Welcome to Mountain West Sport & Spine! **Copay:**

At our office, our goal is to provide you with the most effective and efficient care. To ensure you receive the greatest benefit from your care, please note the following important requests:

Effective Physical Medicine

To Maximize your results, please commit to attending all scheduled appointments.

Late Arrivals

Being on time is necessary in maintaining an efficient experience for you as well as other patients. If you anticipate on being late for an appointment, please call us as soon as possible at (775) 828-2863

Cancellations

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance. You may leave an after-hours voicemail at (775) 448-9413. Please note same day cancelations will be marked as a no show. We are required to report all no shows, cancelations, or reschedules to the work comp adjuster assigned to your case.

No Call/No Show

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. This fee is payable by the patient and is not billable to the insurance company. If you miss two (2) appointments without calling us you will be discharged and you need to return to your referring physicians. Frequent cancellations may also result in discontinuing your rehabilitation.

Co-payments/Deductibles

We will verify your insurance benefits prior to your initial visit; however you are responsible for keeping track of your deductible amounts, network providers, and eligibilty throughout your care. Co-payments are due at the time of service of each visit. Payment can be made by cash, card, or check made out to Mountain West Sport & Spine. Questions regarding billing may be directed to our billing department by calling (775) 448-9421.

By signing you understand and agree to our policies.

Name:_____ DOB: _____ Chart:_____

Signature: _____ Date:_____

Name: _____ Chart: _____

NAME: _____ AGE: _____ BIRTHDATE: ___/___/___
REFERRING PHYSICIAN: _____
CHIEF COMPLAINT: _____
DATE OF INJURY: _____

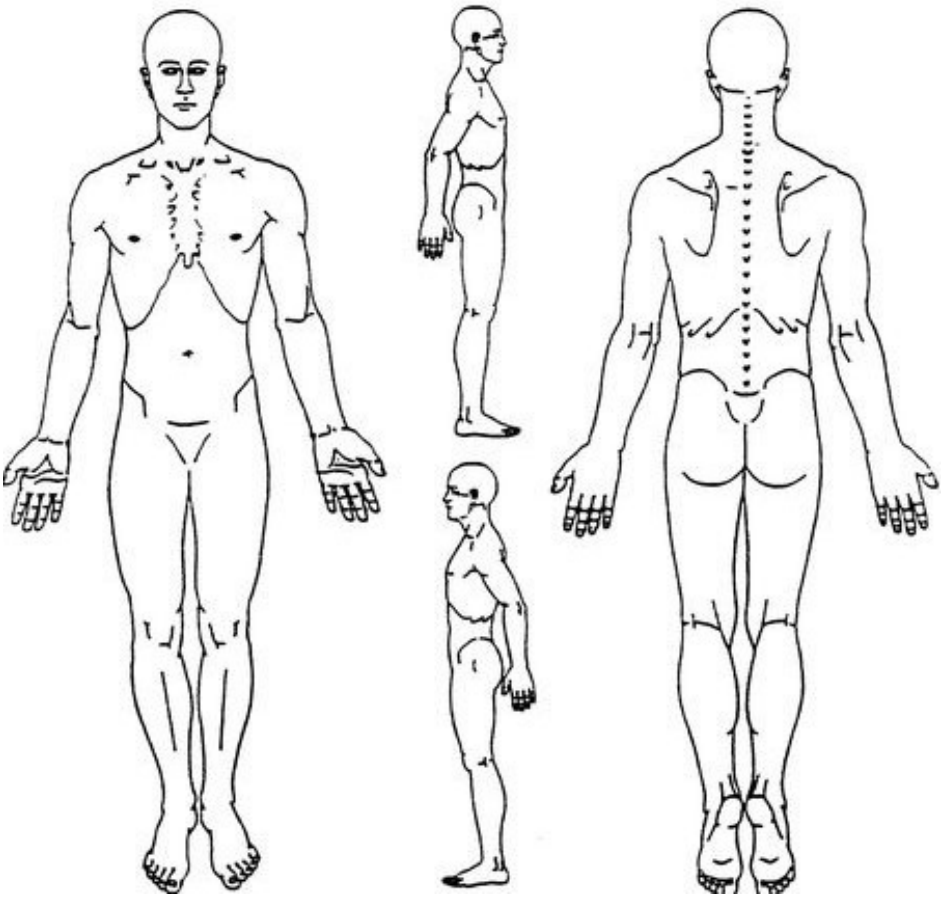
OCCUPATION: _____
ARE YOU CURRENTLY WORKING? _____ IF YES, FULL-TIME __ PART-TIME __
DO YOU HAVE ANY WORK RESTRICTIONS? _____
IS THE INJURY WORK-RELATED? _____
HOW DID THE INJURY OCCUR? PLEASE BE AS SPECIFIC AS POSSIBLE_____
_____
_____
_____
HAVE YOU HAD A RELATED INJURY IN THE PAST? _____ IF YES, DATE: _____
HOW WERE YOU TREATED? _____

