Aury N. Nagy, MD, FAANS

Thank you for choosing Dr. Aury Nagy at Nevada Brain & Spine Care for your neurosurgical needs.

Included in this packet are registration and patient history forms, as well as HIPAA forms that comply with the 2013 HIPAA regulations and guidelines. We ask that you have these forms completed completely prior to your visit, and present this packet to the front desk on the day of your appointment. If you feel you are unable to complete the paperwork prior to your appointment, we ask that you arrive an extra 30 to 45 minutes prior to your actual appointment time.

You must bring your insurance card(s) and photo I.D.

During your appointment, your physician will need to review any radiological images such as X-rays, MRIs, MRAs, Cat Scans, or any other imaging you have had taken for your condition.

Please note that your appointment may be rescheduled if you do not have your CD with you at the time of your appointment. If a facility is to deliver your films, please call our office the day before to verify that we have received them.

Sincerely,
Dr. Nagy's Team
If you have any questions, please feel free to contact our office at (702) 901-4233

Appt Date:____________________________ **Time:** _________ _________ am / pm

PLEASE FILL OUT THE PAPERWORK IN ITS ENTIRETY

PATIENT MEDICAL HISTORY

Today's Date: ______________________

Patient Name: ____
First Middle Last

Date of Birth: ________________ Age: _________ Height: ___________ Weight: ___________

Primary Care Physician: ______________________________________

Referring Physician: ____

REASON FOR TODAYS VISIT

☐BRAIN TUMOR	☐CARPEL TUNNEL SYNDROME	☐CAUDA EQUINA
☐CHRONIC PAIN	☐CEREBRAL PALSY	☐DIZZINESS
☐HEADACHE	☐HERNIATED DISC	☐ARM PAIN
☐LOW BACK PAIN	☐NECK PAIN	☐LEG PAIN
☐NUMBNESS & TINGLING	☐WEAKNESSS IN LIMBS	☐SCOLIOSIS
☐SPONDYLOLISTHESSIS	☐SUBARACHNOID HEMORRHAGE	☐FOLLOW UP VISIT
☐POSTOPERATIVE VISIT	☐SCHEDULED POSTOP VISIT	☐NON-ROUTINE POSTOP VISIT
☐WORK-RELATED HEALTH PROBLEM	☐INDEPENDENT MEDICAL	
☐OTHER *(Explain)*:		

HISTORY OF PRESENT ILLNESS:

Is Your Current Problem The Result Of An Accident?: ☐ NO ☐YES **Date Of Accident:**

If 'YES', What Type Of Accident?:

☐AUTO *(Complete 'AUTO INJURIES' Section Below)* ☐SLIP & FALL ☐FALL ☐BLUNT FORCE TRAUMA

☐WORK ☐OTHER *(Specify)*:

AUTO INJURIES

Date Of Accident:

Street &/Or Intersection Where Accident Occurred:

Where Were You Located In The Vehicle During The Accident?:

☐DRIVER ☐FRONT PASSENGER ☐LEFT REAR PASSENGER ☐RIGHT REAR PASSENGER

Type Of Collision:

☐REAR-ENDED ☐T-BONED ☐SIDESWIPED ☐HEAD-ON COLLISION

☐OTHER *(Specify)*:

Airbags Deployed?: ☐**NO** ☐**YES**

Paramedics Called?: ☐**NO** ☐**YES**

Required Hospital Transport &Evaluation?: ☐NO ☐YES – ***If 'YES', List Hospital:***

Brief Description Of The Accident:

Any Injuries? ☐ NO ☐YES

If 'YES', Please List Injuries:

Any Injuries PRIOR to The Accident? ☐ NO ☐YES

If 'Yes', List Previous Injuries & Dates:

ALLERGIES

Allergy to Latex? ☐ **YES** ☐ **NO**

Allergy To Iodinated Contrast? ☐ **YES** ☐ **NO**

Allergies To Medications:

Food Allergies:

Contact Allergies:

Environmental Allergies:

Other Allergies:

CARDIOVASCULAR

☐ PERIPHERAL VASCULAR DISEASE ☐ CONGESTIVE HEART FAILURE ☐ MYOCARDIAL INFARCTION (HEART ATTACK)
☐ CEREBROVASCULAR DISEASE ☐ HYPERTENSION (HYPERTENSION) ☐ OTHER:

