Dear Patient:

Welcome to The DOCS. Thank you for allowing us the opportunity to assist you with your healthcare needs. We value all our patients and are committed to providing you with high-quality, healthcare services.

This packet includes all the patient forms that will need to be completed in for us to assist you with your care.

1. Intake Form
2. Office Policies
3. HIPAA Brochure
4. HIPAA Acknowledgement
5. Authorization for Use and Disclosure of PHI

Please take a few moments prior to your appointment to review and complete the registration forms. We ask that you bring the completed forms to your appointment along with your insurance card.

Please arrive 15 minutes early to your appointment. The physicians and the staff at The DOCS are looking forward to assisting you with your health care needs. If you have any questions, please call the numbers below and someone will be happy to help you.

Sincerely,

The DOCS

The DOCS Intake Form

Date: _____

Patient First Name: _____MI _____ Last Name: _____

Mailing Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip: _____

Primary Phone ☐Cell ☐ Home: _____Secondary Phone ☐ Cell ☐Home: _____

SSN: _____ Date of Birth: _____ Marital Status: M S D W

Sex: F M Identifying As: F M Employer's Name: _____ Work Phone: _____

Email Address: _____ Web Enable: Y or N (for our patient portal and/or Twistle)

Race: _____(optional) Ethnicity: _____(optional) Language: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

Referring Physician Name:_____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Preferred Pharmacy Name: _____ Phone: _____ Cross Streets: _____

Health Insurance Information (ALL FIELDS ARE REQUIRED)

Primary Insurance Name: _____Customer Service Phone: _____

Policy Holder Name: _____ SSN: _____Date of Birth: _____

Phone: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

Secondary Insurance Name: _____ Customer Service Phone: _____

Policy Holder Name: _____ SSN: _____ Date of Birth: _____

Phone: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

- The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to be payable to The DOCS.

Signature: _____ Relationship to Patient: _____Date: _____

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Pain Diagram

Date: _____
Patient Name: _____

Please indicate on the chart the location of your pain: Please check the words that best describe your pain:

___Aching ___Sharp
___Burning ___Hot
___Dull ___Cold

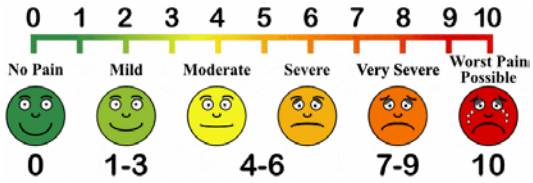
___Numb ___Throbbing

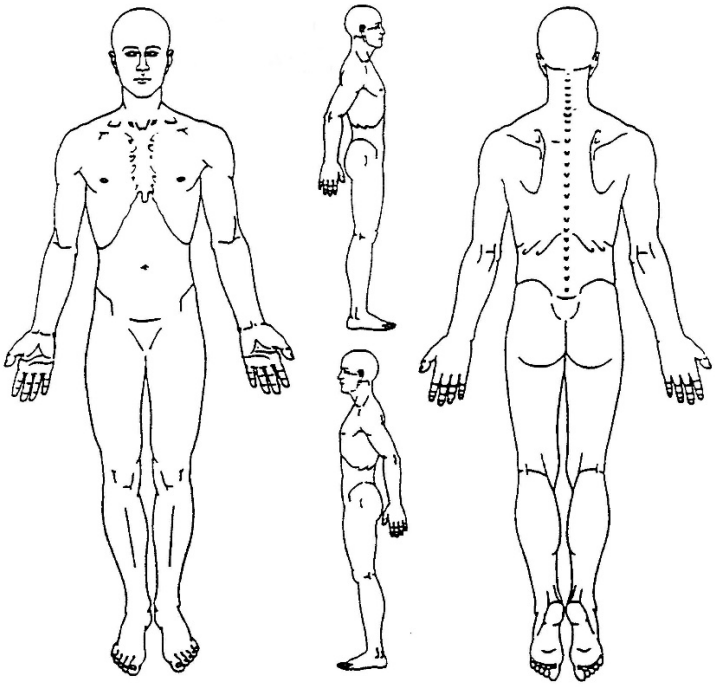
___Nagging ___Tingling
___Stabbing ___Shooting

