Patient Information

Name:	Date of Birth: / /	SSN: - -	Sex:
Mailing Address:	Apt / Unit / Spc / Ste # :		
City:	State:	Zip Code:	
Primary Contact # : ( ) - ☐ Home ☐ Cell ☐ Work	Secondary Contact # : ( ) - ☐ Home ☐ Cell ☐ Work		
Email:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:		
Preferred Billing Method: ☐ Mail ☐ Email	Preferred Language: ☐ English ☐ Spanish ☐ Other:		
Employer:	Occupation:	Employment Type: ☐ Full Time ☐ Part Time ☐ None ☐ Other:	
Referring Physician:	Primary Care Physician: ☐ Same as Referring ☐ Other:		
How Did you hear about us? ☐ Referring Physician ☐ Friend ☐ Family Member ☐ Internet site: ☐ Other:			

Emergency Contact Information

Emergency Contact Name:	Phone # : ( ) - ☐ Home ☐ Cell ☐ Work
Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Power of Attorney ☐ Friend ☐ Other:	

Insurance Information

Primary Insurance:	Secondary Insurance:
Primary Subscriber ID:	Secondary Subscriber ID:
Primary Group Number:	Secondary Group Number:
Subscriber Name:	Subscriber Name:
Relation to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:	Relation to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:

General Consent to Treatment and Patient Responsibilities

Please read the following policies and sign below in the space provided. (A copy will be provided to you upon request)

With the signature below, I authorize the Velazquez Pain Relief Center and their staff to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatments, or therapies necessary to effectively assess, diagnose and treat my illness or injuries and/or maintain my health. I understand that it is the responsibility of my individual treating health care providers to explain to me the reasons for any diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options. In giving my general consent to treatment, I understand that I retain the right to refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees can be made to me as to the results of my evaluation and/or treatment.

Acknowledgement of Patient's Responsibilities. I understand that I am required to provide a valid photo ID (state license, passport, government/military ID) and current insurance card(s) at every visit and to accurately complete all patient registration forms prior to receiving any services from the Velazquez Pain Relief Center. I am aware that my medical coverage is a contract between me and my insurance company and if I fail to provide the Velazquez Pain Relief Center with the correct information in a timely manner, I may be responsible for the full balance of my claims. I agree if I cannot provide an up-to-date insurance card or am unable to provide proof of active eligibility, I may be asked to pay a minimum deposit of **$300 for New Patient** services rendered, **$150 for Established Patient** services rendered, for each visit until coverage is verified. I acknowledge that if my insurance company requires a referral or authorization for any services rendered, it is my responsibility to obtain any referrals, forms, and/or authorizations prior to services being rendered. In the event that I have dual insurance coverage, I understand it is my responsibility to inform the Velazquez Pain Relief Center which insurance company is primary, and which is secondary, so the charges may be billed correctly. If my insurance company changes at any time, I acknowledge it is my responsibility to notify the practice immediately of those changes pertaining to my coverage. I further understand that failing to do so may result in unpaid claims and the full balance of those charges becomes my responsibility. If the correct insurance info is given after services have been rendered and claims are denied for timely filing, I understand that I will be responsible for any unpaid charges, regardless. If my visit may be associated with a work-related injury/claim, I attest that my designated adjuster has contacted the appropriate staff member at the Velazquez Pain Relief Center prior to any visit to coordinate my care.

Authorization for Assignment of Benefits to Physician. I understand that reimbursement on insurance claims can be a long and difficult process. To aid in the prompt processing of my health insurance claims, I authorize the release of medical or other necessary information, including specially protected information such as mental health, substance abuse, and/or HIV/AIDS information about me, to my health insurance(s) in order for the Velazquez Pain Relief Center to be reimbursed for the services rendered. I also authorize my insurance company or other third-party payers to pay the costs associated with the services rendered for my health care directly to the Velazquez Pain Relief Center. Further, if my insurance company should send payment to me, I acknowledge it is my responsibility to issue prompt payment to the Velazquez Pain Relief Center.

