REGISTRATION FORM

PATIENT INFORMATION
Información del paciente

Patient's last name (Apellido) :	First(Nombre):	Middle (Segundo nombre):	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

Birth date (Fecha de nacimiento) : / /	Age (Edad):	Social Security no. (Seguro Social):

Marital status (circle one): Single / (Soltero/a) Married / (Casado/a) Divorced / (Divorciado/a) Separated / (Separado/a) Widowed (Viudo/a)	Sex: ❑ M ❑ F	Home phone (Teléfono): ( )	Cell phone (Cellular): ( )
Street address (Dirección):		Prefer means of contact (Prefieren medios de contacto): ❑ Call ❑ Text ❑ Email:	

City (Ciudad):	State (Estado) & ZIP Code (Código postal):	Primary Language:	Ethnicity:
Occupation (Ocupación):	Employer (Empleo):	Employer phone no.: (Telefono del empleo): ( )	
Referred to clinic by (Referido por):	❑ Dr.	❑ Other:	

IN CASE OF EMERGENCY
En caso de emergencia

Name (Nombre) :	Relationship to patient (relación al paciente):	Telephone number (Numero de teléfono):

INSURANCE INFORMATION
Información de su a seguranza

Insurance Company (Aseguranza):	Subscriber's name (Nombre del suscriptor):	Subscriber's SSN (Seguro social del suscriptor):	Birth date: (Fecha de nacimiento): / /
Policy number (Póliza):	Group number (Numero de grupo):	Patient's relationship to subscriber (Relación al paciente): ❑ Self ❑ Spouse ❑ Child ❑ Other:	
Occupation (Occupacion):	Employer (Empleo):	Employer phone no. (Telefono del empleo): ( )	
Name of secondary insurance (Segunda aseguranza):	Subscriber's name (Nombre del suscriptor):	Subscriber's SSN (Seguro social del suscriptor) :	Birth date: (Fecha de nacimiento) : / /
Policy number:		Group number:	

ATTORNEY INFORMATION
Información de su abogado0

Attorney's name (Nombre del abogado) :	Phone number (Numero de telefono):	Date of accident (Fecha del accidente) :

WORKERS COMP. INFORMATION
Compensación al trabajador

Workers comp name:	Adjusters name:	Phone number:	Date of injury:	Claim number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ProCare Pain and Spine or my insurance company to release any information required to process my claims.

Patient/Guardian signature (Firma del paciente o guardián) ______________________

Date (Fecha) ______________________

PATIENT MEDICATION LIST

Provided by the patient

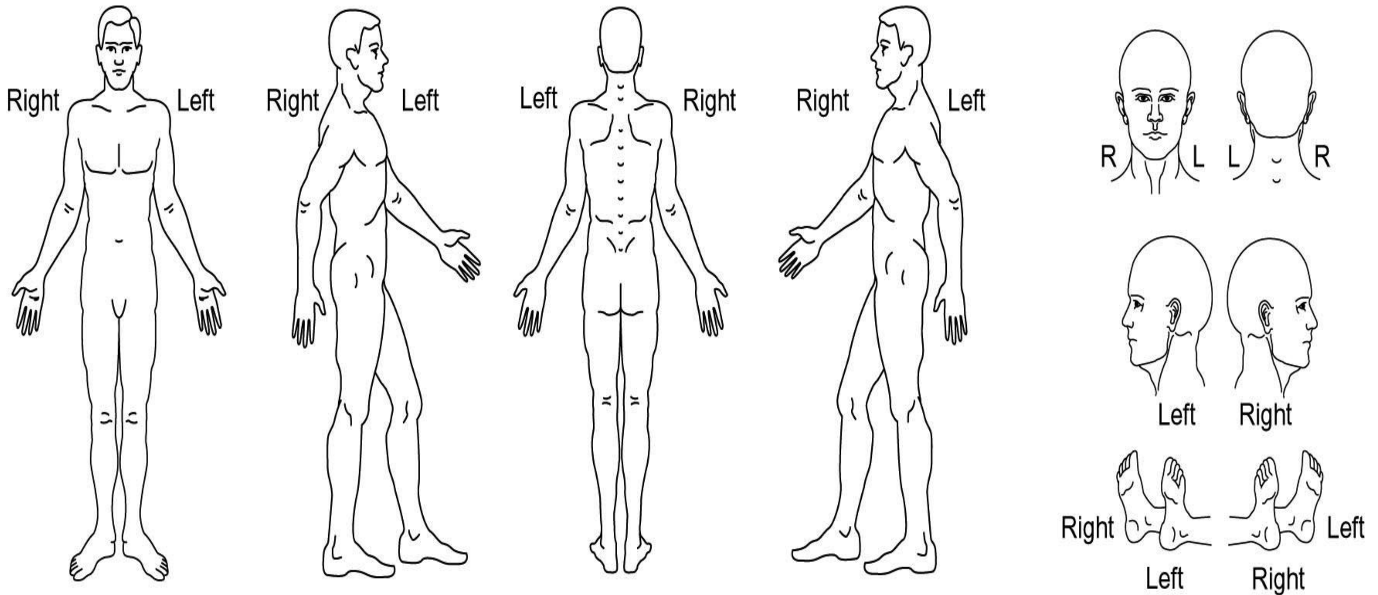
	Medication Name	Dose	Frequency (How Often)	Reason for Taking	Last Taken
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Patient Signature ____________________ **Date** ____________

