Dr. Kevin Debiparshad
M.D., MSC, FRCSC
Orthopedic Surgeon
Fellowship Trained

SYNERGY
SPINE & ORTHOPEDICS

8180 Rafael Rivera Way #100
Las Vegas, NV 89113
P: 702-ORTHO-LV
F: 844-254-1850

Patient Information

Name:_____ **Date:**_____
(Last) (First) (M.I.)

Single/Married/Other:_____ **Gender: M / F** **DOB:**____ / ____/ _____ **Age:**_____

Social Security#:_____ - _____ - _____ **Ethnicity:** **Hispanic / Non-Hispanic**

Race:_____ **Preferred Language:**_____

Address:_____
(Street) (City) (State) (Zip Code)

Phone (Home): _____ **Email:**_____

Phone (Cell): _____ **Phone (Work):**_____

Employer: _____ _____
(Name) (Address)

Referring Physician: _____

Emergency Contact:_____ _____ _____
(Name) (Relationship) (Phone)

Insurance Information: (If applicable)

Primary Insurance:_____	**Secondary Insurance:**_____
Policy Holder:_____	**Policy Holder:**_____
Subscriber Name:_____	**Subscriber Name:**_____
DOB:_____	**DOB:**_____
Social Security#:_____	**Social Security#:**_____
Effective Date:_____	**Effective Date:**_____
ID#:_____	**ID#:**_____
Group#:_____	**Group#:**_____

If you are treating under Personal Injury / LIEN (See Page 2)

Personal Injury Cases (LIENS) (*if applicable*)

Attorney Information:_____ _____
(Name) **(Phone)**

Address:_____ **Date of Injury:**_____

****Our standard policy requires us to bill your health insurance unless you, the patient, specifically request by signature below NOT to do so****

I DO NOT want my health insurance billed:

_____ _____/ _____/ _____
(Print Name) **(Date of Birth)**

_____ _____
(Sign Name) **(Date)**

Please be advised that if you later decided to bill your Health Insurance it will be billed from that time and date only.

Work Comp Information:

Claim Adjuster or Case Manager Name:_____

Employer Receiving Worker's Compensation From:_____

Phone:_____ **Fax:**_____

Claim #:_____ **Date of injury:**____/ _____/ _____

Your Signature:_____ **Today's Date:** _____/ _____/ _____

If you are not a LIEN/Worker's Comp patient than turn to Page 3.

SYNERGY
SPINE & ORTHOPEDICS

Synergy Spine and Orthopedics
Dr. Kevin Debiparshad
8180 Rafael Rivera Way #100
Las Vegas, NV 89113

Phone: 702-678-4658 ***Fax: 844-254-1850***

Authorization to Request Medical Records

Patient:_____ **DOB:**_____ **Date:**_____

Address:_____

This is to authorize:

Synergy Orthopedics
870 Seven Hills Drive #103
Henderson, NV 89052
The office of Dr. Kevin Debiparshad

To request information from:

_____

(Name of Doctor, Insurance Company, Individual, etc.)

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____ Fax:_____

(Check Records to be Requested)

[ ] All Medical Records [ ] Operative Reports [ ] NCV/EMG Reports [ ] Xray/MRI Report

[ ] Lab Work [ ] Office Notes [ ] Other

This Medical Records Request will remain in force for one year from signature date.

I realize that I am entitled to a copy of this authorization:

*_____ _____

(Signature of Patient or Responsible Party) **(Date)**

Office Personnel Requesting:_____

Please Fax To: 1-844-254-1850

Medication List

Patient Name:_____ **DOB:**_____

Date	Medication/Dose	Frequency Taken

Pharmacy Name:_____

Address/Major Cross Roads:_____

Pharmacy Phone:_____

Pharmacy Fax:_____

SYNERGY
SPINE & ORTHOPEDICS

*Name:*_____ *DOB:*___/____/____ *Date:*_____

Are: Married___ Single:___ Children: Y / N - How Many:____ Dominant Hand: R / L

Do you use tobacco? Y / N If yes, how much and how long?_____

Do you drink alcohol? Y / N If yes, how many drinks per day/week?:_____

Do you or have you used recreational drugs? Y / N Which ones?:_____

Do you receive disability compensation? Y / N What kind?_____

What is your occupation?:_____

What is your employment status now? Full Time - Retired - Student - Unemployed

Height:_____ **Weight:**_____ **Any sudden weight loss or gain? Y / N**

Are you or could you be PREGNANT/NURSING? Y / N Last period date:_____

Do you have any ALLERGIES? (IE: Medications, latex gloves, tape, iodine?) Y / N

Please list them if so:_____

_____

Current Medical Conditions (Please list ALL conditions or illness types and date. *IE: Diabetes 2020 - Present*): _____

