Welcome to Advanced Pain Management Center

1. Please provide the front desk with a copy of your driver's license and current insurance cards.
2. **It is your responsibility to know your insurance**. Due to the exactitude of insurances, you will not be seen until all insurances have been verified and referrals have been received. If you have more than one insurance, please let us know immediately as it can take up to two hours to verify insurance.
3. **Please do not leave anything blank in the patient packet**.
4. Do not use the term N/A (not applicable); instead use "none" or "no" where it is needed.
5. Please ask us for help if something needs to be clarified. We are here to help you.

Today's Date _____

Patients Name _____ Birth Date _____
First Middle Last

Social Security Number _____ Home Phone _____ Cell _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Preferred contact method: □ Phone □ Text □ Email_____

Sex: □ Male □ Female Marital Status: □ Single □ Married □Widowed □ Divorced □ Separated

Employer _____ Employer Phone _____ Ext _____

Employer Address _____ City _____ State _____Zip _____

Spouses Name _____ Spouses Cell _____

Referring Doctor _____ Phone _____ Fax _____

Primary Care Physician _____ Phone _____ Fax _____

Emergency Contact (not living with you) _____ Relationship _____Phone _____

Primary Insurance _____ Phone _____ Fax _____

Claims Address _____ City _____ State _____ Zip _____

Policy Holder Name _____ Birth Date _____ ID# _____ Group #_____

Effective Date _____ Relationship to Patient _____

Secondary Insurance _____ Phone _____ Fax _____

Claims Address _____ City _____ State ____ Zip _____

Policy Holder Name _____ Birth Date _____ ID# _____ Group #_____

Effective Date _____ Relationship to Patient _____

Healthcare Reform Questions: Due to recent reforms mandated by the government American Recovery Reinvest Act (ARRA) legislation, doctors are required to ask all patients for their race and ethnicity regardless of insurance to meet Meaningful Use Requirements.

Ethnicity: (check one) □ Hispanic or Latino □ Non-Hispanic □ Declined to Report

Primary Race: (check one) □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White □Unsure or Declined to Report

Language: (check one) □ English □ Spanish □ Arabic □ Chinese □ French □ German □ Japanese □ Russian □ Vietnamese □ Other

Please state your reason for today's visit: _____
_____

Is this an on the job or other work related injury? □ Yes □ No

If so, please complete the following:
Employer Name: _____ Phone _____
Case Worker's Name _____ Case Worker's Phone _____
Date of Injury _____

Is this an injury from a Slip and Fall or Auto related injury? □ Yes □ No

Date of Injury _____ Attorneys Name _____ Phone _____

Insurance Information

The specialty of pain management requires additional paper work for your insurance company. Please be aware that you may receive forms in the mail from your insurance company requesting:

- Accident information
- Coordination of Insurance Benefits Information

Please respond immediately to your insurance.

If you do not respond to the insurance company within 30 days, they will delay your case and will not pay any claims. You will end up responsible for 100% of billed charges and will have no recourse to appeal.

Advanced Pain Management Center

Patient Questionnaire

Date:_____

Name: _____Date of Birth _____ Phone Number _____

Emergency Contact Name_____ Phone Number _____

Referring Physician: _____ Phone _____

Primary Care / Family Physician: _____ Phone _____

HISTORY OF PAIN:

1. What is the main complaint for which you are seeking treatment at the Pain Management Center?

_____

_____

2. How long have you had the pain problem you are currently experiencing?

_____

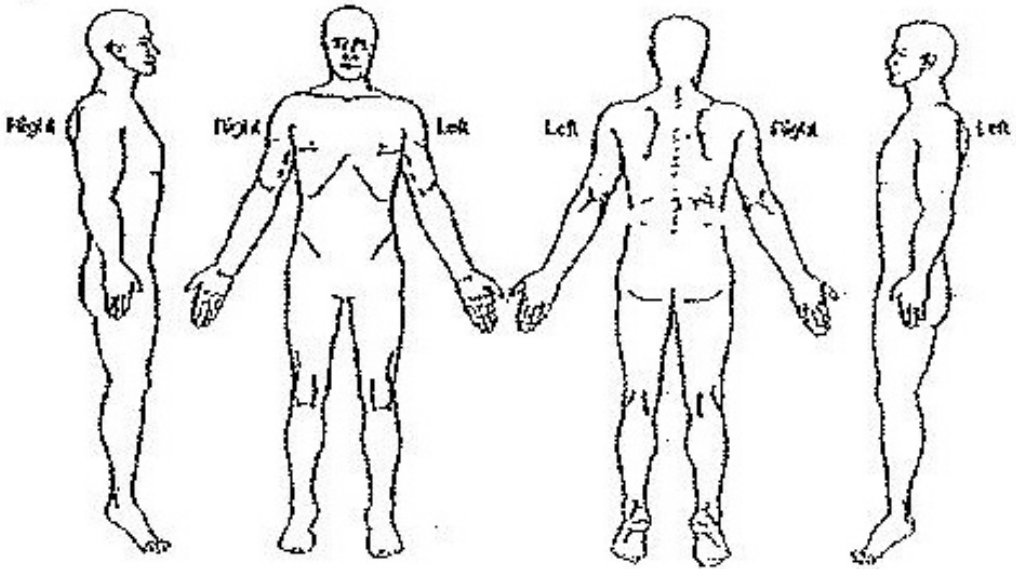
_____

3. What caused your pain to start?

_____

_____

4. On the diagram below, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



5. Please circle the level of your pain on a scale of 0 to 10. (0= no pain; 10= worst imaginable pain)
   Worst Pain: 0 1 2 3 4 5 6 7 8 9 10
   Least Pain: 0 1 2 3 4 5 6 7 8 9 10

6. What type of pain do you have? (Check the box that best describes your pain.)
   ☐Aching ☐ Cramping ☐ Shooting ☐ Throbbing
   ☐Burning ☐ Piercing ☐ Stabbing ☐ Other

7. How often do you have pain?
   _____ Constantly _____ Intermittently

8. What makes your pain feel better? _____

   _____

9. What makes your pain feel worse? _____

   _____

10. Are there any other symptoms associated with your pain?
    ☐ Numbness ☐ Bowel Incontinence ☐ Tenderness of affected area
    ☐ Weakness ☐ Urinary Incontinence ☐ Pain with light touch

11. Are you depressed because of your pain? ___ Yes ___ No

12. Have you ever considered suicide to end your pain? ___ Yes ___ No

13. Has your pain affected any of the following? (Check all that apply.)
    ☐ Sleep ☐ Routine Activities ☐ Work

14. What other treatments have you had in the past to treat your pain?

Date	Type of Treatment	Pain Relief (%)

PAST MEDICAL HISTORY:

Please check any of the following conditions you have had or presently have:

☐ Diabetes	☐ Kidney disease	
☐ Cancer	☐ Thyroid disease	☐ HIV/AIDS
☐ Heart Problems	☐ Ulcer	☐ Hepatitis
☐ High blood pressure	☐ Bleeding problems	☐ Stroke
☐ Asthma, Emphysema	☐ Seizures	☐ Other

PAST SURGICAL HISTORY:

Date	Procedure

PERSONAL AND SOCIAL HISTORY:

1. What is your current martial status?
   ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/widower
2. Do you smoke? ___ Yes ___ No
3. Do you drink alcoholic beverages? ___ Yes ___ No
4. Do you use recreational drugs? ___ Yes ___ No
5. Present employment status:
   ☐ Full Time ☐ Unemployed ☐ Leave of absence ☐ Student
   ☐ Part Time ☐ Retired ☐ Homemaker

FAMILY HISTORY: (Check all that apply)

☐High blood pressure ☐ Heart Attack ☐Heart Disease
☐Hepatitis ☐ Asthma ☐Lupus
☐Diabetes ☐Seizures ☐Multiple Sclerosis
☐Depression ☐ Schizophrenia ☐ Alcoholism
☐Cancer ☐Thyroid disease ☐ Bleeding disorder
☐Other

ALLERGIES: ☐ Yes ☐ No

If yes, please list: _____

MEDICATIONS:

Medications	Medications	Medications

DIAGNOSTIC STUDIES:

Test	Date	Facility Where Test Was Done
X-rays		
CT Scan		
MRI		
EMG/NCV		

Financial Policy and Assignment of Benefits

***Payments for medical services rendered are due at the time of service unless prior arrangements have been made.**

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, the insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions, and your insurance carrier determines final payment. A deposit is required if you are being scheduled for a procedure.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medicaid, or other designated payers of medical benefits to Advanced Pain Management Center for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize Advanced Pain Management Center to release to my insurance carrier or their agents any medical information about me needed to determine these benefits payable for service.

I understand that if my account becomes delinquent and is assigned to an outside collection agency, that an additional mark up of 100% will be added to the amount I owe. I understand the adding of this collection fee as well as the accrual of interest at the statutory rate should by account be assigned to a collection agency. I agree to pay Advanced Pain Management Center for the medical services provided, collection fees if added and interest.

I hereby consent to and authorize medical treatment, tests, and procedures performed in this office that my physician deems advisable and necessary based on his judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

I have read and understand the above statements:

_____ _____

Patient Signature Date

_____

Please Print Your Name

Advanced Pain Management Center

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

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

Advanced Pain Management Center
(our main office)
9029 S. Pecos Road, Suite 2800
Henderson, NV 89074
Fax #702-739-8605

This request applies to all Diagnostic Testing, most recent medication and the last Physicians note. Please send or fax this information to the number above.

If you have any questions regarding this request of Medical Records, please call our office at ((702)739-8323.

Patient Signature: _____

Date: _____

Advanced Pain Management Center

****HIPAA CONSENT FORM****

I understand that as part of my healthcare, Advanced Pain Management Center originates and maintains electronic health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided the NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Advanced Pain Management Center reserves the right to change their and practices and prior to implementation will mail a copy any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and understand that I may revoke this consent in writing, except to the extent that Advanced Pain Management Center has already taken action in reliance thereon.

I also authorize the person(s) listed below to receive information regarding my appointments or treatments while a patient at the Advanced Pain Management Center.

NAME	RELATIONSHIP
_____	_____
_____	_____

I request the following restrictions to the use or disclosure of my health information:

Release of Records

I authorize Advanced Pain Management Center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices

I acknowledge that I have received and read the Notice of Privacy Practices of Advanced Pain Management Center.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature: _____

Please print your name: _____

Date: _____

ADVANCED PAIN MANAGEMENT CENTER
Expectations/Guidelines for chronic opioid therapy

I understand that the treatment I receive at the Advanced Pain Management Center includes opioid and/or sedative mediations. I also agree to the following while receiving these medications.

I understand that the goals of these medications are to increase my activities at home and/or work and decrease my pain symptoms.

I understand that opioid medications are only one part of my therapy and agree to follow all parts of my treatment program (e.g. physical therapy, behavioral pain management. and injections).

I will not obtain any opioid or sedative medications from any other source other than the Advanced Pain Management Center. If I require emergency treatment that includes opioid or sedative medications, I will notify the staff of the Advanced Pain Management Center at the next appointment

I understand that "Doctor shopping" for additional pain medications from other physicians is discouraged and if this occurs, the physician-patient relationship may be jeopardized.

I understand that any lost medication and/or prescriptions will not be replaced or refilled at an earlier date.
I understand that I must provide my pills for a random pill count.

No increase in medication doses should be made without the approval of the prescribing physician.
Opioid pain medications will hopefully make your pain more tolerable, but they should not be used to relieve stress or to promote sleep.

At the discretion of the physician the patient will be required to submit a urine or saliva sample. This is necessary to monitor patient compliance. Failure to submit the required sample will be considered a reason for termination of the physician-patient relationship.

I understand that failure to follow these guidelines may require cessation of opioid therapy, referral to a substance abuse specialist, and possible termination of my patient status at the Advanced Pain Management Center.

CAUTION: Opioid medications may cause drowsiness. **Alcohol and recreational (street drugs} should not be consumed while taking medications. Use care when operating a car or dangerous machine; do not operate a car or dangerous machinery, if you in any way feel that the side effects of your medications will impair your ability to operate in any manner**.
Federal law prohibits the transfer of these medications to any other person other than the patient for whom they are prescribed. Sharing these medications is a felony.

This class of medications can produce the following adverse effects:

- drowsiness
- constipation
- dependence
- nausea, vomiting
- tolerance
- loss of control over the amount of medication used
- impaired judgment
- risk of fatal overdose if not taken as directed
- Constantly seeking more medications and adverse effects of certain aspects of life

I acknowledge and understand the risks of these medications. I agree to use them only as prescribed.

_____
Witness

_____
Patient or Legal Guardian Signature Date/Time

_____
Physician/Practitioner

Advanced Pain Management Center

Satish Sharma, MD

9029 S. Pecos Road, Suite 2800 Henderson, NV 89074

630 S Rancho Ste H Las Vegas, NV 89106

Phone (702) 739-8323 Fax (702) 739-8605

Cancellation of an Appointment
Please notify our office at least 24 hours in advance if you are unable to keep your scheduled office appointment. If you must cancel a scheduled procedure, we require that you call at least three working days (72 hours) in advance. Appointments and procedure times are in high demand, and early cancellation will give another person the possibility to have access to timely care.

How to Cancel Your Appointment
To cancel an appointment, please call (702) 739-8323. You may leave a detailed message on the voice mail if you are unable to speak directly with a receptionist.

Late Cancellation or No Show
Patients failing to cancel their office appointment as indicated above (at least 24 hours in advance) will be billed a cancellation fee of $100 for an initial consult and $50 for a follow-up visit.

Patients failing to cancel their scheduled procedure as indicated above (at least 72 hours in advance) will be billed a cancellation fee of $50.

All fees must be paid in full prior to the scheduling of future appointments.

Patient Name: (Please Print)
_____

Patient Signature:
_____

Date:
_____
_