Modified Mini Screen (MMS)

Client Name: _____ OASAS ID _____
Weeks since admission _____ Interviewer _____
Today's Date _____ Supervisor Initials (Optional) _____

SECTION A

1. Have you been consistently depressed or down, most of the day, nearly every day for the past 2 weeks?	YES ☐	NO ☐
2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	YES ☐	NO ☐
3. Have you felt sad, low or depressed most of the time for the last two years?	YES ☐	NO ☐
4. In the past month, did you think that you would be better off dead or wish you were dead?	YES ☐	NO ☐
5. Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	YES ☐	NO ☐
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	YES ☐	NO ☐
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 1-6	_____	

SECTION B

7. Note this question is in 2 parts. **a.** Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? ☐ YES ☐ NO **b.** If yes, did these intense feelings get to be their worst within 10 minutes? ☐ YES ☐ NO Interviewer: If the answer to BOTH a and b is YES, code the question YES. If the answer to either or both a and b is NO, code the question NO.	YES ☐	NO ☐
8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples include: ☐ Being in a crowd ☐ Standing in a line ☐ Being alone away from home or alone at home ☐ Crossing a bridge ☐ Traveling in a bus, train or car	YES ☐	NO ☐
9. Have you worried excessively or been anxious about several things over the past six months? Interviewer: If NO to question 9, answer NO to question 10 and proceed to question 11.	YES ☐	NO ☐
10. Are these worries present most days?	YES ☐	NO ☐
11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated?	YES ☐	NO ☐
12. In the past month, have you been bothered by thoughts, impulses or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? **Examples include:** ☐ Were you afraid that you would act on some impulse that would be really shocking? ☐ Did you worry a lot about being dirty, contaminated or having germs? ☐ Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? ☐ Were you obsessed with sexual thoughts, images or impulses? ☐ Did you hoard or collect a lot of things? ☐ Did you have religious practice obsessions?	YES ☐	NO ☐

SECTION B (CONTINUED)

13. In the past month, did you do something repeatedly without being about the resist doing it? Examples include: ☐ Washing or cleaning excessively ☐ Counting or checking things over and over ☐ Repeating, collecting or arranging things ☐ Other superstitious rituals	YES ☐	NO ☐
14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include: ☐ Serious accidents ☐ Sexual or physical assault ☐ Terrorist attack ☐ Being held hostage ☐ Kidnapping ☐ Fire ☐ Discovering a body ☐ Sudden death of someone close to you ☐ War ☐ Natural disaster	YES ☐	NO ☐
15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: ☐ Dreams ☐ Intense recollections ☐ Flashbacks ☐ Physical reactions	YES ☐	NO ☐
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 7-15		

NEVADA ADVANCED PAIN SPECIALISTS
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Client Name: _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

1. Have you ever felt that you ought to cut down on your drinking or drug use?
   Yes____ No____
2. Have people ever annoyed you by criticizing your drinking or drug use?
   Yes____ No__
3. Have you ever felt bad or guilty about your drinking or drug use?
   Yes____ No___
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

In the past 12 months, have you: (Indicate "Y" or "N")

1. Used additional drugs/ alcohol other than those required for medical reasons: ___
2. Abused more than one drug at a time: ____
3. Been unable to stop using drugs/ alcohol when you want to: ____
4. Had blackouts or flashbacks as a result of drug/ alcohol use: ____
5. Felt bad or guilty about your drug/ alcohol use: ____
6. Has your spouse or parents complained about your involvement with drugs/ alcohol: ____
7. Neglected your family because of your use of drugs/ alcohol: ____
8. Engaged in illegal activities in order to obtain drugs/ alcohol: ____
9. Experienced withdrawal symptoms (agitation, felt sick) when you stop taking drugs/ alcohol: ____
10. Had medical problems as a result of your drug/ alcohol use (memory loss, hepatitis, convulsions, bleeding etc.): ____
11. Had a past history of addiction: ____

Please indicate substance(s) of choice: _____
_____

Patient Name: _____ DOB: _____

Instructions

This questionnaire contains groups of statements. Pick the statement that best describes the way you feel today. Circle the number beside each statement you have chosen. If several statements in the group seem to apply equally well, circle each one. Be sure to read all of the statements in each group before making your choice.

