



NAME OF PATIENT _____ () MALE () FEMALE
ADDRESS _____ APT _____
CITY _____ STATE _____ ZIP _____
HOME PHONE # _____ CELL PHONE # _____
DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____
MARITAL STATUS _____ E-MAIL ADDRESS _____
OCCUPATION _____ EMPLOYER _____
EMPLOYER ADDRESS _____ PHONE # _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____
ADDRESS _____ PHONE # _____

REFERRED BY () PHYSICIAN () ATTORNEY () INSURANCE () OTHER
NAME _____ PHONE # _____

IF YOU WERE INJURED **DATE OF INJURY** _____ () WORK () AUTO () OTHER
DO YOU HAVE AN ATTORNEY? () YES () NO
ATTORNEY NAME _____

DO YOU HAVE HEALTH INSURANCE? () YES () NO () DO NOT USE

PRIMARY INSURANCE

NAME OF INSURANCE CARRIER _____ INSURED NAME _____
RELATION TO PATIENT _____ INSURED DATE OF BIRTH _____
GROUP NUMBER _____ POLICY NUMBER _____

SECONDARY INSURANCE

NAME OF INSURANCE CARRIER _____ INSURED NAME _____
RELATION TO PATIENT _____ INSURED DATE OF BIRTH _____
GROUP NUMBER _____ POLICY NUMBER _____

I directly assign medical benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether paid or not by my insurance carrier. I hereby authorize the provider to release any information necessary to process my medical claims. I hereby authorize and consent to medical treatment, testing, and procedures that my physician/provider deems advisable and necessary based on his/her judgment

PATIENT SIGNATURE

DATE



Financial Policy and Assignment of Benefits

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, insurance is a contract between you and your insurance carrier. The final responsibility for payment on your account is yours. The exception is those patients with injuries that are covered by worker's Compensation or on a Lien basis. These patients are not responsible for their bills unless the claim/case is denied or they are no longer represented by an attorney.

1. Your co-pay, co-insurance and/or deductible are due at Registration. We accept cash and credit/debit cards; **however, the credit/debit card must be yours.** Like the grocery store and gas station, we require payment before you receive the services. There will be a \$35.00 fee for any returned check.
2. I give Centennial Pain Relief Network the right to send bills to and collect payment from my insurance company. This signed form will be kept in my electronic medical record file.
3. I understand and accept that I am financially responsible for any charges not covered by health care benefits.
4. I also understand that in the event my account becomes past due, interest will accrue at the rate of 1.5% monthly (18% annum). Should my account be referred to a collection agency, interest will continue to accrue at the rate noted herein and collection fee will be assessed to the past –due account. The collection fee shall be equal to a premium of 35% to the delinquent balance. In addition, I will be responsible for all collections cost, attorney fees, court cost, service fees and miscellaneous fees and costs. A photocopy of this financial policy is considered as valid as the original.
5. Should I need to cancel my scheduled appointment, I will do so at least 24 hours before my appointment date. This allows time for others to be seen. If I do not notify Centennial Pain Relief Network in advance, I understand that I need to have a good reason. Otherwise, I agree to pay the following late cancellation fees. If I fail to show up for my scheduled appointment I also agree to pay this fee.

Late cancellation – Failure to show

- Office Visit
- Procedure at Centennial Surgery Center

FEF

\$ 25.00
\$500.00

I have read, understand and accept the Financial Policy as stated. I have been allowed to ask questions and have them answered to ensure my understanding of this Policy.

PATIENT SIGNATURE

DATE

Print Name



PAIN ASSESSMENT BY PATIENT

Please answer the following questions to the best of your ability. Your answers help the physician better understand your pain and the best options for your interventional pain treatment.

