CENTER FOR DISEASES AND SURGERY OF THE SPINE

JOHN S. THALGOTT, M.D.
600 S. RANCHO DR. SUITE 107
LAS VEGAS, NEVADA 89106-4806
PHONE (702) 878-8370 FAX (702) 878-9642

PATIENT REGISTRATION

(Please print clearly)

Patient Information

Last Name _____ First Name _____ Middle _____

Parent/Guardian Name (if patient is under 18) _____

DOB ____ / ____ / ____ Age _____ Gender: ◯M ◯F SS# _____

Height _____ Weight _____

Marital Status: ◯Married ◯Single ◯Widow(er) ◯Smoker ◯Nonsmoker

Spouse Name _____ Spouse Employer _____

Mailing Address _____

City _____ State _____Zip _____

Home Phone _____ Mobile Phone _____

Primary Phone to Contact: ◯Home ◯Mobile E-mail _____

Referring Physician _____ Phone _____

Referring Physician Address _____

Employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____Zip _____

Emergency Contacts

(nearest relative not living with you)

Name _____ Relation _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Primary Insurance

Insurance Carrier Name_____ Phone_____

Member ID _____ Group ID _____

Address _____

City _____ State _____ Zip _____

Claim # _____ Adjuster _____

Subscriber Name (if other than self) _____ Subscriber DOB: _____

SS# _____ Gender: ◯ M ◯ F

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent/Guardian ◯ Other _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Employer _____ Occupation _____

Secondary Insurance

Insurance Carrier Name _____ Phone _____

Member ID _____ Group ID _____

Address _____

City _____ State _____ Zip _____

Subscriber Name (if other than self) _____ Subscriber DOB: _____

SS# _____ Gender: ◯ M ◯ F

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent/Guardian ◯ Other _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Employer _____ Occupation _____

Is your visit today due to a motor vehicle accident? ☐ Yes ☐ No

☐ Legal case: I authorize the release of information to the named attorney:
(If you check this, please complete the Authorization for Use and Disclosure of PHI form)

Attorney Name _____ Phone _____

As part of our ongoing commitment to patient satisfaction, you will receive a survey within a few days of your office visit. The survey will take approximately 5 minutes to complete. Please check how you would prefer to receive the survey:

◯ E-mail ◯ Mail ◯ Phone

If you do not wish to participate in this survey, or have completed one in the last 3 months, you may opt out by checking the following box: ☐

I certify this information provided herein is true and correct. I will notify the medical staff of any changes in my health status. I understand that it is my responsibility to update any changes of address, phone number, name and/or insurance.

I authorize the release of all information necessary to file a complete claim with the insurance company of record. I hereby authorize my insurance benefits be paid directly to the physician and I understand that I am financially responsible for non-covered services.

In the event of collection proceedings, I agree to pay any and all collection and legal fees. I further understand that balances not paid within 90 days from the date of service will be referred to a third-party collection agency and I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus.

Patient/Guardian Signature _____ Date _____

Patient Name _____ Date_____

1. Where is the pain? _____

   _____
2. What date did your pain start? _____
3. Are you pregnant or do you think you might be? ○Yes ○No
4. Have you been treated for your present problems? ○Yes ○No

   If yes, when? _____

   By whom? _____
5. Have you had any of the following diagnostic tests?

   Injections ○Yes ○No Type: _____

   Nerve conduction tests ○Yes ○No

   If yes, when? _____ Where? _____
6. Has this problem disabled you from working? ○Yes ○No
7. Please list all allergies _____

   _____
8. Please list all previous surgeries _____

   _____

   _____
9. Please list any previous serious injuries and the part of the body affected _____

   _____

   _____
10. Have you been diagnosed with Hepatitis C, HIV or TB? _____
11. Any chronic cough lasting longer than 3 weeks, bloody sputum, unexplained weight loss, or night sweats?_____
12. Have you recently traveled outside the U.S.? _____
13. Have you been in contact with anyone with active tuberculosis? _____
14. Please list all medications you are currently taking

Medication/Dosage	How is it taken?	Who prescribed the medication?

Patient Name _____ Date_____

PLEASE READ:
This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the one box which applies to you. We realize you may consider that 2 of the statements in any one section relate to you but please mark just the box which most closely describes your problems.

Section 1 – Pain Intensity
- ○ I can tolerate the pain I have without the use of pain killers.
- ○ The pain is bad but I manage without the use of pain killers.
- ○ Pain killers give me complete relief from pain.
- ○ Pain killers give me moderate relief from pain.
- ○ Pain killers give me very little relief from pain.
- ○ Pain killers have no effect on pain. I do not use them.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ○ I can look after myself normally without causing extra pain.
- ○ I can look after myself normally but it causes extra pain.
- ○ It is painful to look after myself and I am slow and careful.
- ○ I need some help but manage most of my personal care.
- ○ I need help every day in most aspects of self care.
- ○ I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting
- ○ I can lift heavy weights without extra pain.
- ○ I can lift heavy weights but it gives me extra pain.
- ○ Pain prevents me from lifting heavy objects off the floor but I can lift heavy objects if they are on a table.
- ○ Pain prevents me from lifting heavy weights off the floor but I can manage if light and medium weights are conveniently positioned (for example, on a table).
- ○ I can lift only very light weights.
- ○ I cannot lift or carry anything at all.

Section 4 – Walking One Block
- ○ Pain does not prevent me from walking any distance
- ○ Pain prevents me walking more than 1 mile.
- ○ Pain prevents me walking more than ½ mile.
- ○ Pain prevents me walking more than ¼ mile.
- ○ I can only walk using a stick or crutches.
- ○ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
- ○ I can sit in any chair as long as I like.
- ○ I can only sit in my favorite chair as long as I like.
- ○ Pain prevents me from sitting more than 1 hour.
- ○ Pain prevents me from sitting more than ½ hour.
- ○ Pain prevents me from sitting more than 10 minutes.
- ○ Pain prevents me from sitting at all.

Section 6 – Standing
- ○ I can stand as long as I want without extra pain.
- ○ I can stand as long as I want but it gives me pain.
- ○ Pain prevents me from standing more than 1 hour.
- ○ Pain prevents me from standing more than ½ hour.
- ○ Pain prevents me from standing more than 10 minutes.
- ○ Pain prevents me from standing at all.

Patient Name _____ Date_____

Section 7 – Sleeping

- Pain does not affect my sleep.
- Pain occasionally interrupts my sleep.
- Pain interrupts my sleep half the time.
- Pain often interrupts my sleep.
- Pain always interrupts my sleep.
- I never sleep well.

Section 8 – Sex Life

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, gym, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 10 – Travelling

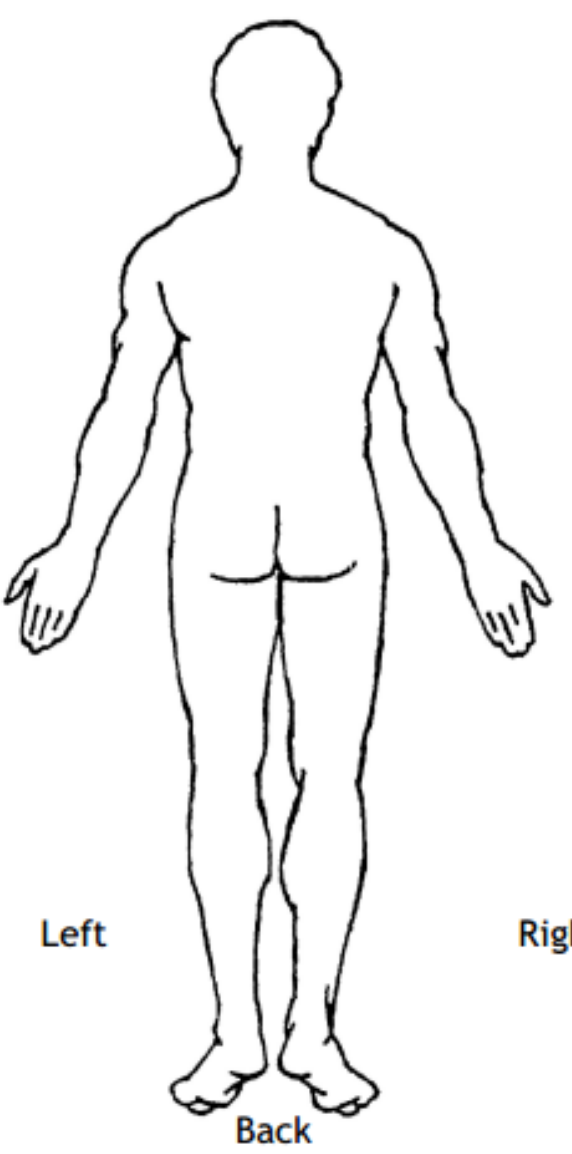
- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

