



Denis G. Patterson, DO
Board Certified Pain Medicine
Board Certified Physical Medicine & Rehabilitation
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www.nvadvancedpain.com

Welcome to Nevada Advanced Pain Specialists

We are committed to providing a comprehensive multi-disciplinary approach for each individual's pain complaints to ensure you receive the most appropriate care.

Every individual is evaluated for the root cause of their pain – not just a “quick fix” approach to only provide symptomatic relief. We employ a methodical and physical medicine oriented approach that includes analysis of biomechanics, joint motion, as well as skeletal, nerve and muscle tissues. Only the latest diagnostic tools and technologies are used by the professionals at Nevada Advanced Pain Specialists to make accurate assessments including: EMG/Nerve testing, MRIs, x-rays, bone scans, and diagnostic pain injections.

The most important information comes from you – the patient. Dr. Patterson will spend time asking questions and listening to you. We understand that your personal experiences with your pain represent some of the most important data available to us for accurate diagnosis and effective treatment.

Once an accurate diagnosis is reached, we will employ various modalities, physical therapy, medication management, and appropriate interventional techniques to treat your pain.

When pain is treated properly, the net result is a more active lifestyle, which will lead to a healthier, happier you!

Sincerely,

Denis G. Patterson, DO
Medical Director – Nevada Advanced Pain Specialists



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PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

1. Driver's License/Photo ID
2. Health Insurance Card(s)
3. Completed forms from this packet
4. Radiographic Imaging (x-rays, CTs, and/or MRIs) films and reports if you have them available.
5. Any important previous medical records
6. A list of your current medications, when they were last filled, and the name of the provider who prescribed them to you.

It is the responsibility of the patient to make sure that all of the above materials are completed and provided to our office at the time of the appointment. If any of the information is not available or incomplete, your appointment may need to be rescheduled.

Our main fax number is (775) 284-8654. Should you need to reschedule your appointment, please call us at your earliest convenience at (775) 284-8650.

We look forward to seeing you soon,

The Staff of Nevada Advanced Pain Specialists



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In order to bill your insurance company, you MUST complete all requested information

DEMOGRAPHIC INFORMATION

Last Name _____ First Name _____ M.I. _____
Physical Address _____
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone () _____ Cell () _____
Email address _____
Social Security # _____ Date of Birth _____
Employer _____ Retired (Y/N) _____ Disabled (Y/N) _____
Address _____ Phone () _____
Referring Physician _____ Phone () _____
Primary Care Physician _____ Phone () _____
Emergency Contact _____ Phone () _____

INSURANCE COVERAGE

Primary Insurance Company _____
Address _____
Insured's Name _____ Social Security # _____
Relationship to Patient: ___Self ___Parent ___Spouse ___Guardian ___Other
Insured's Date of Birth _____ Employer _____
ID # _____ Group# _____

Secondary Insurance Company _____
Address _____
Insured's Name _____ Social Security # _____
Relationship to Patient: ___Self ___Parent ___Spouse ___Guardian ___Other
Insured's Date of Birth _____ Employer _____
ID # _____ Group# _____

WORKERS COMPENSATION

Insurance Company _____ Date of Injury _____
Address _____
Claim # _____ Case Manager _____
Phone # _____ Fax # _____
Employer at time of injury _____ State _____

Name: _____

Reason for appointment:

Past Medical History:

Past Surgical History:

_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Smoker: No ___ Yes ___ If yes, # of packs per day ___
Alcohol: No ___ Yes ___ If yes, average # of drinks per day ___
History of drug addiction: No ___ Yes ___
Place of Birth: _____
Marital Status: _____
Children: No ___ Yes ___ If yes, how many _____
Education: _____
Occupation: _____

Family History:

* Please provide us with any medical conditions that family members have

	Condition	Age	Deceased? (Y/N)
Grandfather:	_____	_____	_____
Grandmother:	_____	_____	_____
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brother:	_____	_____	_____
Sister:	_____	_____	_____

Review of Systems:

* Mark all that apply to your current condition

General:

Fever Weight loss Fatigue Special diet

Eyes:

Visual loss Double vision Injury Glasses
 Inflammation Glaucoma

Ears:

Deafness Ringing Dizziness Pain in ears
 Discharge from ears

Nose:

Nose bleeds Obstruction Discharge from nose

Mouth:

Soreness mouth or tongue Toothache

Throat:

Hoarseness Sore Throat Voice changes

Cardiovascular:

