Patient Name: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

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

Home Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

E-Mail Address: _____

Employers Name: _____ Work Phone: _____

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

Spouse/Parent Name: _____ Date of Birth: _____

Spouse/Parent Employer: _____ Phone Number: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Primary Insurance: _____ Phone Number: _____

Address: _____ ID #: _____

Policy Holder Name: _____ SSN #: _____

Secondary Insurance: _____ Phone Number: _____

Address: _____ ID #: _____

Policy Holder Name: _____ SSN#: _____

Work Related Injury? Yes ☐ No ☐ Date Of Injury: _____ Claim #: _____

Industrial Insurance Carrier: _____ Case Manager: _____

Address: _____ Phone: _____

Nature of Injury/Body Part: _____

Employer at Time of Injury: _____

MEANINGFUL USE DATA

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Not Provided
Primary Language: ☐ English ☐ Spanish ☐ Russian ☐ French ☐ Not Specified
Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Not Provided
Referred By: ☐ Self ☐ Website ☐ Physician ☐ Friend ☐ Other: _____

_____ _____

Patient Signature Parent/Guardian Signature

_____

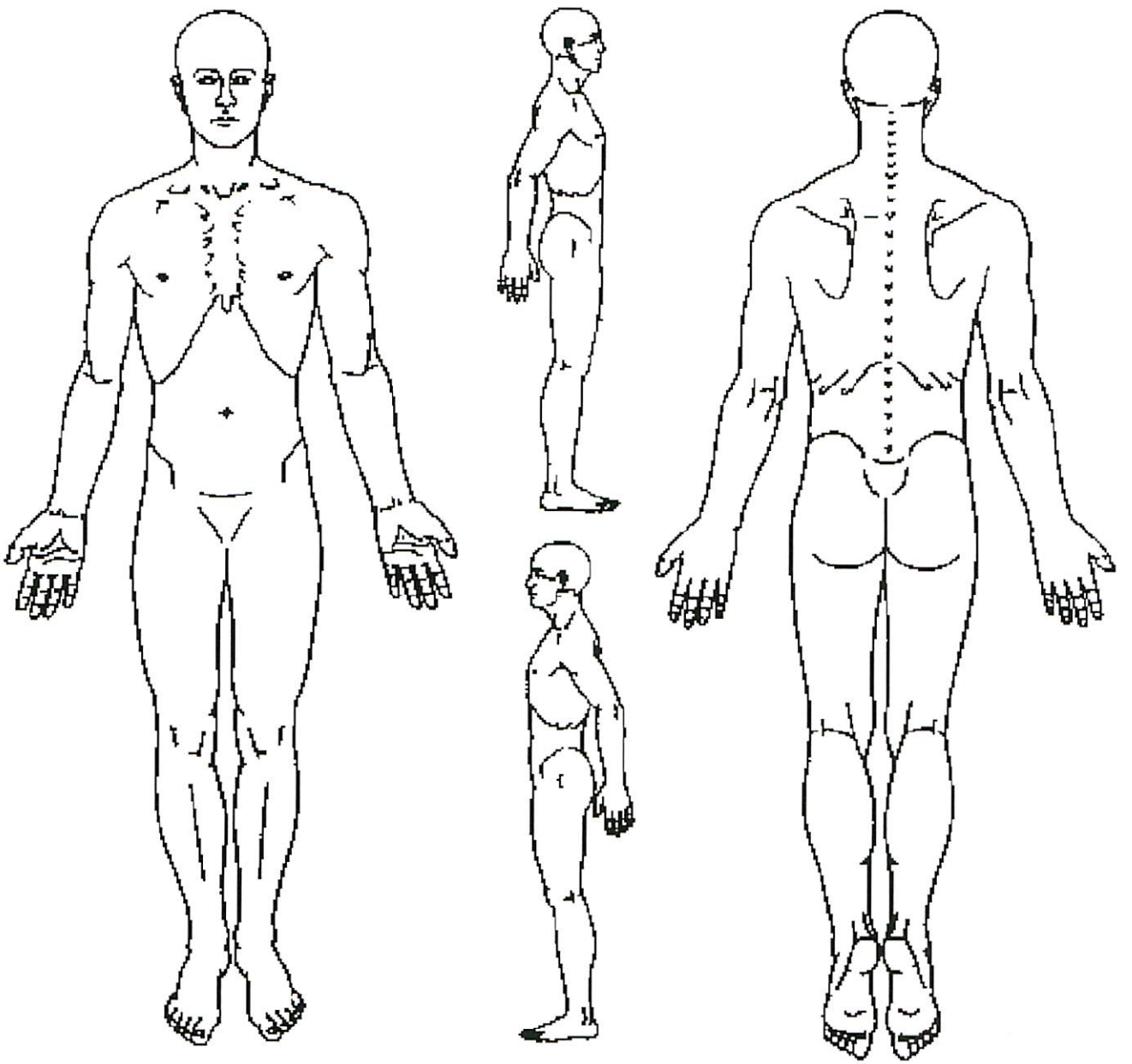
Date

PAIN DIAGRAM

PATIENT'S NAME _____

On the diagram below, please indicate where you are experiencing pain or other symptoms. Use the following to describe your symptoms:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing O = Other



Please rate your current level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's Signature: _____ Date: _____

Name: _____ Date: _____

REVIEW OF SYSTEMS (Circle **YES** or **NO** to the following questions on your health history):

GENERAL: History of weight loss, fever, chills, nausea, vomiting etc.....

EYES: History of dizziness, vision problems, etc..... **Yes** **No**

EARS, NOSE, MOUTH, THROAT: History of sinus disease, nosebleeds, tooth disease, ringing of the ears, deafness..... **Yes** **No**

CARDIOVASCULAR: History of palpitations, irregular heart rate, chest pain, shortness of breath, etc. **Yes** **No**

RESPIRATORY: History of wheezing, shortness of breath, coughing, night sweats, bloody sputum, etc. **Yes** **No**

GASTROINTESTINAL: History of nausea, abdominal pain, vomiting, ulcers, jaundice, vomiting blood, diarrhea **Yes** **No**

GENITIURINARY: History of urinary retention, urgency problems, pain with urination, etc. **Yes** **No**

PSYCHIATRIC: History of nervous breakdown, hallucinations, depression..... **Yes** **No**

ENDOCRINE: History skin or hair growth, thyroid problems, dryness or hair/skin, intolerance to heat/ice, etc. **Yes** **No**

BLOOD AND LYMPH: History of anemia, excessive bleeding, family history of bleeding disorders **Yes** **No**

IF YOU ANSWERED **YES** TO ANY ABOVE QUESTION, PLEASE EXPLAIN:_____

_____

_____

_____

Is there a family history of any of the above problems? **Yes** **No** If Yes, Please explain: _____