Acknowledgement of Covered Services and Claims Processing. I agree that knowing my insurance policy and understanding my covered benefits is solely my responsibility. In addition, I understand that verification of eligibility and benefits does not guarantee payment by my insurance company, any prior authorizations obtained are based on medical necessity, and claims are subject to policy provisions with final payment determined only when my insurance company processes the claim. I am aware that not all services are covered by my insurance company and that health insurance coverage is dependent on the benefits and coverage limitations outlined in my insurance policy. I acknowledge that fees for non-covered services are the responsibility of the patient/guarantor, and I am responsible for confirming all costs associated with the health care services received from the Velazquez Pain Relief Center are paid whether by my insurance company or not. With that, I agree that any balances remaining on my account 90 days after claims have been submitted with no payment issued by my insurance company become my responsibility. I understand that the Velazquez Pain Relief Center reserves the right to begin billing me directly and payment may be required in full at the time of my visit or billed to me on a later date. I understand it is my responsibility to contact my insurance carrier to follow-up on the payment status of any unpaid claims. I understand all copayments, deductibles, and/or coinsurance as indicated by my insurance plan are the patient's responsibility and must

be paid at the time of service (*unless prior arrangements are made*). I understand that this agreement is part of my contract with my insurance company and not doing so would be a violation of this contract. I understand some insurance companies also require information directly from the patient and, if so, I acknowledge that I am required to respond in a timely manner. Failure to do so may result in a denial of claims, and, therefore, I will be held responsible for the payment of services rendered.
I understand that if I have questions regarding coverage and benefits, including deductibles, copays and/or co-insurance for office visits, x-rays and other imaging, injections, other office procedures, and/or surgical procedures, it is my responsibility to refer to my policy for clarification and verification of coverage and benefits and/or to contact my insurance company directly. Outside facility charges are billed separately by the appropriate facilities and we are not responsible for any outside billing facilities fees such as those incurred from lab work, imaging, surgery center charges, and/or any other applicable charges.

Acknowledgement of Account Balances. I understand that I am fully responsible for any outstanding balance on my account and that these balances are required to be paid in full prior to receiving further services from the Velazquez Pain Relief Center. I agree to pay all balances on my account and if I am unable to make payment in full, I will contact the billing department to make payment arrangements. I am aware that accounts become delinquent after 120 days from the first issued statement date. In the event that my account becomes delinquent without satisfactory arrangements made with the billing department, I understand that my balance will be referred to a collection agency, resulting in up to 40% of the unpaid balance in additional collections fees. Any balances over $100 must be paid in full or satisfactory payment arrangements made (which will require a valid credit card stored on file) prior to any future appointments being made. I understand if I pay with a check and it is returned for any reason, a **$25.00 Returned Check Fee** will be applied to my account for each returned check. THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE COMPANY and will be due on or before your next appointment.

Authorization for Release of Medical Information. I understand that health information about me including (if applicable) information related to HIV/AIDS, substance abuse, psychological conditions, and mental health treatment, may be shared with my health insurance carrier(s) or other third-party payers responsible for payment of my health care. Minors: As a minor who consents to receive health care services on my own behalf but utilizes my parent/guardian's insurance policy to pay for my services, I am aware that my parent/guardian will receive an Explanation of Benefits describing the nature of the services provided and, as a result, understand that these services will no longer be confidential.

A photocopy of this consent shall be considered as effective and valid as the original, until revoked by me in writing. This consent shall remain in effect until terminated or updated by me in writing.

I certify that I have read and fully understand the policies as written above.