_____

_____

_____

Prior Surgical History: _____

_____

_____

_____

_____

Name:_____ DOB: ___/___/___ Date:_____

List Previous SERIOUS INJURIES (IE:. Fracture with date):_____

_____

_____

_____

_____

Date of Injury (If applicable): _____ State of Injury:_____

How did the injury occur?_____ Is it work related? YES / NO

Where does it hurt?:_____

Have you been treated for your present problem? Y / N When?_____

And by whom?:_____

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

Pain Clinic/Anesthesiologist _____Anti-Inflammatory/Anti-Depressant_____

Trigger Point Injections_____ Epidural Steroid Injections_____

Chiropractic Therapy_____ Physical Therapy_____

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

How far are you able to walk?_____

SYNERGY
SPINE & ORTHOPEDICS

SYNERGY
SPINE & ORTHOPEDICS

Name:_____ DOB: ___/___ / ___ Date: _____

Circle the words that describe your pains:

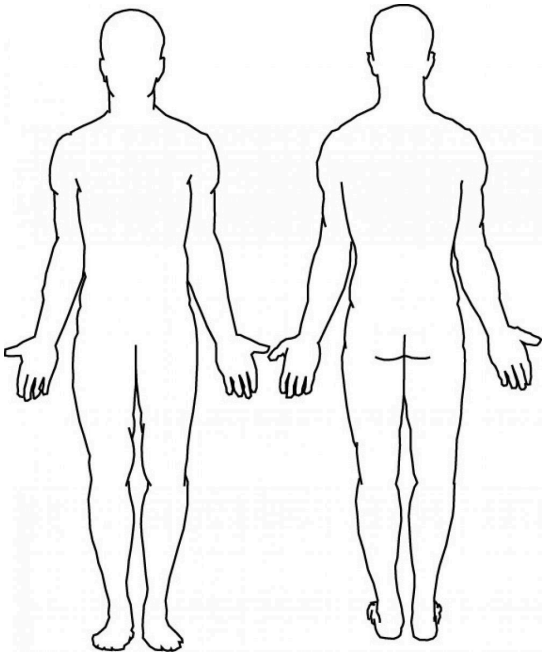
Aching	**Sharp**	**Penetrating**	**Throbbing**	**Gnawing**
Tender	**Nagging**	**Shooting**	**Burning**	**Unbearable**
Numbness	**Stabbing**	**Occasional**	**Miserable**	**Continuous**

Severity of your pain. Circle the number on the line between 0 (no pain) and 10 (worst pain) which best describes how severe your pain is:

1 2 3 4 5 6 7 8 9 10

Please mark the area/s of your pain on the diagram below.

Front



Back

Your pain at it's worst: 1 2 3 4 5 6 7 8 9 10

Your pain at it's best: 1 2 3 4 5 6 7 8 9 10

Disclosure of Protected Health Information

Name:_____ DOB: ___/___/___ Date:_____

Our office will NOT communicate to ANYONE without a written authorization from you - Unless it is in regards to the continuity of treatment.

I hereby authorize the disclosure of my health information to the following persons:

- _____ _____ _____
  Name Relationship Telephone #

Mark which information you would like us to release:

____Any & All Information ____Pre-Procedure Instructions Only ___Appointment Information Only

- _____ _____ _____
  Name Relationship Telephone #

Mark which information you would like us to release:

____Any & All Information ____Pre-Procedure Instructions Only ___Appointment Information Only

- _____ _____ _____
  Name Relationship Telephone #

Mark which information you would like us to release:

____Any & All Information ____Pre-Procedure Instructions Only ___Appointment Information Only

- _____ _____ _____
  Name Relationship Telephone #

Mark which information you would like us to release:

____Any & All Information ____Pre-Procedure Instructions Only ___Appointment Information Only

This authorization will remain in effect until I send a written revocations. The extent of this disclosure is for written and verbal correspondence between the physician and the individual or institution listed above. A release of medical records is a separate form.

