Reno Tahoe Pain Associates

☐ Ali Nairizi, MD, MS
Board Certified in Pain Medicine
Diplomate of the American Board of Anesthesiology

☐ Britt Bickert, PA-C ☐ Garret Berkich, PA-C

New Patient Packet

It is our pleasure to welcome you to Reno Tahoe Pain Associates. We have enclosed forms to be completed prior to your new patient consultation. If able, please mail them back or drop them off with us ahead of your appointment time, so we can prepare your chart for your visit. You may also fax these documents to: 775-384-2478.

We will need copies of your medical records, including any MRI or x-ray reports, by the time of your appointment. Actual film is not necessary. If you do not have copies of the reports from any images pertaining to the reason for your visit, please contact your referring provider and have them faxed to: 775-384-2478.

Please be sure to accurately fill out all of the insurance information, or if applicable, Worker's Compensation information. This is needed to bill for your visit. Failure to provide this information, may lead to you being responsible for the cost of the visit.

You must bring with you ALL OF YOUR PRESCRIPTION, AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING (BOTTLES).

Please plan to spend at least an hour with us at your initial visit. A thorough physical examination and understanding of your medical history, are vital to providing you with the appropriate treatment, and we strive for nothing less.

If you are able, please visit our website: www.renotahoepain.com and explore the Patient Education link to learn more about many of the procedures Dr. Nairizi specializes in. Again, we welcome you and look forward to providing you with excellent care!

If you need to reschedule or cancel your appointment, please provide at least 24 hours' notice, and call us at: 775-384-1127.

Thank you,

Reno Tahoe Pain Associates

☐ 6512 S. McCarran Blvd Suite E. Reno, NV 89509 P: 775-384-1127 F: 775-384-2478

PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle)	Date of Birth	Marital Status (circle)	Primary Care Physician
M / F		*Divorced - Married - Separated - Single - Widowed - Other*	

Preferred Language (circle)	Race (circle)	Ethnicity (circle)
English - Spanish - _____	*Asian - Black - White - Other: _____*	*Hispanic - Not Hispanic - Unknown*

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: [ ] Patient

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Responsible Party?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City / State	Zipcode

Emergency Contact

Check if same as: [ ] Responsible Party

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Emergency Contact?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact

Check if same as: [ ] Responsible Party [ ] Emergency Contact

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Guardian?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information

Check if: [ ] Self Pay

Check if same as: [ ] Responsible Party		Check if same as: [ ] Responsible Party	
Subscriber / Member Name	Date of Birth	Subscriber / Member Name	Date of Birth
What is Patient's Relationship to Subscriber?	Gender (circle) *M / F*	What is Patient's Relationship to Subscriber?	Gender (circle) *M / F*
Primary Insurance Company	Begin Date	Secondary Insurance Company	Begin Date
Insurance Mailing Address	City / State / Zipcode	Insurance Mailing Address	City / State / Zipcode
Subscriber / Member #	Group #	Subscriber / Member #	Group #

Patient/Legal Guardian Signature Date Patient/Legal Guardian Print

Patient Intake Form

Please answer the following questions carefully and accurately. The answers to these questions will help us to understand your pain problem and design the best treatment program for you.

You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission, unless we are required to do so by law (e.g., Worker's Compensation Claim).

Name: _____ D.O.B.: _____/_____/_____

Age: _____ Height: _____ Weight: _____

Would you like a Clinical Summary of today's visit: _____ NO _____ YES

Characteristics of Pain (Chief Complaint):

What is the reason for your visit at Reno Tahoe Pain Associates:

_____ New Onset Symptom Evaluation

_____ Follow-up Evaluation

_____ Ongoing Management

_____ Visit Reason
(Describe):_____
_____

History of Present Illness:

Please describe the location(s) of your pain:

_____
_____

Pain Rating:

Current Pain Level

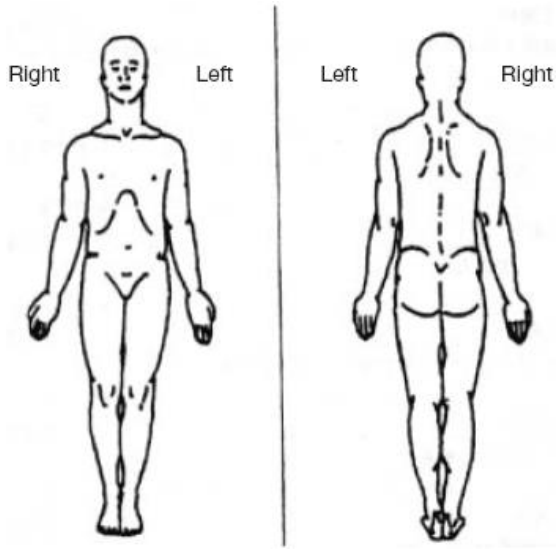
0 1 2 3 4 5 6 7 8 9 10

Minimum Pain Level

0 1 2 3 4 5 6 7 8 9 10

Maximum Pain Level

0 1 2 3 4 5 6 7 8 9 10



Onset of Pain (Cause):

How did your current pain start?