_______________________________________ _______________

Patient Name *(print)* **Date of Birth**

_______________________________________ _______________

Patient or Legally Authorized Representative Signature **Date**

_______________________________________ _______________

Legally Authorized Representative Name *(print)* **Relationship to Patient**

1815 E. Lake Mead Blvd, Suite 317, N. Las Vegas, NV 89030
8845 W. Flamingo Rd, Suite 100, Las Vegas, NV 89147
7425 W. Azure Dr, Suite 150, Las Vegas, NV 89130
T: 702.960.4150 F: 702.960.4154

Cancellation & No-Show Policy

Thank you for entrusting your medical care to the Velazquez Pain Relief Center. Our goal is to provide you with quality Pain Management care in a timely manner. Please read our policies regarding missed appointments and sign below in the space provided.

Office/Telemedicine Appointments

When you schedule an appointment with our practice, a sufficient time block is set aside to provide you with the highest quality care. We understand there may be times when you experience extenuating circumstances or unforeseen emergencies, and you may not be able to keep your scheduled appointment. In order to accommodate the medical needs of our patients, if any changes need to be made to your appointment or if you are unable to attend, you are required to notify our office **24 hours** prior to your scheduled appointment. If your appointment is not cancelled at least 24 hours in advance, a **$25.00 fee** will be applied to your account. THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE COMPANY and will be due at your next appointment. We also understand that delays can happen; however, we do our best to keep other patients and providers on time. Please call to inform our office if you are running late. All patients are allowed a 15-minute grace period on their appointment date (this includes Telehealth visits). After your 15-minute grace period has expired you will be considered a No-Show to your appointment. A $25.00 fee will be applied to your account, due at your next appointment, and you will also have to reschedule to another date.

Surgical Procedure Appointments

Due to the block of time reserved for in-office and surgery center procedures and for the added resources involved, last minute cancellations can cause problems and unnecessary added expenses. If your scheduled surgical procedure is not cancelled at least **24 hours** in advance, a **$50.00 fee** will be applied to your account. THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE COMPANY and will be due at your next appointment.

I certify that I have read and fully understand the policies as written above.

______________________________	______________
Patient Name *(print)*	**Date of Birth**
______________________________	______________
Patient or Legally Authorized Representative Signature	**Date**
______________________________	______________
Legally Authorized Representative Name *(print)*	**Relationship to Patient**

1815 E. Lake Mead Blvd, Suite 317, N. Las Vegas, NV 89030
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Notice of Privacy Practices Pursuant to HIPAA

The Velazquez Pain Relief Center is required by law to maintain the privacy of Protected Health Information and provide individuals with a notice of our legal duties and privacy practices with respect to Protected Health Information.
With my signature below, I acknowledge that I have been made aware of the Notice of Privacy Practices. I also understand that the full NPP is available in each facility and a copy may be provided to me upon request and with any questions concerning or objections to this form, I may contact the HIPAA Compliance Officer.

Authorization for Release of Health Information Pursuant to HIPAA

I hereby authorize the Velazquez Pain Relief Center to disclose, release and/or obtain any of my Protected Health Information, including, but not limited to, information related to treatment, diagnosis, testing, and results, psychiatric care, drug and alcohol abuse, HIV/AIDS confidential information, and any other information that may pertain to the course of my treatment, necessary to process insurance claims or required for any health care related utilization review or quality assurance activities.

A photocopy of this authorization shall be considered as effective and valid as the original, until revoked by me in writing.
This Release of Information will remain in effect until terminated by me in writing.

I authorize the release of my Protected Health Information to the following:

☐ PCP / Medical Provider: ____
☐ Spouse: ____
☐ Child(ren): ____
☐ Other: ____________________________________ Relationship: ______________

☐ ***I do not authorize my information to be released to anyone other than myself.***

I certify that I have read and fully understand the policies as written above.

____ ____________________
Patient Name *(print)* **Date of Birth**

____ ____________________
Patient or Legally Authorized Representative Signature **Date**

____ ____________________
Legally Authorized Representative Name *(print)* **Relationship to Patient**

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE PRESCRIPTION USE

You will be participating in a structured controlled substance therapy program for the treatment of your chronic pain. Your treatment plan will be under the direction of the Velazquez Pain Relief Center. Medications are to be used only as prescribed. If you believe that your condition has changed, then you should call the office during regular business hours and schedule a re-evaluation.