WOULD YOU PLEASE FILL OUT THE FOLLOWING PAIN DIAGRAM? (PLEASE PUT THE CORRESPONDING SYMBOLS SHOWN BELOW INTO THE BODY DIAGRAM WHERE YOU ARE HAVING PAIN).

Height_____ Weight_____ Blood Pressure_____ Pulse_____

Resp_____Dominant Hand __R __L

A = Aching P = Pins/Needles N = Numbness S = Stabbing B = Burning



Name: _____ Chart: _____

WHAT DO THE FOLLOWING ACTIVITIES DO TO YOUR PAIN? (PLEASE CHECK)

	RELIEVES	WORSENS	NO CHANGE
SITTING	__	__	__
STANDING	__	__	__
WALKING	__	__	__
BENDING FORWARD	__	__	__
BENDING BACKWARDS	__	__	__
SIDE BENDING, TWISTING	__	__	__
WALKING UPSTAIRS	__	__	__
WALKING DOWNSTAIRS	__	__	__
COUGHING	__	__	__
SNEEZING	__	__	__

When is your pain worse during the course of the day?

MORNING 0 1 2 3 4 5 6 7 8 9 10

AFTERNOON 0 1 2 3 4 5 6 7 8 9 10

NIGHT 0 1 2 3 4 5 6 7 8 9 10

How bad was your pain when it FIRST STARTED? 0 1 2 3 4 5 6 7 8 9 10

What is your pain level RIGHT NOW? 0 1 2 3 4 5 6 7 8 9 10

Who first treated you? _____
Did the treatment work? If not, explain:
_____

Medications used? _____

How many doctors have you seen? _____

Have you received Physical Therapy? _____If Yes, how many times per week?_____How many weeks?_____

PAST MEDICAL HISTORY:
Past and current medical conditions? _____

_____

Past Surgeries:_____

Drug Allergies: _____

Current Medications:_____

How long have you been on these medications?_____

Name: _____ Chart: _____

REVIEW OF SYSTEMS (answer **YES** or **NO** to the following body parts):

	YES	NO
GENERAL: History of weight loss, fever, chills, nausea, vomiting etc?	__	__
EYES: History of dizziness, vision problems, etc.	__	__
EARS, NOSE, MOUTH, THROAT: History of sinus disease, nosebleeds	__	__
Tooth disease, ringing of the ears, deafness. Etc.		
CARDIOVASCULAR: History of palpitations, irregular heart rate, chest	__	__
Pain, shortness of breath, etc.		
RESPIRATORY: History of wheezing, shortness of breath, coughing,	__	__
Night sweats, bloody sputum, etc.		
GASTROINTESTINAL: History of nausea, abdominal pain, vomiting,	__	__
Ulcers, jaundice, vomiting blood, diarrhea, etc.		
GENITIURINARY: History of urinary retention, urgency problems,	__	__
Pain with urination, etc.		
PSYCHIATRIC: History of nervous breakdown, hallucinations, depression	__	__
ENDOCRINE: History of skin or hair growth, thyroid problems, dryness	__	__
Of hair/skin, intolerance to heat/ice, etc.		
BLOOD AND LYMPH: history of anemia, excessive bleeding, family	__	__
History of bleeding disorder		

