Valley Endocrinology PLLC

M. Fariba Rahnema, M.D., F.A.C.E., E.C.N.U
653 N. Town Center Dr. - Suite 504 - Las Vegas, NV 89144
(702) 701-8400 Phone - (702) 701-8401 Fax

PATIENT REGISTRATION

Name: (Last) _____ **(First)** _____ **(Mi)** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Primary Care Physician: _____ **Referring Physician:** _____

Sex: Male Female **Marital Status:** Single Married Divorced Other

SSN: _____ **Date of Birth:** _____

Employment: Full Time Part Time Student Unemployed

Employer: _____ **Employer Phone:** _____

Employer Address: _____

Primary Insurance: _____ **Insured Party:** Self Spouse Parent

ID #: _____ **Group #:** _____

Name: (Last) _____ **(First)** _____ **(Mi)** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

SSN: _____ **Date of Birth:** _____

Secondary Insurance: _____ **Insured Party:** Self Spouse Parent

ID #: _____ **Group #:** _____

Name: (Last) _____ **(First)** _____ **(Mi)** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

SSN: _____ **Date of Birth:** _____

Emergency Contact: Name: _____ **Relation:** _____

Home Phone: _____ **Cell Phone:** _____

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New healthcare regulations require that we have our patients complete the form below. We are subject to yearly audits by the Centers of Medicare and Medicaid as well as other insurance companies and we need this on file.
Thank you for your cooperation.

Name: _____

Preferred Language:

☐ English ☐Spanish ☐ German ☐ French ☐Italian

☐ Vietnamese ☐ Mandarin ☐ Tagalog ☐ Other: _____

Race:

☐ Hispanic: ☐ Asian ☐ Caucasian ☐ African American ☐ Black

☐ Chinese ☐ Filipino ☐ American Indian or Alaska Native ☐ Japanese

☐ Native Hawaiian ☐ Pacific Islander ☐ Other: _____

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Other: _____

_____ _____
Signature Date

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Patient Name: _____

Pharmacy Name: _____

Two Major Cross Streets: _____ **Phone:** _____

CURRENT LIST OF MEDICATIONS

Please list ALL the medications you are currently taking. For each give the name, the strength of each dose, how often taken and when you began taking it. This list MUST be detailed, accurate and complete. Please consult with your family, pharmacist and all physicians. Do not neglect aspirin, pain medications, hormones, contraceptives, water, diet, nerve or sleeping pills and any other prescription or over the counter drugs.

Name of Medication	Strength of Dose	When Taken	Date Started Taking

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Women Only:

1. Age first period _____
2. Age of menopause _____
3. Date of last period _____
4. Pelvic or vaginal infection _____
5. Contraception used _____
6. # of Pregnancies _____
   Miscarriage _____ Abortion _____
7. Last Mammogram _____
8. Mammogram Result _____
9. Last Pap _____ Result _____
10. Last Colonoscopy _____ Result _____

Men Only:

1. Prostate Concerns or Trouble _____
2. Last Colonoscopy _____ Result _____

Risk Factors:

1. Ever smoked? Yes No
   Packs per day _____ Year Started _____
   Date Quit _____
2. Does anyone smoke in your home? _____
3. Drug Use _____
4. Alcohol Use; # of drinks per day _____
5. Exercise: Frequency/week _____
   Type _____
6. Date of last Tetanus Shot _____
7. Date of last Pneumovax Shot _____

Medical Conditions: **Date:**

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

Family History: **Who:**

1. Alcoholism _____
2. Anemia _____
3. Arthritis _____
4. Anesthetic Complications _____
5. Anxiety _____
6. Asthma _____
7. Birth Defects _____
8. Blood Clots _____
9. Blood Transfusions _____
10. Breast Cancer _____
11. Cervical Cancer _____
12. Colon Cancer _____
13. Depression _____
14. Diabetes _____
15. Growth/Development _____
16. Heart Disease _____
17. Angina _____
18. Hypertension _____
19. High Cholesterol _____
20. Psychiatric Care _____
21. Osteoporosis _____
22. Seizures _____
23. Severe Allergies _____
24. Stroke _____
25. Suicide Attempt _____
26. Bowel Disease _____
27. Heart Attack _____
28. Kidney Disease _____
29. Respiratory Disease _____
30. Liver Disease _____
31. Sexually Transmitted Disease _____
32. Ulcers _____
33. Other Diseases _____
34. Coronary Heart Disease Male <55 _____
35. Coronary Heart Disease Female <65 _____
36. Colon Cancer - Father _____
37. Colon Cancer - Mother _____
38. Lung Disease _____
39. Melanoma _____
40. Ovarian Cancer _____
41. Uterine Cancer _____
42. Other Cancer _____
43. Thyroid Disease _____
44. Weight Disorder _____
45. Headaches _____
46. Other Medical Problems _____
47. PMS _____
48. Endometriosis _____

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HEALTH HISTORY QUESTIONAIRE

Name: _____ **DOB:** _____ **Date:** _____
*Please answer all questions. If you do not know an answer, or do not understand the question, insert a question mark in the space. Please do not leave any blanks.