Medication changes or other reductions in dose will not be made over the telephone. The Velazquez Pain Relief Center will write the controlled substance prescription. One pharmacy will fill all your prescriptions. Our office must agree to the pharmacy you wish to designate.

The primary goal of any treatment plan is to increase function and secondarily to decrease pain. It may require several weeks to achieve a stable dosage schedule without significant side effects. During this period, frequent adjustments in dosage and formulation may be required. This trial may require several weeks during which periodic checks of functional progress will be made. At the end of this time, a decision will be made, based upon your response to your treatment plan, to continue with extended pharmacological therapy or to revise your treatment plan. You agree to participate in other treatments that the physician recommends.

You understand that all medications are to be taken only as directed. Increasing dosage without the supervision of our providers could lead to drug overdose. Drug overdose can cause severe sedation (sleepiness), slowed breathing, and possible death.

You should be aware of potential side effects of controlled substances such as decreases reaction time, clouded judgement, drowsiness, and sleepiness. You should not drive motor vehicles or operate dangerous equipment if you experience any of the above symptoms. Physical dependence can occur when controlled substance medications are used. Abrupt discontinuation of the medication or rapid reduction in dose can result in withdrawal symptoms such as abdominal cramping, nervousness, runny nose, diarrhea, and sweating.

You will contact the physician before taking benzodiazepines (for example, Valium, Xanax, Ativan) or sedatives (for example, Soma, sleep medications, muscle relaxants) and antihistamines (such as, Benadryl or Vistaril) or over-the-counter cold medications. The use of these medications or alcohol with controlled substance medications may produce drowsiness, slowed breathing, blood pressure drop or even death.

You may be asked to provide blood or urine samples to measure blood levels of certain medications. Failure to comply will be grounds for termination of care. *By signing below, you agree to random urine drug screenings.*

Mood altering substances such as tranquilizers and sleeping pills can have adverse effects and interfere with controlled substance therapy. You agree not to take these medications until you have received approval to do so from the physician. Alcohol and illicit drugs (such as, cocaine, heroin, or hallucinogens) can cause adverse effects or interfere with controlled substances therapy. You therefore agree to refrain from the use of these substances.

Losing medications or prescriptions or obtaining medications from other unauthorized sources shall be considered cause for discontinuation of treatment at the Velazquez Pain Relief Center. Lost or stolen medications will not be replaced. Early refills will not be granted for overutilization of controlled substances medication. Only the patient and no one else will use the medications prescribed by the physician. You MUST have an appointment on or before your scheduled refill date. If you do not make you appointments in a timely manner, you may not be seen before your medication runs out. Urgent, last-minute requests for refills are avoidable and therefore will not be granted. Controlled substances medication will not be prescribed or refilled over the telephone. You understand that in all situations it is required that you have an office visit with the physician to have medications prescribed.

The physician will see you at periodic intervals for follow-up and monitoring of your maintenance program. The interval will be determined by your physician. Your prescriptions will be written to approximate these intervals. While physical dependence is to be expected after sustained use of controlled substances, signs of addiction and psychological dependence shall be taken as a need to wean and discontinue controlled substances medication. If it appears to the physician that there is no improvement in your daily function or quality of life from the controlled substances medication, the controlled substances medication will be tapered and discontinued.
You agree that your physician has the authority to disclose the prescribing information to other health care professionals when it is deemed medically necessary as per physician judgement.
You have had all your questions answered satisfactorily. You consent to the use of controlled substances to help control your pain and understand that your treatment with controlled substances will be carried out as described as above.

I certify that I have read and fully understand the policies as written above.