1. ☐ I do not feel sad.
   ☐ I feel sad.
   ☐ I am sad all the time and I can't snap out of it.
   ☐ I am so sad or unhappy that I can't stand it.

2. ☐ I am not particularly discouraged about the future.
   ☐ I feel discouraged about the future.
   ☐ I feel I have nothing to look forward to.
   ☐ I feel that the future is hopeless and that things cannot improve.

3. ☐ I do not feel like a failure.
   ☐ I feel I have failed more than the average person.
   ☐ As I look back on my life, all I can see is a lot of failures.
   ☐ I feel I am a complete failure as a person.

4. ☐ I get as much satisfaction out of things as I used to.
   ☐ I don't enjoy things the way I used to.
   ☐ I don't get real satisfaction out of anything anymore.
   ☐ I am dissatisfied or bored with everything.

5. ☐ I don't feel particularly guilty.
   ☐ I feel guilty a good part of the time.
   ☐ I feel quite guilty most of the time.
   ☐ I feel guilty all of the time.

6. ☐ I don’t feel I am being punished.
   ☐ I feel I may be punished.
   ☐ I expect to be punished
   ☐ I feel I am being punished.

7. ☐ I don’t feel disappointed in myself.
   ☐ I am disappointed in myself.
   ☐ I am disgusted with myself.
   ☐ I hate myself.

8. ☐ I don’t feel I am any worse than anybody else.
   ☐ I am critical of myself for my weakness or mistakes.
   ☐ I blame myself all the time for my faults.
   ☐ I blame myself for everything bad that happens.

9. ☐ I don’t have any thoughts of killing myself.
   ☐ I have thoughts of killing myself, but I would not carry them out.
   ☐ I would like to kill myself.
   ☐ I would kill myself if I had the chance.

10. ☐ I don’t cry any more than usual.
    ☐ I cry more now than I used to.
    ☐ I cry all the time now.
    ☐ I used to be able to cry, but now I can’t cry even though I want to.

11. ☐ I am no more irritate by things than I ever am.
    ☐ I am slightly more irritated now than usual.
    ☐ I am quite annoyed or irritated a good deal of the time.
    ☐ I feel irritated all the time now.

12. ☐ I have not lost interest in other people.
    ☐ I am less interested in other people than I used to be.
    ☐ I have lost most of my interest in other people.
    ☐ I have lost all of my interest in other people.

13. ☐ I make decisions about as well as I ever could.
    ☐ I put off making decision more than I used to.
    ☐ I have greater difficulty in making decisions than before.
    ☐ I can't make decisions at all anymore.

14. ☐ I don't feel that I look any worse than I used to.
    ☐ I am worried that I am looking old or unattractive.
    ☐ I feel that there are permanent changes to my appearance that make me look unattractive.
    ☐ I believe that I look ugly.

15. ☐ I can work about as well as before.
    ☐ It takes an extra effort to get started at doing something.
    ☐ I have to push myself very hard to do anything.
    ☐ I can't do any work at all.

16. ☐ I can sleep as well as usual.
    ☐ I don't sleep as well as I used to.
    ☐ I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    ☐ I wake up several hours earlier than I used to and find it hard to get back to asleep.

17. ☐ I don't get more tired than usual.
    ☐ I get tired more easily than I used to.
    ☐ I get tired from doing almost nothing.
    ☐ I am too tired to do anything.

18. ☐ My appetite is no worse than usual.
    ☐ My appetite is not as good as it used to be.
    ☐ My appetite is much worse now.
    ☐ I have no appetite at all anymore.

19. ☐ I haven't lost much weight, if any, lately.
    ☐ I have lost more than five pounds.
    ☐ I have lost more than ten pounds.

☐ I have lost more than fifteen pounds.