IF YOU ANSWERED **YES** TO ANY ABOVE QUESTION, PLEASE EXPLAIN:
_____

Is there a family history of any of the above problems? _____ If Yes, Please explain:_____

Are you being treated for any medical conditions above? _____

If yes, who is your treating Doctor? _____

Are you: Married___ Single___ Divorced___ Widowed___

What city do you currently live in? _____

Do you have children? _____, if yes, how many? _____
Do you use tobacco? _____, if yes, how much? _____ Do you use alcohol? _____, if yes, how much?_____

VOCATIONAL HISTORY:
Previous type of job or occupation:_____How long have you been at your current job?_____

Demographics

Physical Address:_____ City:_____State:_____ Zip:_____

Mailing Address:_____Appt/PO Box:_____

Home Phone:_____ Marital Status:_____

Social Security No:_____Date of Birth:_____Age:____

E-mail Address:_____

Employer's Name:_____Work Phone:_____

Address:_____City/State:_____Zip:_____

Spouse/Parent Name:_____Date of Birth:_____ SSN:_____

Spouse/ Parent Employer:_____Phone:_____

Emergency Contact Name:_____Relationship:_____

Address:_____Phone:_____

Primary Insurance:_____Phone:_____
Address:_____ID No: _____
Policy Holder Name:_____ Group/Policy No:_____
Secondary Insurance:_____Phone:_____
Address:_____ID No: _____
Policy Holder Name:_____Group/Policy No:_____

Work Related? Yes___ No___ Date of Injury:_____Claim No:_____
Industrial Insurance Carrier:_____Case Managaer:_____
Address:_____Phone:_____
Nature of Injury/ Body Part:_____
Employer at time of injury:_____

MEANINGFUL USE DATA
Referred by: Self___Website___Physician___Friend___ TV Ad___Radio Ad___ Other___
Race: American Indian___ Asian___ African American___ Caucasian___ Not Provided___
Primary Language: English___ Spanish___ Chinese___ French___ Portuguese___ Russian___
Hebrew___ Yiddish___ Hindi___ Japanese___ Not Provided___
Ethnicity: Hispanic Origin___ Non-Hispanic Origin___ Not Provided___
Smoking Status: Never Smoked___ Former Smoker___ Current Occasional Smoker___

Patient Signature_____ Parent/Guardian Signature_____

Date:_____

Name:

Chart:

FINANCIAL POLICY

Thank you for choosing us as your medical care specialist. We are committed to the success of your treatment. Please understand that the payment of your bill is considered integral to our treatment plan and physician/patient relationship. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

We accept most insurances including Medicare, Medicaid, Workers Compensation, and private pay carriers. We are preferred providers on most plans. We require prior authorization for HMO and other plans with Primary Care Physicians. It is your responsibility to make sure we are authorized to treat you, and a referral or authorization is on file. Insurance cards are REQUIRED at the time services are rendered.

Your insurance policy is a contract between you and your insurance company. The bill is your responsibility. As a courtesy we will bill your insurance carrier. However, if your bill remains unpaid 60 days after your visit you will receive a statement from us for payment due. It is your responsibility to contact your insurance company for further instructions on continuity of your care. (some exceptions exist with worker's compensation).

Please be aware some services may be "non-covered" services under Medicare and or other medical insurance programs. This does not mean they are unnecessary or unreasonable to the physician and patient. Charges not covered by the insurance carrier, but reasonable for the treatment of the patient are the patient's responsibility to pay.

Any co-pays or co-insurance are due prior to services being rendered. Cash accounts are to be paid at the time of service unless prior arrangements have been made. Due to the continued rise in costs for processing insurance and billing, our office will charge interest at 1.5% per month on any account thirty days overdue.

Our practice is committed to providing the best treatment possible for our patients and we are careful to charge only what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rules. UCR does not apply to PPO or HMO negotiated rates.

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments and for recheck appointments. This fee is payable by the patient and is not billable to the insurance company.

I have read the foregoing financial policy of Mountain West Sport & Spine. I understand and agree to this Financial Policy.

