SIERRA
NEUROSURGERY
GROUP
Expert Care for Brain, Spine & Pain Management

Board Certified Neurosurgeons
Christopher P. Demers, MD
Hilari L. Fleming, MD, PhD
Jay K. Morgan, MD
Richard G. Perrin, MD
Marshall E. Tolbert, MD, PhD
Dante F. Vacca, MD

Neurosurgery Advanced Practice Providers
Wren Ballard, APRN
Christine Canner-Peterson, APRN
Rachel Chattin, APRN
Caitlin Clarkin, PA-C
Jennifer Keller, APRN
Jennifer Minard, APRN
Jennifer Sanders, APRN

Pain Management
Jacob L. Blake, MD
Andrea Black, APRN
Ashlie Teixeira-Smith, APRN

5590 Kietzke Lane
Reno, Nevada 89511

Telephone
775.323.2080
888.323.2080
Neurosurgery fax
775.323.8216
Pain management fax
775.683.9404
www.sierraneurosurgery.com

Also seeing patients in:
Carson City, NV
Elko, NV
Bishop, Ca

Welcome to Sierra Neurosurgery Group:

Sierra Neurosurgery offers the complete care of surgical and nonsurgical cranial and spinal disorders ranging from degenerative disc disease to cervical and lumbar spine problems as well as brain tumors, chronic pain etc.

We are honored that you have trusted us with your care and will interface with your primary care physicians and any pain physicians, physiatrists or neurologists you have who are involved in your care. Sierra Neurosurgery will work with these physicians in the community to offer you multidisciplinary care in an organized fashion.

Sierra Neurosurgery prides itself on exhausting conservative options, when appropriate before looking at surgical interventions. A thorough initial assessment is performed before formulating a plan of management that you will have input into. Physical therapy, medications, injections and surgery, when appropriate will all be utilized.

In addition to seeing patients in the office, the physicians of Sierra Neurosurgery Group must spend many hours at the hospital performing surgery and caring for their hospital patients. They must also be on call 24 hours a day at the emergency rooms to care for trauma cases, which they do on a rotating basis. Unfortunately, it may require us to make changes in the office schedule for emergency surgeries. We ask for your cooperation and understanding if it becomes necessary for us to reschedule your appointment.

The attached pages are information about the practice and forms that need to be completed prior to your first visit. It is important to be familiar with the information on these forms and ideally, complete them before your visit.

We hope you will be happy with your care with the team at Sierra Neurosurgery. We will strive to reduce your pain, improve your lifestyle and return you to the activities you were doing before your spinal condition affected your lifestyle.

Sincerely,

The Surgeons of Sierra Neurosurgery Group

Patient Name: _____ DOB:_____

Referring Physician: _____

Primary Care Physician: _____

Chief Complaint: _____

PAST MEDICAL HISTORY:

Check the condition(s) that apply to your past medical history and specify date if known:

CARDIOVASCULAR
- ☐ Congestive heart failure
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Arrhythmia
- ☐ Atrial Fibrillation
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Other: _____

HEMATOLOGICAL
- ☐ Anemia
- ☐ Blood Clots/DVT
- ☐ Other: _____

NEURO/PSYCH
- ☐ Epilepsy/seizures
- ☐ Peripheral Nerve Disorder (Carpal tunnel)
- ☐ Migraine Headaches
- ☐ Head Trauma
- ☐ Headaches
- ☐ Meningitis
- ☐ Cerebral Aneurysm
- ☐ Neuropathy
- ☐ Polio
- ☐ PTSD
- ☐ Substance Abuse

NEURO/PSYCH CONT.
- ☐ Psychiatric Care
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Tremor
- ☐ Brain Tumor
- ☐ Stroke/TIA
- ☐ Bipolar
- ☐ Depression
- ☐ Other: _____

PULMONARY
- ☐ Pulmonary Embolism
- ☐ Pneumonia
- ☐ Insomnia
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Other: _____

INFECTIOUS DISEASE
- ☐ Hepatitis B/C
- ☐ HIV/Aids
- ☐ Other: _____

ONCOLOGY
- ☐ Cancer – Where/What _____
- ☐ Other: _____

GASTROINTESTINAL
- ☐ Liver Disease
- ☐ Severe Heartburn
- ☐ Ulcer
- ☐ Other: _____

GENITOURINARY
- ☐ Kidney Disease
- ☐ Urinary Disease
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Osteoporosis
- ☐ Neck Injury
- ☐ Back Injury
- ☐ Gout
- ☐ Arthritis
- ☐ Back Problems
- ☐ Spinal Cord Tumor
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Other: _____

ENDOCRINE/IMMUNOLOGICAL
- ☐ Diabetes
- ☐ Thyroid (Hypo or Hyper)
- ☐ Goiter
- ☐ Immune System Disorder
- ☐ Other: _____

OTHER
- ☐ Problems With Aresthetics
- ☐ Splenectomy

HOSPITALIZATIONS/SURGICAL HISTORY:

Surgery/Procedure	Hospital	Date	Surgeon	Comments

SOCIAL HISTORY

PATIENT NAME: **Date:**

Marital Status:_____Religion: _____Preferred Language: _____

Place of Birth: _____Education: _____Occupation: _____

Children: _____ Sons _____ Daughters_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: American Native or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander
Other Race Do Not Wish to Report White

SMOKER: NO YES PACKS PER DAY: _____# OF YEARS**:** _____YEAR QUIT: _____

CHEWING TOBACCO: NO YES TIMES PER DAY_____ # OF YEARS**:** _____YEAR QUIT: _____

ALCOHOL: NO YES AVG # OF DRINKS/DAY: _____ # OF YEARS: _____YEAR QUIT: _____

HISTORY OF DRUG ADDICTION: YES NO **HISTORY OF STREET DRUG EXPERIENCE:** YES NO

Do you have any religious reasons that prevent you from receiving a blood transfusion? Yes No

FAMILY HISTORY:

Circle any past family medical history and indicate family member

CONDITION	FAMILY MEMBER	CONDITION	FAMILY MEMBER
Arthritis	_____	Leukemia	_____
Cancer	_____	Muscle Disease	_____
Diabetes	_____	Kidney Disease	_____
Heart Disease	_____	Mental illness	_____
Hypertension	_____	Seizure	_____
Inherited Problem	_____	Tuberculosis	_____
Stroke	_____	Bleeding disorder	_____

MEDICATION ALLERGIES

_____

_____

_____

Have you ever had an allergic reaction to: (Circle any that apply to you)

Shellfish Tape Adhesive Latex Dye used in x-ray tests such as a CT scan, kidney test (IVP) or myelogram

CURRENT MEDICATIONS

Patient Name: _____ **Date: _____**

PRESCRIPTION MEDICATION	STRENGTH	HOW OFTEN YOU TAKE

OVER-THE-COUNTER MEDICATIONS, NUTRITIONAL SUPPLEMENTS, ETC.

Do you take aspirin or anti-inflammatory medications? ☐ No ☐ Yes - Please list _____

Do you take any of the following medications?	**Plavix**	**Coumadin**	**Warfarin**	**Pradaxa**	**Xarelto**

Physician who currently prescribes your pain medication: _____

REVIEW OF SYSTEMS

Name:_____ Date: _____

(Check those that apply to your condition currently)

☐ Right Handed
☐ Left Handed
☐ Ambidextrous

General:
☐ Fever
☐ Weight loss
☐ Fatigue
☐ Loss of appetite

Eyes:
☐ Visual loss
☐ Double Vision
☐ Injury

Ears:
☐ Hearing loss
☐ Ringing
☐ Dizziness
☐ Discharge from ear
☐ Pain in the ears

Nose:
☐ Nose bleeds
☐ Obstruction
☐ Discharge

Mouth:
☐ Toothache

Throat:
☐ Hoarseness
☐ Sore throat
☐ Swallowing difficulty
☐ Voice changes

Cardiovascular:
☐ Palpitations
☐ Rapid heart beat
☐ Irregular heart beat
☐ Chest pain
☐ Leg swelling

Respiratory:
☐ Wheezing
☐ Cough
☐ Shortness of breath
☐ Shortness of breath when lying down
☐ Bloody sputum
☐ Night sweats
☐ Sleep Apnea

Have you had the pneumonia vaccine?
☐ Yes ☐ No

Gastrointestinal:
☐ Abdominal pain or colic
☐ Vomiting
☐ Vomiting blood
☐ Nausea
☐ Jaundice
☐ Change in bowel habits

Genitourinary:
☐ Incontinence
☐ Blood in your urine

Musculoskeletal:
☐ Neck pain
☐ Back Pain
☐ History of fractures
☐ Dislocations
☐ Arthritis
☐ Muscle pain
☐ Muscle weakness
☐ Night cramps
☐ Joint swelling
☐ Stiffness

Integumentary:
Skin:
☐ Sores that do not heal
☐ Rash
☐ Easy bruising

Breast:
☐ Lumps
☐ Discharge from nipples
☐ History of breast cancer

Neurological:
☐ Disturbance of smell
☐ Facial numbness
☐ Facial weakness
☐ Taste disturbance
☐ Hearing difficulty
☐ Speech difficulty
☐ Migraine
☐ Headaches
☐ Loss of consciousness
☐ Prior head injury or skull fracture
☐ Involuntary movement
☐ Seizures, epilepsy
☐ Gait difficulty
☐ Incoordination
☐ Numbness or tingling
☐ Pain going down arm
☐ Pain going down leg
☐ Paraplegic history

Psychiatric:
☐ Nervous breakdown
☐ Hallucinations
☐ Depression

Endocrine:
☐ Abnormal growth
☐ Enlarging head, feet, hands
☐ Unusual hair growth
☐ Abnormal change in skin color
☐ Dryness of hair or skin
☐ Intolerance to heat
☐ Intolerance to cold
☐ Excessive thirst

Blood & Lymph Systems:
☐ Swollen lymph nodes
☐ Abnormal bleeding

Allergy and Immune System:
☐ Food allergies

Women: Are you currently pregnant or think you may be pregnant? ☐ Yes ☐ No

CURRENT PAIN DESCRIPTION

Patient Name:_____**Date:**_____

What does the pain feel like? Circle any that apply:

Pressure	Shooting	Burning	Aching	Stabbing	Stinging
Dull	Throbbing	Cutting	Nagging	Sharp	Electrical

How often do you have pain?

Constant – all day & all night | Part of every day/night | Pain only on certain days

What tends to make your pain worse?

Bending	Sitting	Cough/sneezing	Reaching	Exercise Lifting	Driving
Lying down	Walking	Other: _____			

What tends to relieve your pain? _____

When did you first experience your current pain? _____

_____

Have you tried any of these forms of conservative therapies?

Interventions		***Other Therapies***	
Epidural steroids	Botox	Physical Therapy - # of Visits _____	Where _____
Radiofrequency	Spinal cord stimulator	Acupuncture	Chiropractor Therapy
Trigger point injections	Shoulder, hip or knee injections	Massage Therapy	Home Exercise Therapy
Other: _____		TENS	Other: _____

Have you tried any of these medications for your current problem?

Circle it if you think it **helped your pain.** Underline it if it **didn't work.**

NSAIDS	***Muscle relaxants***	***Benzodiazepines***	***Opiates (short acting)***	***Opiates (long acting)***
Ibuprofen	Flexeril	Valium	Norco/Hydrocodone	Methadone
Naproxen	Robaxin	Klonopin	Percocet/Oxycodone	Oxycontin
Meloxicam	Zanaflex	Ambien	Dilaudid	MS Contin
Other:	Other:	Other:	Other:	Other:
_____	_____	_____	_____	_____

Antidepressants	***Anticonvulsants***	***Misc***
Amitriptyline (Elavil)	Neurontin/Gabapentin	Ultram
Cymbalta/Duloxetine	Lyrica/Pregabalin	Lidoderm patch
Wellbutrin	Topamax	Flector Patch
Other:	Other:	Medical Marijuana
_____	_____	

Other things tried in the past which helped:

_____

_____

_____

CONSERVATIVE THERAPY___

Assistive Devices (Circle all that apply)

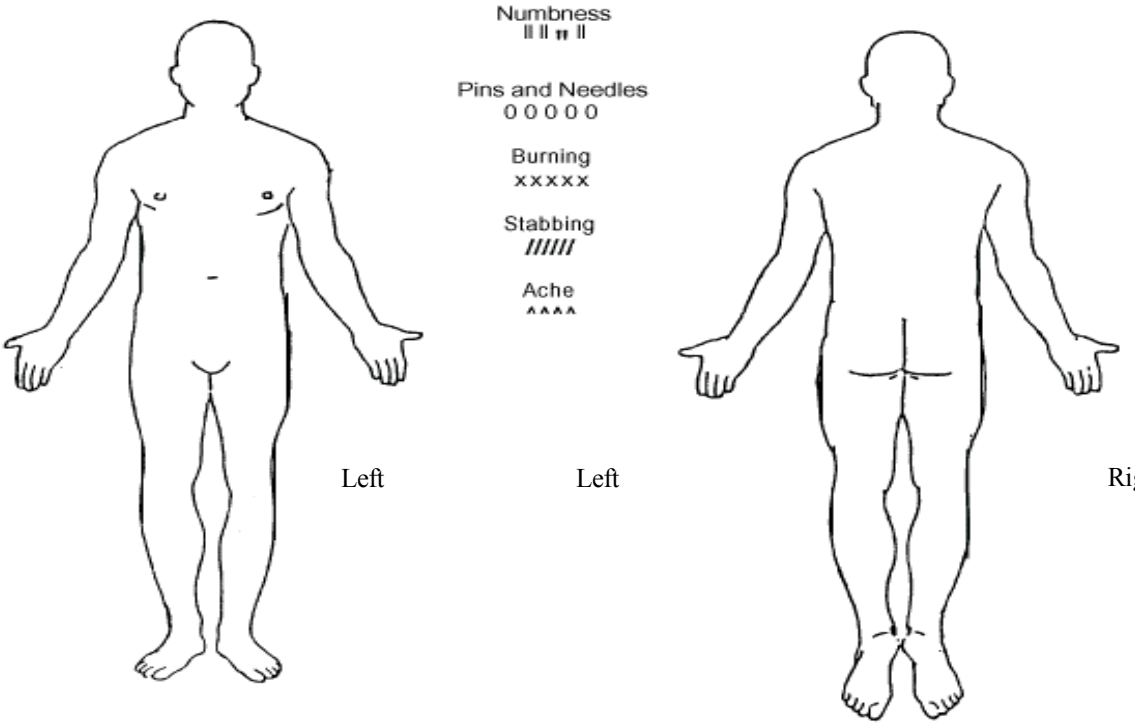
Brace Cane Walker Orthotics Crutch Wheelchair

Falls ☐ No ☐ Yes HowMany/Often: _____

Have you missed work for this condition? ☐ No ☐ Yes Dates: _____

PAIN DIAGRAM____

Mark these drawings according to where you hurt. (If the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.



Please mark with an X on the body form where the pain is worst now.
Please circle the appropriate number below showing how bad your pain is now:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

(If there are multiple locations of pain, please rate all areas.)

Average pain score over the last 7 days: _____

Pain Interferes with: (Circle all that apply) Walking Jogging Personal Hygiene Rising from chair

Standing Sleeping Driving Eating Toileting Dressing/Undressing

The above information is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

I have reviewed the above information with the patient today.

Physician Signature: _____ Date: _____

SIERRA
NEUROSURGERY
GROUP
Expert care for spine and brain

AGREEMENT FOR PRESCRIPTION REQUESTS AND USE OF CONTROLLED SUBSTANCES

As a Neurosurgical practice our treatment is directed towards a neurosurgical solution. Part of your treatment may involve the prescription of analgesic (pain relieving) medications. Analgesic medications do occasionally cause side effects which are more often mild and very manageable. Labs will be ordered periodically as these drugs are cleared through the body by the liver and kidney.

Treatment for pain is done for the acute period. This period should be expected to be 6-8 weeks only. If you have been on analgesic pain medication for 3 months or longer you may require formal pain management and may be referred to a pain management specialist. Although the majority of patients control their medications well, and follow their doctor's orders very strictly, there are some patients that are prone to harmful medication dependency or addiction. Because of this, the State and Federal government carefully regulate many pain medications. This means that the use of these medications involve mutual responsibility between the patient and physician.

IT IS VERY IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING POLICIES AND PROCEDURES. THEY MUST BE FOLLOWED FOR YOUR PHYSICIAN TO PRESCRIBE AND TREAT YOU SAFELY AND EFFECTIVELY.

1. Medication must be used as prescribed and directed unless discussed with your physician. It is life threatening to chew or take a partial tablet of a long acting medication. These include but are not limited to Oxycontin and MS Contin. Increasing your dose without close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and death.
2. If you have a reaction to your medication **DO NOT FLUSH IT OR THROW IT AWAY**. You may be required to bring the remainder to the office to replace with a new prescription.
3. Per the Board of Medical Examiners Regulations, Sec. 1 Chapter 630 and our office policy, controlled substance medications are to be obtained from only one physician. It is a FELONY to knowingly obtain controlled medications from one practitioner without disclosing this fact to all prescribing practitioners.
4. You should discuss any medication changes with your physicians at your appointments and inform them of any new medication allergies.
5. ALLOW FOR **3 WORKING DAYS** FOR PREPARATION OF A WRITTEN PRESCRIPTION FOR PICK UP. ALLOW **48 HOURS** FOR ALL CALL IN RX'S. IF SOMEONE IS TO PICK UP YOUR RX IN YOUR PLACE, THEY MUST BE ON YOUR HIPAA RELEASE OR BE ACCOMPANIED BY A NOTE SIGNED BY YOU. ****Please Initial here that you have read and understand line #5** _____
6. Lost, stolen or misplaced prescriptions or medications may not be replaced. Early requests for refills will not be provided unless you have called and discussed this prior to running out of medication. Selling medication or sharing medication with family, friends, or any other person is illegal and will not be tolerated. You should protect and care for your medication as you would any extremely valuable possession. If you run out of your medication, either because of poor planning or because of taking in excess of what was prescribed, you are responsible for the consequences, including poor pain control and any withdrawal symptoms.
7. PRESCRIPTION REQUESTS WILL BE ADDRESSED MONDAY THROUGH THURSDAY, 9-5 ONLY. Prescriptions are not available Friday, weekends, holidays or after office hours. The on-call physician is on-call for neurosurgical emergencies only.
8. Notify your physician if you are pregnant.
9. The use of alcohol or recreational drugs while on opiods is not allowed. Our office will not provide medications under these circumstances.
10. You are subject to random urine testing if prescribed pain medication.
11. If guidelines are not followed, Sierra Neurosurgery may terminate pain treatment at any time.

We expect you to take the above patient responsibilities seriously.

_____ _____

Patient Name Patient Signature

SIERRA
NEUROSURGERY
GROUP

Expert Care for Brain, Spine & Pain Management

Board Certified Neurosurgeons

Christopher P. Demers, MD
Hilari L. Fleming, MD, PhD
Jay K. Morgan, MD
Richard G. Perrin, MD
Marshall E. Tolbert, MD, PhD
Dante F. Vacca, MD

Neurosurgery Advanced Practice Providers

Wren Ballard, APRN
Christine Canner-Peterson, APRN
Rachel Chattin, APRN
Caitlin Clarkin, PA-C
Jennifer Keller, APRN
Jennifer Minard, APRN
Jennifer Sanders, APRN

Pain Management

Jacob L. Blake, MD
Andrea Black, APRN
Ashlie Teixeira-Smith, APRN

5590 Kietzke Lane
Reno, Nevada 89511

Telephone
775.323.2080
888.323.2080
Neurosurgery fax
775.323.8216
Pain management fax
775.683.9404
www.sierraneurosurgery.com

Also seeing patients in:
Carson City, NV
Elko, NV
Bishop, Ca

MATERIAL RISK NOTICE

There are risks with the use of narcotics. These include, but are not limited to:

1. **BRAIN**: Sleepiness, difficulty thinking, confusion, impaired balance.
2. **LUNG**: Difficulty breathing, shortness of breath, wheezing, slowing of breathing rate.
3. **STOMACH**: Nausea, vomiting, and constipation can be severe.
4. **SKIN**: Itching, rash.
5. **URINARY**: Difficultly urinating.
6. **ALLERGY**: Potential for allergic reaction.
7. **DRUG INTERACTION(S)**: Possibility of interaction with other medications. Can make the effect of both drugs stronger when taken together.
8. **TOLERANCE**: With long term use, an increasing amount of the same drug may be needed to achieve the same pain-relieving effect.
9. **PHYSICAL DEPENDENCE/WITHDRAWAL**: Physical dependence develops within 3-4 weeks when taking these drugs. If they are stopped abruptly, symptoms of withdrawal may occur. These include, but are not limited to, abdominal cramps, abnormal heartbeat, nausea and vomiting, sweating, and flu-like symptoms. These may be life-threatening. All controlled substances need to be slowly tapered under direction of your physician or facility.
10. **ADDICTION**: This refers to the abnormal behavior directed toward acquiring or using drugs in a non-medically necessary manner. People with a history of drug and/or alcohol abuse are at increased risk of developing an addiction.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood and accepted these terms on both pages of the agreement. No narcotic or otherwise habit-forming medications will be prescribed without the acceptance of this agreement.