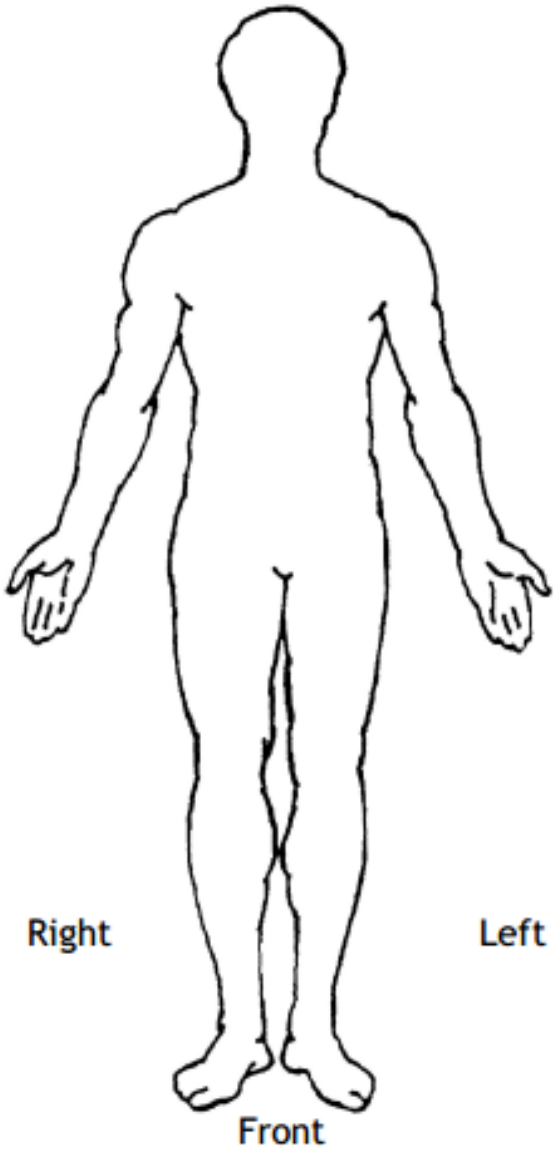
Patient Name _____ Date_____

Patient Pain Drawing

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

ACHE	NUMBNESS	PINS/NEEDLES	BURNING	STABBING
+++++	=========	^^^^^^^^^^^^^^	xxxxxxxxx	//////////////////





Patient Name _____ Date_____

Please answer the following questions about your pain in as much detail as possible.

Approximately when did your pain start? _____

What percent of your waking hours do you have pain? _____

With respect to your physical condition, rate your present disability level

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No disability Total disability

What is your present pain level?

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No pain Unbearable pain

What is your least pain level?

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No pain Unbearable pain

What is your worst pain level?

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No pain Unbearable pain

Pain Location

Put an **X** next to the statements that best describe your present pain location. Put an **XX** next to the statements that describe your worst pain.

	Right	Left	Front	Back	Top
Neck	_____	_____	_____	_____	_____
Upper back	_____	_____	_____	_____	_____
Shoulder	_____	_____	_____	_____	_____
Arm	_____	_____	_____	_____	_____
Mid-back	_____	_____	_____	_____	_____
Low back	_____	_____	_____	_____	_____
Thigh	_____	_____	_____	_____	_____
Buttocks	_____	_____	_____	_____	_____
Calf	_____	_____	_____	_____	_____
Knee	_____	_____	_____	_____	_____
Ankle	_____	_____	_____	_____	_____