____	____________________
Patient Name *(print)*	**Date of Birth**
____	____________________
Patient or Legally Authorized Representative Signature	**Date**
____	____________________
Legally Authorized Representative Name *(print)*	**Relationship to Patient**

VELAZQUEZ PAIN RELIEF CENTER

New Patient Intake Form

Name/ *Nombre*: ____ Date/ *Fecha*: _______________

Height/ Esta*tura*: _____________ Weight/ P*eso*: ____________ BP: ________________ HR:______________

Pain Description:

What caused your current pain episode/ *Que causo tu dolor*? ____

Approximately when did this pain begin/ *Cuando empezo este dolor*? _________________________________

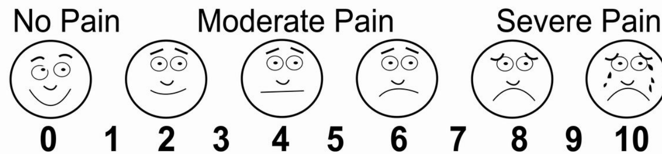
Where is your worst area of pain located/ Donde esta tu peor area de dolor? ___________________________

Does this pain radiate? If so, where? A *donde extiende tu dolor?* _____________________________________

Please list any additional areas of pain/ *Areas adicionales de dolor*: ___________________________________

Pain Description – Check all that apply to your pain (*Marque todo lo que le applica a su dolor*)

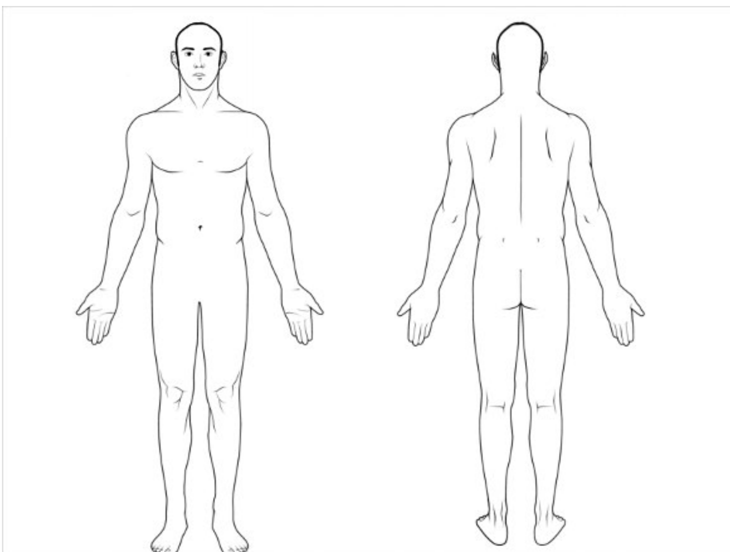
__ Aching/*Dolor*
__ Cramping/ *Calambres*
__ Dull/ *Dolor Sordo*
__ Burning/ *Caliente*
__ Numbness/*Entumecimiento*
__ Shock like/ *Chocante*
__ Stabbing/ *Punzante*
__ Spasming/ *Espasmodico*
__ Squeezing/*Apretado*
__ Sharp/ *Dolor Agudo*
__ Throbbing/ P*alpitante*
__ Pins & needles/ *Pinchazos & hormigueo*



_____ What number on the pain scale (0-10) describes your least pain? *Que numero describe su menor dolor*?

_____ What number on the pain scale (0-10) describes your worst pain? *Que numero describe su peor dolor*?

Since your pain began, how has it changed? ___Decreased ___Increased ___ Stayed the same
Como ha cambiado tu dolor? ___ *Disminuido* ___*Aumentado* ___*Sin alterar*



Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching

Aggravating Factors - What makes your pain worse? (*Que es lo que empeora su dolor?)*

__ Moderate physical activity/ *Actividad fisica moderado*
__ Turning/bending neck or back/ *Doblando o girando el cuello o espalda*
__ Squatting or crouching down/ Agachando
__ Work related activity/ Actividades relacionadas al trabajo
__ Sitting for longer than 30 minutes/ *Estar sentado mas de 30 minutos*
__ Transitioning from sitting to standing/ *Transicion de sentado a parado*
__ Standing for longer than 30 minutes/ *Estar parado mas de 30 minutos*
__ Walking more than a few blocks/ *Caminando mas de un par de cuadras*