- ☐ Injury at work
- ☐ Injury NOT at work
- ☐ Treatment caused (e.g., radiation, surgery, etc.)
- ☐ Motor Vehicle Accident
- ☐ Illness
- ☐ Undetermined

Progression of Pain:

- ☐ Acute (quick/ severe)
- ☐ Gradual (slow)
- ☐ Sudden (unexpected)
- ☐ Variable (intermittent)

Pain Duration:

How long have you had your current pain problem(s)?

_____ Weeks _____ Months _____ Years

Frequency/ Timing of Pain:

How often do you have your pain? (**CHECK ONE)**

- ☐ Constantly (100% of the time)
- ☐ Nearly constantly (60% - 95% of the time)
- ☐ Intermittently (30% - 60% of the time)
- ☐ Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been worse? (**CHECK ONE**)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night
- ☐ No typical pattern

Activities and your pain:

Place a checkmark next to the activities that you have avoided or limited during the past month, because of pain:

- ☐ Going to work
- ☐ Doing yardwork or shopping
- ☐ Socializing with friends and family
- ☐ Participating in recreation
- ☐ Having sexual relations
- ☐ Performing household chores
- ☐ Exercise
- ☐ Sitting
- ☐ Standing
- ☐ Walking

Associated Symptoms:

- ☐ "Pins and needles"
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness

Pain Quality:

How would you describe your pain?

☐ Burning ☐ Cutting ☐ Sharp ☐ Throbbing ☐ Cramping ☐ Dull, Aching

☐ Pressure ☐ Shooting ☐ Other

Relieving and Aggravating Factors:

How do the following affect your pain? (**CHECK ONE FOR EACH ITEM**)

	Decrease	No Change	Increase
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Coughing/ Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐

Attempted Treatments:

Treatment	Date (Approx.)	No Relief	Moderate Relief	Excellent Relief
☐ Bed Rest	___/___/___	☐	☐	☐
☐ Traction	___/___/___	☐	☐	☐
☐ Surgery	___/___/___	☐	☐	☐
☐ Hypnosis	___/___/___	☐	☐	☐
☐ Acupuncture	___/___/___	☐	☐	☐
☐ Nerve Block	___/___/___	☐	☐	☐
☐ TENS	___/___/___	☐	☐	☐
☐ Physical Therapy	___/___/___	☐	☐	☐
☐ Exercise	___/___/___	☐	☐	☐
☐ Heat	___/___/___	☐	☐	☐
☐ Ice	___/___/___	☐	☐	☐
☐ Biofeedback	___/___/___	☐	☐	☐
☐ Psychotherapy	___/___/___	☐	☐	☐
☐ Chiropractic	___/___/___	☐	☐	☐
☐ Other	___/___/___	☐	☐	☐

Effect on Sleep:

- ☐ No effect
- ☐ Pain makes it difficult to fall asleep
- ☐ Pain makes it difficult to stay asleep

Effect on Bowel and Bladder Control:

- ☐ No effect
- ☐ Loss of bladder control
- ☐ Loss of bowel control

Assisting Device:

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Other: _____
- ☐ None

PAST MEDICAL HISTORY:

Medical:

Have you had any of the following health problems? (**CHECK ALL THAT APPLY**)

☐ Angina/ Chest pain ☐ Chronic Cough ☐ Kidney Disease ☐ Seizure or Epilepsy

☐ Arthritis ☐ Diabetes or High Blood Sugar ☐ Liver Disease

☐ Asthma/ Wheezing ☐ Heart Attack ☐ Peptic Ulcer ☐ TIA/ Stroke

☐ High Blood Pressure ☐ Reflux (GERD) ☐ Thyroid Problem ☐ Bleeding Problem

☐ Cancer (type): _____ ☐ Other (type): _____

Surgeries:

Date (Approximate)	Hospital	Type of Operation

General Family Illness:

Please check any health problems that are known to run in your family:

☐ Angina/ Chest pain ☐ Chronic Cough ☐ Kidney Disease ☐ Seizure or Epilepsy

☐ Arthritis ☐ Diabetes or High Blood Sugar ☐ Liver Disease

☐ Asthma/ Wheezing ☐ Heart Attack ☐ Peptic Ulcer ☐ TIA/ Stroke

☐ High Blood Pressure ☐ Reflux (GERD) ☐ Thyroid Problem ☐ Bleeding Problem

☐ Cancer (type): _____ ☐ Other (type): _____

Social History:

Smoker: _____ NO _____ YES If yes, # of packs per day: _____
Alcohol: _____ NO _____ YES If yes, average # of drinks per day: _____
History of drug addiction: _____ NO _____ YES
Marital Status: _____
Children: _____ NO _____ YES How many: _____
Living/Home Status: _____
Education: _____
Occupation: _____

Review of Systems:

Please check all the items you feel are applicable to you:

GENERAL:

- ☐ Fever
- ☐ Night sweats
- ☐ Chills
- ☐ Cold intolerance
- ☐ Fatigue
- ☐ Daytime somnolence
- ☐ Weight gain
- ☐ Weight loss
- ☐ Polydipsia
- ☐ Any ear symptoms
- ☐ Any eye symptoms
- ☐ Any nasal symptoms

RESPIRATORY:

- ☐ Dyspnea
- ☐ Cough
- ☐ Cough Productive of Sputum
- ☐ Hemoptysis
- ☐ Wheezing
- ☐ Other breathing problem

CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Dyspnea at rest
- ☐ Dyspnea with activity
- ☐ Orthopnea
- ☐ Paroxysmal
- ☐ Lower extremity edema
- ☐ Varicosities

GASTROINTESTINAL:

- ☐ Abdominal pain
- ☐ Rectal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Decreased frequency of bowel movement
- ☐ Diarrhea

MUSCULOSKELETAL:

- ☐ Muscle pain
- ☐ Back pain
- ☐ Tender points
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Decreased muscle strength
- ☐ Limb paralysis
- ☐ Difficulty walking
- ☐ Other musculoskeletal problems

NEUROLOGICAL:

- ☐ Headaches
- ☐ Vertigo
- ☐ Lightheadedness
- ☐ Fainting
- ☐ Blackouts
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor
- ☐ Lack of coordination
- ☐ Weakness
- ☐ Difficulty speaking
- ☐ Memory loss
- ☐ Difficulty concentrating
- ☐ Other neurological problems

PSYCHIATRIC:

- ☐ Change in mood
- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Sleep disturbance
- ☐ Suicidal ideation
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Delusions
- ☐ Hallucinations

HEMATOLOGIC/ LYMPHATIC:

- ☐ Easy bruising
- ☐ Difficulty stopping blood flow
- ☐ Lymph node enlargement
- ☐ Lymph node tenderness

Medications:

Please list **ALL** medication(s) that you are currently taking

_____

_____

_____

Please list any pain medication you have tried in the past:

_____

_____

_____

Drug Allergies:

Please list any medications you are allergic too:

_____

_____

_____

☐ **YES**, I am allergic to dye put onto my body ("X-ray dye")

Patient Name:_____

Patient Care and Medication Agreement

Please initial by each bullet point and sign at the bottom of this agreement.

As the patient of Reno Tahoe Pain Associates, I agree to the following:

_____ 1. I will provide complete information about illness/problem, medications and health habits to enable proper evaluation and treatment.

_____ 2. I, and others who accompany me to my appointments or call on my behalf, will show respect to office personnel and other patients. Lack of such may lead to dismissal from the practice.

_____ 3. I will arrive on time for my appointments and understand that if I am more than 10 minutes late, my appointment may be rescheduled.

_____ 4. I will pay co-pays or bills in a timely manner and agree that failure to do so will result in dismissal from the practice.

_____ 5. I will use prescriptions or other medical devices prescribed according to directions, not change the way I take it without first talking to the doctor or other members of the treatment team and I will use only one pharmacy to get all of my medications.

_____ 6. I will bring ALL of my medications in their original bottles to every appointment and understand that refills will not be considered otherwise. I understand I may be asked to bring my medications at any time to be counted to ensure my compliance with taking my medications as prescribed, and understand if I do not do so, I may be dismissed from the practice.

_____ 7. I will consent to random drug screens and understand that if I do not comply, I will be dismissed from the practice.

_____ 8. I understand that refills will be made only during business hours Monday-Friday, and that it is my responsibility to request refills early enough to allow at least two business days for medication refills to be called in for me, should they be approved.

Patient Name:_____

_____ 9. I will accept responsibility for my actions including misuse of drugs (whether illicit or prescription), tobacco, alcohol, or other activities, selling, diverting and sharing my medication. I understand that if I do, my treatment will be stopped.

_____ 10. I will follow the guidelines set for any limitations in work, activity, or diet.

_____ 11. I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____ 12. I will participate in all other types of treatment, multimodal analgesia and comprehensive pain treatments including but not limited to physical therapy, use of TENS unit, pain psychology, medical management, and interventional treatments that I am asked to participate in.

_____ 13. If I am prescribed controlled substance medication at Reno Tahoe Pain Associates, I will only receive my controlled substance medications from my treating physician and his/her treating team at Reno Tahoe Pain Associates and if I receive controlled substance medication from another provider outside of this practice without approval from my treating team at Reno Tahoe Pain Associates, my treatment will be discontinued.

_____ _____

Patient Signature Provider Signature

Financial Policy and Waiver

Insurance Deductibles/ Co-Payments/ Co-Insurance:

In accordance with my insurance contract, I understand that deductibles, co-payments and co-insurances are due at the time of service. This contractual obligation requires that payments be made at the time of service. If I am unable to do so, I understand that my appointment may be rescheduled. All outstanding balances over 30 days old, may be subject to a 10% per annual interest rate.

Verification of Benefits and Non-Covered Services:

Insurance policies may differ patient plan. Reno Tahoe Pain Associates may provide services that my insurance plan excludes. Although Reno Tahoe Pain Associates makes every attempt to notify me of my benefits, it is ultimately my responsibility to verify and understand my coverage, benefits and exclusions. All non-covered services are my responsibility and may be due at time of service.

Change of Insurance:

I must notify Reno Tahoe Pain Associates within 30 days of my new insurance, so that all claims can be re-filed as appropriate. In the even that my insurance changes and I fail to notify the office within 30 days, any outstanding balances associated with denied insurance claims, will become my responsibility.

Private Pay:

If I don't have any insurance coverage, or insurance with which Reno Tahoe Pain Associates does not participate, payment is required in full at time of service.

Collections:

I understand that once an account is places in a collection status, all future services must be paid in full at time of service. If my account is placed into collections, I will be responsible for all collection costs equal to 50% of my outstanding balance, but no less than $25.

No Show/ Late Cancellations:

There is a maximum of 3 allowances for missed or late cancellation visits. If this occurs 3 times, you will be immediately discharged for Reno Tahoe Pain Associates. If you are a new patient, you will not be rescheduled and your referring provide will be notified. If you are more than 10 minutes late for your appointment, you will be rescheduled.

Returned Checks Due to Non-Sufficient Funds (NSF):

Any returned checks due to NSF, will have a $25 charge that must be paid prior to your next appointment, along with the funds originally guaranteed to Reno Tahoe Pain Associates. Your appointment will be rescheduled, if you do not provide payment. Unfortunately, if you have a check that is returned for NSF, Reno Tahoe Pain Associates will no longer accept checks as a form of payment form you. You must provide payment in the form of cash, or credit card.

By signing below, I have agreed to the Financial Policy and Waiver and will adhere to the policies.

_____ Date: _____/_____/_____

Printer Name

_____

Signature

Urine Drug Screening Program

This notice is presented to explain the policy of Reno Tahoe Pain Associates regarding Narcotic Prescriptions and our Urine Drug Screening (UDS) program.

The possible treatments available for pain include various modalities, one of which is the use of narcotic and/ or non-narcotic prescription medications. While these medications may be extremely beneficial, as with any other treatment, there are certain risks associated with their use. Unfortunately, these risks include diversion, obtaining prescriptions for recreational use, or in order to illegally sell medication to others.

This is a major concern to us, as physicians. Additionally, this unsafe and concerning practice has reached national prominence, earning the attention of multiple government and law enforcement agencies, including the United States Drug Enforcement Agency (DEA) and State Law AB47. At Reno Tahoe Pain Associates, we take this matter very seriously.

As part of our decision to ensure proper medication utilization, we employ a urine drug screening program. This program allows us to confirm that medications are being taken as prescribed. It also allows us to ensure the absence of other harmful agents, including recreational or street drugs.

Please understand that a request to submit a sample is not an accusation. The vast majority of tests performed confirm proper medication usage. Additionally, we randomly test patients, thus eliminating any bias that we as providers, may have. However, in certain circumstances, we may obtain mandatory urine drug screenings. We appreciate your understanding and cooperation, and of course, we remain available to discuss any questions, concerns or comments you may have.

Urine Drug Screening Patient Financial Responsibility

Regretfully, this may or may not be covered by your insurance. While a majority of insurance companies do in fact pay for this service, some do not. For this reason, we have an advanced beneficiary notice (ABN) that you will need to sign, if you are screened at our facility. This notice simply states that you understand this screen may not be covered by your insurance, and in the event that it is not, you will be financially responsible for the fees incurred. We will do our best to work with you if your insurance does not pay for this service. Please remember, it is ultimately your responsibility to be aware of your insurance benefits.

Additionally, please be aware that we may use a third-party lab for preliminary and final confirmation of the screen. This means that you may receive an Explanation of Benefits (EOB) for your insurance regarding our initial screen and another one from the third-party that confirms our results. If you have any questions regarding the billing from the third-party lab, please contact them directly.

Please remember that you may or may not receive medications from our facility and this may or may not be tested. This notification is given to prevent any confusion or misunderstanding in the future, and to ensure that all patients understand our commitment to providing the best care and service.

By initialing below, you acknowledge our Urine Drug Screening Program, and adhere to the requirements of RTPA.

_____ Initials

Acknowledgement of Privacy Practices and Policies

Communication Authorization:

I hereby authorize Reno Tahoe Pain Associates to communicate with the following, regarding all aspects of my medical care and financial obligations:

1. _____ Phone Number : _____

Relation: _____

2. _____ Phone Number : _____

Relation: _____

3. _____ Phone Number : _____

Relation: _____

Treatment Authorization:

I hereby authorize Reno Tahoe Pain Associates to render healthcare to me during my visit.

Privacy Notice:

I have been given the option to review Reno Tahoe Pain Associates "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

Medical Records:

I am aware that I may request a copy of my medical records at any time, with written consent. In addition, I understand there may be a fee associated with my request and that without a release on file stating otherwise, my records can only be picked up by me or mailed to the address on file. Please note, third-party requests are also the patient's financial responsibility after 60 days of non-payment.

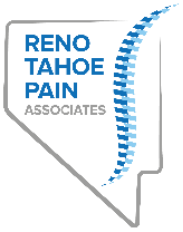
By signing below, I acknowledge Reno Tahoe Pain Associates Privacy Practices and Policies and adhere to them.

_____ Date: _____/_____/_____

Print Your Name

_____

Signature



Consent to Leave Phone Messages/Release of Information

Reno Tahoe Pain Associates has adopted a policy that requires our staff to obtain authorization from the patient to release and/or leave a detailed message for the patient. Secondary to the HIPPA guidelines we need to guard against violating any patient confidentiality and protect our staff.

If we do not have a signed consent on file we may only leave our name and phone number on an answering machine asking you to call back. By completing the consent below you authorize us to release information or leave a detailed message on voicemail or with a specific individual. In order for us to relate any of your medical information to anyone other than yourself please check #3 below.

A. I _____ (print name), give my consent to Reno Tahoe Pain Associates staff to release and/or leave messages regarding my care or lab results as necessary in the following situations

   1. _____ on answering machine at home
   2. _____ on voicemail at work
   3. _____ with_____ (relationship)

_____ _____

Patient Signature Date

B. _____ I do not consent to messages being left. Please contact me directly.

_____ _____

Patient Signature Date

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ D.O.B.: _____/_____/_____

I authorize the use or disclosure of the above named individuals health information as described below. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

P: _____ F: _____

The type and amount of information to be used or disclosed is the ENTIRE MEDICAL CHART, including medical records, office notes, hospital records, pharmaceutical records, laboratory records, x-ray, MRI and CT reports, and any other radiological reports. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health issues, treatment for alcohol, drug use, pregnancy and/or family planning.

This information may be disclosed to and used by the following individual or organization:

Reno Tahoe Pain Associates
6512 S. McCarran Blvd Suite E
Reno, NV 89509
P: 775-384-1127
F: 775-384-2478

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand this revocation will not apply to information that has already been released in response to this authorization. I understand this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains health insurance. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as original.

_____ Date: _____/_____/_____
Signature

_____ Date: _____/_____/_____
Witness Signature