Patient/Guardian Signature _____ Date _____

CENTER FOR DISEASES AND SURGERY OF THE SPINE

ACCIDENT INJURY QUESTIONNAIRE

1. What type of accident did you have? _____
2. When did the injury occur? _____
3. Where did the injury occur? _____
4. How did the injury occur? _____
5. What were the weather conditions? (Rain, sun, wind, etc.) _____
6. Were you the driver? _____
7. If you were a passenger, were you in the front or rear of the vehicle? _____
8. Were you wearing a seat belt? _____
9. Did you lose consciousness? _____
10. What type of vehicle were you in? _____
11. How fast was your vehicle moving? _____
12. Did the airbags deploy? _____
13. What was the estimated damage to your vehicle? _____
14. Where was the damage located on your vehicle? _____
15. Do you believe your injury was work related? ○ Yes ○ No
16. Did you report the condition to anyone? ○ Yes ○ No

    If yes, to whom? _____ Date _____
17. Do you expect to receive or have you been provided with Workers' Compensation benefits?

    ○ Yes ○ No

Patient/Guardian Signature _____ Date _____

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Last Name	First Name	Date Of Birth	Social Security Number
Address	City	State	Zip Code

Facility/Doctors authorized to release medical records (PHI)
Center for Diseases and Surgery of the Spine
600 S. Rancho Dr. Suite 107, Las Vegas, NV 89106
Office (702) 878-8370 Fax (702) 878-9642

Medical records to be released to:(this section must be filled out completely)

Facility or Doctor Name	Office Phone Number	Fax Number	
Address	City	State	Zip Code

This authorization shall expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire (12) months from the date on which it was signed.

Purpose of disclosure:
- ○ Insurance Reasons
- ○ Medical Care
- ○ Personal Reasons
- ○ Legal Reasons
- ○ Other:_____

Description of information to be used or disclosed:
- ○ All PHI in the medical records
- ○ Consultation Reports
- ○ X-Ray Test/reports
- ○ History and Physical reports
- ○ Discharge Summary
- ○ Laboratory Reports
- ○ Progress Notes
- ○ Itemized Billing Statements
- ○ Patient Information Form

The Protected Health Information listed below WILL BE released when included in the above medical information unless specifically indicated otherwise.
Psychiatric/Mental Information *AIDS/HIV/Genetic Information* *Alcohol/Drug/Substance Abuse Information*

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider authorized to release the protected health information. I understand if I do revoke this authorization it will not apply to information that has already been released to this authorization.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorized the disclosure of the protected health information as stated:

Patient Signature	Date	
Patient Representative Signature	Relationship	Date

CENTER FOR DISEASES AND SURGERY OF THE SPINE

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600 S. RANCHO DR. SUITE 107
LAS VEGAS, NEVADA 89106-4806
PHONE (702) 878-8370 FAX (702) 878-9642

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

As required by the privacy regulations created as a results of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we must provide you with he following important information:

- How we may use and disclose your protected health information (PHI).
- Your privacy rights with regard to your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your personal information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices as permitted by law. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past or that we may create or maintain in the future. Our practice will post a copy of our current Notice in a visible location at all times, and you may request a copy of our most current Notice at any time.

A. USES AND DISCLOSURES OF PHI

The following section describes different ways that we use and disclose your health information. Not every use or disclosure will be listed; however, we have listed the various ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by submitting the revocation to us in writing.

1. Treatment. We may use and disclose medical information in the course of your treatment in order to provide, coordinate or manage your health care and any related services. This may include other providers, pharmacies or others who assist in your care, such as your spouse, children, parents or caretaker.
2. Payment. We may use and disclose your PHI, including records, to obtain payment for services and products you may receive from us. This may include activities associated with authorization of services, eligibility and coverage or obtain payment by your health insurance plan or other third parties that are responsible for such payment or information.
3. Health Care Operations. We may use and disclose your PHI to ensure accurate and appropriate business operations. These activities include, but are not limited to, quality assessment activities, employee review activities, or licensing.
4. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
5. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care or who assists in taking care of you.

B. ADDITIONAL USES AND DISCLOSURE THAT MAY BE MADE **WITH** YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to all or part of your PHI being used or disclosed for these purposes. If you have not able to agree or object, the provider will, using professional judgment, determine whether the use is in your best interest. In any event, only the PHI that is relevant to your health care will be disclosed.

