KHAVKIN CLINIC

**Yevgeniy Khavkin, MD**
*Board Certified Neurosurgeon*
*Fellowship Trained Spine Surgeon*
**Ippei Takagi, MD**
*Board Eligible Neurosurgeon*
*Fellowship Trained Spine Surgeon*
**Sherif Al-Hawarey, MD**
*Board Certified Pain Management Physician*
**Arlyn Valencia, MD**
*Physician Assistant*
**Gavin Pope, PA-C**
*Physician Assistant*
**Hayley Washinsky, PA-C**
*Physician Assistant*
**Kimbrelle Pascua, APN**
*Nurse Practitioner*

Today's Date: _____

## PATIENT INFORMATION

Name: _____
First Middle Last

Mailing Address: _____
Street Address/P.O. Box City/State/Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Marital Status: ☒ Single ☐ Married ☐ Divorced ☐ Widowed

How did you hear about us? ☐ Insurance Co. ☐ Internet ☐ Magazine ☐ ER ☐ Family/Friend ☐ Radio/TV ☒ Other: _____

Referred by: _____ Primary Care Physician: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☒ Student

Occupation: _____ Employer: _____

Employer Address: _____

Is today's visit a work related issue? ☒ YES ☐ NO Is there legal litigation? ☐ YES ☐ NO

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

## BILLING INFORMATION

Primary Plan

Name

Insured Name

Relation To Patient

Insured DOB/Insured Social Security #

ID Number/Group Number

## WORKER'S COMPENSATION / ATTORNEY

Insurance Company / Attorney

Employer/Group Name

Adjuster Name

Claim Number/ Date Of Injury

Adjuster Phone Number

Do you have secondary insurance coverage? ☐ YES ☒ NO If so, please provide copy with your insurance card

## CONSENT TO TREAT

I consent to necessary medical treatment as recommended by my physician. I understand that insurance may not cover all recommended medical services, such as preventative health exams, immunizations, screening tests, detailed phone consultations, copies of medical records, preparations of reports and forms or summaries.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. These authorizations shall remain valid until written notice is given by my revoking said authorization.

Patient Signature: _____ Date: 04/17/2019

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## PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by my physician, office staff, and others outside of this office who is involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document.

Patient Signature: _____ Date: _____

## RELEASE OF INFORMATION

I authorized Khavkin Clinic to discuss information with the following:

☐ Family Members ☒ Coaching/Training staff at my school

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Signature: _____ Date: _____

## EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

Relation: _____

## THANK YOU FOR CHOOSING KHAVKIN CLINIC.

Khavkin Clinic is centered on compassionate, conservative and evidenced-based care with patient education being one of our highest priorities. We have organized our practice to include services that complement our treatment philosophy so that you can feel confident that you are receiving the best care possible:

- Electronic medical records
- Durable Medical Equipment (DME) to include lumbar and cervical braces.

If surgery is the treatment option recommended for you, our physicians are affiliated with Medical and Dental Center of Nevada.

This facility is staffed with experienced nurses and support staff who work closely with our physicians to provide the highest quality specialized care in an efficient and personal manner. This facility is equipped with state of the art equipment specific for spine patients who are having an outpatient procedure as well as those who require an overnight stay.

## FINANCIAL DISCLOSURE

We feel it is your right to know that our physicians have ownership in some of the surgical facilities listed above as permitted by both state and federal law.

If you have questions or concerns please let us know, we would be happy to discuss this further with you.

We appreciate the opportunity to serve you and your family and look forward to helping you feel better and get your life back!

Patient Signature: _____ Date: _____

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*Nurse Practitioner*

☒ New Patient ☐ Established Patient (New Problem) Today's Date: _____

Name: _____

DOB: _____ Age: _____ Sex: ☐ M ☒ F Height: _____' _____" Weight: _____ Lbs

Primary Care Physician: _____ Phone: _____

How did you hear about us? ☐ Doctor Referral ☐ Family/Friend ☐ Internet ☐ Insurance ☒ Other: _____

## HISTORY OF COMPLAINT

Is this a work related injury? ☐ Yes ☒ No

Is this a result of a motor vehicle accident or a slip and fall? ☒ Yes ☐ No

Date of Injury: _____

Describe how you were injured: _____

If this is not an injury, when did your pain start? _____

Location of pain: _____

Does pain radiate into extremities? ☐ Right Arm ☐ Left Arm ☐ Left Leg ☐ Right Leg ☒ Buttocks

Intensity: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ▪ 10

What helps with pain? _____ What makes pain worse? _____

## DRUG ALLERGIES

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

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## FAMILY HISTORY & SOCIAL HISTORY

| | Mother | Father | Grandmother | Grandfather | Sibling |
|---|---|---|---|---|---|
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ra | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ | ☐ | ☐ |

Do you smoke? ■ Yes ☐ No If yes, how many packs a day? _____ Number of years smoked: _____

Do you drink alcohol? ■ Yes ☐ No If yes, how many drinks a day/week? _____ / _____ Number of years drinking: _____

Do you exercise regularly? ■ Yes ☐ No If yes, how many days per week? _____ Number of years exercising: _____

## REVIEW OF SYSTEMS

When was your last physical examination? _____ ☐ More than 5 years ago

Have you ever had any of the following conditions? (Circle all that apply)

| | | |
|---|---|---|
| Cancer | High Blood Pressure | Blood Clots In Legs |
| Heart Disease | Migraine Headaches | Excessive Fatigue |
| Stroke | Hepatitis ( A B C ) | Irregular Heartbeat |
| Diabetes | Asthma | Previous Blood Transfusion |
| Seizures | Psoriasis | Headaches (Not Relieved By Medication) |
| Constipation | Depression | Difficulty Breathing |
| Other: _____ | Other: _____ | Other: _____ |

## PRIOR EVALUATION

Please list the name of any physicians/facilities you have been seen for your current condition:

_____

_____

_____

_____

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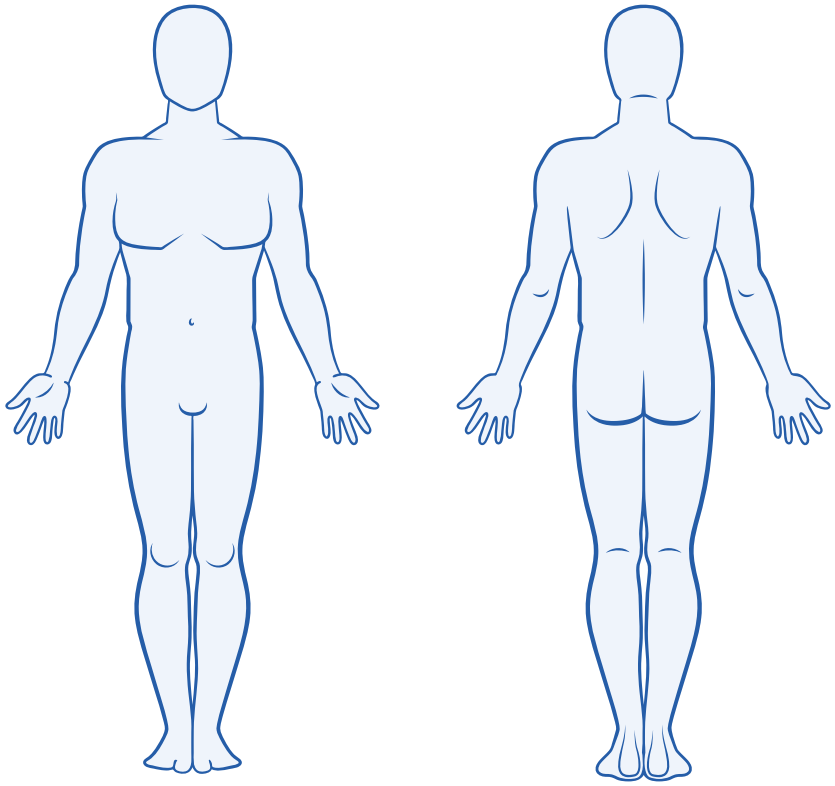
Please list any prior surgeries you have had:

| PROCEDURE | LEVELS | DATE |
|---|---|---|
| Lumbar Disc Surgery | | |
| Lumbar Fusion | | |
| Cervical Fusion | | |
| Other: | | |
| Other: | | |

On the body diagram below, please indicate where your pain is located at the present time.
Please do not indicate areas of pain that are not related to your present injury or condition.



Indicate which of the following you have tried for your pain and if it helped:

| | TRIED | HELPED | | TRIED | HELPED |
|---|---|---|---|---|---|
| Pain Management | ■ Yes ☐ No | ☐ Yes ■ No | Anti-inflammatory/NSAID | ☐ Yes ■ No | ☐ Yes ■ No |
| Epidural Steroid Injection | ■ Yes ☐ No | ■ Yes ☐ No | Chiropractic Therapy | ☐ Yes ■ No | ☐ Yes ■ No |
| Trigger Point Injections | ■ Yes ☐ No | ■ Yes ☐ No | Physical Therapy | ☐ Yes ■ No | ☐ Yes ■ No |

How long are you able to sit/stand comfortably? _____

How far are you able to walk? _____

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Patient Name: _____ D.O.B.: _____ Date: _____

Please include all prescribed medications, over the counter medications, vitamins, herbals, and supplements taken.
This list will be updated at each visit.

| DATE | MEDICATION | DOSE | FREQUENCY TAKEN | DISCONTINUED |
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Pharmacy Name: _____

Location: _____

Phone: _____ Fax: _____

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## AGREEMENT FOR NARCOTIC MAINTENANCE THERAPY

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your physician to comply with the law and CDC guidelines regarding controlled pharmaceuticals.

The long-term use of pain medication is somewhat controversial as there is a risk of developing dependency and abuse. It is necessary that the use of these narcotic pain medicines be accurately monitored and regulated. Please read and initial each of our policies:

____ All narcotic medication must always come from one physician as required by law. It is inappropriate as illegal for multiple physicians to be prescribing pain medications.

____ No refills will be allowed after 3:00 PM on weekdays and after 1:00 PM on Fridays. No refills provided on weekends. **DO NOT CALL ANSWERING SERVICE REQUESTING REFILL(S).**

____ Refills will not be given if you have not been seen in the office within the last 90-days.

____ Narcotic medications must all be obtained from same pharmacy. Filling prescriptions at multiple pharmacies in not acceptable. The prescribing physician is authorized to discuss all diagnostic and treatment details with the pharmacist at the dispensing pharmacy at any time.

____ Refills should be requested via your pharmacy not our office unless a change of medication needs to be discussed.

____ Medications will not be replaced if they are lost, fall in the toilet, eaten by pets, left on airplane, etc. If medications are stolen a police report must be filed in order to get a refill. Otherwise, early refills will not be authorized.

____ If it appears that narcotic medications are being used inappropriately and against medical advice the responsible legal authorities may be notified. All confidentiality is waived and consent is given by patient to provide the appropriate authorities with full access to the patient's records.

____ I understand that failure to adhere to these policies will result in permanent cessation of all narcotic medication by our physicians.

____ If you are under the care and/or being treated by a pain management physician you must obtain a release of care sent to our office before narcotic medication will be prescribed.

____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

____ In this case, my provider will NOT taper off the medicine over a period of several days, and you may experience withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

____ I would also be amendable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances.

____ I will not use alcohol while being prescribed this medications. I will be monitored for alcohol metabolites during random drug testing.

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____ I will not share my medication with anyone.

____ I will not attempt to obtain any controlled medication, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced under NO CIRCUMSTANCES.

____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. NO refills will be available during evenings or on weekends.

____ I agree to use only one pharmacy to fill all of my medications.

____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment period.

____ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will constitute a breach of this agreement.

____ I will bring unused pain medicine to every office visit.

____ I agree to follow these guidelines that have been fully explained to me.

## I HAVE READ AND AGREED TO THE ABOVE MENTIONED TERMS:

Patient Signature: _____ Date: _____

**I obtain my pain medication from my primary physician/pain management doctor:**

Dr. _____ and will continue to do so until I discuss these changes with one of our physicians.

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____

☐ PATIENT REFUSED TO SIGN

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Patient Name: _____ D.O.B.: _____ Date: _____

## OFFICE POLICIES

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our office and financial policies as an essential element of your care and treatment. Please read the following carefully. If you have questions about your account, charges, insurance, or payments, please speak with one of our representatives.

Office hours are 9 :00am to 5:00pm Monday through Friday. All routine telephone calls to the office should be made during these hours.

## INSURANCE PLANS

If you are insured, we will bill those insurance plans with which we have an agreement. However, it is ultimately your responsibility to become familiar with the details of your insurance plan coverage. To find out what your insurance plan covers and what your financial obligation may be, we strongly recommended that you call the customer service or member services department of your insurance company (the phone numbers are on your insurance card) prior to your first visit. Your deductible that is due at the time of the visit. In the event that your health plan determines a service to be "non-covered," we will bill you, and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you. If your insurance coverage is with a plan that we do not have an agreement, payment is expected, in full, at the time of service. As a courtesy, we will submit a claim to your insurance company on your behalf.

You are responsible to notify us of your insurance, any changes to your insurance, and to provide the necessary information about your insurance plan (or plans if you have more than one coverage); therefore, please have your current insurance card(s) with you at all times, as well as your prescription card (if different).

## MEDICARE

Khavkin Clinic is a participating Medicare provider. Not all Medicare patients have traditional Medicare. If you have signed up for a Medicare Advantage Plan, it Is your responsibility to verify if our doctors are participating providers with your specific plan. Most Medicare Advantage Plans require prior authorization or referrals from your primary care provider or IPA. If you have a Medicare Advantage Plan, you are responsible for obtaining prior authorization and/or referral for your initial visit. We will request authorization for follow up visits and surgeries. If you have traditional Medicare we will collect the estimated coinsurance at the time of service. If you have a Medicare Advantage Plan, we will collect your specialist co-pay at the time of service. Any amount not paid by your insurance company within 30 days will be billed to you. If your insurance coverage is with a plan that we do not have an agreement or if you do not have the required prior authorization, payment is expected, in full, at the time of service. As a courtesy, we will submit a claim to your insurance company on your behalf.

## MEDICAID

Khavkin Clinic is a participating Medicaid provider for Nevada Medicaid and Arizona Medicaid. Not all patients have traditional Medicaid. If you have signed up for a Medicaid HMO, it is your responsibility to verify if our doctors are participating providers with your specific plan. Most Medicaid HMO Plans require prior authorization or referrals from your primary care provider or IPA. If you have a Medicaid HMO, you are responsible for obtaining prior authorization and/or referral for your initial visit. We will request authorization for follow up visits and surgeries. If your insurance coverage is with a plan that we do not have an agreement with or if you do not have the required prior authorization, payment is expected, in full, at the time of service.

## SELF-PAY ACCOUNTS

If you do not have a valid insurance plan to cover the cost of our services, you will be required to make full payment at the time of service.

## I HAVE READ AND AGREED TO THE ABOVE MENTIONED TERMS:

Patient Signature: _____ Date: _____

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## HIPAA COMPLIANT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____

Patient's Name: _____

Effective Date: _____

Expiration of authorization of release of information: _____

I, _____ hereby authorize the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.

Specific Information that may be used/disclosed: All Medical Records, Radiology Reports, Office Visit/Consultation Notes, Progress Reports, Lab Results, Testing Results.

Information will be used/disclosed for the following purpose(s): **CONTINUITY OF CARE**

Persons/organizations authorized to use or disclose the information:

_____

Phone: _____ Fax: _____

**Persons/organizations authorized to receive the Information:**

KHAVKIN CLINIC
653 N. TOWN CENTER DRIVE, SUITE# 602
LAS VEGAS, NEVADA 89144
PHONE: (702) 888-1188 FAX: (702) 673-1155

I understand that this authorization Is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment I understand that I may inspect or copy the information used or disclosed. I understand that I may revoke this authorization at any time by notifying KHAVKIN CLINIC in writing, except to the extent that:

a) Action has already been taken as a result of this authorization; or

b) If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that I have a right to request and receive a Notice of Privacy Practices from KHAVKIN CLINIC.

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
If not signed by patient, print name of Personal Representative | Description of Personal Representative's Authority

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Patient Name: _____ D.O.B.: _____ Date: _____

## PATIENT HIPAA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

**Acknowledgment of Practice's Notice of Privacy Practices:**
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices {NPP) and agree to its terms.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
If not signed by patient, print name of Personal Representative Description of Personal Representative's Authority

Above signature was not obtained because:

☐ Patient is unable to sign and is unaccompanied by a representative. Patient left with all pertinent disclosures.

☐ Patient refused to sign.

☒ Patient refused forms.

## DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

| Print Name | Relationship to You | Telephone # | What we may disclose |
|---|---|---|---|
| | | | ☐ Any and all info<br>☐ Pre/Post procedure instructions<br>☒ Appointment info only |
| | | | ☐ Any and all info<br>☐ Pre/Post procedure instructions<br>☒ Appointment info only |
| | | | ☐ Any and all info<br>☐ Pre/Post procedure instructions<br>☒ Appointment info only |

## REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

| | | |
|---|---|---|
| **Home Phone:** | | ☒ OK to leave message with detailed information<br>☐ Leave message with callback number only |
| **Cell Phone:** | | ☐ OK to leave message with detailed information<br>☒ Leave message with callback number only |
| **Email Address:** | | ☐ OK to leave message with detailed information<br>☒ Leave message with callback number only |

_____ _____
Patient or Personal Representative Date