Relieving Factors – What helps your pain? (*Que mejora el dolor?)*

__ There are no relieving factors / *no hay factores de alivio*
__ Massage / *masage*
__ Heat / *calor*
__ Ice/ *hielo*
__ Spine adjustment or manipulation/ *manipulacion de espalda o ajustes*
__ Pain medications/ *medicamento para dolor o analgesicos*
__ Relaxation or rest/ Descanso
__ Light physical activity/ *Actividad fisica ligera*
__ Stretching/ *Estirando*

Is your pain/ Es su dolor?:
__ Constant/ *constante* vs __ Intermittent/ *Intermitente* ?

Activities of Daily Living Affected/ *Actividades diarias afectadas*

__ Eating/ *comiendo*
__ Sleeping/ *dormido*
__ Intimacy/ *relaciones sexuales*
__ Housekeeping/ *limpiendo la casa*
__ Shopping/ *compras*
__ Personal hygiene or grooming/ *hygiene personal*
__ Toileting/ *Ir al bano*
__ Bathing or dressing/ *banarse o vestirse*
__ Working/ *trabajando*
__ Cooking/ *cocinando*
__ Driving/ *conduccion*
__ Caring for children/ cuidado de ninos

Diagnostic Tests and Imaging/ *Pruebas o imagenes diagnosticas*

Mark all of the following tests you have had that are related to your pain/ *seleccione todo lo que aplica*
___ XRAY ___ MRI/*resonancia magnetica* ___ CT scan/*tomografia computarizada*
___ EMG/Nerve conduction study (*estudio de los nervios*) ___ None/*ninguna*

Have you previously been treated for this pain? *Has tenido tratamiento para este dolor en el pasado?*

___ Chiropractic / *Chiropractico* ___ Physical Therapy*/ terapia fisica*
___ Surgery/*cirugia* Other/ *Otra*:________________________________

Medications/ *Medicamentos:*

1. ________________________________
2. ________________________________
3. ________________________________
4. _____________________________________
5. _____________________________________
6. _____________________________________

*Are you on any blood thinners? *Esta tomando anticoagulantes*?________________________________

Past Medical History/ *Condiciones Medicas*:

__ Diabetes	__ High blood pressure	__ Asthma
__ Kidney disease	__ High cholesterol	__ Emphysema
__ Stroke	__ Coronary artery disease	__ Thyroid disease
__ Seizures	__ Congestive heart failure	__ Cancer
__ Hepatitis	__ Arrhythmia	__ Depression

Other: ____

Allergies/ *Alergias*:

1. ________________________________
2. ________________________________
3. ________________________________
4. _____________________________________
5. _____________________________________
6. _____________________________________

*Are you allergic to latex? *Alergia al latex*?____
*Are you allergic to iodine/ IV contrast? *Alergia al yodo/contraste de yodo IV*?______________________

Past Surgical History/ *Cirugias anteriores*:

__ Coronary bypass	__ Bariatric surgery	__ Spine surgery
__ Coronary stents	__ Hysterectomy	__ Orthopedic surgery
__ Pacemaker	__ Tubal ligation	__ Endoscopy/colonoscopy
__ Heart valve	__ C-section	__ Hemorrhoidectomy
__ Gallbladder	__ Bladder surgery	__ Tonsillectomy
__ Appendectomy	__ Prostate surgery	__ Thyroidectomy
__ Bowel/stomach resection	__ Breast surgery	__ Cataracts

Other: ____

Social History:

Smoker: __ Yes __No __ Former smoker
Alcohol: __ Yes __No __ Socially __ Rare
Substance Abuse: ____

Advanced Directive:

Surrogate decision maker: ____ YES ____NO
Do not resuscitate: ____ YES ____NO

OPIOID RISK TOOL (ORT)

Patient Name: ______________________________

Date of Birth: ______________________________

Date: __________________________

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL				