

NAME: \_\_\_\_\_ S.S.#: \_\_\_\_\_  
(LAST) (FIRST) (INITIAL)

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_ OKAY TO TEXT/EMAIL COMMUNICATION/UPDATES? Yes No

MARITAL STATUS: S M W D BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SEX: M F

RACE: WHITE AMERICAN INDIAN OR ALASKA NATIVE ASIAN AFRICAN AMERICAN NATIVE HAWAIIAN OR PACIFIC ISLANDER

ETHNICITY: NOT HISPANIC OR LATINO HISPANIC OR LATINO

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE # \_\_\_\_\_

**IF ON MEDICARE IS IT YOUR PRIMARY COVERAGE?** Yes No

**PRIMARY INSURANCE**

INSURED NAME: \_\_\_\_\_ s.s.#: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (INITIAL)

INSURANCE CARRIER: \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

CARRIER ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

PHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

**SECONDARY INSURANCE**

INSURED NAME: \_\_\_\_\_ s.s.#: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (INITIAL)

INSURANCE CARRIER: \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

CARRIER ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

PHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

**ADVANCED DIRECTIVE (LIVING WILL)**

DO YOU HAVE AN ADVANCED DIRECTIVE? YES NO

WOULD YOU LIKE TO KEEP A COPY ON THE CHART? YES NO

**PAYMENT AUTHORIZATION**

I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician. I further authorize the release of any and all medical or other information related to such services to my insurance carrier in order to determine benefits due me. I agree to be personally and fully responsible for payment for medical services rendered. I understand that any balances not paid in a timely fashion are subject to additional financial and/or collection charges. I understand that if I cancel a clinic appointment, it must be within regular clinic hours at least one clinic day prior to my appointment, or a fifty dollar surcharge will be required prior to attending any future appointments. I consent to receive calls from Advanced PainCare for my protected healthcare and other services at the phone number(s) above, including my wireless number.

PATIENT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Pain can be rated on a scale of 0-10. "0" would indicate no pain at all, while "10" would represent the worst pain you can imagine: (select one)

Today:            0   1   2   3   4   5   6   7   8   9   10

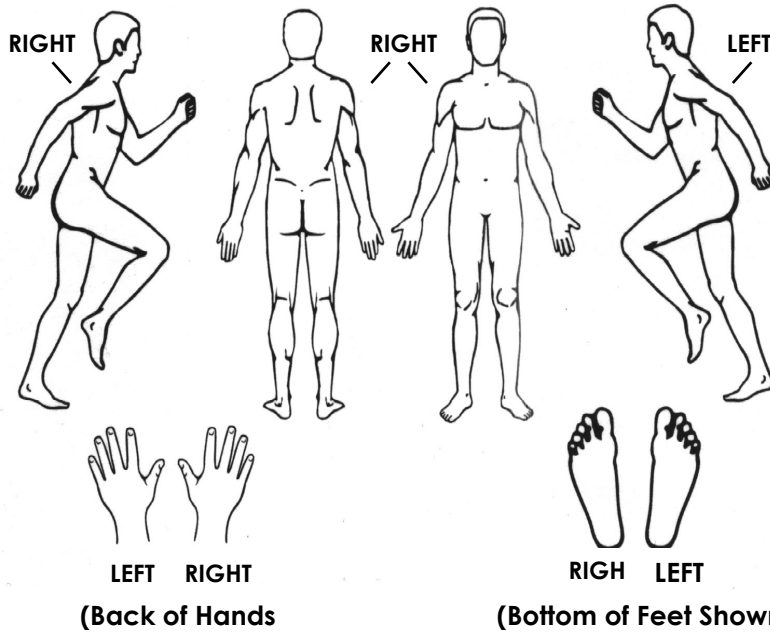
Daily Average:   0   1   2   3   4   5   6   7   8   9   10

Smoker                      Yes   No

Blood Thinners            Yes   No

Aspirin or NSAIDS        Yes   No

Diabetic                      Yes   No



**Select the words that describe your pain:**

- |          |            |
|----------|------------|
| Aching   | Throbbing  |
| Stabbing | Gnawing    |
| Sharp    | Unbearable |
| Tender   | Burning    |
| Shooting | Electrical |
| Tingling | Crawling   |
| Stinging | Numbing    |