RESPIRATORY

☐ BRONCHITIS ☐ ASTHMA ☐ EMPHAYSEMA ☐ CHRONIC PULMONARY DISEASE
☐ PNEUMONIA ☐ LUNG CANCER ☐ OTHER:

GASTROINTESTINAL

☐ LIVER DISEASE ☐ COLON CANCER ☐ ULCERS ☐ GASTRITIS
☐ OTHER:

GENTIOURINARY

☐ RENAL/KIDNEY DISEASE ☐ KIDNEY STONES ☐ PROSTATE CANCER ☐ UTERINE CANCER
☐ CERVICAL CANCER ☐ ENDOMETRIOSIS ☐ OTHER:

MUSCULOSKELETAL

☐ ARTHRITIS ☐ SPINE FRACTURES ☐ CERVICAL SPINE DISEASE ☐ THORACIC SPINE DISEASE
☐ LUMBAR SPINE DISEASE ☐ SCOLIOSIS ☐ HERNIATED DISC ☐ OTHER:

SKIN/BREAST

☐ SKIN CANCER ☐ BREAST CANCER ☐ CONNECTIVE TISSUE DISEASE ☐ OTHER:

PSYCHIATRIC

☐ DEPRESSION ☐ ANXIETY DISORDERS ☐ INSOMNIA ☐ ALCOHOL/SUBSTANCE ABUSE
☐ OTHER:

ENDOCRINE

☐ DIABETES TYPE I ☐ DIABETES TYPES II ☐ DIABETES WITH END ORGAN FAILURE ☐ THYROID DISEASE

HEMATOLOGY/LYMPHATIC

☐ ANEMIA ☐ HEMOPHILIA ☐ BLOOD CLOTTING DISORDER ☐ OTHER
☐ BLOOD TRANSFUSION IF BLOOD TRANSFUSION CHECKED, PLEASE GIVE DATE:

IMMUNOLOGIC

☐ AIDS ☐ HIV POSITIVE ☐ AUTOIMMUNE DISEASE ☐ OTHER:

OTHER PROBLEMS

☐ DEMENTIA ☐ PARAPLEGIA ☐ LYMPHOMA ☐ LEUKEMIA
☐ TUMOR

FAMILY HISTORY

FAMILY MEMBER	ALIVE	DECEASED	Cause Of Death	Age
Father	☐	☐		
Mother	☐	☐		
Sister/Brother (Chose	☐	☐		
Sister/Brother *(Circle*	☐	☐		
Sister/Brother *(Circle*	☐	☐		

PATIENT OCCUPATION

What Is Your Current Occupation?

What Is Your Current Work Status? ☐ WORKING FULL TIME ☐ WORKING PART TIME

☐HOMEMAKER ☐RETIRED (HEALTH REALTED) ☐RETIRED VOLUNTARILY
☐STUDENT ☐UNPAID LEAVE ☐MEDICAL DISABILITY (SHORT TERM)
☐MEDICAL DISABILITY (LONG TERM) ☐UNEMPLOYED ☐OTHER:

If You Are Currently Working, Indicate Your Work's Physical Demands:

☐SEDENTARY – LITTLE OR NO LIFTING, SEATED MOST OF THE TIME
☐LIGHT/MODERATE – LIGHT TO MODERATE LIFTING, ON FEET PART OR MOST OF THE TIME
☐HEAVY – HEAVY LIFTING, STAIRS, LADDERS, SQUATTING, ETC...

If You Are Currently Working, Has Your Spine Or Brain Condition Impacted Your Work Status And/or The Amount Of Physical Work You Can Perform?

☐YES ☐NO INDICATE THE DATE LAST WORKED:

Marital Status: ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

Do You Have Children? ☐YES ☐NO

If 'YES', Specify: How Many ADULT (18 Or Older) Dependents? **How Many Child (0-17 Years Old) Dependents?**

Living Situation: ☐LIVES ALONE ☐LIVES WITH SPOUSE ☐LIVES WITH PARENTS
☐LIVES WITH PARTNER ☐LIVES WITH CAREGIVER ☐LIVES WITH RELATIVES
☐LIVES WITH ROOMMATES ☐LIVES IN GROUP HOME

Do You Smoke? ☐YES ☐NO **If Yes, How Many Packs/Day?** **How Long Have You Been Smoking?**