1. Emergencies. We may use or disclose your PHI in an emergency treatment situation. If this happens, your provider will try to obtain your consent as soon as reasonable practicable after the delivery of treatment. If your provider is required by law to treat you and the provider has attempted to obtain your consent but is unable, he or she may still use your PHI to treat you.
2. Others Involved in Your Health Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify or that may be responsible for your care, your PHI that directly relates to that person's involvement in your health care. If you are unable to object to such a disclosure, we may disclose such information if we determine that it is in your best interest. We may use or disclose your PHI to an authorized public or private entity to assist and coordinate uses and disclosures to family or other individuals

involved in your health care.

3. Communication Barriers. We may use and disclose your PHI if your provider attempts to obtain your consent but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to under the circumstances.

C. ADDITIONAL USES AND DISCLOSURE THAT MAY BE MADE **WITHOUT** YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

1. Public Health. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of.
    - Maintaining vital records, such as births and deaths.
    - Preventing or controlling disease, injury or disability.
    - Notifying a person regarding potential exposure to a communicable disease.
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
    - Reporting reactions to drugs or problems with products or devices.
    - Notifying individuals if a product or device they may be using has been recalled.
    - Notifying appropriate government agencies and/or authorities regarding the potential abuse or neglect of a patient, including domestic violence. However, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. Health Oversight. We may use or disclose PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Required by Law. We may use or disclose PHI to the extent required by law. The use or disclosure will be limited to the relevant requirements by the law. You will be notified, as required by law, of any such uses or disclosures.
4. Legal Proceedings. We may disclose PHI in the course of any judicial or administrative proceeding, in response to a court or administrative order, discovery request, subpoena, or other lawful process by another third party involved in the dispute.
5. Law Enforcement. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes including:
    - Legal processes and otherwise required by law.
    - Limited information requests for identification and location purposes.
    - Pertaining to victims of crime.
    - Suspicion that death has occurred as a results of criminal conduct.
    - In the event that a crime occurs on the premises of the practice, and
    - Medical emergency (not on the practice's premises) and it is likely that a crime has occurred.
6. Coroners, Funeral Directors and Organ Donation. We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for other duties authorized by law. We may also disclose information to a funeral director, as authorized by law, in order to permit the director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
7. Food & Drug Administration. We may disclose your PHI to an FDA authorized person or company to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements or to conduct post-marketing surveillance, as required.
8. Military Activity and National Security. When appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forced personnel (1) for activities deemed necessary by appropriate command authorities; (2) for purpose of determination by the Department of Veteran Affairs of your eligibility for benefits, or; (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the present or others legally authorized.
9. Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of this notice.

D. YOUR RIGHTS REGARDING YOUR PHI

1. Confidential Communications. You have the right to request that our practice communicate with you about your health related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, but not leave a message on the answering machine or with the answering service. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer, whose name is listed elsewhere in this Notice.
2. Request Restrictions of your PHI. You have the right to ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations (TPO). You may also request that any part of your PHI

not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must make your request in writing to the Privacy Officer listed elsewhere in this Notice. You must include (1) the information you wish restricted, (b) whether you are requesting to limit our use, disclosure or both and, (3) to who you want the limits to apply.

Your provider is not required to agree to a restriction. If your provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI may not be restricted. If your provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

3. Inspect and Obtain Copy of Your PHI. You have the right to inspect and obtain a copy of PHI about you that is contained in your medical record. A medical record includes medical, billing and any other records used for making decisions about you. However, under federal law, you may not inspect or receive copies of the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. You may be required to submit your request for records in writing and a fee may be charged by the practice for the cost of copying, mailing, labor and supplies associated with your request.
4. Request Amendments to Your PHI. You have the right to request an amendment of PHI about you in your medical record for as long as we maintain it. The request must be in writing and submitted to the Privacy Officer listed elsewhere in this Notice. You must provide us with a reason that supports your request for an amendment. In certain cases, we may deny your request for an amendment. If your request is denied, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
5. Request Accounting of Certain Disclosures of Your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations (TPO) as described in this Notice. You have the right to specific information regarding these disclosures that occurred after April 14, 2003. This accounting is a list of certain non-routine disclosures our practice has made, if any, of your PHI for non-TPO purposes. Use of your PHI as a part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer listed elsewhere in this Notice and you must state a time period, which may not be longer than six (6) years from the date of disclosure, and may not include dates prior to April 14, 2003.
6. To Obtain a Paper Copy of This Notice. Upon request, you have the right to obtain a paper copy of this notice, even if you have previously agreed to accept this notice electronically.
7. Complaints/Questions. You may file a complaint with our office or with the Secretary of Health and Human Services if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint. For information about the complaint process, please contact the Privacy Officer listed elsewhere in this Notice.