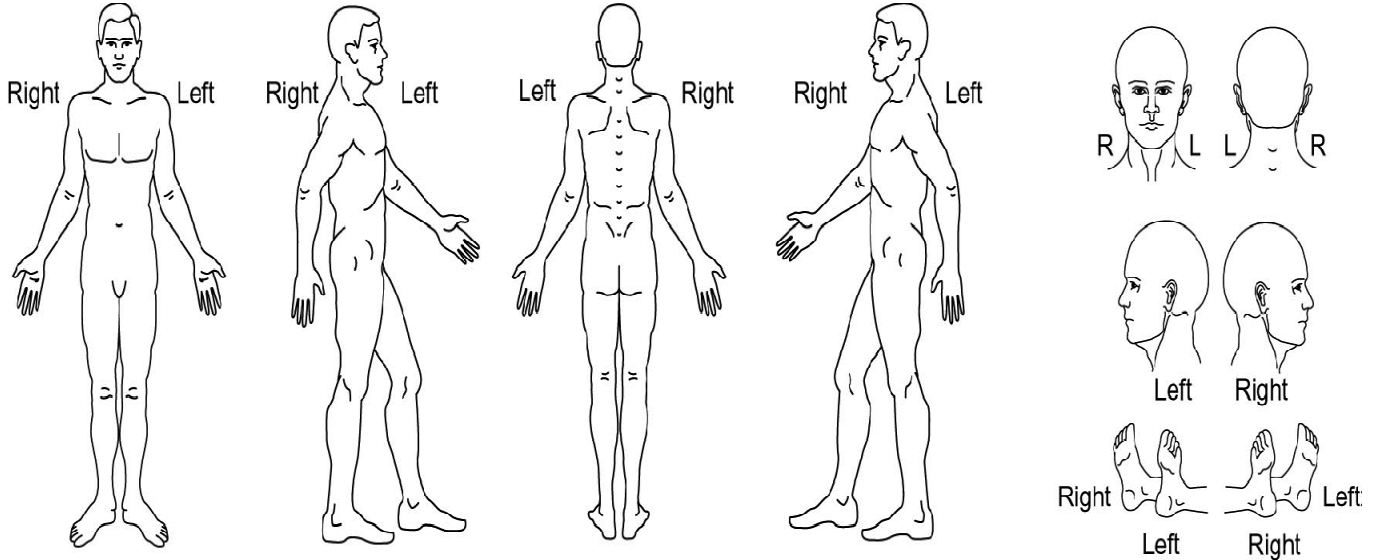
Date Form Completed: _____ Patient name: _____

PLEASE PRINT

Date of Birth: ___/___/___ Male [] Female [] Primary Insurance or Attorney Name: _____

Shade the area where you currently feel pain and indicate type of symptoms you are feeling.

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



Choose the face that best describes how you feel!



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

Using the above scale, please answer the following questions:

Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 7 days.

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 7 days.

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that best describes your pain at its **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10

If Patient is unable to fill out and sign this form please indicate your name & relationship with this patient:

PATIENT SIGNATURE: _____

DATE: _____



Patient Consent for Use and Disclosure of Protected Health Information

I hereby consent to Centennial Pain Relief Network using and disclosing protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). This may include photographs or other images, which are made of me during procedures as long as such photos are used for Treatment, Payment, and Health Care Operations ONLY. **Initials:** _____

I hereby authorize Centennial Pain Relief Network to call any of the telephone numbers provided by me to advise me of any items/information related to my personal care that assist the practice in carrying out treatment, payment, health care operations, such as appointment reminders, insurance items, laboratory/pathology results, etc. I consent to the use of the following communications.

- Telephone number preferred: (____) _____ - _____
- Leave message on answering machine of above telephone number
- Leave message with anyone who answers the above telephone number regarding appointment confirmations, cancellations or changes.
- Email messages at: _____@_____._____
- Text messages at:
Carrier Name: _____ Telephone Number: _____ **Initials:** _____

I hereby acknowledge Centennial Pain Relief Network's use and disclosure of protected health information about me to treat me or assist in my treatment. This includes but may not be limited to information involved in my health care treatment or payment or Centennial Pain Relief Network's health operations (for example—not all inclusive---other physicians, pharmacies, laboratories, clinical representatives, others that assist in my care such as my spouse, children or parents unless I object) in accordance with Centennial Pain Relief Network's Privacy Notice.

- Password: _____ Password Hint: _____ Answer: _____
- Release my information to no one.
- Release to the following:

Name

Relationship

Name

Relationship

Name

Relationship

Emergency Contact: _____ Telephone Number: (____) _____ - _____ **Initials:** _____

I may revoke my consent in writing except to the extent that Centennial Pain Relief Network has already used or disclosed PHI in reliance upon my prior consent. If I do not sign this consent, it will not affect the services or treatment provided to me by Centennial Pain Relief Network. **Initials:** _____

Print Patient Name

Signature of Patient (or Legal Guardian)

Date

Print Witness Name

Signature of Witness

This Consent Form automatically expires when treatment is discontinued.



Informed Consent - Prescription Medications

Before a prescription medication is included in your Treatment Plan, you must review, understand and accept the requirements of this policy.

I acknowledge that I have been informed of the risks of prescribed medications, as well as the policies related to such prescriptions.

Personal Risks:

- Increasing your dose may result in death and overdose.
- Abruptly stopping prescribed medications may result in drug withdrawal, seizure and death.
- Mixing alcohol and other illicit drug may result in death.
- Taking multiple prescribed medications from multiple doctors may result in overdose death.
- Driving or operating heavy equipment may result in death and injury to others and myself.
- Failing to keep prescribed medications locked up may result in over dose and death of my children and other people's children.