Palpitations Rapid heart rate Irregular heart beat
 Chest pain Shortness of breath Leg swelling
 Leg pains while walking High blood pressure

Respiratory:

Shortness of breath Wheezing Cough Bloody sputum
 Night sweats History of pleurisy Tuberculosis
 Pneumonia Asthma

Gastrointestinal:

Nausea Abdominal pain Vomiting Vomiting blood
 Jaundice Change in bowel habits History of ulcer
 Weight loss

Genitourinary:

Urinary tract infection Painful urination Kidney Stones
 Incontinence Blood in urine Prostate cancer
 Difficulty stopping and starting urine stream

Musculoskeletal:

History of fractures Dislocations Sprains Neck pain

Arthritis Muscle pain Stiffness Mid-back pain
 Muscle weakness Night cramps Joint Swelling
 Low back pain

Integumentary (skin): Abnormal sweating Itching Rash
 Sores that do not heal Easy bruising

Neurological: Disturbance to smell Facial numbness Difficulty chewing
 Facial weakness Taste disturbance Hearing difficulty
 Balance problems Speech difficulty Headaches
 Swallowing difficulties Paraplegic history
 Loss of consciousness Pain going down arm
 Pain going down leg Involuntary movement
 Seizures/epilepsy Gait difficulty Coordination issues
 Numbness, tingling or burning Urinary control problems
 Prior head injury or skull fracture

Psychiatric: Nervous breakdown Hallucinations Depression

Endocrine: Diabetes Abnormal growth Enlarged head, feet, hands
 Unusual hair growth Abnormal change in skin color
 Thyroid or goiter problems Dryness of hair or skin
 Heat intolerance Cold intolerance Excessive thirst
 Excessive urination

Blood & Lymph Systems: Anemia Swollen lymph nodes Abnormal bleeding
 Family history of bleeding disorder

Allergy and Immune System: Migraine Food Allergies AIDS
 Immune system disorder

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

Date: _____ Age: _____ Name: _____

Where is your pain now? (Please complete the pain drawing)

