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

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Pain Management

Jacob L. Blake, MD
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Also seeing patients in:
Carson City, NV
Elko, NV
Bishop, Ca

Dear Patient,

Welcome to **Interventional Pain Management** at Sierra Neurosurgery Group. We are honored that you have trusted us with your care! The **Interventional Pain Management (IPM) Team** offers comprehensive treatment of many pain disorders, ranging from spinal conditions to migraine headaches.

The members of the **IPM Team** at Sierra Neurosurgery consists of Dr. Jacob L. Blake and his highly trained Mid-Level Providers.

Dr. Blake received his medical training at the University of Nevada School of Medicine and completed residency and fellowship training at the University of California, San Diego. He is board certified by the American Board of Anesthesiology in both Pain Medicine and Anesthesiology. He has ten years of experience practicing Interventional Pain Management and seven years of experience practicing Anesthesia.

The **IPM Team** prides itself on exploring all non-invasive or minimally invasive pain treatments before employing more advanced procedures or recommending surgical consultation.

Your **IPM Team** will interface with your primary care physician (PCP) and any surgeons, neurologists, or physical therapists also involved in your care. The **IPM Team** will work with these providers in the community to offer multidisciplinary care in an organized fashion.

Dr. Blake and his mid-level providers will coordinate a unique balance of traditional western medicine therapies combined with cutting edge, complementary, and alternative therapies. We employ a team approach with the ultimate goal of improving your pain, physical function, and quality of life!

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 prepared to provide the medical information on these forms and, ideally, complete them before your visit on the attached forms or via our patient portal.

We will strive to deliver exceptional service and we hope you will be happy with your care. We promise to make every possible effort to reduce your pain and to return you to the activities you were doing before your pain condition affected your lifestyle.

Sincerely,

The **Interventional Pain Management Team** at Sierra Neurosurgery Group

Welcome To Our Office

Date: _____

Name: _____ Nickname: _____
Last First MI

SSN: _____ Birthdate: _____ Age: S 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)

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**	**Xeralto**

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

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

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)

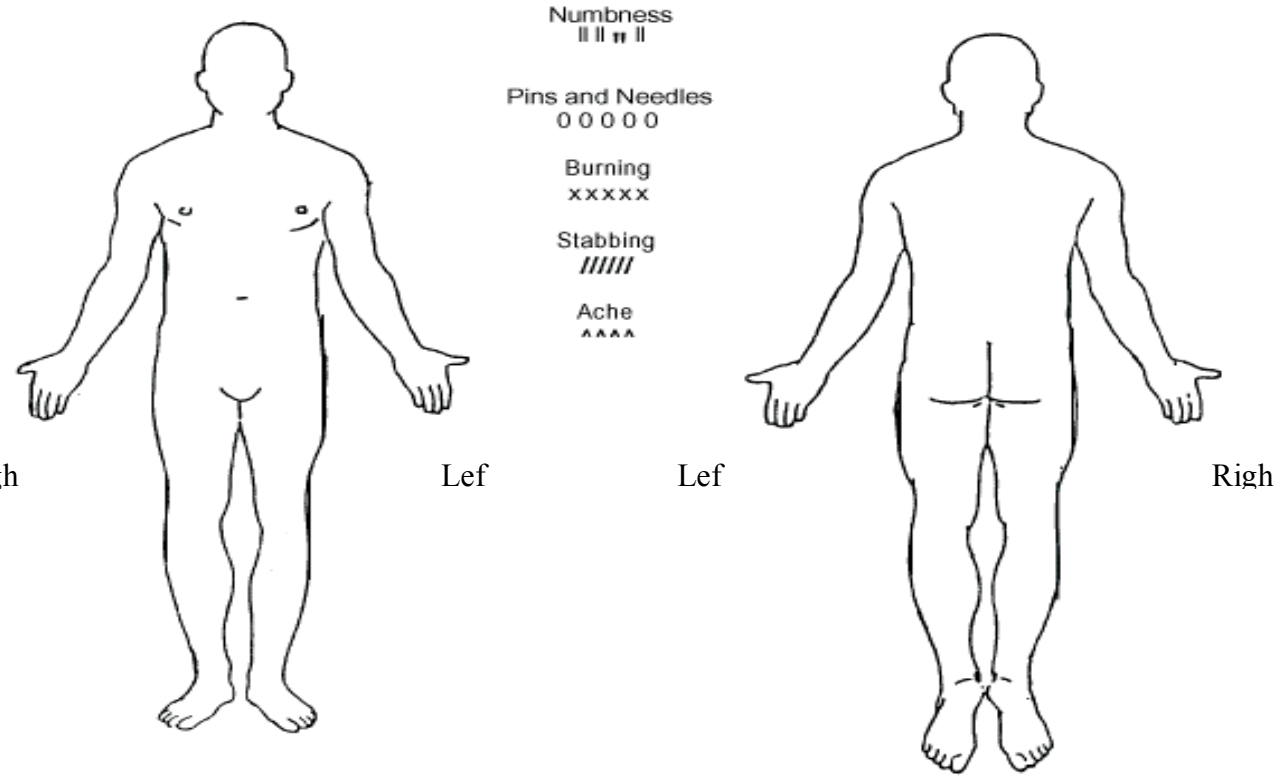
Brace Cane Walker Orthotics Crutch Wheelchair

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: _____

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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 _____

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.