Other risks;

- I understand that pain is a symptom .The chronic use of prescribed medications may block the symptoms of pain. These symptoms may be crucial in diagnosis of a heart attack, stroke or intestinal obstruction. Failing to make those diagnoses may result in death if you can't feel the symptoms.
- The use of chronic prescribed medications may cause acceleration of injuries and degenerative process by overuse of the injured body part.
- The use of chronic prescribed medications may result in depression, inactivity, and weight gain, which in the long run will make your pain worse.
- The chronic use of prescribed medications will cause narcotic induced hyperalgesia (increased sensitivity to pain), which will make your pain harder to treat and aggravate your perception of pain.
- The chronic use of prescribed medications will adversely affect your interpersonal relationships.

Now if you still think you need prescribed medications to function, we will prescribe them to you under the following circumstances only:

- You will work with us to engage in healthy activities and decrease your narcotic dose.
- You will keep all prescribed medications locked up
- You will take what is prescribed only.
- You will not go to multiple doctors.
- You will agree to random drug screening.
- You will come in for scheduled appointments.
- You will not receive early refills.
- We will not call in any prescribed medications.
- You will not get more than a one-month supply at a time.
- You understand we will check with the state board of pharmacy to see what prescriptions you have gotten.

I _____ have read the above information or it has been read to me. I have been given time to ask questions regarding the treatment of pain with prescribed medications and have them answered to my satisfaction. I hereby consent to participate in the prescribed medication therapy if it is a part of my Treatment Plan. I agree to abide by all rules as they are defined in this Consent. I have been provided a copy of this document for my own records.

Patient's signature: _____

Date: _____

Physician's signature: _____

Date: _____



ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that _____ has reviewed the following information in detail with me. I have been given the opportunity to have my questions addressed. I understand and accept the information presented and have been offered a copy of the documentation.

Financial Policies

Patient Privacy Notice “Health Insurance Portability & Accountability Act “HIPAA”

Consents

Patient Name

Date

Patient (Guardian) Signature



RECORDS RELEASE

(Medical Record from Another Entity)

Date of Request: _____

Last Name: _____

First Name: _____

Patient's Address: _____

City, _____ State, _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Medical records needed from: _____

Medical records needed from date of service _____ to _____.

I hereby authorize and request that you release all medical records including MRIs, EMGs, x-rays, other radiology diagnostic tests, laboratory tests, and other tests so designated below to:

Centennial Pain Relief Network
4454 N Decatur Blvd
Las Vegas, NV 89130
FAX: 702-839-1301

Other designated Tests:

If needed by specific date, please identify: _____

Patient Signature

Date



RECORDS RELEASE

(From Centennial Pain Relief Network to another Entity)

Date of Request: _____

Last Name: _____ First Name: _____

Patient's Address: _____

City, _____ State, _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Medical records needed from date of service _____ to _____.

I hereby authorize and request that you release all records including MRIs, EMGs, x-rays and other tests to:

If needed by specific date, please identify _____

Patient Signature

Date



INFORMED CONSENT – FACT & FICTION

Fiction: An Informed consent absolves the doctor from malpractice in case you have a bad result.

Fact: An Informed consent absolves the doctor of assault charges. If you have a bad outcome you can still sue the doctor.

Fiction: Risk applies only to me

Fact: Informed consent is about relative risks. Relative risk is about statistics. Relative risk is defined as the probability of something happening to you when you do something opposed to doing nothing.

The law requires that we inform you of the risks associated with having a medical procedure. Before we do that lets look at some relative risks

For example look at some relative risks

- Relative risk of dying in a car accident 1 in 6,500/per year
- Relative risk of dying in a car accident over a lifetime: 1 in 83
- Relative Risk of dying in an airplane 1 in 400,000
- Relative risk of getting hit by a car crossing the street 1 in 48,500
- Relative Risk of drowning 1 in 88,000/year
- Relative risk of being murdered in your lifetime 1 in 16,500
- Relative risks of getting hit by lightning is 1 in 200,000 for your lifetime

Now, that you understand the concept of relative risk. You are in a better position to understand the relative risks of the procedure.

- Relative risk of dying from anesthesia is 1 in 400,000
- Relative risk of dying from the procedure is 1 in 700,000
- Relative risk of a wound infection is 1 in 5,000
- Relative risk of a nerve injury related to the procedures is 1 in 150,000
- Relative risk of paralysis from the procedure is 1 in 250,000
- Relative risk of a spinal headache is 1 in 3500

Now that we have met our obligation and explained to you the relative risks of surgery.....Please drive carefully”

Patient Name

Date