Chief Complaint

List the problems which have brought you here to seek medical help and approximately when each began.

	Problem	Date Began
1		
2		
3		
4		
5		

GENERAL HEALTH AND HABITS

Characterize your present health status: Excellent Very Good Average Poor

Exercise:

Do you exercise regularly: YES NO
How long have you exercised on a regular basis: _____
Type of exercise(s): _____
_____
How often: _____ days/week
_____ mins/day

Nutrition:

Your weight: 10 yrs ago: _____ 5 yrs ago: _____
Now: _____
Your appetite: Excellent Good
Fair Poor
Are there foods you avoid or limit for health reasons?
_____

Smoking:

Do you smoke: YES NO
How many per day: _____ How many years: _____
What do you smoke: Cigarettes Pipe Cigars
When did you quit: _____ years _____ months
How long have you smoked: _____ years _____ months

Alcohol/Beverages:

How much alcohol do you drink:
_____ per day _____ per week
When did you stop: _____ years _____ months
Caffeinated beverages (coffee, tea, cola)
Cans/bottles: _____ per day _____ per week

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgeries you have, including the nature of each operation and where and when it was done.

Surgery	Nature	Where/When

Valley Endocrinology PLLC

PATIENT HISTORY AND REVIEW OF SYSTEMS (18 YEARS AND OLDER)

Name: _____ **Date:** _____

Check if you have the following:

GENERAL
____ Fever
____ Chills
____ Sweats
____ Anorexia
____ Fatigue
____ Weakness
____ Weight Loss
____ Malaise
____ Sleep Disorder

EYES
____ Vision Loss -1 Eye
____ Double Vision
____ Eye Irritation
____ Vision Loss - Both Eyes
____ Blurring
____ Eye Pain
____ Halos
____ Eye Discharge
____ Light Sensitivity

EARS, NOSE AND THROAT
____ Ringing in Ears
____ Ear Discharge
____ Earache
____ Decreased Hearing
____ Nasal Congestion
____ Nose Bleeds
____ Difficulty Swallowing
____ Hoarseness
____ Sore Throat

CARDIOVASCULAR
____ Diff. Breathing at Night
____ Near Fainting
____ Chest Pain or Discomfort
____ Racing/Skipping Heart Beats
____ Fatigue
____ Lightheadedness
____ Shortness of Breath w/ Exertion
____ Palpitation
____ Swelling of Hands and Feet
____ Difficulty Breathing Lying Down
____ Fainting
____ Leg Cramps with Exertion
____ Bluish Color Lips/Nails
____ Weight Gain

RESPIRATORY
____ Breathing Disturbs Sleep
____ Cough
____ Shortness of Breath
____ Coughing up Blood
____ Chest Discomfort
____ Wheezing
____ Excessive Sputum
____ Excessive Snoring

GASTROINTESTINAL
____ Excessive Appetite
____ Loss of Appetite
____ Indigestion
____ Vomiting Blood
____ Nausea
____ Vomiting
____ Yellow Skin Color
____ Gas
____ Abdominal Pain
____ Abdominal Bloating
____ Hemorrhoids
____ Diarrhea
____ Change in Bowel Habits
____ Constipation
____ Dark, Tarry Stools
____ Blood in the Stools

GENITOURINARY
____ Foul Urinary Discharge
____ Blood in Urine
____ Urinary Frequency
____ Inability to Empty Bladder
____ Urinary Urgency
____ Kidney Pain
____ Trouble Starting Stream
____ Painful Urination
____ Nighttime Urination
____ Inability to Control Bladder
____ Genital Sores
____ Lack Sexual Drive
____ Erectile Dysfunction
____ Excessively Heavy Period
____ Missed Periods
____ Unusual Urinary Color
____ Abnormal Vaginal Bleeding
____ Pelvic Pain