Is your pain constant or intermittent?
___Constant ___Intermittent

How long have you had this pain?
_____

Intensity of pain (Circle a Number):





What brings on your pain or makes it worse? _____
What makes it better? _____
Does your pain limit your activities? ___YES ___NO
If so please explain: _____
Does the pain affect your sleep? ___YES ___NO
If so please explain: _____
Is the pain the result of an illness or injury? ___YES ___NO Job related? ___YES ___NO
If so please explain (including the date of the illness or injury): _____
_____
Are you currently working? ___YES ___NO What is your occupation: _____
If not, please explain: _____

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Functional Activities Questionnaire

Administration

Ask informant to rate patient's ablility using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did (the activity) but could do now = 0
- Never did and would have difficulty now = 1

Writing checks, paying bills, balancing checkbook	
Assembling tax records, business affairs, or papers	
Shopping alone for clothes, household necessities, or groceries	
Playing a game of skill, working on a hobby	
Heating water, making a cup of coffee, turning off stove after use	
Preparing a balanced meal	
Keeping track of current events	
Paying attention to, understanding, discussing TV, book, magazine	
Remembering appointments, family occasions, holidays, medications	
Traveling out of neighborhood, driving, arranging to take buses	
Total Score:	

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Pain Patient Medical History

Date:_____
Name: _____

Previous Treatments:
Please check any of the following treatments you may have had, including the date and result if possible.

			Dates	Did this help you?	
Physical Therapy	Yes	No	_____	Yes	No
Nerve Blocks/Epidurals	Yes	No	_____	Yes	No
Traction	Yes	No	_____	Yes	No
Acupuncture	Yes	No	_____	Yes	No
Chiropractic	Yes	No	_____	Yes	No

Others (Please include all medications which were tried in the past)
_____

Surgeries/Illnesses:
Please list all past surgical procedures, significant illnesses or injuries.

Surgery, Illness or Hospitalization	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Allergies:
List any allergies to medications: _____

Are you allergic to X-ray dye (Iodine)? Yes ☐ No ☐ Shellfish? Yes ☐ No

Medications:

Medication	Dosage	Frequency	How long have you taken it?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

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Pain Patient Checklist

	Performed	Date
1. Screening Labs	Yes / No	
2. Neurocog Eval.	Yes / No	
3. Functional Ass.	Yes / No	
4. Imaging	Yes / No	
5. Procedures		
6. Supplements		

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Office Policies

Required for Each Visit

- **THE PATIENT**
- Current insurance card(s)
- Driver's License or other state/government issued picture ID
- Co-pay for the day's visit (cash, Visa, Mastercard or Discover)
- Deductible that may be due for the day's visit
- Payment for any existing balance from previous billing
- List of/or current medications
- Any pump or meter device you use (should upload online prior to arrival)
- Any recent lab or testing results
- Referral if we do not have one on file and your insurance requires it

Walk in Appointments

We will not disrupt our regularly scheduled patients to accommodate a walk-in appointment, unless it is a true emergency. Call the office and speak to our staff if you feel you or your child needs to come to the office that same day.

Late Appointments

Because of our physicians' schedules, we may ask you to reschedule if you arrive to the office more than 15 minutes past your appointment time. Late arrivals cause appointments arriving on time to be late. Continuous late arrivals may result in discharge from the practice.

Cancellation and Missed Appointments

If it is necessary to cancel your appointment, we require that you cancel **AT LEAST 24 HOURS** prior to the appointment time. Failure to cancel the appointment with sufficient notice will result in a $50 fee for office visits. As a courtesy we provide appointment reminders, however, **you are still responsible for the cancellation even if you did not receive a reminder.** We reserve the right to discharge you from the practice for missing appointments frequently.

After Hours Calls

Our physicians are available on call 245 hours/day-365 days/year for calls of a truly urgent nature. Since our practice is charged per call for after hours calls to the nurse advice line, non-urgent calls made after hours may be charged $15.00 per call.