1. Have you had any new medical labs, x-rays, or studies done since your last visit? **Yes**   **No**

If yes, explain: \_\_\_\_\_ Facility: \_\_\_\_\_

2. Have your prescription medications changed since your last visit? (eg Blood Thinners, NSAIDS or Aspirin)? **Yes**   **No**

If yes explain: \_\_\_\_\_

3. Have you visited an emergency room/urgent care center since your last visit? **Yes**   **No**

If yes, explain: \_\_\_\_\_

4. Any changes in your overall Medical Health since your last visit? **Yes**   **No**

If yes, explain: \_\_\_\_\_

**OFFICE USE ONLY:**

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. What makes your pain worse? \_\_\_\_\_  
\_\_\_\_\_

6. What makes your pain better? \_\_\_\_\_  
\_\_\_\_\_

7. Pain interferes with my daily activities: (select one)

Never      Sometimes      Most of the time      Always

8. Pain interferes with my sleep: (select one)

Never      Sometimes      Every Night

9. Have you experienced?

Loss of sensation	Yes	No
Weakness	Yes	No
Inability to maintain balance	Yes	No
Loss of control of other body functions	Yes	No

Explain: \_\_\_\_\_

10. Have you tried other treatments since your last visit? (eg Surgery, Physical Therapy, Procedures)

If yes, explain: \_\_\_\_\_

11. Overall, what treatment has been most effective in relieving your pain?

Procedures	Surgery	Acupuncture
Physical Therapy	Counseling	Chiropractic
Medication	Exercise	_____

12. What percent reduction of your pain do you attribute to this treatment?

25%      50%      75%      Other \_\_\_\_\_

## FINANCIAL POLICY

You are financially responsible for the medical services you receive. Please review our policies below and print and sign your name at the end to indicate your agreement to these terms.

### APPOINTMENTS

**1. Copayments** for clinic visits are due at the time of service. If you are unable to make your copayment at that time, Advanced PainCare reserves the right to reschedule your appointment until such time you are able to make your copayment. Payment for any outstanding balance is due at your appointment unless previous payment arrangements have been made with the billing department.

**2. Procedure Prepayment.** Advanced PainCare collects your payment for a procedure at the time of service. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of an overpayment you may request a refund once we have received payment from your insurance carrier. We reserve the right to reschedule your procedure until prepayment has been made.

**3. Missed Appointments and Late Arrivals.** If you are more than 15 minutes late, we may reschedule your appointment. Missed appointments are subject to a \$50 No Show Fee. This fee is your responsibility and will not be billed to your insurance company.

### INSURANCE PAYMENTS

**4. Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

**5. Coverage Changes and Timely Submission.** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Advanced PainCare must submit a claim on your behalf to your insurer. If Advanced PainCare is unable to submit your claim within this period because we have not been supplied with your correct information, you will be responsible for the charges. If your plan changes, or your insurer changes and we are not a contracted provider for that plan or insurer and we were not advised of this change prior to services being rendered, you will be responsible for all charges.

**6. Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by Advanced PainCare, you are considered a Self Pay patient. Your charges will be based on our current Self-Pay fee schedule (Available by request). Self Pay patients are expected to make payment in full at the time of service.

## BENEFITS AND AUTHORIZATION

**7. Insurance Plan Participation.** We participate in many, but not all insurance plans. It is your responsibility to contact your insurance company to verify that Dr Fishell participates in your plan. Out of network benefits usually have higher deductibles and copayment.

**8. Referrals** and prior authorization requirements vary widely among insurance carriers and plans. If your carrier requires a referral for you to be seen by Advanced PainCare, it is your responsibility to be aware and to obtain this referral or authorization.

**9. Prior Authorization** and Non-Covered Services. Advanced PainCare may provide services that your insurance plan excludes or that require authorization. It is ultimately your responsibility to ensure that services being provided to you are a covered benefit and authorization has been obtained. Advanced PainCare, as a courtesy to our patients makes a concerted effort to determine if the services we order are covered by your insurance plan, and if so, whether or not prior authorization for treatment is required. If authorization is needed, we will request this on your behalf.

**10. Out of Network payments.** If we are not part of your insurance carrier's network and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Advanced PainCare immediately.

## ACCOUNT BALANCES AND PAYMENTS

**11. Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

**12. Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency, which may result in reporting to credit bureaus. Advanced PainCare reserves the right to refuse treatment to patients with outstanding balances over 120 days old.