_____ _____

Patient Signature (Parent of Guardian if Patient is a minor) **Date**

SYNERGY
SPINE & ORTHOPEDICS

*Name:*_____ *DOB:*_____ *Date:*_____/ _____/ _____

Dear Valued Patient, starting January 1st, 2018, our office and our Doctor will continue to implement all regulations mandatory by the Controlled Substance Abuse Act, aimed at curbing the opioid epidemic. If you received a prescription for a controlled substance, you should be aware that you will likely experience a change in processes that may extend the length and frequency of your provider visit. We will continue to implement the following: reports on your prescriptions through state wide prescription database, obtain your written informed consent to receive prescribed controlled substances for pain, evaluate you for possible risks of addiction or dependence on controlled substances including psychiatric evaluations, and randomized urine or blood toxicology screens. We appreciate your patience with us as we work through the implementation of these new law changes. During this process, we are committed to continuing to provide you with the BEST possible care.

Opioid Risk Assessment:

Please circle your answer (YES or NO)

- **Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you?**

  YES / NO (Please circle one)

- **Do you ever use your medication MORE OFTEN, that is, shorten the time between dosages?**

  YES / NO (Please circle one)

- **Do you ever feel high or get a buzz after using your pain medication?**

  YES / NO (Please circle one)

- **Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?** **YES / NO** (Please circle)

- **Have you ever gone to multiple physicians including emergency room doctors, seeking more of your pain medication?**

  YES / NO (Please circle one)

- **Do you ever need early refills for your pain medication? YES / NO** (Please circle one)

****************READ THE FOLLOWING CAREFULLY - THIS MAY NOT PERTAIN TO YOU***************

If you wish to WAIVE the option to be prescribed prescription narcotic/controlled substance medications and will refuse any and all controlled substance prescriptions - Please sign below. By signing below: You agree that all medications, which may be offered as treatment to you - that are considered controlled substances under the DEA Act and Prescription Laws - will be forfeit by you and all prescriptions offered to you. Our office will make every attempt to NOT prescribe you controlled substances, but ultimately by signing below, it is YOUR responsibility to not fill and/or accept narcotic prescriptions. This agreement will remain in effect until revoked in writing by YOU, the patient, and this form is updated at that point in time moving forward from the date it is updated.

_____	_____	_____
PRINT NAME	**SIGN NAME**	**DATE**

Name:_____ **DOB:**_____ **Date:**____/ ____/ _____

Nevada Written Informed Consent
Controlled Substance Therapy for Pain

Please review the information listed here and put your *initials* next to each item when you have reviewed it, you can always ask your provider during your visit if you have any questions regarding any items, and feel you understand and accept what each statement says.

_____I understand that, due to risk of possible overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone (Brand name: Narcan and Evzio) is now available without a prescription. I may obtain naloxone from a pharmacist.

_____**For Women:** It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome.

_____I understand the manner in which my prescriber will address requests for refills of a prescription.

_____I understand that prescriptions should always be stored in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I can return my medications in a bottle to a local pharmacy, a local drug take back day, a local police or sheriff substation in my community.

_____Anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risks. I have told my prescriber if I or anyone in my family has had any of these types of problems.

_____I may become addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications. I will discuss with my prescriber the proper use of the controlled substance.

_____When I take these medications regularly, I will become physically dependent on them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

_____When I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk of being injured.

SYNERGY
SPINE & ORTHOPEDICS

Nevada Written/Informed Consent Continued:

SYNERGY
SPINE & ORTHOPEDICS

_____

_____When I take these medications I may experience certain reactions or side effects that could be dangerous. Including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

_____I will discuss with my prescriber and I understand the potential risks and benefits of treatment using controlled substances, including if a form of controlled substance that is designed to deter abuse is available, the risks and benefits of using that form.