Initials:_____

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Prescription Refill/Prior Authorization

We require regular office visits for **ALL** of our patients taking prescription medication. It is recommended to ask for refills if necessary during the visit with your physician. If you do not and therefore call back later with your requests or your pharmacy submits a request on your behalf, **please allow 24-48 hours to complete the request. However, if prior authorization is required, please allow 7-10 business days.** Keep in mind that we cannot control how long it may take for you insurance to grant approval and we cannot guarantee that approval will be granted at all. In some cases the process can take several weeks and still result in us needing to change your medication due to your insurance companies formulary or policies. Also, if you are overdue for follow up, and or lab testing, your request may be denied or only partially filled until you complete the testing and follow up**. It is your responsibility to give us you current preferred pharmacy information at each visit.**

Social Media

In an effort to ensure fair and honest patient feedback, and to prevent the publishing of libelous content in any form, by accepting and signing this clause, you agree not to post any complaint or negative review to any platform of social media without allowing us 90 days from the day of service to resolve any issue pertaining to any service, including but not limited to: billing issues, medication requests, consultation issues, laboratory tests, clinical procedures, problems with attending physicians or any problems with clinic staff. Should you violate these terms, you will be provided a seventy-two (72) hour opportunity to retract the content in question. If the content remains, in whole or in part, it is hereby agreed that the dispute shall be referred for binding arbitration.

Insurance, Billing and Patient Responsibility

The DOCS understands that insurance information can be confusing and overwhelming. Every plan is different, and it is critical to know what services your plan will cover and what services will become your responsibility. We recommend that you read and understand the "Summary of Benefits and Coverage Guide," provided by your health plan or contact your health insurance provider and/or your HR department at work to assist you with this. **We have provided the following definitions to help you:**

- **Deductible:** the amount you owe for health care services before your health insurance plan begins to pay.
- **Coinsurance:** Your share of the costs of health care service, calculated as a percentage (for example, 20%) of the total cost. This generally is in addition to your assigned co-pay.
- **Co-Pay:** A fixed amount (for example, $15) you pay each time you see a physician. Your insurance requires you to have payed this fee prior to them covering the associated service.

We are contractually obligated by your insurance company to collect your co-pay at the time of service.

Initials:_____

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Your co-pay is also required at each follow up visit. If we have information that you have not met your deductible at the time of service, **we will collect any applicable deductible amount at the time of service.**

As a courtesy to our patients, The DOCS will bill your primary and secondary insurance companies. Please remember that **your insurance is a contract between you and the insurance company, not the doctor.** You are responsible for balances after primary insurance has paid and payment in full is due within 60 days of receipt of the statement. We participate with **most** plans, but if we do not accept your insurance, you will be responsible for the entirety of the visit charges.

Your insurance may require that you receive a referral from your primary care provider. If this is the case, please make sure that your doctor sends that over to our office, so that your visit will be covered. If we do not receive this information, we will bill the visit directly to you. It is not our responsibility to obtain the referral.

If you are uninsured, we do offer "cash-pay discount prices" on our services. Feel free to ask our staff for details.

We accept cash, Mastercard, Visa and Discover. **We do not accept American Express or personal checks at check-in. If paying cash, please come prepared with bills no larger than $20.**

If your account balance is not paid in full after 60 days following receipt of the statement, your account by be referred to collections:

Should my account be referred for collection to an attorney, collection agency or another collection service, I agree to pay the costs of collection, including but not limited to attorney fees, court costs and other reasonable collection fees as may be assigned. Additionally, an interest rate of 10% monthly or 10% annually may be charged until my financial obligation is paid in full. Furthermore, I understand that until my account is paid in full that the total amount owed may increase due to interest assessed.

By signing below, the responsible party acknowledges that he or she has read and understood the financial policy of The DOCS and is bound by the terms and conditions set forth therein. You also understand that failing to sign this agreement may result in discharge from the practice.

Signed _____ **Date_____**

Patient Name _____ **Date of Birth_____**

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Medication Management Agreement

_____
Patient Name

This agreement is between the above-named Patient and Physician for the purpose of establishing clear conditions for the prescription and use of pain-controlling medications or controlled substances prescribed by the Physician for the Patient. Both parties agree that the agreement is essential in maintaining the trust and confidence in the Physician/Patient relationship.

