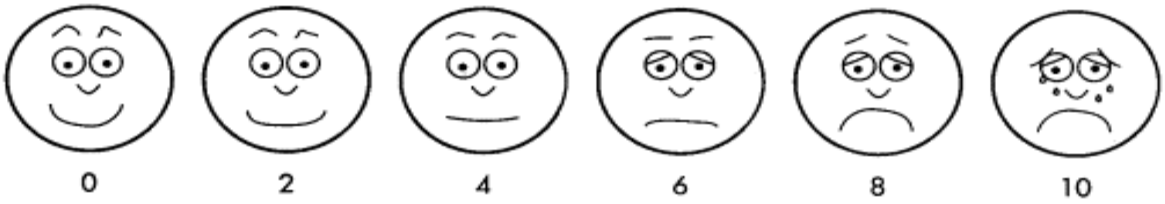
On the following diagram, Please indicate the area where you currently feel pain.

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
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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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2809 W Charleston Blvd #150, Las Vegas, NV 89102
1655 W Horizon Ridge Pkwy, Henderson, NV 89012
7730 W Cheyenne Ave #107, Las Vegas, NV 89129
1569 E Flamingo Rd, Las Vegas, NV 89119
9327 W Sunset Rd, Las Vegas, NV 89148

Phone: (702)476-9999 Fax: (702)946-5022

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____
to release healthcare information of the patient named above to:

Name: NEVADA COMPREHENSIVE PAIN CENTER

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Unless specified above, this authorization will expire one year from the date of signing.

NEVADA COMPREHENSIVE PAIN CENTER

OPIOID AGREEMENT AND INFORMED PAIN MANAGEMENT CONSENT

The purpose of this agreement is to give you necessary information about the medications you will be taking for pain management and to assure that you and your health care provider comply with all State and Federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for the moderate to severe pain with the intent of reducing pain and increasing function. The health care provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of your treatment depends on the mutual trust and honesty between you and your provider and your full understanding and agreement of the risk and benefits of using opioids to treat your pain.

I,_____agree that as part of my treatment for pain that opioid (morphine-like) drugs may be prescribed. I understand that these drugs can be very useful, but also have a high potential for misuse and are therefore closely controlled by local, state, and federal government. Because my health care provider is prescribing such medication to help manage my pain, I agree to the following stipulations:

1. **I AM RESPONSIBLE FOR MY MEDICATIONS.** I agree to take medication ONLY as prescribed.
   A. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression, or even death.
   B. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal, WITHDRAWAL SYMPTOMS can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot/cold flashes, "goose flesh", abdominal cramps, and/or diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.
2. **I WILL NOT ACCEPT OR REQUEST CONTROLLED SUBSTANCE MEDICATION FROM ANY OTHER PHYSICIAN OR INDIVIDUAL WHILE I AM RECEIVING MEDICATION FROM MY PROVIDER AT NEVADA COMPREHENSIVE PAIN CENTER.** I understand that doing so will result in ***IMMEDIATE*** discharge from the practice.
3. There are side effects with medication therapy (especially opioids), which may include but not limited to: skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).
4. It is my responsibility to notify my physician immediately if I need to visit another physician or emergency room due to pain, or if I become pregnant.
5. I understand that all medication is strictly for my use, especially opioids, and agree ***NEVER*** to give or sell any portions of my medication to others as it may endanger that person's health and is **AGAINST THE LAW.**
6. I will inform my physician of all medications I am currently taking, including any herbal remedies as they can interact with opioids and produce serious side effects.
7. I will return to the clinic as instructed by my physician.
8. I understand that my prescription will ***NEVER*** be mailed to me. If I am unable to obtain my prescriptions monthly, I will transfer my care completely to a new provider.
9. **ANY EVIDENCE OF DRUG HOARDING, ACQUISITION OF ANY OPIOID MEDICATION OR ADJUCTIVE ANALGESIA FROM OTHER PHYSICIANS (WHICH INCLUDES EMERGENCY ROOMS), UNCONTROLLED DOSE ESCALATION OR REDUCTION, LOSS OF MEDICATION OR PRESCRIPTIONS OR FAILURE TO FOLLOW THE AGREEMENT MAY RESULT IN TERMINATION OF THE PHYSICIAN/ PATIENT RELATIONSHIP.**
10. I will communicate fully with my physician to the best of my ability at the initial and all follow up visits about my pain levels and functional activity along with any side effect I am experiencing. This information allows my physician to adjust my treatment plan accordingly.
11. **I agree that I will not use ANY illicit substances**, such as cocaine, marijuana, etc. while taking these medications. I am aware that if I do so, this may change my treatment plan, including safe discontinuation of my treatment plan or complete termination of the physician/patient relationship.

