SILVER STATE NEUROLOGY | DR. CHRISTOPHER MILFORD

DATE_____ 2585 Montessouri Street Suite 100, Las Vegas, NV 89117 Phone 702-272-0694 Fax 702-272-0659

PATIENT INFORMATION - INFORMACION DE PACIENTE

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, M.I.) - NOMBRE DE PATIENTE (APELLIDO, NOMBRE, M.I.)				SSN - SEGURO SOCIAL
TELEPHONE - TELEFONO	SEX - SEXO	DOB - FECHA DE NACIMIENT	AGE - EDAD	MARITAL STATUS - ESTADO MATRIMONIAL
PATIENT ADDRESS - DIRECCION				APT / SPACE / UNIT #
CITY - CIUDAD			STATE - ESTADO	ZIP CODE - ZONA POSTAL
PATIENT'S GAURDIAN NAME - NOMBRE DEL PERSONA RESPONSIBLE			GUARDIAN'S OCCUPATION - OCUPACION	
GUARDIAN'S EMPLOYER'S ADDRESS - DIRECCION DEL EMPLEADOR				TELEPHONE - TELEFONO
CITY - CIUDAD			STATE - ESTADO	ZIP CODE - ZONA POSTAL

NOTIFY IN CASE OF AN EMERGENCY -NOTIFICA EN CASO DE EMERGENCIA	TELEPHONE - TELEFONO	RELATIONSHIP - RELACION	
EMERGENCY ADDRESS - DIRECCION	CITY - CIUDAD	STATE - ESTADO	ZIP CODE - ZONA POSTAL

RESPONSIBLE PARTY - REPRESENTABLE DE RESPONSIBLE

RESPONSIBLE PARTY

GUARANTOR NAME (LAST, FIRST, M.I.) - PERSONA RESPONSIBLE			SSN - SEGURO SOCIAL
GUARANTOR ADDRESS - DIRECCION			TELEPHONE - TELEFONO
CITY - CIUDAD		STATE - ESTADO	ZIP CODE - ZONA POSTAL
GUARANTOR EMPLOYER - EMPLEADOR		OCCUPATION - OCUPACION	
GUARANTOR EMPLOYER'S ADDRESS - DIRECCION DEL EMPLEADOR			TELEPHONE - TELEFONO
CITY - CIUDAD		STATE - ESTADO	ZIP CODE - ZONA POSTAL

MD

Is this visit the result of an accident?	REF. DOCTOR - DOCTOR DE FREFERENCIA	HOW DID YOU HEAR ABOUT OUR OFFICE?

INSURANCE INFORMATION - ASEGURANZA INFORMACION

PRIMARY INS

PRIMARY INSURANCE CO - PRIMARIA ASEGURANZA			TELEPHONE - TELEFONO
ADDRESS - DIRECCION	CITY - CIUDAD	STATE - ESTADO	ZIP CODE - ZONA POSTAL
POLICY HOLDER'S NAME - NOMBRE DE EL ASEGURADO	DOB - FECHA DE NACIMIENTO		SSN - SEGURO SOCIAL
RELATIONSHIP TO PATIENT - RELACION CON I	POLICY HOLDER'S EMPLOYER - NOMBRE DEL EMPLEADOR DEL ASEGURO		
POLICY NUMBER - NUMERO DE POLIZA	GROUP NUMBER - NUMERO DE GRUPO		EFFECTIVE DATE - FECHA DE EFECTO

SECONDARY INS

SECONDARY INSURANCE CO - ASEGURANZA SEGUNDARIA			TELEPHONE - TELEFONO
ADDRESS - DIRECCION	CITY - CIUDAD	STATE - ESTADO	ZIP - ZONA POSTAL
POLICY HOLDER'S NAME - NOMBRE DE EL ASEGURADO	DOB - FECHA DE NACIMIENTO		SSN - SEGURO SOCIAL
RELATIONSHIP TO PATIENT - RELACION CON I	POLICY HOLDER'S EMPLOYER - NOMBRE DEL EMPLEADOR DEL ASEGURO		
POLICY NUMBER - NUMERO DE POLIZA	GROUP NUMBER - NUMERO DE GRUPO		EFFECTIVE DATE - FECHA DE EFECTO

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the signature is as valid as the original. A fee will be charged if I do not call 24hrs prior to canceling your appointment(s). - La information obtenida es completa y correcta. Por este medio usted autoriza el desclosamiento de informacion necesaria al hacer reclamos con mi aseguranza. Tambien asigno benefecios que de otra manera serian pagados a mi a que sean asignados a mi doctor o grupo indicado en el reclamo. Yo entiendo de que soy responsible por doctors los cargos relacionados a servicios medicos prestados independientemental tipo de aseguranza. Vas a pagar si no llamas 24hr para cancelar su cita(s).

PATIENT SIGNATURE	GUARANTOR SIGNATURE	DATE

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NEUROLOGY

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DATE: _____ NAME: _____ DOB: _____

PATIENTS: PLEASE COMPLETE THIS QUESTIONNAIRE BEFORE YOU SEE THE PHYSICIAN.

The information you and the answers provided are essential for a thorough evaluation. The following pages include questions regarding your medical history, and family and circumstances the event occurred. Please check the question and print you response in the given space as appropriate. If you do not know the answer to a given question, or if it is not applicable in your case, leave it blank. This information will be used to help the physician to understand about you and any of your medicine history; in order to make a diagnosis, decides about specific treatment plan and you general care.

This information will be kept strictly confidential.

Thank you

What do you see as your main problem or concern?

Describe when and in what circumstances it started and your physical location, what part of the body it affects, if it is still worsening?

What medicines, surgery, and therapy, if any, have you already tried for your condition?

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The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses.. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	

Total score= _____

Analyze Your Score

Interpretation:

- 0-7: it is unlikely that you are abnormally sleepy
- 8-9: you have an average amount of daytime sleepiness
- 10-15: you may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
- 16-24: you are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness. The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5.

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Sleep Study Pre-Screening Questionnaire & Epworth Sleepiness Scale

FIRST NAME: DOB: HEIGHT:

MIDLE INTIAL: GENDER: M F WEIGHT:

LAST NAME: NECK SIZE:

HAVE YOU BEEN DUAGNOSED OR TREATED FOR ANY IF THE FOLLOWING CONDITIONS? PLEASE CIRCLE YES OR NO.

High Blood Pressure	YES	NO	Heart Disease	YES	NO
Diabetes	YES	NO	Lung disease	YES	NO
Insomnia	YES	NO	Narcolepsy	YES	NO
Morning Headaches	YES	NO	Stroke	YES	NO
Depression	YES	NO	Sleep Apnea	YES	NO
Nasal Oxygen Use	YES	NO	Restless Leg Syndrome	YES	NO
Sleeping Medication	YES	NO	Pain Medication	YES	NO

SLEEP QUESTIONS:

PLEASE CIRCLE YES OR NO.

Do you snore?	YES	NO
Is your snoring interrupted by pauses or choking?	YES	NO
Has anyone ever said that you stop breathing or have pauses in your breathing during your sleep?	YES	NO
Do you have problems keeping your legs still at night r need to move them to feel comfortable?	YES	NO
How many hours of sleep do you usually get per night	YES	NO
Do you know the recommended amount of sleep per night is 7-9 hours?	YES	NO
Do you feel fatigues, exhausted or tired?	YES	NO
Do you feel that in some way your sleep is not refreshing or restful?	YES	NO
Do you have periods of the day when you have trouble paying attention, remembering things or staying awake?	YES	NO

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FINANCIAL POLICY

We are committed to providing you with the best possible care. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance contract is between you and your employer and the insurance company, we are not party to that contract. All charges are you responsibility from the date of service rendered. We realized that insurance companies need processing time, however all charges will become due and payable if the insurance company does not reimburse Silver State Neurology within 90 days or within the guidelines mandated by the NV state Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. Many companies require a referral from the primary care physician. We will attempt to obtain these as a courtesy; however, the policy holder must be pro-active in assuring the requirements are met prior to the visit.

If you have medical insurance, with whom we are contracted we will bill your insurance company. All deductibles, co-payments and non- covered items are due at the time of check-in.

Collection Fees Policy

I, _____ (patient/ guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/ legal fees that may be added to my account.

_____ _____

Signature of patient, parent/ guardian Date

Returned Checks: A $25 non-sufficient funds fee will be charges for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's office.

IINITIALS _____

No Show Fees: there is a $25.00 no-show/late-cancellation fee for office visits and $75.00-$150.00 fee for testing appointments. All appointments must be canceled by 3 p.m. of the previous day. Insurance will not cover charges for no show or late cancelations. INITIALS _____

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Patient Communication Authorization

Name _____ Date of Birth: _____

PLEASE LIST CONTACT PHONE NUMBERS:

Home _____

Other _____

IF YOU ARE NOT AVAILABLE MAY WE LEAVE A VOICE MESSAGE OR EMAIL YOU?

- o NO DO NOT LEAVE A VOICE MESSAGE
- o YES, LEAVE A VOICE MESSAGE
- o EMAIL _____

IF YOU ARE NOT AVAILABLE- WHO MAY WE COMMUNICATE WITH?

- o COMMUNICATE WITH SELF ONLY

Please check all that apply.

- o SPOUSE (Name)_____ PHONE _____
- o ANY INFORMATION
- o APPOINTMENT INFORMATION

- o CHILD (Name) _____ PHONE _____
- o ANY INFORMATION
- o APPOINTMENT INFORMATION
- o OTHER (Name) _____ PHONE _____

(Relationship to Patient) _____

- o ANY INFORMATION
- o APPOINTMENT INFORMATION

_____ _____
Patient Name of legal representative Date

_____ _____
Patient Signature or legal representative Witness

Please notify us of any changes

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Christopher Milford M.D.

PLEASE READ AND RETURN TO FRONT DESK

Notice of Policy Practices

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.

Use and Disclosures

- Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
- Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for *services*.
- Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Christopher Milford, M.D. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
- Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law- enforcement investigations, and to comply with government mandated reporting.
- Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states' public health department.
- Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

- Appointment reminders. Your health information will be used by our staff to sent you appointment reminders.
- Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and service that we believe may interest you.

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Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning you medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to you protected health information
- The right to receive an accounting of how and to who your protected health information has been disclosed
- The right to receive a printed copy of this notice

Christopher Milford, M.D. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice,

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify' our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information

You may generally inspect of copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk or Office Supervisor. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like t o submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Christopher Milford, M.D.
2585 Montessouri St., Ste. 100
Las Vegas, NV 89117

If you believe that your privacy rights have been violated you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint

Contact Person

The name and address of the person yo can contact for further information concerning our privacy practices is:

Privacy Officer
Christopher Milford, M.D.
2585 Montessouri St., Ste. 100
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702-272-0694

Effective Date This Notice is effective on or after April 14, 2003.

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Christopher Milford, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

Christopher Milford, M.D. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the notice of Privacy Practices for Christopher Milford, M.D.

Name of Patient (Print of Type):_____

Signature of Patient:_____

Date: _____

Signature of Patient Representative:_____

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient: _____

**********For Office Use Only**********

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices
Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- o The patient was undergoing emergency treatment
- o The patient declined to sign the acknowledgement
- o Other _____

Signature: _____

Name of Patient (Print or Type): _____

Name of Staff Member: _____

Date: _____

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMTION PURSUANT TO NRS 45 CFR164.508

TO: _____

Name of Healthcare Provider/ Physician/ Facility

RE: Patient Name: _____ Date of Birth: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: Office notes, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, progress notes, clinic records, treatment plans, test results, histories, photographs, telephone messages, and records received by other medical providers.

All radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, video/CDs/films and reports.

You are authorized to release the above records in the above-entitled matter to supply copies of such records to:

Silver State Neurology

2585 Montessouri St. Ste100

Las Vegas, NV 89117

I understand the following":

A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
B. The information released in response to this authorization may be re-disclosed to other parties.
C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Name of Patient _____ Date _____

Signature of Patient _____ Witness _____

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NARCOTIC AGREEMENT

This is an agreement between _____(me, the patient) and Silver State Neurology (my providers). It explains how I receive my medication(s) (pain medication, narcotics, muscle relaxers, sleeping medication(s) and/or other controlled drugs prescribed). I agree to take my medication responsibly and to follow all orders.

1. I agree to use the following pharmacy only:

   Name: _____ Location: _____
2. I will attend all of my office visits. I will come in immediately, if asked.
3. I will not go to the ER or to other providers for these or similar medications.
4. I will bring my medication bottles to my appointment if instructed to do so.
5. I am personally responsible for my medications. I will treat them as my other valuables. I understand that they will not be replaced if lost, stolen, or destroyed.
6. I will not give my medication(s) to anyone else or take anyone else's medication(s).
7. I will not request early refills or take more than the prescribed amount.
8. For safety reasons, refill requests will only be honored at the time of my appointments.
9. I will inform my doctors of any new medication(s) or medical conditions.
10. I agree to allow Silver State Neurology to perform urine tests as needed to make sure I use my medication correctly.
11. I will not operate a car or other equipment when I use my medication(s) unless approved to do so.
12. It is my responsibility to comply with applicable laws while taking these medication(s).
13. I will not use alcohol or illegal drugs when using these medication(s).
14. I understand that there can be side effects from these medication(s) including sedation, itching, nausea, vomiting, difficulty urinating, constipation, and/or other problems.
15. I understand that these medication9s) could cause dependence.
16. I understand that suddenly stopping these medication(s) may be dangerous.
17. If I violate these conditions, my provider may not refill the medication(s) and may require that I obtain help to decrease my use of the medication(s).
18. I know that violating these conditions may result in my dismissal from the practice with no more than a 30 day notice.
19. I further agree that my pain medication(s) or other prescriptions may be stopped or decreased at any time for any reason, by my providers.
20. I will be completely honest about my use of these and all other medication(s). I will ask questions if I do not understand something or if I feel that I may be having trouble with the medication(s).
21. Finally, I understand that the above is not a complete list. I will be careful and will exercise caution and common sense.

_____ _____
Patient Name Date

_____ _____
Patient Signature Witness

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