When controlled substances (opiates, narcotics, sedatives) are prescribed, communications must be clear, because the Drug Enforcement Administration (DEA) monitors the prescribing and use of these medications closely. It is understood that these medications do not cure pain conditions, and may cause other problems. The main goal is this therapy is to reduce pain and improve the Patient's quality of life (physical and vocational functioning).

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Physician:

1. I will have <u>one</u> physician or medical provider prescribing pain medication for me while I am being treated by Scott Martin, MD, **with the following exceptions:** an urgent or emergency situation or for post-surgical pain. I will notify any other treating physicians of this contractual agreement, and will notify Scott Martin, MD (with 24 hours)of the reason for the requesting or needing additional pain medication from another physician or medical provider.
2. I will have only <u>one</u> Pharmacy dispensing my pain medication while I am a patient of Scott Martin, MD.
   Pharmacy:_____located at: _____
3. I realized that these medications are regulated by the federal Drug Enforcement Agency (DEA)I agree not to share, sell, or trade my medication for money, goods, services, or any other purposes.
   a. I agree to safeguard my medication from loss or theft by keeping them in a secure or locked location, and that the consequence of my failure to do is that I will be without my prescribed medication until next scheduled refill date, and that I may be subject to discharge from Scott Martin, MD if I fail to comply with this. In addition, the following rules apply: Medications <u>will not</u> be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication is stolen and I file a proper police report regarding the theft, an exception may be made. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might have access to them.
   b. Only the patient (no one else) will use the medication prescribed by Scott Martin, MD.
   c. There will be random calls to pharmacies to confirm that the patient is not receiving controlled medications from other sources.

d. Refills will only be addresses during regular office hours. There will be no refills on evenings or weekends. Your medication(s) will only be refilled as scheduled.

4. If you do not have a follow up appointment on or before your refill due date, please call the office 72 hours prior to your refill due date. I f you do not call within 72 hours, your refill may be delayed. I understand that I must have a primary care doctor or provider (PCP) at all times while being treated at Scott Martin, MD I also understand that once my condition is stable and requires maintenance only, that my PCP will assume/resume prescribing my pain medications.
5. I agree that I will submit to random blood or urine toxicology screening if requested by any of my physicians or providers, to determine my compliance with my pain medication regimen.
6. I agree that I will use my medication as prescribed, and will not take it at a rate, dose or route other than that prescribed. If I do not take the medication(s) as prescribed, then I will be subject to discharge from the care of Scott Martin, MD.
7. I agree not to use or distribute any illegal or illicit drugs, medications or substances. If I do not comply with this condition I understand that I will be subject to discharge from the care of Scott Martin, MD.
8. I waive any applicable right or privilege of confidentiality with respect to the prescribing of any pain medication, and I authorize the prescribing physician and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency or authority in misuse, sale, or other diversion of my pain medication. I authorize Scott Martin, MD to provide a copy of this agreement to my pharmacy, my PCP, and acknowledge that I have received copy myself.
9. I waive any applicable right or privilege of confidentiality with respect to the prescribing of any pain medication, and I authorize the prescribing physician and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency or authority in misuse, sale, or other diversion of my pain medication. I authorize Scott Martin, MD to provide a copy of this agreement to my pharmacy, my PCP, and acknowledge that I have received copy myself.
10. I agree to bring all of my unused pain medications, and all empty pain medication containers, boxes or bottles to all of my appointments.
11. I agree that any discussion about my treatment or changes to my pain medication regimen will take place only during my appointments, and not on the phone, by e-mail, or letter.
12. I agree to allow the Physician/Provider at Scott Martin, MD to discuss my medical care with any of my other medical care providers or physicians.
13. I will telephone Scott Martin, MD only for **urgent** medical problems, or to change or discuss my appointment schedule.
14. I understand that I will be periodically re-evaluated and my case reviewed. If it is determined that I am improving in function or quality of life, as well as pain relief, then my pain medications may be tapered and/or discontinued.
15. I agree that this agreement is essential to my medical care, and all of my physicians' ability to treat my pain effectively, and that failure on the part of the Patient (myself) to comply with the terms of this Agreement may result in the withdrawal of all prescribed medication by the

Physician/Provider Scott Martin, MD, and the termination of the physician-patient relationship, with immediate discharge from Scott Martin, MD.