E. PRIVACY CONTACT/QUESTIONS AND FURTHER INFORMATION

For questions regarding this notice and further information regarding any of its contents, you may contact:

Kevinann Salva, Privacy Officer
600 S. Rancho Dr. Suite 107
Las Vegas, NV 89106
Phone: (702) 878-8370

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MEDICATION POLICY

If you are prescribed medication during your treatment, there are several guidelines you must follow and you will be required to take a urinalysis for Therapeutic Drug Evaluation.

1. The medications given to you should be taken as prescribed by your doctor. The medications may not be used for any purpose other than that which they were given to you. These medications may not be given or sold to any other individual.
2. You will be given a specific amount of medication to last a specific length of time. You must keep track of your medications to make sure you do not run out before the specific time. It is your responsibility to have follow-up appointments scheduled far enough in advanced so that you do not run out of medication.
3. We are not a pain management facility and will not refill pain medications, except in instances of surgery. If you need a refill for pain medication, we will be happy to refer you to a pain management facility.
4. Requests for medication refills will only be considered during regular office hours (9:00 a.m. to 5:00 p.m., Monday through Thursday). No refills will be given after hours, weekends or holidays.
5. Requests for medication refills should be called to your pharmacy who will, in turn, call our office. Please allow 48 hours for this procedure. No refills of medications will be given if you have not been seen for 3 months. Your refill will need to be reviewed by your physician and may not be refilled until you have been seen again. It is your responsibility to make a follow-up appointment with your doctor. This will be strictly enforced.
6. If you call for medications or refills outside of regular office hours, you will be instructed to go to the emergency room and the emergency room physician will decide whether or not to refill your medication. Emergency department policy regarding medication refills is typically very strict and there is no guarantee that you will get your refill. If the emergency department is busy, you may be required to wait a long period of time to be seen.
7. While under the care of the physician, all pain medications will be given at the physician's discretion.
8. Telephone requests for prescription renewals are accepted only during regular business hours. In some instances, there is a 24-hour waiting period before prescriptions will be refilled, so call for your refills accordingly. We are very cautious about refilling your medications too early, so follow your instructions carefully.

Patient/Guardian Signature _____ Date _____

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Patient Name _____ **SS Number** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: Your insurance company does not pay for all of your health care costs and will only pay for covered items and services when the rules are met. The fact that insurance may not pay for a particular item or service, even some care that you or your health care provider have good reason to think you need, does not mean that you should not receive it. There may be good reason your doctor recommended it. We expect that your insurance company will not pay for the service(s) described below.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
Services that are accident or work related. Any services requiring authorization or referral not supplied to this office. If this office is given wrong insurance information or services not covered.	**All services that are accident or work related and services not covered by insurance.**	**$100.00 to $100,000.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance company cannot require us to do this.
- CDSS is not a provider for most HMOs. We are unable to bill your insurance company, even as a courtesy, if we are not contracted with your HMO insurance company.
- CDSS is not a provider for Culinary or Teacher's Health Trust. We will bill your insurance as a courtesy and once the insurance processes your claim, you will receive a bill for the remainder.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1. YES.** I want **D.** _____ the services listed above, regardless of insurance coverage. I understand that my insurance company may not cover this service.

☐ **OPTION 2. NO.** I don't want **D.** _____ services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal the decision with my insurance company.**

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CENTER FOR DISEASES AND SURGERY OF THE SPINE

JOHN S. THALGOTT, M.D.
600 S. RANCHO DR. SUITE 107
LAS VEGAS, NEVADA 89106-4806

PLEASE INITIAL EACH SECTION OF THIS PAGE AND SIGN AT THE BOTTOM INDICATED THAT YOU UNDERSTAND THE POLICIES OF CENTER FOR DISEASES AND SURGERY OF THE SPINE. IF YOU HAVE QUESTIONS, PLEASE DO NOT HESITATE TO ASK FOR AN EXPLANATION FROM ANY MEMBER OF OUR STAFF.