If No, Specify: ☐NEVER SMOKED ☐QUIT SMOKING 0-6 MONTH AGO
☐QUIT SMOKING 6-12 MONTHS AGO ☐QUIT SMOKING > 1 YEAR AGO, < 2 YEARS AGO
☐QUIT SMOKING > 2 YEARS AGO

Do You Drink Alcohol? ☐NO ☐OCCASIONAL ☐LIGHT (1 DRINK/DAY)
☐MODERATE (2-4 DRINKS/DAY) ☐HEAVY (5 OR MORE DRINKS/DAY)

Do You Use Illicit Drugs? ☐NEVER ☐RARELY ☐ONCE A MONTH
☐ONCE A WEEK ☐ONCE OR MORE A DAY

Are You At Risk For HIV? ☐YES ☐NO

SPINE SPECIFIC

Indicate The Highest Recreational Level You Engaged In Just Prior To Your Spine Condition

☐CONTACT SPORTS ☐N/A - DISABLED ☐SEDENTARY
☐LIGHT RECREATION ☐NON-CONTACT SPORTS ☐NO RESPONSE

Is Your Recreation Level Affected By Your Spine Condition? ☐YES ☐NO

MEDICATIONS

Are You Taking Pain Medications?

☐NO ☐YES, OVER THE COUNTER PAIN MEDICATIONS ☐YES, PRESCRIBED PAIN MEDICATIONS

List Your Current Medications

MEDICATION NAME	DOSE	FREQUENCY

PAST SURGICAL HISTORY

Have You Ever Had Problems With Anesthesia? ☐YES ☐NO EXPLAIN:

Have You Had Prior Spine Surgery? ☐YES ☐NO IF YES, PLEASE LIST BELOW

List Your Previous Surgeries

SURGERY	MONTH/DAY/YEAR	SURGEON	ANY COMPLICATIONS?

DIAGNOSTICS STUDIES

Indicate If You Have Undergone Any Of The Following Therapies Or Diagnostics Studies For Your Condition

- [ ] BED REST
- [ ] ANTI-DEPRESSANT
- [ ] ACUPUNCTURE
- [ ] BEHAVIOR THERAPY
- [ ] BRACING/IMMOBILIZATION
- [ ] CHIROPRATOR
- [ ] EPIDURAL STEROID INJECTIONS, DATE(S): ______ PHYSICIAN WHO PERFORMED INJECTIONS: ______
- [ ] MEDICATIONS
- [ ] EMG BIOFEEDBACK
- [ ] EXCERSISE THERAPY
- [ ] PHYSICAL THERAPY
- [ ] TENS
- [ ] TRACTION
- [ ] BONE DENSITY STUDY
- [ ] MRI OF BRAIN
- [ ] MRI OF CERVICAL SPINE
- [ ] MRI OF THORACIC SPINE
- [ ] MRI OF LUMBAR SPINE
- [ ] CT OF BRAIN
- [ ] CT OF CERVICAL SPINE
- [ ] CT OF THORACIC SPINE
- [ ] CT OF LUMBAR SPINE
- [ ] CT OF PELVIS
- [ ] X-RAY OF CERVICAL SPINE
- [ ] X-RAY OF THORACIC SPINE
- [ ] X-RAY OF LUMBAR SPINE
- [ ] X-RAY OF HIP
- [ ] OTHER (SPECIFY):

REVIEW OF SYMPTOMS

Please Check The Medical Condition(S) Below Which Apply To You Either Now Or In The Past

GENERAL
- [ ] FEVER
- [ ] WEIGHT LOSS
- [ ] WEIGHT GAIN
- [ ] NIGHT SWEATS
- [ ] EXCESSIVE FATIGUE

GASTROINTESTINAL
- [ ] INDIGESTION
- [ ] NAUSEA
- [ ] VOMITING
- [ ] VOMITING BLOOD
- [ ] JAUNDICE
- [ ] ABDOMINAL PAIN
- [ ] CHANGE IN BOWEL HABITS

CARDIOVASCULAR
- [ ] HIGH BLOOD PRESSURE
- [ ] IRREGULAR PULSE
- [ ] HEART MURMUR
- [ ] HIGH CHOLESTEROL
- [ ] SWELLING OF EXTREMITIES
- [ ] LEG PAIN AND/OR SWELLING