16. I understand that is I am discharged from Scott Martin, MD and the care of the prescribing physician due to non-compliance with this agreement, that I may be given prescriptions for 30-day tapering supply of my medication(s), so as to avoid withdrawal symptoms.
17. This agreement will be reviewed and renewed every 12 months it is in affect.

This agreement is entered into on this_____day of_____, 20_____.

_____ _____

Patient Signature Provider Signature

_____

Print Patients Name

8352 W. Warm Springs Rd., 3rd Floor, Las Vegas, NV 89113
Office: (702) 851-7287 Fax: (702) 851-7286

At The DOCS, we respect our legal obligation to keep information private that identifies you. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect this information and what rights you have regarding it.

FOR MORE INFORMATION

If you need more information or have questions about our privacy practices, please contact the offices' Privacy/Security Officer, Brian Bauer, via US Mail: 8352 W. Warmsprings Rd., 3rd Floor, Las Vegas, NV 89113; via phone: (702)851-7287.

PRIVACY COMPLAINTS

If you believe that your privacy has been violated, you should immediately contact us. We will not take action against you for filing a complaint. You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services. The address is:

Office of Civil Rights

U.S. Department of Health and Human Services

200 Independent Avenue, S.W.

Room 509F, HHH Building

Washington, DC 20201

The DOCS

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Las Vegas, NV 89113
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www.thedocsnv.com

the docs
clinical specialists
endocrine · diabetes · obesity

HIPAA Privacy Information

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice:

March 17, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND ASK OUR STAFF IF YOU HAVE ANY QUESTIONS.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit our office(s), a record of your visit and notes are recorded.

Typically, this record contains your symptoms, examination/test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among health professionals who contribute to your care.
- Legal document describing care you received.
- Means by which you or a payer can verify that services billed were provided.
- A source of data for medical research.
- A source of information for public health officials to help improve health of the nation.
- A Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of our offices as we compiled the information, the information itself belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and request copies of your health record as provided for in 45 CFR 164.524
- Obtain accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations.
- Revoke our authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Our offices are required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or inform you that you need to make another appointment. We may also call, write, or email to notify you of other services available at our offices that may be of interest to you. Unless you tell us otherwise, we may leave a message on your answering machine or voicemail, or with someone who answers you phone if you are not available.

We will not make any other uses or disclosures of your information unless you sign a written "authorization form". Federal law mandates the content of an "authorization form". In all situations, other than those described above, we will ask you for your written authorization before using or disclosing your information. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. Revocations must me in writing.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We routinely use your information for these purposes without any special permission, the most common reasons being for treatment payment or health care operations.

Examples of how we use or disclose information for treatment purposes are setting up appointments, testing or examination (including labs), prescribing medications (including pharmacies), referring you to another provider for care, or getting copies of your health information from another facility that you may have seen or are currently seeing. We may also disclose information to your insurance company for billing, other payors payments, and our outside collections service for outstanding accounts. Rarely, we may also have to disclose information for financial or billing audits, internal quality assurance, or outside professional or academic programs.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

In some limited situations, the law allows or requires us to use or disclose you information without your permission. Examples of such uses are:

- When a state or federal law mandates that certain information be reported for a specific purpose.
- To governmental authorities about victims of suspected abuses, neglect, or domestic violence.
- For health oversight activities, such as the licensing of professionals, for audits for payors, or for investigation of possible violations of health care laws.
- For health related research.
- To prevent a serious threat to health or safety.
- Of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an avoidable byproduct of permitted uses or disclosures.
- For legal purposes, such as subpoenas or court orders.
- For law enforcement purposes, such as information pertaining to a victim of a crime; or to report a crime.
- To a medical examiner, or to funeral directors, or to organizations that handle organ or tissue donations.
- For specialized government functions, such as intelligence activities, disaster relief activities, or other national security activities authorized by law.
- For public health purposes, such as contagious disease reporting, investigation and surveillance, and notices to and from the FDA or devices of de-identified information.
- Relating to worker's compensation programs.
- To "business associates" who provide services for us and who commit to respect the privacy of your information.
- Unless you object, we will also share relevant information about your care with your family or other caregivers who are helping with your medical needs.