MUSCULOSKELETAL
____ Muscle Cramps
____ Joint Pain
____ Joint Swelling
____ Joint Fluid Present
____ Back Pain
____ Stiffness
____ Muscle Weakness
____ Arthritis
____ Gout
____ Loss of Strength
____ Muscle Aches

BREAST
____ Left Breast Lump
____ Right Brest Lump
____ Nipple Discharge
____ Bloody Discharge from Nipple
____ Breast Pain
____ Abnormal Mammogram
____ Breast Enlargement

NEUROLOGICAL
____ Diff. with Concentration
____ Poor Balance
____ Headaches
____ Coordination Difficulty
____ Numbness
____ Inability to Speak
____ Falling Down
____ Tingling
____ Brief Paralysis
____ Visual Disturbances
____ Seizures
____ Weakness
____ Sensation of Room Spinning
____ Tremors
____ Fainting
____ Excessive Daytime Sleepiness
____ Memory Loss

DERMATOLOGICAL
____ Excessive Perspiration
____ Night Sweats
____ Suspicious Lesions
____ Changes in Nail Beds
____ Dryness
____ Poor Wound Healing
____ Unusual Hair Distribution
____ Skin Cancer
____ Itching
____ Changes in Skin Color
____ Flushing
____ Rash

PSYCHOLOGICAL
____ Sense of Great Danger
____ Anxiety
____ Thoughts of Suicide
____ Mental Problems
____ Depression
____ Thoughts of Violence
____ Frightening Visions/Sounds

ENDOCRINE
____ Excessive Hunger
____ Cold Intolerance
____ Heat Intolerance
____ Excessive Urination
____ Excessive Thirst
____ Weight Change

HEMATOLOGY
____ Enlarged Lymph Nodes
____ Bleeding
____ Skin Discoloration
____ Abnormal Bruising
____ Fevers

ALLERGY
____ Persistent Infections
____ Hives or Rash
____ Seasonal Allergies
____ HIV Exposure

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HEALTH INFORMATION AND PRIVACY ACT
RELEASE OF PATIENT INFORMATION
PATIENT AUTHORIZATION FORM

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I _____ give my authorization for Valley Endocrinology to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, personal identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use or disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical or hospital services.

By signing this form you consent to out using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at Valley Endocrinology.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as requested by Law, Public Health issues requested by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you choose not to sign this consent, it may be difficult for Valley Endocrinology to provide treatment. You will be provided with a copy of this signed authorization upon your request.

Signature: _____

Printed Name: _____

Date: _____

Witness: _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND/OR CAREGIVERS

In the event Valley Endocrinology may need to give your medical information, may we…(check all that apply).

_____ Leave a detailed message on an answering machine.
_____ Leave a message with my spouse or family member.
_____ Call you on your cell phone, the number is: _____
_____ Call you at work, the number is: _____
_____ **ONLY** speak to you directly.

I, _____ DOB _____, give Valley Endocrinology and staff, authorization to disclose my protected health information to the following family, friends and/or caregiver.

Name: _____ **Relation:** _____
Name: _____ **Relation:** _____
Name: _____ **Relation:** _____
Name: _____ **Relation:** _____
Name: _____ **Relation:** _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Valley Endocrinology.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment and healthcare operations in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization and I need not sign the form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtained from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify a date this authorization will expire one year from the signature date on this form.

_____ _____
Signature of Patient/ Guardian/ Personal Representative **Date**

_____ _____
Signature of Employee **Date**

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MEDICAL RECORDS RELEASE

I authorize the release of my medical information:

☐ **ALL MEDICAL RECORDS** (*Including but not limited to progress notes, history, physicians orders, lab results and diagnostic tests*)
☐ **LAB REPORT(s)** ☐ **XRAY REPORT(s)** ☐ **DC SUMMARY**

*I authorize the above records to be **RELEASED FROM:***

Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

*I authorize the above records to be **RELEASED TO:***

Valley Endocrinology
653 N. Town Center Dr.
Suite 504
Las Vegas, NV 89144
Phone: (702) 701-8400 ~ Fax: (702-701-8401

The expiration of this authorization will be:

☐ 90 days from signature ☐ On this date: _____
☐ When this event happens: _____

Reason for disclosure of this health information:

☐ Transfer of records to another provider
☐ Transfer of records to complete health records at another entity
☐ Insurance Claims Information ☐ Attorney
☐ Person Use ☐ Other: _____

Additional Patient Information

- I understand that I have the right to revoke this authorization. I understand that to revoke this authorization I must do so in writing to Valley Endocrinology. I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- I understand that I do not have to sign this authorization to receive treatment.
- I understand that my health information may be subject to re-disclosure and not protected by the federal privacy rule.
- I understand that if I do not specify an expiration date, this authorization will expire 6 months from signature date.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PATIENT SSN: _____ **PHONE:** _____

SIGNATURE: _____ **DATE:** _____

Valley Endocrinology PLLC

Financial Policy

_____ *Initials* 1. Patients are required to pay their co-pay at the time of service. If you cannot pay, you must speak with billing department before your office visit, to set up payment arrangements except for new patients.