20. ☐ I am no more worried about my health than usual.
☐ I am worried about physical problems such as aches and pains, or upset stomach or constipation.
☐ I am very worried about physical problems and its hard to think of much else.
☐ I am so worried about my physical problems that I cannot think of anything else.

21. ☐ I have not noticed any recent change in my interest in sex.
☐ I am less interested in sex now that I used to be.
☐ I am much less interested in sex now.
☐ I have lost interest in sex completely.

Instructions

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the *one line* that applies to you. We realize you may consider that two statements in any one section relate to you, but please just mark the check box that most closely describes your problem.

Section 1 – Pain Intensity

☐ I can tolerate the pain that I have without needing pain medication.
☐ The pain is bad but I manage with taking pain medication.
☐ Pain medication gives complete relief from the pain.
☐ Pain medication gives moderate relief from the pain.
☐ Pain medication gives very little relief from the pain.
☐ Pain medication has no effect on the pain and I do not take any.

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 my personal care.
☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives me extra pain.
☐ Pain prevents me from standing for more than one hour.
☐ Pain prevents me from standing for more than 30 minutes.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 4 – Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than six hours of sleep.
☐ Even when I take tablets I have less than four hours of sleep.
☐ Even when I take tablets I have less than two hours of sleep.
☐ Pain prevents me from sleeping at all.
☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
☐ Pain prevents me from lifting heavy weights, but I can lift light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 6 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than ½ of a mile.
☐ Pain prevents me from walking more than ¼ of a mile.
☐ I can walk using only a cane or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 7 – 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 for more than one hour.
☐ Pain prevents me from sitting for more than ½ of an hour.
☐ Pain prevents me from sitting for more than ¼ of an hour.
☐ Pain prevents me from sitting at all.

Section 8 – Sex Life

☐ My sex life is normal and causes no extra pain.
☐ My sex life is normal but causes some pain.
☐ My sex life is normal but it 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 upon my social life apart from limiting my more energetic interests – e.g. dancing, 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 can manage journeys over two hours.
☐ Pain restricts me to journeys of less than one hour.
☐ Pain restricts me to short journeys under 30 minutes.
☐ Pain prevents me from travelling except to the doctor or hospital.

Instructions

Click a checkbox along the line that expresses your thoughts from 0% to 100% in each section. Read each statement carefully. There are words to help you with each statement. If you need help, please ask.

Section 1: Pain Intensity

To what degree do you rely on pain medication or pain relieving substances for you to be comfortable?

None Some All the time

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section II: Personal Care

How much does pain interfere with your personal care (getting out of bed, brushing teeth, dressing, etc.)?

None (NO PAIN) Some I cannot get out of bed

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section III: Lifting

How much limitation do you notice in lifting?

None (I can lift as I did) Some I cannot lift anything

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section IV: Walking

Compared to how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

I can walk the same		Almost the same		Very little		I cannot walk
0% (☐	: ☐ : ☐ : ☐ : ☐ : ☐	) 100%				

Section V: Sitting

Back pain limits my sitting in a chair to:

None, pain Same as before		Some		I cannot sit at all
0% (☐	: ☐ : ☐ : ☐ : ☐ : ☐	) 100%		

Section VI: Standing

How much does your pain interfere with your tolerance to stand for long periods?

None, pain Same as before		Some		I cannot stand
0% (☐	: ☐ : ☐ : ☐ : ☐ : ☐	) 100%		

Section VII: Sleeping

How much does pain interfere with your sleeping?

None, same as before		Some		I cannot sleep at all
0% (☐	: ☐ : ☐ : ☐ : ☐ : ☐	) 100%		

Section VIII: Social Life

How much does pain interfere with your social life (dancing, games, going out, eating with friends, etc.)?

None Same as before	Some	No activities total loss

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section IX: Travelling

How much does pain interfere with your travelling in a car?

None Same as before — Some — I cannot travel

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section X: Vocational

How much does pain interfere with your job?

None No interference — Some — I cannot work

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section XI: Anxiety/Mood

How much control do you feel have over the demands made on you?

