SIERRA REGIONAL SPINE INSTITUTE

SPINAL SURGERY:

James R. Rappaport, M.D.

Phelps C. Kip, M.D.

James H. Olson, M.D.

PHYSICAL MEDICINE:

Robert G. Berry Jr., M.D.

Christopher D. Twombly, M.D.

Dallin L. DeMordaunt, M.D.

FOR OUR PATIENTS

The primary goal of our practice is the best possible healing and recovery for every patient. To that end, we have established procedures which allow patients to be evaluated promptly and them to be given every opportunity to take an active role in the decision-making and treatment processes. Our clinical experience has shown that those who become participants in their own health care decisions are far more likely to achieve an optimal level of healing and recovery.

INFORMED DECISION MAKING

Making a truly informed medical decision involves more than a single decision. It is a step-by-step process in which you take responsibility for making a number of decisions. Your decision to seek help was the first step in that process. The rest of the process is described below.

1. Understand your condition:
   a. listen *carefully* to your health care professionals when you are presented with a diagnosis of your condition and description of your treatment options
   b. ask questions during your appointments about anything you do not understand

THE BENEFITS FOR YOU

By taking ownership of your health care decisions, you are likely to have:

a. **less anxiety** prior to and during your treatment
b. **a better mental attitude**, which can help to increase your body's own healing powers
c. **a speedier recovery**, because you are committed to actively participating in returning to a normal level of activity
d. **the best recovery possible** because you have realistic goals and work steadily to achieve them

TESTING AND SURGERY AUTHORIZATIONS

Please allow adequate time for this process, approximately 2-3 weeks. You will be notified promptly when authorization has been received and the procedure has been scheduled.

PRESCRIPTION AND MEDICATION RENEWALS

Please follow the required procedure for prescription refills:
CALL YOUR PHARMACY WITH ALL REFILL REQUESTS
DO NOT CALL THE OFFICE!
Your pharmacy may leave a message on our pharmacy line. All messages left during regular hours are returned to your pharmacy before 5:00 PM daily. Special circumstances may take up to **48 HOURS** for this process to be completed.
PLEASE PLAN AHEAD! DON'T WAIT UNTIL THE LAST MINUTE TO GET YOUR PRESCRIPTIONS REFILLED! **PLEASE**, DON'T CALL AFTER 5:00 PM OR ON WEEKENDS FOR REFILLS; THE ON CALL PHYSICIAN MAY NOT KNOW YOUR MEDICAL HISTORY AND CANNOT REFILL YOUR PRESCRIPTIONS.

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):

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____

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: ________________________________

Sierra Regional Spine Institute
6630 S. McCarran Blvd #4
Reno, NV 89509
775-828-2873
775-828-2890 (fax)

New Patient consent to the Use and Disclosure of Protected Health Information for the Treatment, Payment, or Health Care Operations for
SIERRA REGIONAL SPINE INSTITUTE

I, ________________________________, understand that as part of my health care, SIERRA REGIONAL SPINE INSTITUTE originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. 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

I understand and have been provided with a NOTICE OF INFORMATION 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
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that SIERRA REGIONAL SPINE INSTITUTE is not required to agree to the restrictions requested. 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 may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that SIERRA REGIONAL SPINE INSTITUTE reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should SIERRA REGIONAL SPINE INSTITUTE change their notice, they will send a copy of any revised notice to the address I have provided, via US Mail.

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/Guardian Signature:__________________________________ Date: __________________

For Office use only: Consent Received by:_____________________ Date__________________
Consent refused by Patient, and TX refused as permitted________________

SIERRA REGIONAL SPINE/ORTHOPEDIC REHAB SPECIALISTS OF NV
HEALTH SURVEY

Instructions for Completing the Questionnaire: Please answer EVERY question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the square that best represents your response.

General Health

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor

2. Compared to one year ago, how would you rate your health in general now?

Much better Now than one year ago	Somewhat better Now than one one year ago	About the same as one one yr ago	Somewhat worse now than one year ago	Much Worse Now than one year ago

3. The following items are about activities you might do during a typical day. Does your Health now limit you in these activities? If so, how much?

	Yes, Limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities, such as running, lifting heavy Objects, participating in strenuous sports			
b. Moderate Activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
c. Lifting or carrying groceries			
d. Climbing several flights of stairs			
e. Climbing one flight of stairs			
f. Bending, kneeling, or stooping			
g. Walking more than a mile			
h. Walking several blocks			
i. Walking one block			
j. Bathing or dressing yourself			

SIERRA REGIONAL SPINE INSTITUTE

6630-A South McCarran Blvd Ste 4
Reno, NV 89509
775-828-2873

FINANCIAL POLICY

Thank you for choosing us as your spine 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.

Regarding Insurance:
We accept most insurances, 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.

Payment Due At Time of Service:
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.

Usual and Customary Rates (UCR)
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.

Missed Appointments:
Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $150.00 for New Patient visits, and $30.00 for recheck appointments. This fee is payable by the patient and is not billable to the insurance company.

I have read the financial policy of Sierra Regional Spine Institute. I understand and agree to this Financial Policy.

Patient Name:_______________________________________ Date:_____________________

Patient/Guardian Signature:____

Rev date 03.18.06

SIERRA REGIONAL SPINE INSTITUTE
PAIN DRAWING

Patient Name: ___________________________________ Date_______________

Where is your pain now? (Please identify the areas of pain by marking on the drawing below. Use the appropriate sympbols to identify the sensations you feel. Include all affected areas. (to complete the picture please draw your face).

ACHE = **aaa** NUMBNESS= **nnn** PINS & NEEDLES= **…..** BURNING= **bbb**
STABBING= **sss**

FRONT SIDE

BACK SIDE

Which is more troublesome To you, (mark with X)

Back Pain __________

Leg Pain ___________

How much pain do you have right now?

0 1 2 3 4 5 6 7 8 9 10
(no pain) (Worst pain)
(10 being the worst pain ever)