Numbness =====

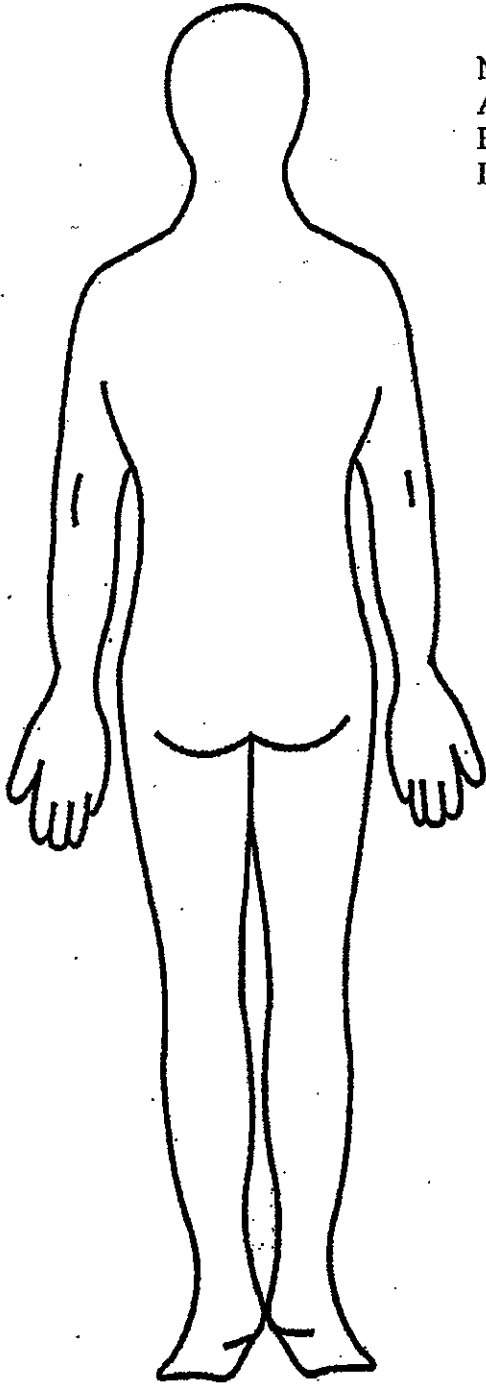
Pins & Needles ++++++

Burning XXXXXXXXXXXXXXX

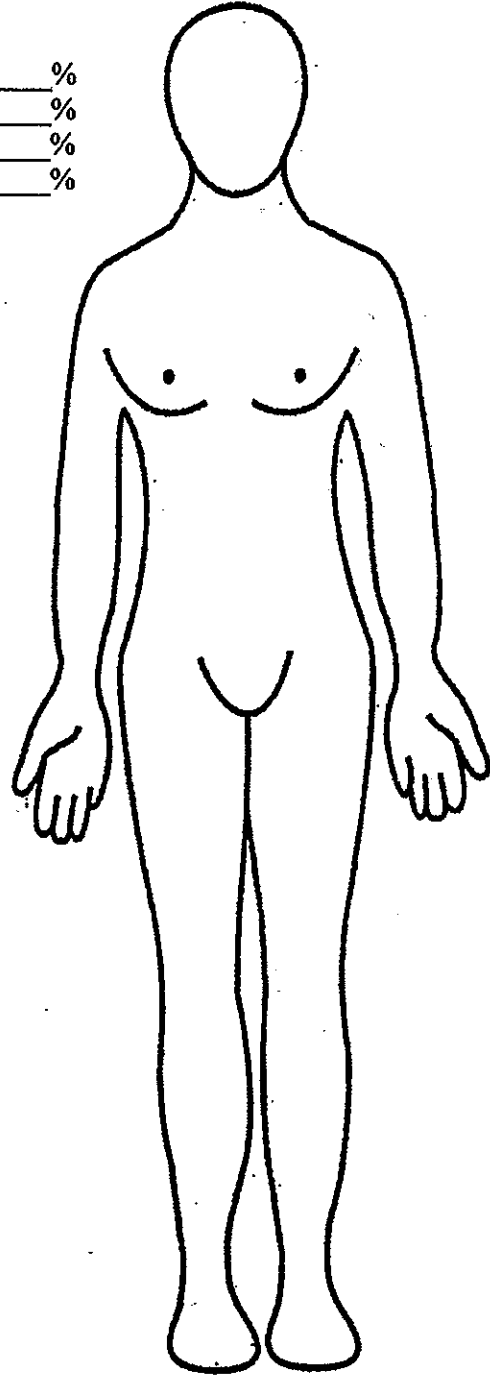
Stabbing ////////////////

Ache ~~~~~

Shooting _____



Neck Pain _____ %
Arm Pain _____ %
Back Pain _____ %
Leg Pain _____ %



Pain Level: 0 1 2 3 4 5 6 7 8 9 10

What is your current overall functional activity level?
(working, recreation, household activities, sleeping, etc.)

On a scale from 0-100, 0 = Completely Limited 100 = Fully Functional

% 0 10 20 30 40 50 60 70 80 90 100%



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Physicians' Information

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

Physician Name	Specialty	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name

Today's Date



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MEDICATION AGREEMENT & REFILL POLICY

As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. If Nevada Advanced Pain Specialists has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians, pharmacies, and hospitals.

1. I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is essential. I agree to actively participate in all aspects of my treatment plan to maximize functioning and improve coping with my condition.
2. If it appears to the provider that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as directed by the prescribing provider.
3. I agree to follow the dosing schedule prescribed to me by my physician or P.A.
4. I agree to **never** share my medications with others nor will I sell or exchange my medication for any reason.
5. I agree to always keep my medications safeguarded and within my control.
6. I agree to notify Nevada Advanced Pain Specialists if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medication. Before any new medication can be prescribed, I must bring the unused medication to the Nevada Advanced Pain Specialists office for disposal.
7. I agree that if I receive narcotic medications from Nevada Advanced Pain Specialists I am **not** allowed to receive the same type of medications from another physician (including the emergency room or clinic) without the express consent or consultation with Nevada Advanced Pain Specialists.
8. I agree to use only one pharmacy for my pain-related medications unless extenuating circumstances prevent this from being possible. In this event, I will notify Nevada Advanced Pain Specialists of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.
9. I will count my pills that I receive from the pharmacy and will ensure that the proper amount is received. I understand that my physician will not cover me for any shortage of medication. Any shortage found must immediately be discussed with the pharmacy upon receipt of the filled prescription.
10. I understand that medication refills involving narcotic pain medication will require a scheduled office visit with my prescribing physician at Nevada Advanced Pain

Specialists. **Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased over the telephone.**