Patient Name:_____ Date:_____

Patient/Guardian Signature:_____

Name: _____Chart: _____

New Patient Consent to the Use and Disclosure of Health Information

for Treatment, Payment, or Healthcare Operations for

MOUNTAIN WEST SPORT & SPINE

I, _____ understand that as part of my health care, MOUNTAIN WEST SPORT & SPINE originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. Furthermore, I understand that Mountain West Sport & Spine will access any available electronic prescription history. I understand that this information serves as:

- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care (to include electronic communication with your pharmacy.)

I understand and have been provided access to review and or retain the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, marketing, or fundraising and
- The right to request restrictions as to how my health information may be used or disclosed except to carry out treatment, payment, or health care operations

I understand that MOUNTAIN WEST SPORT & SPINE will agree to the restrictions requested except for restrictions which impede treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization could refuse to treat me as permitted by Section *164.506* of the Code of Federal Regulations.

I further understand that MOUNTAIN WEST SPORT & SPINE reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should MOUNTAIN WEST SPORT & SPINE change their notice, a current notice is posted and I may request a current copy at any time.

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

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand the terms of this consent and I _____Accept (_____Decline) these terms.

Patient's Signature _____
Date: _____

Name: _____ Chart: _____

PATIENT AUTHORIZATION

PLEASE READ THE NOTICE OF PRIVACY PRACTICES POSTED IN THIS OFFICE or request a copy for your records.

Please list the family members or other persons whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and healthcare operations):

_____

_____

Please list the family members or significant others whom we may inform about your medical condition IN AN EMERGENCY:

Name:_____ Phone #:_____

Name:_____ Phone #: _____

Please print the address where you would prefer to have billing and or correspondence sent if other than your home address:_____

_____

Please print the telephone number where you want to receive calls about appointments or other healthcare information if other than your home number (keep in mind Cell phones are not secure lines)_____. Also note, messages will be left on your answering machine or voice mail).

By signing this form, I am confirming my authorization for use/disclosure of my protected health information as described in this form and the NOTICE OF PRIVACY PRACTICE. I understand that signing this form is not a condition of treatment. I am confirming that I have read the NOTICE OF PRIVACY PRACTICE and agree with all statements contained within. I understand that I may revoke this authorization at any time by giving written notice to this office.

PRINT Name: _____

SIGNATURE: _____

Guardian/Parent (if under 18) PRINT:_____

Guardian/parent signature: _____

Date: _____

Name: _____ Chart: _____

Pain Medication Policy

PATIENT NAME: _____ DOB: _____

DATE: _____

Definition and Purpose

The Pain Treatment Agreement is to document the approach to pain management. Medication treatment includes drug prescriptions along with other modalities. This agreement is for the purpose of defining the terms of care for the patient. Our goal at, Mountain West Sport & Spine, is to have patients weaned off pain medications by the end of three months.

Terms and Conditions

The patient must agree to the following:

1. I will not request or accept any narcotic prescriptions from another medical provider.
2. I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications may cause withdrawal symptoms.
3. I understand that I must keep my medications in a safe place.
4. I understand that my provider will NOT supply additional refills for the prescriptions of medications that I may lose.
5. If my medications are stolen, my provider will refill the prescription ONE time only if a copy of the police report of the theft is submitted to the physician's office.
6. I will NOT give my prescription to anyone else.
7. I will only use one pharmacy.
8. I will not call the office for refills. I will call my pharmacy.
9. I will allow 24 hours for a prescription refill.
10. I understand there will be NO early refills, for ANY reason.
11. Requests for a change in prescriptions will be discussed at appointments ONLY.
12. I understand that there will be absolutely NO EXCEPTIONS to this policy.
13. I understand that I am subject to random urine drug screening which is intended to protect me and my prescribing physician, P.A. or APN for purposes including but not limited to: adverse reactions between prescribed and non- prescribed medications, to establish a "baseline" for mediation in my system, and to assist in monitoring the efficacy of the medication prescribed by my physician.

Compliance

Failure to comply with the terms and conditions of the Mountain West Sport & Spine Pain Agreement may result in **discontinuation of medication refills**. Random drug profiles may be obtained.

Patient Signature: _____ Date: _____