_____

_____

Are you being treated for any medical conditions above? **Yes** **No** If YES, who is your treating doctor? _____

Do you smoke? **Yes** **No** If yes, how many per day? _____

Do you drink alcoholic beverages? **Yes** **No** If yes, how often?_____

MEDICATION:

Name of Medication	Dose	#/Day	Reason for taking (diagnosis)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies:

Name of Medication	What happens (symptoms)?
_____	_____
_____	_____
_____	_____

Patient Signature _____ Date_____

Pain Medication Agreement

==========

PATIENT NAME: _____ **DOB:** _____

DATE: _____

Definition and Purpose

The Pain Treatment Agreement is to document the approach to pain management. Medication treatment includes drug prescriptions along with other modalities. The agreements is for the purpose of defining the terms of care for the patient.

The use of controlled substances may cause addiction and are only one part of treatment of pain. The goals of using these medications

Terms and Conditions

The patient must agree to the following:

1. I will take the medication only as prescribed.
2. I agree to random pill counts of the prescribed medication in my possession.
3. I agree to testing and monitoring of drug use when deemed medically necessary by my provider.
4. I will not request or accept any narcotic prescriptions from another doctor.
5. I will be responsible for making sure that I do not run out my medication on weekends and holidays, because abrupt discontinuation of these medications may cause withdrawal symptoms.
6. I understand that I must keep my medication in a safe place.
7. I understand that my provider will NOT supply additional refills for the prescriptions of medications that I may lose.
8. If my medications are stolen, my provider will refill the prescription ONE time only if a copy of the police report of theft is submitted to the physician's office.
9. I will NOT give or share my prescription with anyone else.
10. I will only use one pharmacy.
11. I will not call the office for refills. I will call my pharmacy.
12. I will allow 24 hours for a prescription refill.
13. I understand there will be NO early refills, for ANY reason.
14. Requests for a change in prescriptions will be discussed at appointments ONLY.
15. I understand that there will be absolutely NO EXCEPTIONS to this policy.
16. I agree to inform my provider of the following:
    a. Of any other controlled substance I've consumed either those prescribed or otherwise.
    b. Whether or not I consume alcohol or any other cannabinoid compound while using prescribed controlled substances.
    c. Whether or not I have been treated for side effects or complications related to the use of controlled substances related to the use of controlled substance, including if I have experienced an overdose.
    d. Any other state that I previously resided or had a prescription for a controlled substance filled.

