SIERRA REGIONAL SPINE INSTITUTE
ORTHOPEDIC REHABILITATION SPECIALISTS OF NEVADA
6630 S McCarran Blvd #A-4
Reno, NV 89509
775-828-2873 or 888-268-1399

Scheduling PMR : 775-448-9413
Scheduling surgeons: 775-448-9414
Elko Scheduling: 775-777-9669

SURGEONS:
☐ James Rappaport, MD
☐ Phelps Kip, MD
☐ James Olson, MD
☐ Stacy Mierau, PA-C
☐ Shannon Rumble, A.P.N.
☐ Rachael Hueftle, A.P.N.

PHYSICAL MEDICINE & REHAB
☐ Robert Berry, MD
☐ Chris Twombly, MD
☐ Dallin Demordaunt, MD
☐ Casey Dye, A.P.N.
☐ Christopher Fisher, MD (Elko)

Welcome to our practice!

You are scheduled with the above marked physician on

Day of Week: ........................ Date: ........................ Time: ........................

To more efficiently serve you, we ask that you go to our website at www.sierraregionalspine.com and download the New Patient Packet of forms for completion. Please bring completed forms and your insurance cards and photo identification (so we may copy for our records). You will be asked to pay any co-payments or co-insurance amounts at the time of your appointment. Please arrive thirty (30) minutes early.

You will be contacted prior to your appointment for confirmation. If for any reason you cannot keep your scheduled appointment, please contact our office as soon as possible to reschedule.

It is VERY IMPORTANT for you to know which hospitals, laboratories, and radiology facilities your insurance requires for testing, so we may schedule you at the proper facility if the need arises. This information can be obtained by calling the customer service or verification of benefits number on your insurance card or by calling your employer.

This office requires all past X-rays, MRIs, CAT scans, and Bone Scans relevant to the appointment. Please obtain all pertinent films and bring them to the scheduled appointment. If you are unable to obtain the films, please contact our radiology department at 828-2873 x 130 and provide the location of your films. Your assistance is needed for our radiology department to help obtain the films for you.

Thank you. We look forward to seeing you in our office!
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 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.

Understand your condition:
Listen carefully to your health care professionals when you are presented with a diagnosis of your condition and description of your treatment options.

THE BENEFITS FOR YOU
By taking ownership of your health care decisions, you are likely to have:

- a speedier recovery, because you are committed to actively participating in returning to a normal level of activity
- 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. Expect Fridays. 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 PRESCRIPTION REFILLED. MESSAGES LEFT AFTER 2:00 P.M. ON FRIDAYS WILL NOT BE RETURNED UNTIL MONDAY. THE ON CALL PHYSICIAN DOES NOT KNOW YOUR HEALTH HISTORY AND WILL NOT REFILL PRESCRIPTIONS.
SIERRA REGIONAL SPINE INSTITUTE
ORTHOPEDIC REHABILITATION SPECIALISTS OF NEVADA

6630 S McCarran Blvd #A-4
Reno, NV 89509
775-828-2873

SIERRA REGIONAL SPINE INSTITUTE IS LOCATED INSIDE THE QUAIL MEDICAL PART AT
6630 SOUTH MCCARRAN BLVD BUILDING A, SUITE #4.

TAking HIGHWAY 395 SOUTH
EXIT #63 (S. VIRGINIA/KIETZKE) STAY TO THE LEFT WHICH WILL BRING YOU TO KIETZKE. AT
STOPLIGHT, MAKE A LEFT THE NEXT LIGHT WILL BE SOUTH MCCARRAN - MAKE A RIGHT. THE
NEXT LIGHT WILL BE TALBOT LANE - MAKE A LEFT. QUAIL MEDICAL PARK WILL BE TO YOUR
IMMEDIATE RIGHT.

TAking HIGHWAY 395 NORTH
EXIT NEIL ROAD. AT STOPLIGHT MAKE A LEFT. GET INTO THE RIGHT LANE AND MAKE A RIGHT
ONTO KIETZKE THE NEXT LIGHT WILL BE SOUTH McCARRAN - MAKE A LEFT. THE NEXT LIGHT
WILL BE TALBOT LANE - MAKE A LEFT. QUAIL MEDICAL PARK WILL BE TO YOUR IMMEDIATE
RIGHT.
# SIERRA REGIONAL SPINE INSTITUTE
ORTHOEDIC REHABILITATION SPECIALISTS OF NEVADA

**DATE:**

**Patient Name:**

**Physical Address:**

**Mailing Address:**

**Home Ph#:**

**other ph#:**

**Marital Status:** S  M

**SS#:**

**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:**

**Address:**

**Phone:**

**ID No:**

**Policy Holder Name:**

**Group/Policy No:**

**Secondary Insurance:**

**Address:**

**Phone:**

**ID No:**

**Policy Holder Name:**

**Group/Policy No:**

<table>
<thead>
<tr>
<th>Work Related?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim No:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Industrial Insurance Carrier:**

**Address:**

**Phone:**

**Nature of Injury/Body part:**

**Who was your employer at the time of your 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
- [ ] Chinese
- [ ] French
- [ ] Hebrew
- [ ] Hindi
- [ ] Japanese
- [ ] Spanish
- [ ] Portuguese
- [ ] Russian
- [ ] Yiddish
- [ ] Other
- [ ] Not Provided

**Ethnicity:**

- [ ] Hispanic Origin
- [ ] Non Hispanic Origin
- [ ] Not Provided

**Smoking Status:**

- [ ] Never Smoked
- [ ] Former Smoker
- [ ] Current Occasional
- [ ] Current daily smoker
- [ ] Not Provided

**Referred By [ ] Physician [ ] Self [ ] Friend [ ] Website [ ] Other**

**[ ] Name**

**[ ] Name**

**[ ] Name**

**[ ] Other**

**Patient Signature:**

**Parent/Guardian Signature:**
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.

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 plans. 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. This includes any phone consults with the physician, physician assistant or Nurse Practitioner.

