Relevium
pain specialists

3975 S. Durango Drive Suite 107
Las Vegas, NV 89147
702.940.8007

Patient Information

First Name	Last Name	Middle	Birth Date	Gender ☐ M ☐ F

Address	City	State	Zip Code

Preferred Phone	☐ Cell ☐ Home	Email	Social Security Number

Employer	Occupation	Employer Phone Number

Emergency Contact Name	Relationship to patient	Emergency Contact Phone Number

Insurance Information

☐ Self-Pay/Cash
Skip this section

Insurance Company	Subscriber's Name	Birth Date	Patient Relationship to Subscriber
			☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance

Insurance Company	Subscriber's Name	Birth Date

Who would you like us to bill for services?
Our policy is to bill your insurance unless you indicate otherwise.

○ Health Insurance
○ Lien

The above information is true to the best of my knowledge. I authorize my health insurance benefits to be paid direclty to my physican. I grant my physcain all rights to appeal and receive all relevant documention from my insurnace company. Furthermore, I grant Relevium Pain Specialists to act as an authorizied representative when working with my health insurance company.
I understand that I am financially responsible for any balance. Past due balances may be assessed 1.5% late fee. I also authorize Relevium Pain Specialists to release my infrormation required to process my claim.

_____ _____
Patient/Guardinan Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Bill of Rights

(You may refuse to sign this acknowledgement)

I, _____, have been provided the opportunity to review this office's Notice of Privacy Practices and Patient Bill of Rights, as required by law. I understand that a copy will be provided upon my request.

_____ _____
Patient/Guardian Signature **Date**

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy, but acknowledgement was unable to be obtained because

____ Individual refused to sign
____ Communication Barriers prohibited from obtaining the acknowledgement.
____ Other_____

Authorization Pertaining to Medical Records

Patient Information			
Name		Birth Date	Preferred Phone
Address	City	State	Zip Code

Authorization to Request Medical Records

My signature below authorizes **Relevium Pain Specialists** to request **ALL** of my medical records on my behalf **EXCEPT** the following:

☐ Mental Health ☐ Xray/MRI/Imaging Report ☐ Operative Reports

☐ Lab Work ☐ Office Notes ☐ Other: _____

I understand that I am entitled to a copy of this Authorization.

_____ _____

Patient/Guardian Signature **Date**

Authorization to Release Medical Records

Information to be disclosed: I authorize the release of the following health information: **(check the applicable box below)**

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

❑ Only the following records or types of health information

_____.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

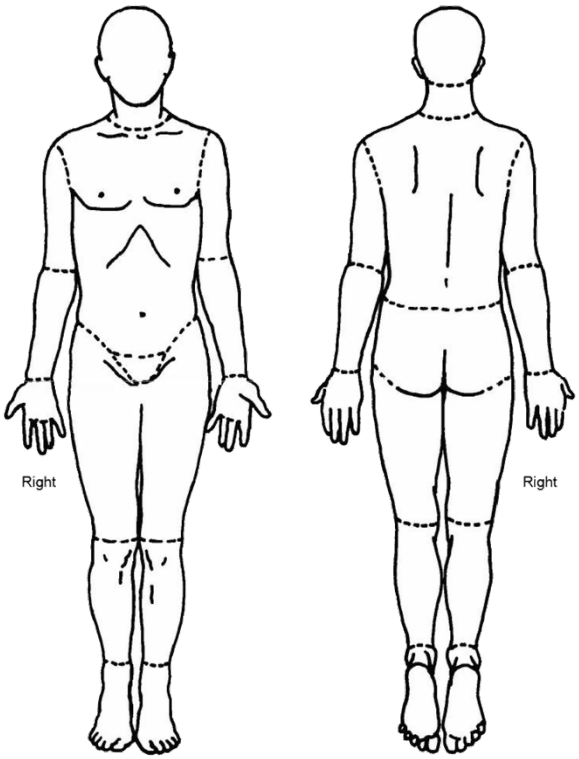
_____ _____

Patient/Guardian Signature **Date**

Present Complaint					
What is your major problem/complaint today?					
Was there a specific injury?			Date of Injury:		
Is this a work- or automobile-related injury?					
Which other providers have you seen for this problem?					
Who is your Primary Care Physician/Internist:			Phone:		
Check words that describe your pain:					
☐ Aching	☐ Continuous	☐ Gnawing	☐ Occasional	☐ Sharp	☐ Tender
☐ Burning	☐ Deep	☐ Miserable	☐ Penetrating	☐ Shooting	☐ Throbbing
☐ Cramping	☐ Dull	☐ Numb/Tingling	☐ Sore	☐ Stabbing	☐ Unbearable
What makes your symptoms feel better?			What makes your symptoms feel worse?		