_____ _____ _____

Patient Name Patient Signature Today's Date

_____ _____

Pharmacy Name Pharmacy Telephone Number

SIERRA
NEUROSURGERY
GROUP
Expert Care for Brain, Spine & Pain Management

Board Certified Neurosurgeons
Christopher P. Demers, MD
Hilari L. Fleming, MD, PhD
Jay K. Morgan, MD
Richard G. Perrin, MD
Marshall E. Tolbert, MD, PhD
Dante F. Vacca, MD

Neurosurgery Advanced Practice Providers
Wren Ballard, APRN
Christine Canner-Peterson, APRN
Rachel Chattin, APRN
Caitlin Clarkin, PA-C
Jennifer Keller, APRN
Jennifer Minard, APRN
Jennifer Sanders, APRN

Pain Management
Jacob L. Blake, MD
Andrea Black, APRN
Ashlie Teixeira-Smith, APRN

5590 Kietzke Lane
Reno, Nevada 89511

Telephone
775.323.2080
888.323.2080
Neurosurgery fax
775.323.8216
Pain management fax
775.683.9404
www.sierraneurosurgery.com

Also seeing patients in:
Carson City, NV
Elko, NV
Bishop, Ca

PROVIDERS' INFORMATION

Please list the names, specialties, and phone numbers of your other healthcare providers:

Provider Name	Specialty	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient Name Today's Date

Welcome To Our Office

Date: _____

Name: _____ Nickname: _____
Last First MI

SSN: _____ Birthdate: _____ Age: _____ Sex: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____ Cell Phone: ( ) _____

Marital Status: _____

Email Address: _____ May we send information to your e-mail? ☐ Yes ☐ No

Employer: _____ Years Employed: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: ( ) _____ May we contact you at work? ☐ Yes ☐ No

Name of Spouse: _____ Birthdate: _____

SSN: _____ Employer: _____

Occupation: _____ Work Phone: ( ) _____

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

How did you hear about our office? PCP Family or Friend Internet Ad You are a Previous Patient

Other _____ In case of emergency, contact: _____

Phone: _____ Relationship: _____

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE

Responsible Party: _____ Relationship to patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Cell: ( ) _____ DOB: _____ Age: _____

SSN: _____ Employer: _____

Occupation: _____ Work Phone: ( ) _____

Insurance Information

[Primary Insurance] Name of Insurance Company:

_____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's DOB: _____

Policy ID Number: _____ Group Number: _____ Group Name: _____

[Secondary Insurance] Name of Insurance Company:

_____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's DOB: _____

Policy ID Number: _____ Group Number: _____ Group Name: _____

COMPLETE THIS SECTION ONLY IF INSURANCE IS WORKERS COMPENSATION

Name of Workers Compensation Carrier:

_____

Address: _____

City: _____ State: _____ Zip: _____

Date of Injury: _____ Claim Number: _____

Adjuster's Name: _____ Phone Number: ( ) _____

Litigation? ☐ Yes ☐ No Name of Attorney: _____

Nurse Case Manager: _____ Phone Number: ( ) _____

Our office will file insurance claims for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. *In the event that you should receive payment from your insurance carrier(s) for services rendered by Sierra Neurosurgery, that check should immediately be forwarded to our office as to avoid a balance with Sierra Neurosurgery Group*. See our complete financial policy for details.

****Assignment of Benefits**

I hereby assign all right, title, and interest of my primary and secondary insurance to Sierra Neurosurgery Group for the treatment of my medical services.

Patient Signature _____ Date _____
(Parent/Guardian if minor)

For Internal Use Only: MRN_____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME_____
Last *First* *Middle*

PREVIOUS NAME(S)_____ **GENDER:** M____ F____

STREET ADDRESS / P.O. BOX_____

CITY_____ **STATE**_____ **ZIP CODE**_____

PHONE NUMBER _____ **EMAIL**_____

DATE OF BIRTH _____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____
Signature of patient or authorized representative Date Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Name of Authorized Representative (Printed) Relationship Date Time

_____
Address of authorized representative signing this form (please print):

_____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:_____ Name of Witness:_____
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.