_____Before I am prescribed any pain medications, we will discuss non-opioid, alternative means of treatment for my symptoms including physical therapy, chiropractic care, NSAIDS, injections, and life style modifications.

_____Every pain medication, including controlled substances, has different benefits and risks in the treatment of my symptoms.

_____My prescriber may prescribe pain medications, including controlled substances, I will discuss with my prescriber the important provisions of the treatment plan established for me in a clear and simple manner.

Patient Signature	**Printed Name**	**Date**

If the patient is an unemancipated minor, as the Parent/Guardian, I will discuss with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

Parent/Guardian Signature	**Printed Name**	**Date**

SYNERGY
SPINE & ORTHOPEDICS

Synergy Orthopedics Financial Policy

Thank you for choosing Synergy Spine and Orthopedics as your medical treatment and care provider. The following is our financial policy. If you have any questions, please do not hesitate to ask our Practice Manager, Mario Moya.

All co-pays and deductibles are due at the time of service. We accept cash, checks, and credit cards. We will submit insurance claims on your behalf, if we are a contracted provider for your insurance company. If your insurance company changes, it is your responsibility to inform the office immediately. Please provide a copy of the front and back of your insurance card.

PLEASE BE AWARE THERE IS A NO SHOW FEE OF $50 PER VISIT IF PATIENT DOES NOT NOTIFY OUR OFFICE AT LEAST 24 HOURS PRIOR TO VISIT

Please read the following carefully:

- Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract. Our relationship is with you, therefore, you are ultimately responsible for any service, regardless of your insurance coverage.
- If all services are not covered by your insurance company, for whatever reason, it is your responsibility to know what is and is not covered. Fees for non-covered services are due at the time services are rendered, unless prior arrangements have been made for payment arrangements.
- Our office charges are for the doctor's services only. Fees for labs and braces are billed separately by the appropriate providing company.
- If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly.
- Our billing process consists of one statement, one audit letter, and one final notice. If you fail to respond to the final statement, your account will be forwarded to a collection agency and you will be discharged from the practice.
- **Returned checks are subject to a $25.00 fee.**
- **Disability/FMLA/Insurance Forms: Each packet and/or form requires a $50.00 pre-payment** before the they will be completed. These forms may take 7-10 business days to complete and will be faxed to the required recipient only, unless otherwise noted/requested.
- Refunds are processed upon request and are paid within 90 days.
- I authorize the release of any medical or other information to process my claim. I request assignment of benefits to Synergy Spine and Orthopedics. I authorize payment to go directly to Synergy Spine and Orthopedics/Dr. Kevin Debiparshad.

_____	_____	_____
Patient Signature	**Printed Name**	**Date**

SYNERGY
SPINE & ORTHOPEDICS

Acknowledgement of Receipt of Notice of Privacy Practices

Synergy Spine and Orthopedics reserves the right to modify the privacy practices outlined in this notice.

<u>By signing this form:</u> I have received a copy or acknowledge that a copy of the Notice of Privacy Practices for Synergy Spine and Orthopedics may be provided to me by verbal request.

_____

Printed Name of Patient

_____

Signature of Patient

_____

Today's Date

_____

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

SYNERGY
SPINE & ORTHOPEDICS

Notice of Privacy Practices

Uses 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 tests and procedures will be available in your medical records 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. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Options. Your health information may be used as necessary to support the day to day activities and management of Synergy Spine and Orthopedics. For example, information on the services 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 mandate 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 or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will 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 send you appointment reminders when requested.

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 services that we believe may interest you.

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 your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and whom your health information has been disclosed.
- The right to receive a printed copy of this notice.

Synergy Spine and Orthopedics - 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.

Requests to Inspect Protected Health Information
You may generally inspect or 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 Kristen Haisupa, the office manager. 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 to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Synergy Orthopedics
8180 Rafael Rivera Way #100
Las Vegas, NV 89113

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 you can contact for further information concerning our privacy practices is:

Mario Moya, Office Manager - Synergy Spine and Orthopedics
8180 Rafael Rivera Way #100
Las Vegas, NV 89113
Phone: 702-678-4658
mario@synergyorthopedics.com

Effective Date: March 26th, 2024