**13. Returned Checks** will be subject to a \$25 returned check fee.

**14. Refunds** for overpayment are made only after there has been full insurance reimbursement for all medical services on your account.

**15. Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

## AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the financial policy of Advanced PainCare, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Advanced PainCare. I understand that I am financially responsible for all services I receive from Advanced PainCare. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Print Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Patient Rights and Responsibilities

### As a patient, you have the right:

- To be treated with respect and courtesy, including recognition of personal beliefs and values.
- To receive care in a setting and environment committed to patient safety.
- To privacy and confidentiality.
- To coordination and continuity of your health care.
- To know the identity of physicians and others involved in your care.
- To information presented in terms you understand, including treatment and care options.
- To be involved in decisions regarding your health care plan.
- To access health care records according to the Advanced PainCare Notice of Privacy Practices.
- To be heard if problems, complaints or grievances arise.
- To be informed of charges for services as well as payment options.

### As a patient, you have a responsibility:

- To provide complete medical information to your health care providers, including a list of medications and devices for each visit.
- To ask questions so that you have a clear understanding.
- To make informed decisions.
- To report any changes in your health and medications.
- To report any changes in your health insurance plan and contact information, ie: address, phone numbers.
- To understand your health problems and to follow agreed upon plans and instructions for your care.
- To recognize the impact of your lifestyle choices on your personal health.
- To keep schedule appointments on time, or reschedule in a timely manner.
- To respect the rights, privacy and confidentiality of other patients and clinic personnel.
- To accept financial obligations and understand your own health insurance benefits.
- To treat Advanced PainCare staff and providers with respect and courtesy.

Print Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_

**PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

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I, \_\_\_\_\_, by signing this authorization am authorizing  
(Patient Name)  
confidential communication of my health information to the following recipients:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Medical Provider involved in my care \_\_\_\_\_

The type and amount of information to be disclosed is as follows:

- Complete Health Records
- Physical Exams
- Lab Results
- Consultation reports
- Appointments
- Billing Information
- Procedure reports

I understand I have the right to revoke this authorization at any time by submitting the request in writing to Advanced PainCare.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Office Hours: Monday through Thursday  
8:00 am to 5:00 pm  
CLOSED ON FRIDAY**

## **PHONE SYSTEM MESSAGING**

In an effort to provide a high standard of care and service to our patients we are currently using a patient call phone messaging system.

When you call **Advanced PainCare at 932-0606** you will hear the following greeting:

Thank you for calling Advanced PainCare, the office of Dr. Michael Fishell.

Please listen carefully to the following options:

- If this is a medical emergency, please hang up and dial 911.
- If you know your parties extension, please dial it now.
- To better serve you, please choose from the following options:
  - If you have recently had a procedure and have a question regarding that procedure Press 1
  - If you are a new patient calling to schedule an appointment Press 2
  - For medical assistant messaging including medication refill request Press 3
  - For procedure scheduling Press 4
  - For billing questions Press 5
  - For medical records Press 6
  - All other calls Press 0

**Timely response will best be obtained by  
leaving a message on the appropriate extension.**

Please leave only one message with your name, best number to reach you at and a brief message. Duplicate messages only encumber the system and take valuable time that could be better used in our follow up response.

We thank you in advance for your cooperation in participating in our phone messaging procedure to provide a high standard of care and service to you.

### **ANSWERING SERVICE**

**After hours, Fridays, weekends, holidays  
answering service WILL NOT TAKE GENERAL MESSAGES.  
This service is only for those who recently had a procedure and  
have a question regarding that procedure.**







Michael Fishell, M.D.

Michael Fishell, M.D.  
2865 Siena Heights Drive, Suite 120  
Henderson, NV 89052  
(702) 932-0606  
FAX: (702) 932-0605

Henderson, NV 89052  
(702) 932-0606

Privacy Officer: Practice Manager

Effective Date: MARCH 1, 2003

## NOTICE OF PRIVACY PRACTICES

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

### Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associated (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

### How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

### Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

(over)

## **Uses and Disclosures of Protected Health Information Requiring Your Written Authorization**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

## **Your Individual Rights Regarding Your Medical Information**

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

**Right to Request Confidential Communications.** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

## **Changes To This Notice**

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice with the effective date in the upper right corner of the first page.