NEUROLOGICAL
- [ ] FAINTING SPELLS
- [ ] BLACKING OUT
- [ ] SEIZURES
- [ ] PROBLEMS WITH MEMORY
- [ ] DISORIENTATION
- [ ] DIFFICULTY WITH SPEECH
- [ ] INABILITY TO CONCENTRATE
- [ ] DOUBLE VISION
- [ ] BLURRED VISION
- [ ] FACE WEAKNESS
- [ ] INCOORDINATION
- [ ] HEADACHES

HEMATOLOGY/LYMPHATIC
- [ ] EASY BRUISING
- [ ] EXCESSIVE BLEEDING
- [ ] GLAND PROBLEMS
- [ ] ANEMIA

BREAST
- [ ] BREAST PAIN
- [ ] BREAST TENDERNESS
- [ ] BREAST SWELLING
- [ ] NIPPLE DISCHARGE

PSYCHIATRIC
- [ ] ANXIETY
- [ ] DEPRESSION
- [ ] INSOMNIA

GENITOURINARY
- [ ] BLOOD IN URINE
- [ ] URINARY FREQUENCY
- [ ] PAINFUL URINATION
- [ ] URINARY URGENCY
- [ ] INCONTINENCE

ENDOCRINE
- [ ] APPETITE CHANGES
- [ ] THYROID PROBLEMS
- [ ] EXCESSIVE THIRST
- [ ] EXCESSIVE URINATION
- [ ] EXCESSIVE SWEATING
- [ ] DECREASED SWEATING
- [ ] COLD INTOLERANCE
- [ ] HEAT INTOLERANCE
- [ ] HAIR CHANGES

HEAD, EARS, EYES, NOSE, THROAT
- [ ] WEARS GLASSES/CONTACT LENSES
- [ ] EYE INFECTION
- [ ] EYE INJURY
- [ ] GLAUCOMA
- [ ] CATARACTS
- [ ] WEARS HEARING AIDS
- [ ] HEARING LOSS
- [ ] EAR PAIN
- [ ] EAR INFECTION
- [ ] RINGING IN THE EARS
- [ ] BALANCE DISTURBANCE
- [ ] VERTIGO
- [ ] NOSE BLEED
- [ ] NASAL CONGESTION
- [ ] NASAL DRAINAGE
- [ ] INABILITY TO SMELL
- [ ] SINUS PROBLEMS
- [ ] SINUS HEADACHES

RESPIRATORY
- [ ] CHRONIC COUGH
- [ ] SHORTNESS OF BREATH
- [ ] BLOODY SPUTUM

MUSCULOSKELETAL
- [ ] NECK PAIN
- [ ] ARM PAIN
- [ ] ARM WEAKNESS
- [ ] BACK PAIN
- [ ] LEG PAIN
- [ ] LEG WEAKNESS
- [ ] JOINT PAIN
- [ ] JOINT SWELLING
- [ ] DECREASED RANGE OF MOTION

This form is confidential and part of your medical record.

The above information is accurate to the best of my knowledge.

SIGNATURE OF PATIENT OR PERSON COMPLETING THIS FORM **DATE**

I reviewed the above information.

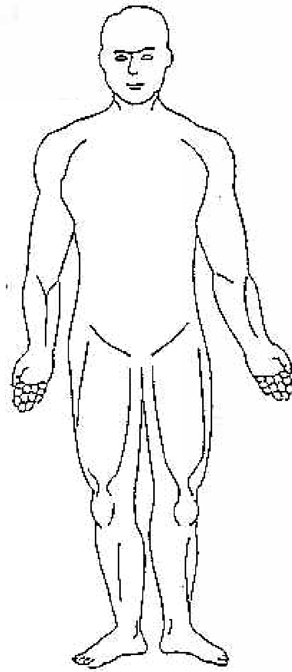
PHYSICIAN SIGNATURE **DATE**

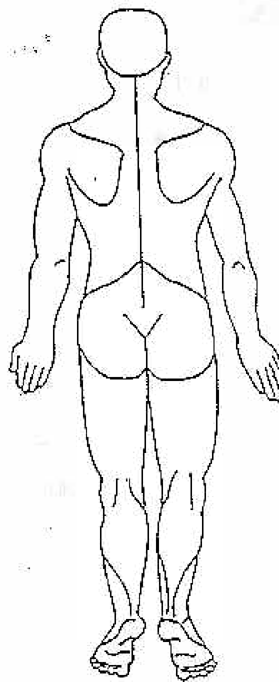
Pain Diagram

Name:________________________ Date: __ / __ / ____

Where is Your Pain?

Please select the areas where you feel pain in the diagram below, or print and shade the areas in.





Please mark the pain level (0 – 10) that most accurately represents your pain for each indicated area:

Neck

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

Left Arm

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑥ ⑨ ⑩ UNBEARABLE

Right Arm

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE

☐ I do not have neck or upper extremity pain.

Please mark the pain level (0 – 10) that most accurately represents your pain for each indicated area:

Back

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑥ ⑨ ⑩ UNBEARABLE

Left Leg

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑥ ⑨ ⑩ UNBEARABLE

Right Leg

NONE ① ② ③ ④ ⑤ ⑥ ⑦ ⑥ ⑨ ⑩ UNBEARABLE

☐ I do not have back or lower extremity pain.

WELCOME TO OUR OFFICE!

Today's Date: ____________________

Referring Physician: ____________________

Patient Name: ____________________
First Middle Last

Home Address: ____________________

City: ____________ State: ____________ Zip: ____________

Sex: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W Birth Date: ________ Age: ________

Home Phone: ( ) ____________ Cellular Phone: ( ) ____________

Work Phone: ( ) ____________ May we contact you at work? ☐Yes ☐No

Email Address: ____________ May we send information here? ☐Yes ☐No

Occupation: ____________ SSN: ____________

Employer: ____________________

Employer's Address: ____________________

City: ____________ State: ____________ Zip: ____________

In case of emergency, please contact: ____________________

Home Phone:( ) ____________ Work Phone:( ) ____________

Relationship to Patient: ____________________

Please complete the following if someone other than the patient is financially responsible

Name: ____________________
First Middle Last

Home Address: ____________________

City: ____________ State: ____________ Zip: ____________

Sex: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W Birth Date: ________ Age: ________

Home Phone: ( ) ____________ Cellular Phone: ( ) ____________

Relationship to Patient: ____________________

Occupation: ____________ SSN: ____________

INSURANCE INFORMATION

Today's Date: ____________________

Patient Name: ______________________________________ Birth Date: __________
First Middle Last

Did your injury happen on the job? ☐ No ☐ Yes

If yes, did you report the accident to your employer? ☐ No ☐ Yes

Was this a result of an auto injury? ☐ No ☐ Yes

What date did the injury occur? ____________________

Please complete the following section according to the insurance carrier or party liable for your claims.

PRIMARY INSURANCE/AUTO INSURANCE/ OR WORKER'S COMPENSATION INFORMATION

Name or Insurance Company: ______________________________

Address: ______________________________

City: ____________________ State: ____________________ Zip: ____________________

Insured's Name: ______________________________

Insured's DOB: ____________________ Insured's SSN: ____________________

Group or Claim Number: ____________________ Policy ID Number: ____________________

Adjuster or Contact Name: ____________________ Phone Number: (   ) ____________________

SECONDARY INSURANCE OR ATTORNEY INFORMATION (IF APPLICABLE)

Name or Insurance Company: ______________________________

Address: ______________________________

City: ____________________ State: ____________________ Zip: ____________________

Insured's Name: ______________________________

Insured's DOB: ____________________ Insured's SSN: ____________________

Group or Claim Number: ____________________ Policy ID Number: ____________________

Adjuster or Contact Name: ____________________ Phone Number: (   ) ____________________

All professional services rendered are charged to the patient. ***The patient is responsible for all fees, regardless of insurance coverage.***
In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to Dr(s) Garber, Kaplan, Douds, Nagy, Glickman, and McNulty.
The undersigned guarantees payment in full. Guarantor understands all patients including those with Medicare or other insurance, are personally responsible for the balance after the insurance company has made payment. I hereby assign and direct you to pay any surgical or medical benefits under claims submitted directly to Jason E. Garber, M.D., Stuart S. Kaplan, M.D., Gregory L. Douds, M.D., Aurangzeb N. Nagy, M.D., Scott G. Glickman, D.O., and Patrick S. McNulty, M.D. I also authorize the release of any medical records or information requested by the insurance companies in connection with the above assignments. I understand that my doctor has no obligation to my attorney to furnish consult, narrative reports, or depositions. I also understand that under no circumstances, will my doctor appear as a witness in court on my behalf.

