NEW PATIENT REGISTRATION

Patient Name: ____ **DOB:** _____________ **SS#:** ________________________

Home Phone: _______________**Cell Phone:** _________________ **Responsible Party/Relation:** _____________________

Email: ____________________________________ **Marital Status:** ☐ **Single** ☐ **Divorced** ☐ **Widow** ☐ **Married**

Reason for Visit: ____

Home Address: ____ **City**_____________ **State:** ________**Zip**___________

Primary Insurance: ___________________________________ **ID#:** _________________ **Group#:** __________________

Policy Holder: __________________________**Relationship:** ___________ **SS#:** ______________ **DOB:** ______________

Employer: ______________________ **Job Title:** ___________________**Work Phone:** _____________________________

Secondary Insurance: ______________________________ **ID#:** __________________ **Group#:** ____________________

Policy Holder: __________________________**Relationship:** __________ **SS#:**_______________ **DOB:** ______________

Employer: _____________________________________ **Job Title:** ________________**Phone:** ______________________

Referring Physician: ____________________ **Address:** ___________________________ **Phone:** ____________________

PCP: __________________________ **Address:** ___________________________ **Phone:** __________________________

Specialist: _____________________ **Address:** ___________________________ **Phone:** ___________________________

MRI/CT Scans/X-Rays (Where performed): ________________________**When:** ____________**Phone:** ______________

Emergency Contact: _______________________ **Relationship:** _______________________ **Phone:** _________________

Lemper Pain Center/United Care Centers/Center for Surgical Intervention patients only:

Is this accident related? Y N Type: __Motor Vehicle __Work Comp __Other: _________ **Accident State:** _____ **Date:** ________

Were you at fault? Y N Do you have a Liability? Y N Are you claiming it on No-Fault Insurance Y N

Auto Ins_____________________ **Claim #** ____________ **Phone:** ___________________________ **Fax:** _______________________

Is there Med Pay available? Y N Policy limits: $______________________ **Agents Name:** _____________________________

Is there a Lien? Y N Attorney: ________________________________ **Phone:** ___________________ **Fax:** __________________

Workers Comp Carrier: __________________________________ **Phone:** _______________________ **Fax:** _______________________

Case Worker: ____________________**Claim #:** ____________________**Date of Injury:** __________**Injury Site:** _________________

Did you sustain an injury at work? Y N
Are your injuries accident related? Y N
Are you currently employed? Y N

Are you covered under an employer or union policy? Y N
Is your spouse or other family member employed? Y N
Do you have a secondary insurance policy? Y N

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers completely. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information as I know it is my responsibility to do so. I additionally agree that if my account is sent to collection due to failure to pay, I will be financially responsible for including a 25% collections fee, other collection fees, court costs, attorney fees and any other fees incurred due to my debt.

____ ___________________________

Patient Signature/Guardian Signature **Date**

____ ___________________________

Witness **Date**

How did you hear about us?

Magazine Billboard Friend Doctor Internet Other: __________________

Lemper Pain Centers/United Care Centers
United Longevity Centers/The Center for Surgical Intervention
5950 S. Durango Dr. Las Vegas, NV 89113

Patient Name: ______________________________ **Date of Birth:** ____________________________

The Center: **Lemper Pain Centers, United Care Centers, United Longevity Centers, and The Center for Surgical Intervention will hereinafter be referred to as "The Center."**

Authorization For Treatment**:** I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents. ***Initial***______

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; 25% collection fees, other collection fees, court costs, attorney fees and any other fees incurred due to my debt. ***Initial***______

Assignment of Benefits: I authorize The Center 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 to:

Lemper Pain Centers/United Care Center/
United Longevity Centers/The Center for Surgical Intervention
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 The Center. ***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. The Center is the **only** physician to prescribe the patient controlled substances.
2. Controlled substances are refilled **every two weeks** (15 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, I will no longer be prescribed controlled substances.
9. I understand that I will be subjected to intermittent drug testing, and agree to submit to such at any time for any reason. I further understand, I will be financially responsible for incurred charges from such testing.

Initial________

Notice of Privacy Practices: THIS NOTICE DESCRIBES HOW MEDICALINFORMATION 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: ___________________________

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***_______

Aesthetic/Cosmetic Services: Payment for Aesthetic/Cosmetic Services is required at the time of service. These services are considered cosmetic in nature and therefore are not billable to health insurance plans.

Initial_______

No Show Cancellation Policy All cancellations must be made 24 hours in advance. Failure to do so will result in a charge of $70.00 per office visit, $1,600.00 for all procedures. ***Initial***_______

Medical Records Release

I, hereby authorize the release of my medical records to:

Lemper Pain Centers/United Care Centers
United Longevity Centers/The Center for Surgical Intervention
5950 S. Durango Dr.
Las Vegas, NV 89113
702-562-3039 office
702-562-6928 fax

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.