Total (no change) — Some — None

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section XII: Emotional Control

How much control do you feel you have over your emotions?

Total (no change) — Some — None

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section XIII: Depression

How depressed have you been since the onset of pain?

Not depressed — Overwhelmed

by depression

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section XIV: Interpersonal Relationships

How much do you think your pain has changed your relationships with others?

Not changed Drastically changed

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section XV: Social Support

How much support do you need from others to help you during this onset of pain (i.e. taking over chores, fixing meals, etc.)?

None needed Some All the time

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

Section XVI: Punishing Response

How much do you think others express irritation, frustration or anger toward you because of your pain?

None Some All the time

0% (☐ : ☐ : ☐ : ☐ : ☐ : ☐) 100%

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Nevada Advanced Pain Specialists

Consent to Treatment

The undersigned, being of 18 years of age, does hereby consent to any mental health and/ or addiction examination, diagnosis or treatment, which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician or other provider licensed in the state of Nevada and working for Nevada Advanced Pain Specialists, and their agents and employees, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

This authorization shall remain in effect until _____, 20_____, unless sooner revoked in writing.

_____ _____

Date Signature

_____

Patient Name

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Behavioral Health Cancellation and Rescheduling Policy

To gain the most benefit from our office and to ensure that other clients 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 our schedule and you being late will affect the next client.

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 giving less than 24 hours' notice of cancellation, you will be charged $25. This is NOT covered by your insurance and this amount will have to be paid before scheduling another appointment.

If you miss (no show) more than 2 appointments or reschedule more than 2 initial evaluation appointments, you may not be seen ever again by behavioral health and other treatment referrals might be considered to re-evaluate your motivations for healing.

Thank you for helping us provide the best care possible.

Acknowledgement of Cancellation Policy

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

_____ _____

Date Signature

_____

Patient Name

NEVADA ADVANCED PAIN SPECIALISTS

PRIVACY PRACTICES NOTICE

The Effective Date of This Notice is _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

****

PRIVACY PRACTICES NOTICE

This page describes the type of information Nevada Advanced Pain Specialists ("NAPS") will gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information, except when the release is required by law, or permitted by law without your authorization.

If the practices described in this notice meet your expectations, there is nothing you need to do. If you prefer additional limitations on the use of your medical information, you may request them following the procedure below.

If you have any questions about this notice, please contact our Privacy Officer at the address below.

The regulations also require that we make a good faith effort to obtain your written acknowledgement that you have received this Notice. This is why you will be asked to sign this form at the end.

Who Will Follow This Notice

This notice describes practices of all of the persons and entities in NAPS regarding the use of your medical information and that of:

Any health care professional employed by or contracted with NAPS who is authorized to enter information into your hospital chart or medical record.

All departments and units of NAPS you may visit.

All NAPS employees, staff and other personnel who may need access to your information.

All entities, sites and locations of NAPS that follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes as described in this notice.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by NAPS, whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

a. keep confidential any medical information that concerns your condition or treatment, how your care is paid for and demographic information, if such information can be used to identify you;

b. give you this notice of our policies, procedures and information privacy practices with respect to medical information about you; and

c. follow the terms of the notice that is currently in effect.

Nevada Law

In addition to federal law, Nevada law places more stringent limitations on the disclosure and use of mental health information, genetic information, communicable disease information and blood and urine tests. Other federal regulations place more stringent requirements on drug and alcohol abuse information. We shall comply with those more stringent restrictions.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures we will try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different health care professionals also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside NAPS who may be involved in your medical care or that provide services that are part of your care.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, your insurance may need to know about treatment you received so they will pay us or reimburse you for the treatment. We may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance will cover the treatment, or to undertake other tasks related to seeking payment for services provided. We may also disclose medical information to another health care provider who is or has been involved in your treatment, so that that provider may seek payment for services rendered.

For Health Care Operations Purposes. We may use and disclose medical information about you for health care operations purposes. This is necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you, or to otherwise manage and operate NAPS effectively. We may also disclose information to doctors, nurses, technicians, training doctors, medical students, and other NAPS personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave NAPS. Otherwise, we will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to the person(s) threatened and/or someone able to help prevent the threat.