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Statement of Financial Policy

Thank you for choosing Sierra Neurosurgery Group Interventional Pain Management

Sierra Neurosurgery Group Interventional Pain Management is dedicated to the best possible care for your pain needs. The following information will make dealing with the financial aspects a little easier.

Payment methods: Cash, check, and credit card. Payment plans can also be discussed.

Insurance reimbursements: In the event that you should receive reimbursement from your insurance carrier(s) for services rendered with Sierra Neurosurgery Group Interventional Pain Management, you should immediately forward to our billing department.

Copays and deductibles: Payment of any applicable deductibles, co-payments, or co-insurance amounts are due before services are rendered. This applies to both office visits and procedures.

If you are not enrolled in an insurance plan: Payment in full is required at the time of service.

Returned check fee: $25.00. This will be added to your account and you may be asked to submit payment in cash, credit card or cashier's check.

Completing documents: Our office may complete forms for disability, FMLA, medical marijuana or DMV. There is a $35.00 fee per form. The office can give you a quote. Please allow our staff 7-10 business days to complete your forms.

Prior authorization: If your insurance required prior authorization or referrals for your office consultation and any visits thereafter, and if this authorization or referral has not been obtained prior to your visit, you will be expected to pay for all charges incurred at the time of your visit. If your insurance subsequently authorize our services, your payment will be refunded upon receipt of the insurance payment. If your insurance requires prior authorization for treatment such as x-rays, labs, imaging, etc., our office will work with your insurance company to obtain authorization. It is your responsibility to make sure such authorization is ultimately obtained.

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Please be advised that some of our physicians together with a number of local physicians are part owners/investors in Summit Surgery Center and the Surgery Center of Reno. The physician owners do not receive a referral fee for performing your surgery at these surgery centers. If you would prefer to schedule your procedure or surgery at another surgery center or a hospital, please ask and we will make every effort to accommodate your wishes.

SUMMARY NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT OF RECEIPT:

Under Federal law, Sierra Neurosurgery Group Interventional Pain Management (SNG IPM) is required to protect the privacy of certain parts of your protected health information (PHI) we hold in our files. Upon your request, SNG IPM must give you a notice (referred to as out "Notice of Privacy Practices") of our legal duties and privacy practices concerning the permitted uses and disclosures of your PHI and your rights regarding our use and disclosure of your PHI. You have the legal right to review our Notice of Privacy Practices before you sign the consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. IF we change our notice, you may obtain a copy of the revised notices by accessing our website (www.sierraneurosurgery.com) . You have the right to restrict how we use and disclose your PHI for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, we do decide to grant your request, we are bound by our agreement with you. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI for the purposes of treatment, payment and health care operations. If you have any questions, you may contact the privacy officer at the number above.

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FINANCIAL POLICIES CONTINUED

INTERVENTIONAL PAIN MANAGEMENT AT SIERRA NEUROSURGERY CANCELLATION POLICY

To gain the most benefit from our office and to ensure that other patients receive the highest level of care, it is essential to keep all your scheduled appointments.

No-show appointments will be charged a $25.00 fee that will be collected prior to being allowed to reschedule the appointment. A second offense may result in discharge from care.

Cancelling appointments. We understand the need at times to cancel your appointment. If you must cancel your appointment, please give us notice at least 24 hours in advance. There are other patients requiring our care and your appointment can be given to someone else if we are given enough notice.

Cancelling your appointment with less than 24 hours notice or rescheduling your appointment 3 times or more may result in a $25.00 charge. This charge will be collected prior to scheduling another appointment.

Appointment delays. If you are more than 10 minutes late for an appointment, you may not be seen that day. If you are going to be more than 10 minutes late for your appointment, please do your best to let us know so that we can rearrange the schedule if possible. It is our goal to provide every patient with timely pain care.

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for Sierra Neurosurgery Group**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize Sierra Neurosurgery Group to release medical information required to process my claim**

Signed_____**Date:**_____

- **I have read and understand the Financial Policy for Sierra Neurosurgery Group**

Signed_____ **Date:**_____

- **I authorize Sierra Neurosurgery Group to obtain my medical and medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____

I authorize the following family member(s) access to my medical and financial information. I understand this person may contact Sierra Neurosurgery Group on my behalf. Please allow _____, who is my (spouse, friend, child, parent, significant other) access to my medical and financial information. List any additional people you would like to have access to this information

_____

_____

Signed_____ **Date:**_____

SIERRA NEUROSURGERY INTERVENTIONAL PAIN MANAGEMENT
Pain Management Psychologic Screening Tool – Required by AB 474

A. Please circle your gender?	**Female**	**Male**
Family History **B. Do any of your relatives have a history of one (or multiple) of the following?**	**YES**	**NO**
Alcohol abuse	☐	☐
Illicit substance abuse	☐	☐
Prescription drug abuse	☐	☐
Personal History **C. Do you personally have a history of one (or multiple) of the following?**	**YES**	**NO**
Alcohol abuse	☐	☐
Illegal drug abuse	☐	☐
Prescription drug abuse	☐	☐
D. Are you between the ages of 16-45?	**YES**	**NO**
E. Do you have a history of preadolescent sexual abuse?	**YES**	**NO**
F. Do you personally have a history of one (or multiple) of the following?	**YES**	**NO**
ADD, OCD, Bipolar, Schizophrenia	☐	☐
Depression	☐	☐
Thank you for your answers!		
Office Use (Score)		