12. The use of alcohol together with opioid medications is contraindicated. **I WILL NOT USE ALCOHOL WHILE TAKING OPIOID MEDICATION.**

13. **I AM RESPONSIBLE FOR MY PRESCRIPTIONS, I UNDERSTAND THAT:**
    A. Refill prescriptions can be written for a *maximum* of a one month supply and will be filled at the *same* pharmacy.
    B. It is my responsibility to schedule appointments for the next refill before I leave the clinic or within three days of the last clinic visit.
    C. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. IF MY MEDICATION IS SOTLEN, I WILL FILE A REPORT WITH MY LOCAL POLICE DEPARTMENT AND PROVIDE A COPY OF THE REPORT TO MY PHYSICIAN. If my medications are lost, misplaced, or stolen, my physician may choose not to replace the medications or to taper and discontinue the medications.
    D. REFILLS WILL NEVER BE MADE AS AN ***"EMERGENCY",*** SUCH AS FRIDAY AFTERNOON BECAUSE I SUDDENLY REALIZE I WILL "RUN OUT TOMORROW".
    E. Prescriptions for pain medication or any other medication will be done only during an office visit or during regular office hours. NO refills of ANY medication will be done on evenings or weekends.
    F. I agree that I must bring back all opioid medications, adjunctive medications prescribed by my physician in the original container/ bottle at every visit.
    G. I understand and agree that my prescriptions will not be written in advance due to vacations, meetings, or other commitments.
    H. I understand that if I miss an appointment for a prescription refill, another appointment will be made as soon as possible. **IMMEDIATE OR EMERGENCY APPOINTMENT MAY NOT BE GRANTED**.
    I. I understand that "walk-in" appointments for opioid refills may not be granted.
14. While physical dependence is to be expected after long-term use of medications, especially opioids, signs of addiction, abuse or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.
    A. **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes to the point that abruptly stopping these medications can cause a withdrawal response. It should be noted than physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to insulin or prednisone.
    B. **Addiction** is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life, if I exhibit such behavior, the drug will be tapered and I will not be candidate for an opioid trial. I will be treated for addiction.
    C. **Tolerance:** means a state of adaptation in which exposure to the drug includes changes that result in a lessening of one or more of the drug's effects overtime. The dose of the opioid medication may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.
15. If it appears to the physician/ provider that there is no improvement in my daily function or quality of life from the controlled substance, my medications may be discontinued. I will gradually reduce my medications as prescribed by my physician/ provider.
16. If I have a history of alcohol or drug misuse/ addiction, I must notify the physician/ provider of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is necessity.
17. I will keep my regular appointment, and sometimes two to three days extra if the prescription ends on a weekend or holiday. I understand and agree to comply with the provision of extra medication which will not be used without explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

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18. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. I will cooperate any time I am asked to provide a urine sample. If I decide not to provide a urine sample, I understand that my physician/ provider may change my treatment plan, including safe discontinuation of the opioid medications when applicable and/or complete termination of my physician/ patient relationship. The presence of a non-prescribed drug(s) in my urine can be grounds for the termination of my physician/ patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.
19. I agree to allow my health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the physician feels it is necessary.
20. I understand that non-compliance with ANY of the above mentioned conditions may result in a re-evaluation of my treatment plan and discontinuation of my medications especially opioid therapy. I may be gradually taken off these medications or even discharged from Nevada Comprehensive Pain Center.

I,_____have read the above information or it has been read to me and all of my questions have been answered regarding the treatment of pain with opioids. I hereby give my consent to participate in the opioid medication therapy and acknowledge receipt of this document.

Patient's signature:_____ Date: _____

Physician's signature:_____ Date: _____