Please place an X next to the description(s) that best describe(s) your symptoms/function due to pain on MOST days.	
	No Pain
	Minimal Discomfort – Barely noticeable. Rarely uncomfortable. Does NOT limit function.
	Mild Discomfort – Only notice pain if I focus on it. I only avoid the most rigorous activities.
	Mild Pain – Pain is annoying, but I can mostly ignore it. Stops some productive activities.
	Mild to Moderate – Short intervals of pain, but I can do most normal daily activities and work tasks. Sometimes interferes with daily activities, such as running errands, exercise, job performance, and house chores.
	Moderate – Pain is troubling and breaks my concentration. Pain is ALWAYS on my mind, but I push through the day. I cannot perform normal tasks without increase in pain.
	Moderate to Severe – Pain significantly limits my normal daily life functions. I cannot concentrate due to pain. Hard to do anything but think about pain. **Almost unable to work because of pain.**
	Severe – **Pain is impossible to tolerate for long periods.** Frequent crying. I cannot perform basic tasks due to pain.
	Debilitating – **I no longer do ANY normal activities due to pain.** I cannot focus on anything else but pain. I no longer work due to pain, or I rarely leave my bed because of pain.
	Disabling – **Uncontrollable screaming and crying due to pain.** I can barely function or talk. I feel like I should go to the emergency room.
	Worst Imaginable – **Call an ambulance! I need immediate emergency medical attention!** Paralyzing. In and out of consciousness due to pain.

Please mark/circle where you usually feel pain/symptoms.



Medications & Drug Allergies		
Please List Any Prescription or Over-The-Counter Medicine You Are Taking ☐ I am not taking any medicines		**Please List Any Drug Allergies** ☐ No known drug Allergies
Medication/Dose	Frequency Taken	Are you Allergic to any of the following? ☐ Latex ☐ Betadine ☐ Shellfish ☐ IV dye / Iodine ☐ Other_____ ☐ Other_____

****If you take medication(s) that thin your blood, list them here:** _____

Past Medical History/Review of Systems
Do You Have Any Other Medical Issues? If So, Please Mark Them Below.

☐ I Do Not Have any Known Medical Problems/I am Otherwise Healthy

Cardiovascular (heart):
- ☐ Atrial fibrillation/arrhythmia
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis (DVT/blood clot)
- ☐ Heart Attack, when: _____
- ☐ Hypertension (high blood pressure)
- ☐ Palpitations (racing heart)
- ☐ Peripheral Vascular Disease

Endocrine/Metabolic:
- ☐ Diabetes: Type I / Type II
- ☐ Diabetic Neuropathy
- ☐ High Cholesterol
- ☐ Hyperthyroid (high thyroid)
- ☐ Hypothyroid (low thyroid)
- ☐ Obesity
- ☐ Unintentional Weight Loss/Gain

Musculoskeletal:
- ☐ Arthritis/Osteoarthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Respiratory:
- ☐ Asthma
- ☐ COPD/Chronic Bronchitis
- ☐ Difficulty Breathing
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Bloody Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gastric ulcer
- ☐ GERD/heartburn/acid reflex
- ☐ Inflammatory Bowel Disease
- ☐ Nausea
- ☐ Vomiting

Infectious/Integument/Immunity:
- ☐ Fevers
- ☐ Herpes simplex (HSV I / 2)
- ☐ Herpes zoster (shingles)
- ☐ Hepatitis: A / B / C
- ☐ HIV/AIDS
- ☐ Impaired Immunity
- ☐ Skin Rash

Eyes/Ear/Nose/Throat:
- ☐ Difficulty Swallowing
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Nosebleed
- ☐ Ringing in Ears
- ☐ Vision Changes