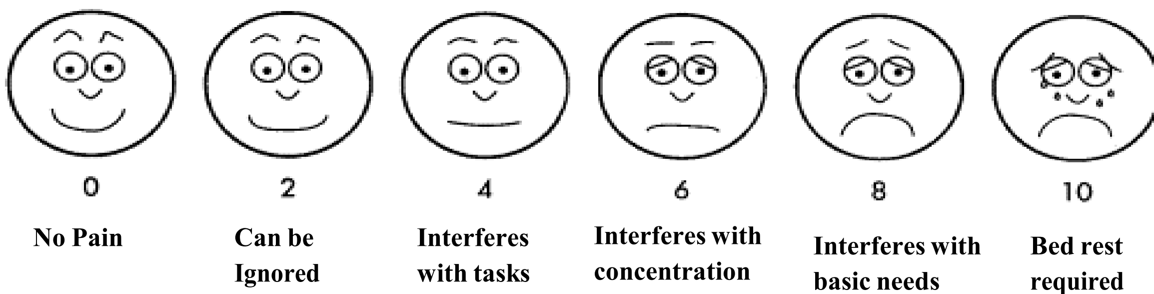
ProCare
PAIN AND SPINE

On the following diagram, Please indicate the area where you currently feel pain.

Numbness ++++++ Pins & Needles: OOOOOOO Burning: XXXXXXXX



Choose the face that best describes how you feel!



No Pain	Can be Ignored	Interferes with tasks	Interferes with concentration	Interferes with basic needs	Bed rest required

PATIENT SIGNATURE:____ **DATE:**_______________

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient,

Thank you for choosing ProCare Pain and Spine for your health care needs.

Payment for services is due at the time services are rendered. We accept cash, Mastercard, Visa, and Discover. We will submit an insurance claim on your behalf. Please notify our office immediately if your insurance information changes.

- All copays are due at the time of service and must be paid by cash, credit or debit. No checks will be accepted for copays.
- Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Our relationship is with you.
- You have the right to waive your insurance at any time. If you do not inform us of your insurance carrier information at the time of service, you are voluntarily waiving your right to use your insurance, and will be responsible for the fees incurred.
- You are responsible to know your insurance benefits. We can assist you in finding sources for this information.
- We will release any requested medical records or documents to your insurance carrier if required.
- Our office will attempt to collect fees from your insurance carrier. If your carrier denies payment, these fees will be transferred to you.
- ANY RETURNED CHECKS WILL BE SUBJECT TO A $25 FEE.
- Financial arrangements can be made through our administrator.
- You are responsible for any collection fees, legal fees, or court costs.
- All office visits are subject to a $25 “No show” fee unless cancelled within 48 hours prior to the appointment date. This fee is not billable to any insurance or attorney and is payable prior to any future visits.

If you have any questions or concerns, please ask our staff.

By signing this form you acknowledge that you have read and accept this agreement.