Lemper Pain Centers/United Care Centers
United Longevity Centers/The Center for Surgical Intervention
5950 S. Durango Dr.
Las Vegas, NV 89113

Patient initiated Insurance Complaint

Patient Name: ___________________________D.O.B______________

Address: ____

City, State, Zip: ____

Phone: ____

Date: ______________________

The attached claim form was filed with _____________________ Insurance Company on ___________________. It has not been paid or denied.

Benefits were assigned to Brian A Lemper, D.O. and as of today's date, payment has not been received. I am personally responsible for payment of this bill.

This letter serves as a formal written complaint against _____________________________ Insurance Company. This letter also serves as notification of my intent file a formal complaint with the Insurance Commissioners if this matter is not resolved immediately.

____
Signature

Name ________________________________ Birthdate: ______________ Date ______________________

Dominant Hand ☐ Right ☐ Left Marital Status (Check One) ☐ Single ☐ Divorced ☐ Widow ☐ Married

Occupation _______________________ _______________________ Date symptoms began _____________

Referring physician ____

List current symptoms ____

What treatment, if any, have you had for these symptoms? ______________________________

Were you in an accident? ☐ Yes ☐ No If yes, what date? ______________________________

What type of accident? ____

What treatment did you receive for this? Was there a hospitalization?

____

____

____

What makes the pain better? ____

What makes the pain worse? ____

MEDICAL HISTORY/REVIEW OF SYSTEMS

Disease or Disorder	You	Family	**Disease or Disorder**	You	Family
Diabetes	☐	☐	Vein Trouble	☐	☐
Stroke	☐	☐	Blood Clots	☐	☐
Thyroid Problems	☐	☐	Bleeding Disorders	☐	☐
Dizziness	☐	☐	Hiatal Hernia	☐	☐
Fainting	☐	☐	Ulcers	☐	☐
Seizures	☐	☐	Blood in Bowel	☐	☐
Cough	☐	☐	Hepatitis/Jaundice	☐	☐
Chronic Bronchitis	☐	☐	Other Liver Disease	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Shortness of Breath	☐	☐	Malignant Hypothermia	☐	☐
Pneumonia	☐	☐	Anesthesia Problems	☐	☐
Tuberculosis	☐	☐	Other Lung Problems	☐	☐
Chest Pain	☐	☐	Menstrual Problems	☐	☐
Heart Disease	☐	☐	Gout	☐	☐
Pacemaker	☐	☐	Psoriasis	☐	☐
High Blood Pressure	☐	☐	Rheumatoid Arthritis	☐	☐
Irregular Heart Beat	☐	☐	Lupus	☐	☐
Cancer	☐	☐	Sickle Cell Anemia	☐	☐
Muscle/Joint Pain	☐	☐	Weakness	☐	☐
Numbness	☐	☐	Excessive Thirst	☐	☐
Urinary Symptoms	☐	☐	Anxiety	☐	☐
Scoliosis	☐	☐	Tingling	☐	☐

List all past operations, serious illnesses & hospitalizations, including dates:

____ year: __________

____ year: __________

Office - 5950 S. Durango Dr. Las Vegas, NV 89113 • Phone 702-562-3039 • Fax 702-562-6928
Billing/Correspondence • 9811 W. Charleston Blvd. Suite #2-389 • Las Vegas NV 89117

______________________________________ year:________

List any **ALLERGIES** to medication, food, or **LATEX** and the reaction they cause

Medication	Reaction

List all medications you are currently taking. Please indicate dosage, times per day and reason for the medication. If none at this time, please state "None". Please include over the counter medications and herbal medications in this list:

Medication	Strength/Dosage	How do you take it?	How often?

Do you use alcohol ☐ Yes ☐ No What type? How often?

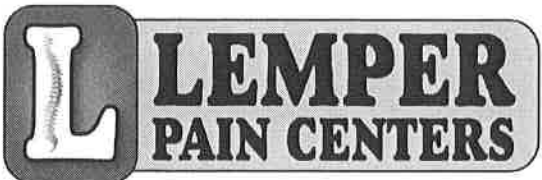
Do you use tobacco ☐ Yes ☐ No What type? How often?

Family History

Father Living? ☐ Yes ☐ No Siblings Living? ☐ Yes ☐ No

Children Living? ☐ Yes ☐ No Mother Living? ☐ Yes ☐ No

Are you taking any blood thinners? (Ex: Lovenox, Warfarin, Aggrenox, Plavix, Coumadin etc.)



Name ______________________________ Birthdate:______________ Date ____________________

Using the diagram, identify all areas that have pain, numbness, and/or tingling.