Compliance

Failure to comply with the terms and conditions of the Reno Carson Spine Pain Medication Agreement may result in **discontinuation of medication refills.** Random drug profiles may be obtained.

Patient Signature _____ **Date**_____

Prescriber Signature_____ **Date**_____

Reno Carson Spine
Dr. Halki
6490 S. McCarran Blvd. Bldg. D#38
Reno, NV 89509
PH: (775)870-1050
FX: (775)499-5982

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTHCARE INFORMATION

Patient Name:_____ SS#:_____
Address:_____ Phone #:_____
_____ Date of Birth:_____

I HEARBY AUTHORIZE THE RELEASE OF MY PRIVATE HEALTHCARE INFORMATION

FROM:

_____
_____
_____
_____

TO:

Name of Doctor/Facility: Reno Carson Spine
Address: 6490 S McCarran Blvd. Bldg.D#38
Reno, NV 89509
Phone: (775) 870-1050
Fax: (775) 499-5982

INFORMATION TO BE RELEASED

I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:

( ) History/Physical Exam
( ) Progress Notes
( ) Lab Reports
( ) X-ray Reports
( ) Medication History
( ) Other
( ) Specific Dates:_____

( ) Substance Abuse (including drug/substance)
( ) Mental Health (including psychotherapy notes)
( ) HIV related information & testing

Release of above information requires patient/legal guardian signature here:

Patient/Legal Guardian: _____ **Date:** _____

PURPOSE OF DISCLOSURE

( ) Changing Physicians ( ) Consultation/ 2nd Opinion ( ) Continuing Care
( ) Legal ( ) School ( ) Insurance ( ) Other: _____

AUTHORIZATION SIGNATURE: I understand that this authorization will expire 365 days from the date I signed this form.

Patient/Legal Guardian:_____ Date:_____

Witness/Staff Member:_____ Date:_____

Reno Carson Spine
Dr. Halki
6490 S. McCarran Blvd. Bldg. D#38
Reno, NV 89509

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Reno Carson Spine, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____

Patient Financial Responsibility

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities.

_____ (initial) This is a legally binding contract between RENO CARSON SPINE and you. The words, I, me, my, you and your all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of RENO CARSON SPINE's services. Cash, check/money order, or credit cards are acceptable forms of payment for these services.

_____ (initial) I understand there will be a $20.00 fee for all returned checks.

_____ (initial) If co-payments are not made at the time of service, I understand that my appointment may be rescheduled. I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give RENO CARSON SPINE my current address and other contact information.

_____ (initial) Current insurance cards must be presented at every office visit. RENO CARSON SPINE is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give RENO CARSON SPINE my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay RENO CARSON SPINE the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give RENO CARSON SPINE the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that RENO CARSON SPINE can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

_____ (initial) If I do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

____ (initial) At time of my appointment I agree to make a payment towards any outstanding balance on my account from previous services.

_____ (initial) I understand that if I fail to pay the balance on my account this may result in RENO CARSON SPINE pursuing any collection means possible.

I have read and I understand RENO CARSON SPINE's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature _____ **Date:** _____

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to RENO CARSON SPINE. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS**. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document. I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize RENO CARSON SPINE to deposit checks received on my account when made out in my name.

I have read and I understand RENO CARSON SPINE's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature _____

Date: _____

PATIENT FINANCIAL RESPONSIBILITY

RENO CARSON SPINE is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your co pay at the time of your office visit. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit.

As a courtesy, RENO CARSON SPINE will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use.

I have read and I understand RENO CARSON SPINE's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature _____ **Date:** _____

MEDICARE/MEDICARE ADVANTAGE (MCO) PATIENT's

For Medicare/Medicare Advantage (MCO) patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to RENO CARSON SPINE for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits. I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

Medicare/Medicare MCO Number: _____

Patient Name: (Print) _____

Patient Signature _____ **Date** _____