Patient HIPAA Acknowledgement and Consent Form

Patient Name (Printed): _____Date of Birth: _____

Notice of Privacy Practices.

_____ (Patient/Representative initials) I acknowledge that I have received The DOCS Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in The DOCS Notice of Privacy Practices.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

We want to stay connected with our patients. Patients in our practice may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), text messaging and/or Twistle to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health

reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time (see next page).The practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is**_____.

I authorize to receive messages and share medical information via **Twistle.**

-OR-

I decline _____ (Patient/ Representative Initials) to receive communication via text.
I decline _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.
I decline _____ (Patient/ Representative Initials) to receive communication via email.

I decline _____ (Patient/ Representative Initials) to receive messages and share information via Twistle.

Note: *This clinic uses an Electronic Health Record and all your demographics and consent information will be updated to what you provide us.*

Release of Information.

I hereby permit The DOCS and the physicians or other health professionals involved in patient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports,

operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Pick-up. There may be times when you need a friend or family member to pick-up a prescription (script). In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** _____ (Patient/Representative Initials) to designate the following individual to pick up a prescription on my behalf:
  - Name: _____ Date: _____
  - Name: _____ Date: _____
- ***I do not want*** _____ (Patient/Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature_____ Date:_____
Patient/Parent/Guardian/Patient Representative Name (Printed) _____
Patient Name (Printed): _____ Date of Birth: _____

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

_____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via* ***text****.*

_____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via* ***via cellular telephone call****.*

_____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via* ***email****.*

Patient Name: _____

Patient/Patient Representative Signature: _____ Date: _____

Time: _____

8352 W. Warmsprings Rd., 3rd Floor, Las Vegas, NV 89113
Office: (702)851-7287 Fax: (702)851-7286

Welcome to The DOCS free, secure HIPAA compliant messaging platform used to ease the communication between you the patient an our office care teams and other health providers in a secure manner.

The communication tool can be used for: copies of lab results (to have lab values reviewed, please schedule an appointment with your provider), prescription requests, pump uploads, scheduling changes, and insurance/billing inquiries. Please allow 24 to 48 business hours upon receipt of your request for a staff member to process and complete the request. Twistle is NOT a substitute for emergent situations. Twistle hours of operation remain the same as clinical operations hours: 7:30am to 5:00 PM.

How to Twistle:

1. Please give the preferred email address/smart phone number to our office staff.
2. You will get an invite to Twistle in your email or through text message. Click on the 'Join' Button.
3. You will be brought to the 'Join' screen. Create your Twistle Account.
4. You are now at the welcome screen for Medical Queries.
5. You will subsequently get invites to each of the other clinical areas or groups. You should accept all of them for better communication
6. Now you are ready to communicate. To send a message click on the blue pencil at the top
7. You can select the group that you wish to communicate with; you can include other groups as well.
8. If you wish to include an attachment, look for the paperclip near the "send button".

We hope that this streamlines communication for you. Your time is precious, and we seek to make communication faster, easier, secure and more efficient. Thank you.

Sincerely,

The DOCS care team.

8352 W Warm Springs Rd., 3rd Floor, Las Vegas, NV 89113
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Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name: _____Patient DOB:_____
Address: _____City: _____ State: _____Zip: _____

I authorize the use or disclosure of the above named individual's PHI to be released as follows:
__All Medical Records __ Lab/X-ray __Other_____
Reason for Request:
__Medical Care __Personal Insurance __Attorney ___Other_____

This authorization is given and to remain in force for the specified period:
__From _____to_____
__For the period of 1 year beginning on: _____

The following named individuals are granted permission to access my medical information and communicate on my behalf:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

There will be a "Fee of 60 cents per page plus postage if applicable when releasing records directly to parent or patient".

Transfer Records From:
Name: _____
Address: _____City: _____State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

Send Records To:
Name: _____
Address: _____City: _____State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

Signature of Parent, Guardian or Personal Representative:
Signature: _____ Date: _____
Print name of above: _____ Relationship to Patient: _____

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