Office hours are 9:00 a.m. to 5:00 p.m., Monday through Thursday. All routine telephone calls to the office should be made during these hours. Routine calls made after business hours will be returned the following business day.
Patient Initials _____

I understand that it is my responsibility to contact the physician's office if I am unable to make my appointment. I understand that if I do not give the office a 24 hour notice, I will be charged a $50 "no show" fee. I also understand that if I'm more than 15 minutes late for my schedule appointment, I may be asked to reschedule.
Patient Initials _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.
Patient Initials _____

I hereby consent to have myself photographed by CDSS or a designated assistant. I understand that the photographs are to be used for purposes of documentation and evaluation of my treatment and will be treated as part of my medical record. I give my permission for these materials to be used by CDSS to assist in my treatment.
Patient Initials _____

I hereby authorize and request John S. Thalgott, M.D. to release my complete medical records (including x-rays) when referring to other facilities concerning my treatment at Center for Diseases and Surgery of the Spine.
Patient Initials _____

I hereby assign to John S. Thalgott, M.D., Physicians' Assistants, and/or surgical techs, all benefits for surgical and medical care payable under the attached policy/policies. I also authorize release of information to secure payment. A photocopy of this assignment is to be considered valid as the original. Patient Initials _____

I understand that I am financially responsible for all services rendered, whether or not paid by my insurance company. Payment is expected at the time of service. We accept Visa and Mastercard for your convenience. If you are on a lien, it is your responsibility to notify our office in writing if there are any changes in your legal representation. Any services performed prior to this office receiving written notification to bill insurance will be the patient's sole responsibility due to insurances having to be billed in a timely manner. There will be a charge of $35.00 for all returned checks. Patient Initials _____

I understand that I will receive a separate bill from the laboratory for any cultures, blood or urine samples taken at this office. Patient Initials _____

In the event of collection proceedings, I agree to pay any and all collection and legal fees. I further understand that balances not paid within 90 days from the date of service will be referred to a third-party collection agency and I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus. Patient Initials _____

ORTHOPEDIC OR SPINAL EMERGENCIES USUALLY REQUIRE HOSPITAL ADMISSIONS. IF YOU SHOULD FIND YOURSELF IN AN EMERGENCY SITUATION, PLEASE GO TO THE NEAREST HOSPITAL EMERGENCY ROOM AND SOMEONE WILL REACH YOUR PHYSICIAN THROUGH THE ANSWERING SERVICE. PLEASE KEEP IN MIND THAT ON SOME WEEKENDS THERE WILL BE OTHER SURGEONS COVERING YOUR DOCTOR'S PRACTICE AND THEREFORE, YOU MAY BE SEEN BY SOMEONE OTHER THAN YOUR DOCTOR.

Patient/Guardian Signature _____ Date _____

In accordance with Section 6003 of the Patient Protection and Affordable Care Act (PPACA), which went into effect January 1, 2011, you have the right to be informed that you may receive treatment at any facility of your choosing. Some of the facilities are listed below.

MRI Centers within a 25 mile radius of Center for Diseases and Surgery of the Spine:

Integrated Diagnostic Center
600 S. Rancho Dr. Ste. 102
Las Vegas, NV 89106
702-938-1102
0 miles

Desert Radiology
2020 Palomino Ln. Ste. 100
Las Vegas, NV 89106
702-759-8720
.23 miles

Insight Imaging – Mountain Diagnostics
800 Shadow Ln.
Las Vegas, NV 89106
702-366-9700
.61 miles

Steinberg Medical Imaging
2950 S. Maryland Pkwy.
Las Vegas, NV 89109
702-240-1232
4 miles

Las Vegas Radiology
4880 S. Wynn Rd. Ste. 100
Las Vegas, NV 89103
702-430-3815
5.33 miles

Pueblo Medical Imaging
8551 W. Lake Mead Blvd. Ste 150
Las Vegas, NV 89128
8.56 miles