________________________________ Patient Signature

__________________ DATE

"HIPAA"-Privacy Authorization Form

Authorization for use or disclosure of Protected Health Information

Patients Name: ________________________________ Date of Birth: ____________________

I authorize the following individual(s) to obtain my personal/medical information:

________________________________ ________________________________
Name Relationship

________________________________ ________________________________
Name Relationship

________________________________ ________________________________
Name Relationship

________________________________ ________________________________
Name Relationship

I understand and agree to the ProCare Pain and Spine Notice of Privacy Practices which describes how my protected medical information may be used and disclosed, and may be given a copy if requested.

________________________________ ________________
Patient or representative Signature Date

This authorization will expire one year from the date of signing.

Fax: (775) 622-4150 Email: contact@procarepainandspine.com

HIPAA Compliant Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____ Date of Birth: ____________

Address: ____ Phone: ________________

City/State/Zip Code: ____

This Authorization allows ProCare Pain and Spine to:

☐ **Send** copies of your medical record to the provider/person/facility below.

☐ **Receive** copies of your medical record from the provider/person/facility below. Fax: _______________

Name of Provider/Person/Facility: ____________________________________ Phone: _____________

Address: ______________________________________ City/State/Zip: ________________________

Purpose of Request: Healthcare Appointment and Coordination of Care

Information to be Released:

□ Initial Consultation Note □ Most Recent Office Visit Note(s) □ Radiology Reports: ________

□ Procedure Note(s) □ Dates of Service: From: ______ to ______ □ Other: _________________

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans, or health care clearinghouses, which must follow federal standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights with Respect to this Authorization:
1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above-named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for the duration that I am an active patient. To initiate revocation of this authorization, I must submit this in writing to NVCPC. 3) I understand that a digital replication of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by federal law. 5) I understand that I have the right to refuse to sign this authorization, I am signing this authorization voluntarily, and that treatment, payment, or eligibility for benefits may not be conditioned on obtaining this authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of; Alcohol, Drug Abuse and/Psychiatric records, Sexually Transmitted Disease(s), and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to obtain copies of my health information, by contacting the Compliance/Privacy Officer.

Expiration Date: This authorization is valid while under active treatment, and will expire upon discharge from the practice, or the following date __________.

I have reviewed and understand the content of this authorization form. By signing this authorization, I am confirming it accurately reflects my permission.

Signature of Patient or Legal Representative: ______________________________ **Date**: ______________

Witness: ____ **Date** ______________

If not signed by patient, select authorized authority (provide documentation):
□ Parent of Minor Child □ Power of Attorney □ Representative of Custodial Adult □ Other: ________________

Patient Privacy, Rights, and Responsibilities
Privacidad, derechos y responsabilidades del paciente

The medical and clinical support team at ProCare Pain and Spine (ProCare) recognizes you have rights while receiving treatment within the specialty medical group. In return, there are responsibilities expected from you as the patient. These rights and responsibilities include:

El equipo médico y clínico de ProCare Pain and Spine reconoce que usted tiene derechos mientras recibe tratamiento dentro de nuestro grupo médico de especialistas. A cambio, se esperan responsabilidades de usted como paciente. Estos derechos y responsabilidades incluyen:

A patient has the right to:
El paciente tiene derecho a lo siguiente:

- be treated with dignity, courtesy, and respect
- ser tratado con dignidad, cortesía y respeto

- be treated free of discrimination, due to race, color, national origin, disability, age, religion, sex, or sexual preference
- ser tratado sin discriminación debido a su raza, nacionalidad, limitaciones físicas, edad, religión, sexo u orientación sexual.

- have personal and health information kept private
- que la información personal y de salud se mantenga de forma privada

- a prompt and reasonable response to questions and requests
- una respuesta rápida y razonable a preguntas y solicitudes

- know what patient support services are available, including interpreter services if the patient does not speak English
- saber qué servicios de apoyo están disponibles para el paciente, incluyendo un intérprete si el paciente no habla inglés

- know what rules apply to the patients conduct
- saber qué reglas se aplican a la conducta de los pacientes

- provided information concerning diagnosis, a plan of care, treatment options, risks and benefits, and prognosis
- recibir información sobre el diagnóstico, plan de atención, opciones de tratamiento, riesgos, beneficios, y pronóstico de su condición

- refuse treatment, except as otherwise provided by law
- rechazar el tratamiento, salvo que la ley disponga lo contrario

- be given, upon request, full information and necessary counseling on the availability of known financial resources of the patients care
- recibir, bajo previa solicitud, la información y asesoría necesaria sobre la disponibilidad de recursos financieros conocidos para el cuidado de los pacientes

- know, upon request and in advance of treatment, whether medical provider or facility accepts the Medicare assignment rate
  saber, bajo previa solicitud y antes del tratamiento, si el proveedor o el grupo medico acepta las tarifas establecidas por Medicare

- receive, upon request, prior to treatment, a reasonable estimate of charges for medical care
- recibir, bajo previa solicitud y antes del tratamiento, un estimado de los cargos por atención médica

- receive a copy of a reasonable clear and understandable, itemized bill and, upon request, to have charges explained
- recibir una copia de la cuenta de cobro que sea clara y comprensible, y bajo previa solicitud se le expliquen los cargos

- treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- Tratamiento para cualquier afección médica de emergencia que se deteriore por no proporcionar el tratamiento.

- express concerns regarding any violation of patient rights
- expresar inquietudes con respecto a cualquier violación de los derechos del paciente

- file a grievance regarding treatment or care that is (or fails to be) provided
- presentar una queja sobre el tratamiento o la atención que se brinda o se dejó de brindar.

- know sharing of certain health information for continuity of care, referral to a specialist or payment may occur
- saber que se comparte cierta información de salud para la continuidad de la atención, remisión a un especialista o el pago de servicios puede ocurrir

- choose someone to act for you (e.g., legal guardian, medical power of attorney)
- elegir a alguien que actúe por usted (por ejemplo, tutor legal, poder médico)

A patient is responsible for:
El paciente es responsable de:

- providing to the medical and clinical support team, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient's health
- informar al equipo médico y clínico, dentro de su mejor conocimiento, información precisa y completa sobre sus problemas de salud actuales, enfermedades pasadas, hospitalizaciones, medicamentos y otros asuntos relacionados con su salud.

- reporting to the medical team if treatment care plan is not understood, will be not be followed, or if it has been stopped
- informar al equipo médico si no se comprende el plan de tratamiento, si no se seguirá o si se ha suspendido.

- following the signed consents and agreements established with the medical team, and keeping appointments
- seguir los acuerdos y contratos que se han firmado y establecido con el equipo médico además de asistir a sus citas

- for your own actions for refusing treatment or not following the medical team instructions
- por sus propias acciones para rechazar el tratamiento o no seguir las instrucciones del equipo médico

- assuring that the financial obligations are fulfilled as promptly as possible
- asegurar que sus obligaciones financieras se cumplan lo antes posible

- following healthcare facility rules and regulations affecting patient care and conduct
- seguir las reglas y regulaciones del centro médico que afectan la atención y conducta del paciente

- you and family/caregiver/visitors/children being respectful of all the medical and clinical support teams, whether in person or by phone, as well as other patients. Be informed of the rules apply to the patients conduct
- que usted / su familia / persona que lo cuida / acompañantes / niños respeten al equipo clínico y de atención médica, ya sea en persona o por teléfono, así como a los otros pacientes. Ser informado de las reglas que se aplican a la conducta del paciente.

- bringing only American Disability Act (ADA) recognized service animals, no emotional support animals
- traer solo animales de servicio reconocidos por la Asociación Americana de Discapacidad (ADA), no se aceptan animales de apoyo emocional dentro de la clínica.

Code of Conduct for Patients:
Código de conducta para pacientes:

In an effort to provide a safe and healthy environment for medical, patients and their family/caregivers/visitors, ProCare expects patients and accompanying family/caregivers/visitors to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and medical and clinical support teams. The following list is not exhaustive, some prohibited items are:

En un esfuerzo por proporcionar un entorno seguro y saludable para el equipo clínico y de atención médica, los pacientes y sus familiares / personas que los cuidan / visitantes, ProCare espera que los pacientes y sus familiares / personas que los cuidan / visitantes se abstengan de comportamientos inadecuados que son perjudiciales o representan una amenaza para los derechos o la seguridad de otros pacientes, equipo clínico y de atención médica. La siguiente lista no es exhaustiva; estos son algunos de los artículos prohibidos:

- possession of firearms or any weapon, physical assault or inflicting bodily harm
- posesión de armas de fuego o cualquier tipo de arma usada para infligir daño físico o corporal

- climbing on furniture or toys in disarray or causing disturbance (Adults are to supervise and control children at all times). Failure to supervise children will necessitate rescheduling the appointment so appropriate supervision can be provided
- subirse a los muebles, juguetes desordenados o conductas que interrumpan el flujo de la clínica (los adultos deben supervisar y controlar a los niños en todo momento). Si no hay supervisión apropiada de los niños, será necesario hacer otra cita para que se pueda proporcionar la supervisión adecuada.

ProCare PAIN AND SPINE

- making verbal threats to harm another individual, intentionally damaging equipment, or property, or throwing objects
- hacer amenazas verbales para perjudicar o lesionar a otro individuo, dañar intencionalmente equipo o propiedad privada, arrojar objetos

- making menacing gestures, using foul language, attempting to intimidate or harass other individuals
- hacer gestos amenazantes, usar lenguaje grosero, intentar intimidar u hostigar a otras personas

- making harassing, offensive, or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- acosar, hacer declaraciones ofensivas o intimidantes, o amenazas de violencia a través de llamadas telefónicas, cartas, correo de voz, correo electrónico u otras formas de comunicación escrita, verbal o electrónica

- racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, disability, language, or sexuality
- insultos raciales o culturales u otros comentarios despectivos asociados con, pero no limitados a, raza, discapacidad, idioma o sexualidad

The organization prides itself on accommodating patients and firmly adheres to the following posted statement:
La organización se enorgullece de atender a los pacientes y se adhiere firmemente a la siguiente declaración publicada:

"ProCare Pain and Spine does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status."

"ProCare Pain and Spine no discrimina y no permite la discriminación, que incluye, sin limitaciones, la intimidación, el abuso o el acoso, basado en la raza, el color, la religión, la nacionalidad , la ascendencia, la edad, el género, discapacidad física o mental, orientación sexual, identidad o expresión de género o estado serológico del VIH, o en base a la asociación con otra persona debido a la raza, color, religión, nacionalidad, ascendencia, edad, género, discapacidad física o mental, orientación sexual real o percibida por la persona , identidad o expresión de género o estado serológico del VIH".

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any medical or clinical support team member. Violators are subject to removal from the facility and/or discharge from the practice. Patients who are violators will be discharged from the practice and may include prosecution to the fullest extent of the law. Family/Caregivers/Visitors who are violators will be asked to leave immediately from all ProCare properties, which includes being banned from all properties in the future; may include having trespassing charges filed against them; may include being prosecuted to the fullest extent of the law.

Si está sujeto a alguno de estos comportamientos o es testigo de un comportamiento inapropiado, informe a cualquier miembro del equipo clínico y de atención médica inmediatamente. Los infractores están sujetos a ser desalojados de la instalación y / o ser expulsados de la práctica. Los pacientes que sean infractores serán expulsados de la práctica y se les aplicara todo el peso de la ley. Se les pedirá a los familiares / personas que cuidan los pacientes / visitantes que sean infractores que se retiren inmediatamente de la propiedad de ProCare, lo que incluye la prohibición de todas las otras clínicas en el futuro; se pueden presentar cargos de traspaso en contra de ellos; lo puede incluir ser procesado con todo el peso de la ley.

Complaints:
Quejas:

If you have a concern about your rights or responsibilities, please let us know. Contact us in writing at: Patient Grievances: 1000 Caughlin Crossing, Suite 55, Reno NV 89519.

Si usted tiene alguna preocupación con respecto a sus derechos o responsabilidades, por favor déjenos saberlo. Nos puede contactar por correo a: Patient Grievances: 1000 Caughlin Crossing, Suite 55, Reno NV 89519.

Please acknowledge receipt of the Patient Privacy, Rights, and Responsibilities below:
Por favor documente haber recibido los Derechos de Privacidad y Responsabilidades del paciente a continuación:

Signature of Patient/Legal Representative: ____________________________________ Date: __________________

Firma del Paciente/representante legal: ____________________________________ Fecha: _________________