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 $100.00 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 Sierra Regional Spine Institute and Orthopedic Rehabilitation Specialists of Nevada. I understand and agree to this Financial Policy.

Patient Name: ___________________________ Date: ___________________________

Patient/Guardian Signature: ____________________________________________

Rev date 01/23/2012 pf
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 (SRSI)
ORTHOPEDIC REHABILITATION SPECIALISTS OF NEVADA (ORSON)

I, ________________________________, understand that as part of my health care, SRSI and/or ORSON 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. Furthermore, I understand that SRSI and/or ORSON will access any available electronic prescription history and will submit whenever possible, any prescriptions electronically through a secure website. I understand that this information and activity 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 SRSI and/or ORSON 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 SRSI and/or ORSON reserve 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 SRSI AND OR ORSON 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 ___________________
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: _______________________

Sierra Regional Spine Institute
Orthopedic Rehabilitation Specialists of Nevada
6630-A South McCarran Blvd # 4
Reno, NV 89509
775-828-2873
Orthopedic Rehabilitation Specialists of Nevada

INITIAL EVALUATION

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 AN INJURY IN THE PAST? □ Yes □ No 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

XXXX ACHING PAIN HEIGHT________

///// SHARP PAIN WEIGHT________

|||||| TINGLING PAIN R. L. HANDED

^^^^ BURNING PAIN BLOOD PRESSURE________

----- NUMBNESS PULSE _______ RESP________

FRONT SIDE BACK SIDE

Rev date: 01.23.12
Orthopedic Rehabilitation Specialists of Nevada (continued initial eval form)

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>RELIEVES</th>
<th>WORSENS</th>
<th>NO CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SITTING</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>STANDING</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>WALKING</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>BENDING FORWARD</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>BENDING BACKWARDS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SIDE BENDING, TWISTING</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>WALKING UPSTAIRS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>WALKING DOWNSTAIRS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>COUGHING</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SNEEZING</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Time</th>
<th>No Pain</th>
<th>Moderate Pain</th>
<th>Severe Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORNING</td>
<td>0 1 2 3</td>
<td>4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>AFTERNOON</td>
<td>0 1 2 3</td>
<td>4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>NIGHT</td>
<td>0 1 2 3</td>
<td>4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

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 on these medications? ____________________________

Rev date: 01.23.12
Orthopedic Rehabilitation Specialists of Nevada  (initial evaluation form continued)

<table>
<thead>
<tr>
<th>REVIEW OF SYSTEMS (answer YES or NO to the following body parts):</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL: History of weight loss, fever, chills, nausea, vomiting etc?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>EYES: History of dizziness, vision problems, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>EARS, NOSE, MOUTH, THROAT: History of sinus disease, nosebleeds, Tooth disease, ringing of the ears, deafness, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>CARDIOVASCULAR: History of palpitations, irregular heart rate, chest Pain, shortness of breath, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>RESPIRATORY: History of wheezing, shortness of breath, coughing, Night sweats, bloody sputum, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>GASTROINTESTINAL: History of nausea, abdominal pain, vomiting, Ulcers, jaundice, vomiting blood, diarrhea, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>GENITOURINARY: History of urinary retention, urgency problems, Pain with urination, etc</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>PSYCHIATRIC: History of nervous breakdown, hallucinations, depression</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>ENDOCRINE: History of skin or hair growth, thyroid problems, dryness of hair/skin, intolerance to heat/ice, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>BLOOD AND LYMPH: history of anemia, excessive bleeding, family History of bleeding disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

______________________________________________________________

Is there a family history of any of the above problems? ☐ Yes ☐ No If Yes, Please explain:

______________________________________________________________

Are you being treated for any medical conditions above? ☐ Yes ☐ No

If yes, who is your treating Doctor?
Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
What city do you 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?

______________________________________________________________

Patient Signature
Date

Physician signature (reviewed entire intake form with patient)

Rev date: 01.23.12 3 OF 3
SIERRA REGIONAL SPINE INSTITUTE
ORTHOPEDIC REHABILITATION SPECIALISTS OF NEVADA

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 Sierra Regional Spine Institute and Orthopedic Rehabilitation Specialists of Nevada, 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.

Compliance
Failure to comply with the terms and conditions of the Sierra Regional Spine Institute and Orthopedic Rehabilitation Specialists of Nevada Pain Agreement may result in discontinuation of medication refills. Random drug profiles may be obtained.

Patient Signature: ___________________________

Date: ___________________________