Kidney/Urinary:
- ☐ Blood in Urine
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Unable to Urinate
- ☐ Uncontrolled Urination

Neurologic:
- ☐ Dizziness/Vertigo
- ☐ Lightheadedness
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Parkinson Disease
- ☐ Passing Out/Syncope
- ☐ Seizure: last seizure _____
- ☐ Stroke/TIA, when _____

Psychiatric:
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Feeling Sad/Depressed/Irritable
- ☐ Flashbacks/Nightmares
- ☐ Major Depressive Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ I am having suicidal thoughts
- ☐ I plan to commit suicide

Miscellaneous:
- ☐ Anemia
- ☐ Bleeding Disorder:
- ☐ Blood Clotting Disorder:
- ☐ Cancer: Type & Treatment_____
  _____
- ☐ Other: _____

Past Surgical History Have You Had Any Surgery in the Past? (please include Dates)	
☐ I Have Never Had a Surgery	
☐ Appendix Removal _____	☐ Tonsillectomy _____
☐ C-Section _____	☐ Tubal Ligation _____
☐ D & C _____	☐ Vasectomy _____
☐ Gallbladder Removal _____	☐ Other: _____
☐ Hysterectomy _____	☐ Other: _____
☐ Joint Replacement _____	☐ Other: _____

Do you have any metal in your body? _____ If yes, it is MRI-compatible (titanium)?_____

Family & Social History	
Do any diseases run in your family? ☐ Yes ☐ No ☐ Unknown If so, which one(s):	
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Alcohol use? ☐ Yes ☐ No If so, how much? _____
Tobacco Use: ☐ Never Smoker ☐ Former Smoker: Quit: _____ ☐ Current Smoker: Packs/day: ___ # of years: ___ ☐ Chewing tobacco	Recreational Drug use? If so, which ones? _____
Are you Pregnant or Nursing? ☐ Yes ☐ No	Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed
Number of Children:	

Opioid Risk Tool	
This is a screening tool to be administered by each patient on an initial visit. State law requires opioid risk screening prior to prescribing opioids. **It is our policy to screen all patients regardless of whether medications are prescribed.**	
Mark each box that applies:	
1. Someone in my immediate family abuses:	
Alcohol	☐ **1**
Illegal Drugs	☐ **1**
Prescription Drugs	☐ **1**
2. I have a history of substance abuse:	
Alcohol	☐ **1**
Illegal Drugs	☐ **1**
Prescription Drugs	☐ **1**
3. I am between 16 – 45 years old	☐ **1**
4. I have a history of psychological disorder:	
ADD, OCD, Bipolar, Schizophrenia	☐ **1**
Depression	☐ **1**
Total the points above	

Relevium Pain Specialists
3975 S. Durango Dr. Ste 107 Las Vegas, NV 98147-4156
Phone: 702.940.8007 **Fax:** 702.832.1940

POLICIES

Thank you for choosing our practice for your pain management needs. We are committed to building a successful physician-patient relationship. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship.

Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

CO-PAYS

The patient or responsible party is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made. We accept cash, checks, pay-pal, or credit cards.

ESTIMATES

For procedures, such as an injection, a cost estimate will be provided upon request. This is an estimate. Only once your insurance company processes the claim will the final amount be determined. We will ask for a portion of the estimated balance before the procedure is performed. Should any amount be overpaid, a refund can be issued or applied to any outstanding balances. If you wish to provide a payment method on-file, we can settle the remaining balance.

INSURANCE CLAIMS

Insurance is a contract between you and your insurance company. We suggest you contact your insurance company in regards to whether we are preferred contracted providers. We will bill your primary, secondary, and tertiary insurance companies as a courtesy to you. To properly bill your insurance companies, we require that you disclose all insurance information.

Failure to provide complete insurance information may result in patient responsibility for the entire bill. If you fail to provide us with insurance coverage for services in a timely manner and your insurance company denies your claim for timely filing, you agree to take full responsibility for those charges. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits once they receive the insurance claim.

If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. To reiterate, it is your responsibility as the covered insured on your insurance to know your benefits and exclusions of your policy. We will not fraudulently change diagnoses from the supporting documentation for a better outcome from your insurance company. If we have exhausted all our efforts in collecting from your insurance and payment is delayed over 90 days, you agree to take responsibility of those charges in arrears up with your insurance company and pay our office in full for such charges.