11. **I agree to keep all scheduled appointments. I understand no medications will be given for cancelled or no-show appointments.** I agree also to be prompt to my appointments and understand that if I am more than **15 minutes** late I will have to reschedule.
12. I understand that medication refills cannot be made after hours or on the weekend. The Nevada Advanced Pain Specialists refill hours are 8:00am – 2:00pm. Calls after 2:00pm will be addressed the following business day.
13. I agree to bring my medications from any other physician's office to Nevada Advanced Pain Specialists for my office appointments.
14. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
15. I understand that I am solely responsible for the safekeeping of my medication and I must treat my medications as I would my money or valuable possession. **The Nevada Advanced Pain Specialists physician will under no circumstances replace LOST or STOLEN prescriptions or medications.**
16. I understand that my treatment at Nevada Advanced Pain Specialists may legally require a monthly visit so that my doctor can properly evaluate my progress, and/or adjust appropriate narcotic pain medications every 30 (thirty) days.
17. I understand that abusive behavior or harassment toward any of the Nevada Advanced Pain Specialists staff will not be tolerated. Harassment includes, but is not limited to, more than 2 (two) phone calls to the office in one business day.
18. I will not show up at the Nevada Advanced Pain Specialists office unannounced seeking medication refills.
19. Medication refills will be made only as often as it is directed on the label. No early refills will be authorized
20. I will not use "street" or illegal drugs. I agree to random drug screen tests to verify that I am only using drugs consistent with this agreement.
21. I understand that a forged or falsified prescription will result in the immediate dismissal from Nevada Advanced Pain Specialists and possibly criminal proceedings as required by law.
22. I understand that if I do not follow this medication agreement, I may be dismissed from Nevada Advanced Pain Specialists, at their discretion.
23. This contract will become part of my permanent medical record.

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:** Difficulty 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 heart beat, nausea and vomiting, sweating, flu-like symptoms. These may be life-threatening. All controlled substances need to be slowly tapered under the direction of your physician or facility.

9. **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 accept these terms. No narcotic or otherwise habit-forming medications will be prescribed without the acceptance of this agreement,

Pharmacy Name

Pharmacy Telephone Number

Patient Name

Patient Signature

Today's Date



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Nevada Advanced Pain Specialists 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 of your scheduled appointments.

If you are more than 15 minutes late for an appointment, you may not be seen that day. We try to keep to our schedule and you being late will affect the next patient.

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

If you fail to attend your appointment without calling or give less than 12 hours notice of cancellation, you will be charged \$40.00. This is not covered by insurance and this amount will have to be paid before scheduling another appointment.

If you cancel 3 appointments or miss 2 appointments, you will be discharged from our care.

Thank you for helping us provide the best care possible.

Acknowledgement of Cancellation Policy

I have read and understand the Nevada Advanced Pain Specialists Cancellation Policy

Signature

Date



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KNOW YOUR INSURANCE PLAN

Your health insurance is based upon a contract between you and the insurance company, or in some cases, the insured party's employer and the insurance company. If your employer has selected your plan, it is customary for the employer to describe and discuss the benefits of the plan with the employee. It is the responsibility of the insurance company to provide supporting documentation (Plan Benefit Booklet) and the Enrollment Card of the insured.

It is the responsibility of the insured party who benefit from this plan, or who receives benefits from this insurance plan to know:

- The commencement date of the plan
- If there is an annual deductible, and how much
- Which hospital, laboratory, and radiology center the carrier is contracted with
- The amount of your co-payment

It is your responsibility to present the insurance card to the receptionist when checking in. It is also your responsibility to notify our office of any changes or termination of your plan.

The contract between the "Provider Service" (Physician) with any insurance company is:

- To provide quality medical care to the patients
- To submit the claim for service to the appropriate carrier in a timely fashion
- To give credit to the patient for any "contracted discount"
- To collect co-payments and other balances due from patient at time of service

If you ever have questions regarding your coverage, you will need to contact your employer or call the number listed on the back of your insurance card. Please refer to your Explanation of Benefits from your insurance company and your monthly statement from Nevada Advanced Pain Specialists.

We will bill services at the end of each work day. If you have provided information that is not accurate, we will be required to bill you directly. Changes made to your insurance information after the fact comes with a \$25.00 charge to you.

Signature

Date

* Physicians in this practice may have a financial interest or relationship with companies that provide products, services or facilities used in your care. This does not affect the care or medical decision-making used in your treatment and details are available upon request.