_____ *Initials* 2. I understand I am financially responsible for all charges whether or not paid by my insurance company also that it is my responsibility to know my benefits. I hereby authorize Valley Endocrinology to release all information necessary to secure payment. I authorize payment of my medical benefits directly to Valley Endocrinology.

_____ *Initials* 3. Should you issue a check that is returned to us "UNPAID", the following will occur: You will receive a telephone call from a Valley Endocrinology representative, asking you to come in and make the check good within 48 hours. We will, collect the original check amount, bank fees determined by our bank and a $25 re-processing fee. Should this happen again, the bank fees increase and our second processing fee increases to $50. No checks will then be accepted here in the future. This repayment and any future payments will be accepted in cash, credit or debit card.

_____ *Initials* 4. I understand that Valley Endocrinology is a participation physician in the Medicare Program. I understand that Medicare patients are responsible for the annual deductible of $183 and the amount equal to 20% of the Medicare allowable.

_____ *Initials* 5. I hereby authorize Valley Endocrinology to furnish information to my insurance company concerning my examinations, findings and treatment.

_____ *Initials* 6. If you are not able to keep your appointment, you must call 24 hours prior and cancel. If you no show or do not cancel, we will charge you $50 for that missed doctor appointment, if an ultrasound appointment is missed we will charge you $100. In fairness to other patients you must follow these guidelines. I also understand that if I do not show for my appointments three times that I may be dismissed from the practice.

_____ *Initials* 7. I understand that in the event my account is referred to a collection agency due to lack of payment on my part, I agree to pay all collection fees that will be added to my balance which is charged by the collection agency.

_____ *Initials* 8. All forms requiring the provider's time to complete, bears a $25 fee that must be paid at the time of completion. Insurance companies will not pay for this service.

_____ *Initials* 9. Medical records requests bear a .60 per page fee NRS 629.061. We are authorized by the Federal Government to charge for these requests. If you are moving and wait until you select your new provider, we will honor the request from another provider's office and fax at no charge. Should you want a copy of all your records, we will collect .60 per page, plus postage if applicable. You must allow Valley Endocrinology one week to process your request. If you have an outstanding balance we will not release records until your account is paid.

By signing below, I acknowledge all of the above and agree to provisions in Valley Endocrinology's policy. If I do not sign this acknowledgment I am aware I will be subject to Valley Endocrinology not accepting my insurance, I will pay cash for my visits at the time of service. I also acknowledge Valley Endocrinology will not issue any medical records unless I have given Valley Endocrinology the names of whom, I authorize the release of my medical records. I have read and agreed to all the provisions of the financial policy. I understand that I am ultimately responsible for all the profession fees incurred for professional services by the physician.

_____ _____

Signature of Responsible Party Date

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PLEASE READ AND RETURN TO FRONT DESK

NOTICE OF PRIVACT 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

- **Treatment:** Your health information may be used by staff members or disclosed to other healthcare 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 professional 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 source of coverage such as 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 Operations:** Your health information may be used as necessary to support the day-to-day activities and management of Valley Endocrinology. 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 state's public health.
- **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 authorizations. 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 not affect or undo any use of 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.
- **Information about Treatment:** Your health information may be used to send information that you may find interesting on the treatment and management of your medical condition. W may also send you information describing other health related products and services that we believe may interest you.
- **Fund Raising:** Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

☐

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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 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 and accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Valley Endocrinology Duties

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

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

Right to Revise Privacy Practices

As permitted by the law, we reserve the right to amend our privacy policies and practices. These changes in our policies and practices may be required by changes in the 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 or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect of 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 of 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:

Privacy Officer
Valley Endocrinology
653 N. Town Center Dr Ste # 504
Las Vegas, NV 89144

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing that 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:

Privacy Officer
Valley Endocrinology
653 N. Town Center Dr Ste # 504
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Effective Date This Notice is effective on or after April 14, 2003.

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Acknowledgement of Receipt of Notice of Privacy Practices

Valley Endocrinology reserves the right to modify the privacy practices outlined in the notice.