We do supply some services that we are aware of that insurance carriers do not consider a covered benefit of contracts. For any non-covered services we will require payment in full on the day of services. If you are scheduled for a surgical procedure, we will expect your copayment, coinsurance, and/or deductible prior to the services provided.

REFERRALS AND PRE-AUTHORIZATIONS

If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

SELF-PAY ACCOUNTS

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, and/or patients without an insurance card on file with us. If there is a discrepancy with the information you have provided to us, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full at time of service.

MISSED APPOINTMENTS

There will be a $25 fee for missed appointments if you do not give a 24-hour notice. This charge cannot be billed to your insurance; therefore, it will be solely your responsibility. For procedures that are missed, a $100 fee will be assessed. After two (2) consecutive missed appointments, you may be dismissed from our practice.

MEDICAL RECORD COPIES

All requests for medical records must be done so in writing. Please allow us 10 working days to complete your request, as this is within the legal limits. Please be advised that there is no administrative fee but there is a fee of $0.60 per page, as well as cost of postage. This is assessed at the discretion of our office and is in accordance with Nevada Annotated code NRS 629.061.

FAMILY MEDICAL LEAVE ACT (FMLA)

FMLA is for serious medical conditions ONLY. We are able to provide documentation for intermittent FMLA on a temporary, as-needed basis, depending on your employer's requirements. We are unable to properly evaluate for short-term and long-term disability. We can assist you in obtaining a formal disability evaluation if needed. For all FMLA requests please allow 7-10 business days for review and completion of documentation. To complete FMLA paperwork, a $25 fee will be collected prior to us starting the paperwork. This fee cannot be billed to your insurance, and is solely your responsibility.

PRESCRIPTION REFILL REQUESTS

It is our office policy to refill medications during office hours only. We are required to keep accurate records of all medications prescribed to stay within state and federal laws and prescribing guidelines. Therefore, when you notice you have only three days remaining, please call your pharmacy. If you need another refill, the pharmacist will contact us via phone or fax a request. Faxed requests are the preferred method for refill requests and create less chance of errors of the wrong drug or dosage being refilled. Allow three (3) business days for our office to refill your prescription(s) in a timely manner. Changes to medication regimens should be discussed with your physician in person during a follow up visit, not via a phone call, except in certain extreme circumstances. Farther you agree to allow us to access all previously filled medication to minimize potential medication interactions.

MINORS

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. Minors must be accompanied by a parent or guardian unless a signed release to treat and financial arrangements have been made prior to services.

OUTSTANDING BALANCE POLICY

It is our office policy that all accounts are paid within 90 days. All past due accounts will be sent a 60-day collection letter. If payment is not received within the 90 days, the account will be sent to the collection agency that we work with. I understand that I am personally responsible to pay all collections fees associated with my account, including reasonable attorney fees and reasonable agency fees. I understand that in the event my account is turned over to a third-party collection agency, a collection fee of an amount up to 50% of my account balance will be added to my balance and that I am responsible to pay that amount. Once your account is turned over to the collection agency you will be considered discharged from the practice until financial obligations have been met and satisfied. If financial obligations are met you will be welcomed back into our practice but as a "cash at the time of service patient" until a sufficient period of time.

REFUNDS

If a refund is due to you and payment was made via credit card, please be advised that a 5% fee will be deducted from your refund due to credit card fees.

CELL PHONES

By providing a cell phone number you have authorized contact for any activity involving our services to you, including but not limited to the resolution to the balance of your account. This number will only be used for in-house or any business entity contracted to perform duties resulting from services provided to you by this office.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving services, you are ultimately responsible for payments on your balance. Our office will not bill any other personal party.

Authorization to Release Information and Assignment of Medical Benefits:

I hereby authorize Relevium Pain Specialists to treat the named patient. I authorize the release of medical information necessary to process insurance claims for treatment. Photocopies of this are valid as the original. I authorize medical benefits to be directly paid to Andrew Hall, MD PLLC DBA Relevium Pain Specialists. I understand that I am financially responsible for any services from this office regardless of insurance coverage.

_____ _____

Patient Name (authorized guarantor) Signed (authorized guarantor)

_____ _____

Patient Date of Birth Signed Date