Special Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of

recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the overall health care system, the conduct of government programs, and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful order from a court.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Protective Services for the President, National Security and Intelligence Activities. We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official where the release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer at the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. In some circumstances, if you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the NAPS will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (i) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (ii) Is not part of the "designated record set" kept by the NAPS; (iii) Is not part of the information which you would be permitted to inspect and copy; or (iv) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. This accounting will not include many routine disclosures; including those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made to the facility directory as discussed above, those made for national security and intelligence purposes and those made to correctional institutions and law enforcement in compliance with law.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request additional restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

However, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply

Right to Opt Out of Electronic Transmission. Under Nevada law, you have the right to "opt-out" of electronic transmissions of your medical information. However, NAPS may not be able to provide care for you if you choose to exercise this right.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. If complying with your request entails additional expense over our usual means of communication, we may ask that you reimburse us for those expenses.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, please request one in writing from our Privacy Officer at the address below.

Changes To This Notice

We reserve the right to change our policies and practices concerning the privacy of your medical information and this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will always post a copy of the current notice in the patient waiting rooms. The notice will contain the effective date on the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with NAPS or with the Secretary of the Department of Health and Human Services. To file a complaint with NAPS, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Privacy Officer

The Provider's Privacy Officer is: *{Name, Mailing Address, Telephone, Fax, e-mail, other means of correspondence}*

Acknowledgement

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

Signature: _____ Date: _____

Print Name: _____

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy Practices Notice.

Date: _____

Name of Patient: _____

Reason for refusal/failure: _____

_____

Signature of NAPS Employee: _____

File Signed Copy of this Page with Patient's Record

NEVADA ADVANCED PAIN SPECIALISTS

AUTHORIZATION FOR THE RELEASE

OF PROTECTED HEALTH INFORMATION

This Authorization authorizes the release of Protected Health Information ("PHI") pursuant to 45 CFR Parts 160 and 164 and certain Nevada laws.

1. The undersigned authorizes Nevada Advanced Pain Specialists ("NAPS") to release the following information: (describe in a "specific and meaningful fashion")

_____

_____

_____

2. The information may be disclosed by employees or business associates of NAPS.

3. The information may be disclosed to: (insert name or other specific identification of the persons or entities to which the disclosure will be made)

_____.

I understand and agree that the information to be disclosed includes the following types of information which are protected under Nevada law:

3.1 _____ blood, breath or urine test results

3.2 _____ communicable disease information, including information about sexually transmitted disease, including HIV and AIDS.

3.3 _____ information about mental health treatment I have sought and/or received.

3.4 _____ information about drug and/or alcohol abuse treatment I have sought and/or received.

3.5 _____ psychotherapy notes (See **Note** at end of form.)

4. The disclosure may be made for the following purpose (describe specifically. If disclosure it at patient's request, "At request of patient" will suffice. If more than one purpose, describe each.)

_____

_____

5. This authorization will expire on (date) _____, or when (describe occurrence) _____.

6. I acknowledge: (i) that I have the right to revoke the authorization at any time, and (ii) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law. I understand that I may revoke this authorization only in a writing sent by certified mail to NAPS at 10715 Double R Blvd., Reno, NV 89521, Attn: Privacy Officer. The revocation will be effective only upon receipt, except (1) to the extent NAPS has acted in reliance on the

authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use to the protected health information to lawfully contest a claim. Further information on the right to revoke may be provided from time to time in the NAPS's Notice of Privacy Practices.

I understand that treatment by NAPS is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on an authorization to use PHI to determine payment.

Date:_____

Signed by :_____

Print Patient's Name: _____

If person signing is other than patient, state authority under which signature is made: _____

NOTE: If psychotherapy notes are to be disclosed, a separate copy of this authorization form must be used. An authorization for the release of psychotherapy notes cannot be combined with an authorization to release other protected health information.

The patient must be given a copy of this authorization.