Signature:
I have received a copy of the Notice of Privacy Practices for Valley Endocrinology.

_____
Name of Patient (Print or 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)

**********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 _____. This acknowledgment was not obtained because:

☐ The patient was undergoing emergency treatment

☐ The patient declined to sign the acknowledgment

☐ Other

Signature:

_____
Name of Patient (Print or Type)

_____
Name of Staff Member

_____
Date

Valley Endocrinology 653 N Town Center Dr. Ste #504 Las Vegas, Nevada 89144
Phone: 702-701-8400 Fax: 702-701-8401

2018 Narcotics Changes from U.S. Department of Justice * Drug Control Division

Dear Patients,

Effective immediately, all Schedule II, III, & IV narcotics prescribing laws have changed. These laws signed by the Governor of The Great State of Nevada known as HB7095 from 2017 and the New AB474 for 2018 are policy's governing the prescribing of medications for control and aiding to the continued well-being of patients health. These changes are direct result of abuse of medications. Use of such medications will be monitored for risk of dependency, overdosing, abuse and even death.

Each patient must be seen intermittently in order to receive any prescriptions for these Scheduled II, III, & IV drugs and will be closely monitored. We will intermittently monitor your labs for affects; speak to you about the long term affects and have you sign this document stating you agree to this required monitoring. At any time you have a question; you will ask your provider for a clear explanation. Valley Endocrinology has the absolute authority to refer you to "Pain Management", if the past course of pain management is no longer effective.

Scripts for these types of narcotics will be written often for two months. The written scripts will be issued at the same time for 30 days each, stapled together and must be presented to the pharmacist in the same manner, they cannot be separated. A follow up visit with your provider must be made for the end of the 60 script before you leave the facility and the appointment must be kept before any refills are written. This process will not deviate. We will not renew any of these narcotics. If you cannot follow these guidelines, Valley Endocrinology will have no alternative but to discharge you from our facility as non-compliant. Any excuses for the loss of your prescription for controlled narcotics, will not be honored. We cannot write a new prescription until the time framed allowed, for this narcotic, has come to fruition or you will be referred to a "pain management" provider for the duration of your need for such a medication. We cannot refill any of these medications over the telephone.

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Phone: 702-701-8400 Fax: 702-701-8401

2018 Narcotics Changes from U.S. Department of Justice * Drug Control Division

Sharing of medications is prohibited and Valley Endocrinology providers will not renew any medications in question as result of sharing. The drugs pertaining to this change are: NORCO, CODEINE w/o TYLENOL, HYDROCODONE, HYDROMORPHONE, METOPON, MORPHINE, OXYCODONE, OXYMORPHONE, FENTANYL, METHADONE, AMPHETAMINE, MATHAMPHETAMINE, METHYLPHENIDATE, PENTOBARBITAL, NABILONE, DURAGESIC, FENTANLYL PATCHES, PERCOCET, PERCODAN, OXYCONTIN, TYLOX, CONCERTA, ADDERALL, DEXTROAMPHETAMINE, & VYVANSE are all **Schedule II narcotics.**

PHENDIMETRAZINE, CODEINE with TYLENOL and TESTOSTERONE are **Schedule III narcotics**

FLURAZEPAM, LORAZEPAM, TEMAZEPAM, TRIAZOLAM, ZALEPLON, ZOLPIDEM, ZOPICLONE, MODAFINIL, LYRICA, GABAPENTIN , CYMBALTS, CONTRAVE, BELVIQ, & PHENTERMINE are all **Schedule IV narcotics.**

No more than 14 days of a controlled substance will be written, for an "Acute Alignment". Please sign this document, knowing it will be placed into your medical chart as your acknowledgement of this policy. I also understand a Prescription Mentoring Report will be accessed before any of these medications are prescribed and every ninety days (90) thereafter as long as I am being prescribed these types of medications. I also acknowledge that should I abuse these medications, I may be discharged from this facility and reported to the DEA if abuse or unauthorized utilization is proven by the Valley Endocrinology facility.

Patient Name (Please Print):_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Valley Endocrinology PLLC

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A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the Nevada Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After the arbitration hearing, which is usually less formal than a court preceding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of the doctor is bound.

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What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and have an attorney of your choice, at your expense. This agreement generally helps to lower litigation time and costs for both patients and physicians. Further, both parties are spared the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Nevada and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy

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NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ *INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."*

By: _____
Physician or Duly Authorized Representative Signature (Date)

By: Valley Endocrinology
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

_____
Patient's Representative's Signature (If applicable) (Date)

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records