Signature of Patient or Responsible Party: ______________________________
Date

Witness Signature: ______________________________

FOR INTERNAL USE ONLY:

Patient ID &Insurance cards presented & scanned in? ☐ No ☐ Yes

If 'No', reason ID card(s) not presented: ______________________________

Employee Initials: __________

ADDITIONAL INFORMATION

Today's Date: ____________________

Patient Name: ____ Birth Date: ____________

First Middle Last

PHARMACY INFORMATION

Name: ____

Street Address: ____

Cross Streets: ____

Telephone: ____

RACE *(Please select one):*

☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American

☐ American Indian/Alaskan Native ☐ White ☐ Other ☐ More than One Race

☐ No Response

ETHNICITY *(Please select one):*

☐ Hispanic ☐ Non-Hispanic ☐ No Response

PRIMARY LANGUAGE *(Please select one):*

☐ English ☐ French ☐ Spanish ☐ German ☐ Italian ☐ Russian ☐ Polish

☐ Chinese ☐ Other

Do you have any Implanted Metal Objects in your body? ☐ Yes ☐ No

Do you have any Vascular Grafts? ☐ Yes ☐ No

Do you have Pacemaker? ☐ Yes ☐ No

Are you claustrophobic? ☐ Yes ☐ No

Do you wish to be pre-medicated (sedated) for MRI Scans? ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Referring Physician: ____________________ ☐ Hospital: ____________________

☐ Current Patient ☐ Friend ☐ Internet ☐ Yellow Pages

☐ Magazine ☐ Newsletter ☐ Newspaper ☐ Other: ____________________

INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

Today's Date: ______________________

Patient Name: ____
First Middle Last

In accordance with Nevada law AB 474, prior to giving me a Controlled Substance prescription and the usage of opioid medications, my provider is required to obtain my written consent.

Common names of Controlled Substance prescriptions include but are not limited to:

- Buprenorphine
- Carfentanil
- Codeine
- Fentanyl (Abstral, Actiq, Duragesic, Fentora, Lazanda, Subsys)
- Hydrocodone (Lorcet, Lortab, Vicodin, Zohydro ER)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine (Demerol)
- Methadone (Dolophine, Methadose)
- Morphine (Arymo ER, Avinza, Kadian, MS Contin, MSIR, Oramorph SR)
- Oxycodone (OxyContin, Roxicodone, Oxecta)
- Oxymorphone (Opana)
- Tramadol (ConZip, Ultram, Ryzolt)

My provider has explained to me that these medications may include opioids and/or other drugs that can be used to treat pain, anxiety insomnia, attention deficit disorder, depression and other conditions. I understand that these medications have known risks and side effects, and can be harmful if taken without medical supervision. I further understand that taking these medications can lead to tolerance, physical dependence and/or developing an addictive disorder. Stopping the medication abruptly may lead to withdrawal symptoms and/or psychological dependence or addiction that is an abnormal psychological craving of the medication to the point of becoming a danger to oneself or others.

I understand that the most common side effects that can occur with the use of these medications include but are not limited to:

- Constipation
- Nausea/Vomiting
- Excessive Drowsiness or Sleepiness
- Itching
- Urinary Retention (Inability to Urinate)
- Low Blood Pressure
- Irregular Heart Rate
- Inability to Sleep
- Depression
- Impaired Judgement and/or Reasoning
- Respiratory Depression (Slow or no Breathing)
- Impotence
- Tolerance to Mediations
- Physical or Psychological Dependence
- Addiction
- Death

For Female Patients of Child Bearing Age:

I understand that there are unknown side effects of the prescribed medications that could harm an unborn child. If I am not pregnant, I will use appropriate contraception (birth control) during the course of my treatment. If I become pregnant or am uncertain, I will notify my provider immediately.

I further understand that it may be dangerous for me to operate a motor vehicle or other machinery while taking these medications.
The risks, benefits and alternative treatments, including their risks and benefits have been explained to me. I understand that not every possible risk and benefit is listed on this form and that this consent includes the most common side effects or reactions. I acknowledge that I have been warned about the dangers of overdose and/or combining the prescribed medications with other drugs or alcohol may cause serious illness or death.

