

Lemper Pain Centers
5950 S. Durango Dr.
Las Vegas, NV 89113

Patient Name: _____ **Date of Birth:** _____

Financial Responsibility I understand and agree that, regardless of my insurance/lien status, I am ultimately responsible for the balance of my account for any services rendered. **I will notify you of any changes in my status or the Insurance information, as I understand it is my responsibility.** I additionally agree that if my account is sent to collections due to failure to pay, I will be financially responsible for; 35% collection fees, other collection fees, court costs, attorney fees and any other fees incurred due to my debt. **Initial** _____

Assignment of Benefits I authorize Brian A. Lemper DO, Ltd, or The Center for Surgical Intervention to endorse and deposit checks received for payment of my health care benefits in the event they are made out to me. I hereby instruct and direct my Insurance Company to pay by check made out to **and** mailed to the following address; or if my current policy prohibits direct payment to the doctor or facility, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Brian A Lemper, DO, Ltd.

9811 W Charleston Blvd Ste 2-389, Las Vegas, NV 89117

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. This assignment will remain effective until written notice of cancellation. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Dr. Brian Lemper's office and/or The Center for Surgical Intervention. **Initial** _____

Controlled Substance Policy It is a felony to request or receive prescriptions from a provider for controlled substances if that Provider is not made aware of other prescriptions. I further understand that I should avoid driving or using dangerous equipment that requires a high level of alertness. By accepting prescriptions for controlled substances from this practice, you acknowledge that you understand and will comply with this policy.

1. Dr. Brian Lemper is the **only** physician to prescribe the patient controlled substances.
2. Controlled substances are refilled **once a month** (30 day period).
3. Patients need to make a follow-up appointment **at least two weeks** prior to medication due.
4. Medication refills will not be given early. Controlled substances are not refilled by phone or fax.
5. Controlled substance prescriptions that are stolen, or lost by other circumstances, you must provide this office with a copy of the police report. **NO EXCEPTIONS.**
6. I will comply and use the medication for its intended use only and as directed.
7. If you run out of your prescription before it is due, that means you are not taking the medicine as prescribed. If you are having extreme pain, please call the office at 562-3039.
8. I further understand that if I am not compliant with the above, Brian A. Lemper, DO will no longer prescribe controlled substances. **Initial** _____

Notice of Privacy 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. The following are examples of instances where information may be shared; laboratory analysis, imaging companies, second opinions, past medical history, insurance Carriers, the Office of Insurance Commissioners and Legal Council. If there is any other party you would like listed to keep on record allowing us to release any information in the event we are unable to reach you or you would like us to discuss matters with on your behalf, please list them here:

Name: _____ Relationship: _____

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released the written authorization of the individual, as provided for by law. **Initial** _____

No Show Cancellation Policy All cancellations must be made 24 hours in advance. Failure to do so result in a charge of \$70.00 per office visit, \$1,600.00 for initial consults and all procedures, and \$60.00 for all life fitness/massage therapy visits. In the event of an emergency, please contact our office as sc **Initial** _____ as possible and the situation will be considered on a case-by-case situation.

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Continued

Medical Records Release I, hereby authorize the release of my medical records to:
Brian A Lemper, DO, Ltd.
5950 S. Durango Dr., Las Vegas, NV, 89113, Fax: 702-562-6928

Initial _____

Patient Name: _____

Date of Birth: _____

Patient Address: _____

City, State, Zip: _____

Dated on this _____ day of _____, 20____.
(day) (month) (year)

Patient Signature

Witness

I certify that I have received this document and have been provided an opportunity to review it. If I have any questions, I can call (702) 562-3039 and speak to an office representative.