In addition I have been informed of:

- Proper use storage and disposal of these medications
- How refills will be addressed
- If the medication is an opioid, I understand that I can get the medication to counteract its effects (an opioid antagonist) without a prescription

For Minors:

I have been informed of the risks that my child may abuse, misuse or divert these controlled substance medications. I have been informed of the ways to detect such misuse.

The goal of this treatment is for the management of my current medical condition. I understand that my treatment plan will be tailored for me. I further understand that I may withdraw from this treatment plan and discontinue medication use at any time. I understand that prior to doing so I need to inform my provider since there may be a medical risk associated with abrupt termination of these medications.

I have been given an opportunity to ask questions about my condition and treatment and the risks and benefits of the prescribed controlled substance(s).

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, the Prescription Monitoring Program (PMP), my health plans and my other healthcare providers.

I authorize and direct my provider to prescribe controlled substance(s). I understand in order to initiate or continue treatment with controlled substances I must agree to the condition set forth above.

______________________________________ ______________

SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE DATE

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the prescribed medications to the patient or patient's legal representative. I have answered all the questions fully and I believe the patient/legal representative fully understands what I have explained.

______________________________________ ______________

PROVIDER SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

Today's Date: ____________________

Patient Name: ____ Birth Date: ____________
First Middle Last

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format

you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.nevadabrainandspine.com. To obtain a paper copy of this notice, contact the Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer at (702)835-0088. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.
If you have any questions about this notice, please contact the Privacy Officer at (702) 835-0088

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

Today's Date: ____________________________

Patient Name: ____Birth Date: ______________
First Middle Last

I HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

____
Signature of Patient or Personal Representative

____
Date

____
Signature of Patient or Personal Representative

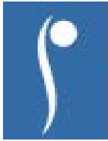
____
Description of Personal Representative's Authority

FOR OFFICE USE ONLY

Notice of Privacy Practices sent/delivered on: __________________________ Initials: _______

Signed Acknowledgment of Receipt received on: __________________________ Initials: _____

Patient Refused or Failed to Acknowledge Receipt on: __________________ Initials: _______



NEVADA
BRAIN & SPINE CARE

DISCLOSURE OF INFORMATION

Today's Date: ____________________________

I, ____ (Print Full Legal Name), give permission for this office to leave detailed messages on the answering service/voicemail messaging at:

☐ My Home Phone (please initial) ___________
☐ My Cellular Phone (please initial) ___________

DISCLOSURE OF INFORMATION TO PATIENT'S COMPANION(S)

The physicians at Nevada Brain and Spine Care are committed to complying with HIPAA regulations. Therefore, we require our patients to sign authorization stating that companion(s) (family members, friends, etc.) accompanying them to their appointment are approved to hear discussion regarding the patients health information.

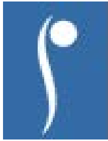
TO BE COMPLETED BY THE PATIENT

I authorize the following individuals to be involved in the discussion of my medical health information and relieve Nevada Brain and Spine Care of any responsibility for harmful neglect (release of medical health information) by my authorized companion(s):

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

____
Patient Name (Please Print)

____ ________________
Patient Signature **Date**



NEVADA
BRAIN & SPINE CARE

HIPAA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Today's Date: ___________________

Patient Name: ____ **Birth Date:** ___________
First Middle Last

Authorizes:
____
____
____

To Release To:
Nevada Brain and Spine Care
2471 Professional Court
Las Vegas, NV 89128

Format to be provided:
☐ Printed Copy ☐ Electronic Copy Dates of Service:___________ to ___________

Information to be released:
☐ Office visits ☐ Procedure reports ☐ Entire record ☐ Billing ☐ Lab results ☐ Medications
☐ Consultations ☐ Diagnostic results ☐ Other (Specify)______________________________

Purpose of disclosure:____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be disclosed 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 a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "authorizes" entity above.
3. I understand a photocopy 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, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the 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/or Psychiatric records, Sexually Transmitted Disease 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 inspect my health information, or obtain copies of my health information, by contacting the Privacy Officer.

Expiration Date: This authorization is good until the following date ___________ or for one year from the date signed.
I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

______________________________________ ________________
Signature of Patient or Legally Authorized Representative **Date**

If signed by other than patient, select authority and PROVIDE DOCUMENTATION:
☐ Parent of minor child ☐ Power of Attorney ☐ Representative of Deceased's Estate
☐ Representative of incapacitated adult ☐ Other (Specify): ______________________

Witness Signature: ______________________________