DPM
DIMURO PAIN MANAGEMENT

(702) 747-4799 (702) 747-4667

North Office | 3970 W. Ann Road., Suite 100, North Las Vegas, 89031
Central Office | 5550 W. Flamingo, Suite A-2, Las Vegas, NV 89103
South Office | 8475 S. Eastern Ave. Suite 203, Henderson, NV 89123

Personal Injury INITIAL INTAKE Questionnaire

Welcome to DiMuro Pain Management! This practice was created by Dr. John DiMuro shortly after he completed his government service as Chief Medical Officer for the State of Nevada under Governor Brian Sandoval. We are happy that you have chosen our practice for the treatment of your pain complaints. Our office is fully equipped to both diagnose and treat any type of pain complaint. However, in order to provide the best overall care, we need some information about you.

While we all hate to complete paperwork, it is extremely important that this information be obtained by our office. As many patients who suffer an injury have engaged legal representation, the information you provide here is part of the medical-legal record and will serve as the document of record for our ractice regarding your injury and comprehensive medical history. While completing this Initial Intake form may be time-consuming, please understand that many of the recommendations made by our DPM providers including prescription medications, imaging studies and injection therapy, will be impacted by not only the details of your injury, but your medical history as well. For example, if you have cancer, medication allergies, have metal in your body or even use blood thinners, treatment options may vary as this information will directly impact your medical care.

If the information requested in this simple questionnaire seems redundant, please understand that each medical specialist may need to obtain different information than other specialists. Pain Management is a unique medical subspecialty that requires some additional information that if not provided in this document, will ultimately have to be obtained at some point during your visit today. You will likely be thinking, “Why do I have to answer the same questions again?” and “I already filled this out for another doctor.” Please understand that medical offices do not routinely make it a simple process to share your medical records and we rely upon the information you provide in this document as the foundation for our medical decision-making.

Thank you for taking the time to complete this informational packet. We welcome you to our practice and look forward to working with you throughout your recovery.

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Personal Injury INITIAL INTAKE Questionnaire

Date of Appointment

Phone Number	Month	Day	Year
Email Address			

Language Preference

☐ English ☐ Spanish ☐ Other, Please Identify

PATIENT INFORMATION

Legal First Name
Legal Last Name
Current Address

Date of Birth			Are you:
Month	Day	Year	☐ Right Handed ☐ Left Handed ☐ Ambidexterous

Gender	Height		Weight
☐ Male ☐ Female	Feet	Inches	Pounds

DETAILS OF INJURY

1	Is your injury a result of a motor vehicle accident? ☐ Yes ☐ No			
2	If your injury is due to something other than a motor vehicle accident, please answer #4,5 & 6 and then skip to #14			
3	How many total vehicles were involved in the accident?			
4	Were you "on the clock" or working at the time of the accident? ☐ Yes ☐ No If yes, what is the name of the company for which you were working at the time of the accident?			
5	What is the exact date of the injury?	Month	Day	Year
6	What time of the day did the accident occur?	Hour	Minute	☐ AM ☐ PM

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7 Were you wearing a seat belt? ☐ Yes ☐ No

8 What was your position in the car? ☐ Driver ☐ Passenger ☐ Rear Behind Driver
☐ Rear Behind Passenger ☐ Rear Center ☐ Other (Please Describe):

9 What make and model motor vehicle were you in? | Make | Model

10 Was anyone else in the vehicle with you at the time of the accident? ☐ Yes ☐ No
If yes, what are their names?

Individual #1 Individual #4

Individual #2 Individual #5

Individual #3 Individual #6

11 What make and model car(s) were involved in the accident (if known)?

Make #1	Model #1	Make #2	Model #2	Make #3	Model #3

12 ☐ Did your vehicle impact the other vehicle **OR** ☐ Did the other vehicle impact your vehicle?
☐ Was your vehicle in motion at the time of the impact?

13 What part of your vehicle was impacted? (Check all that apply) ☐ Front ☐ Rear ☐ Passenger ☐ Driver ☐ Side

14 Please describe how the accident/injury occured. (Include location - Street names, Provide us with the most specific known location)

15 Did you anticipate the crash? ☐ Yes ☐ No Did airbags deploy? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No If yes, for how long?

16 Did the police come to the scene of the accident/injury? ☐ Yes ☐ No

17 Did an ambulance come to the scene of the accident/injury? ☐ Yes ☐ No

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Personal Injury INITIAL INTAKE Questionnaire

18 How exactly did you leave the scene of the accident/injury? ☐ Did you drive the car from the accident?

☐ Did someone Pick you up and give you a ride? ☐ Were you transported via ambulance from the scene?

☐ Other (Please Describe): _____

19 Where did you go immediately after the crash? Select one: ☐ Did you go to your home?

☐ A Relatives Home? ☐ An Urgent Care? ☐ A Hospital? ☐ Other (Please Describe):

MEDICAL CARE SINCE INJURY

20	What is the exact date you first sought medical care for injuries sustained in the accident?	Month	Day	Year

21 What type of medical provider have you been evaluated by?

☐ Hospital Emergency Room ☐ Urgent Care

☐ Primary Care Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Pain Doctor

☐ Other (Please Describe): _____

22 Have you had any imaging studies performed? ☐ Yes ☐ No If yes, have you had X-Rays? ☐ Yes ☐ No

Have you had an MRI? ☐ Yes ☐ No Do you know the name of the facility? ☐ Yes ☐ No

If yes, please identify where you had them performed and the name of the provider

☐ A Doctor's Office ☐ Hospital ☐ Free-standing Imaging Center ☐ Other (Please Describe):

23 If known, what body parts were imaged? ☐ Neck ☐ Back ☐ Shoulder ☐ Leg

☐ Other? Explain: _____

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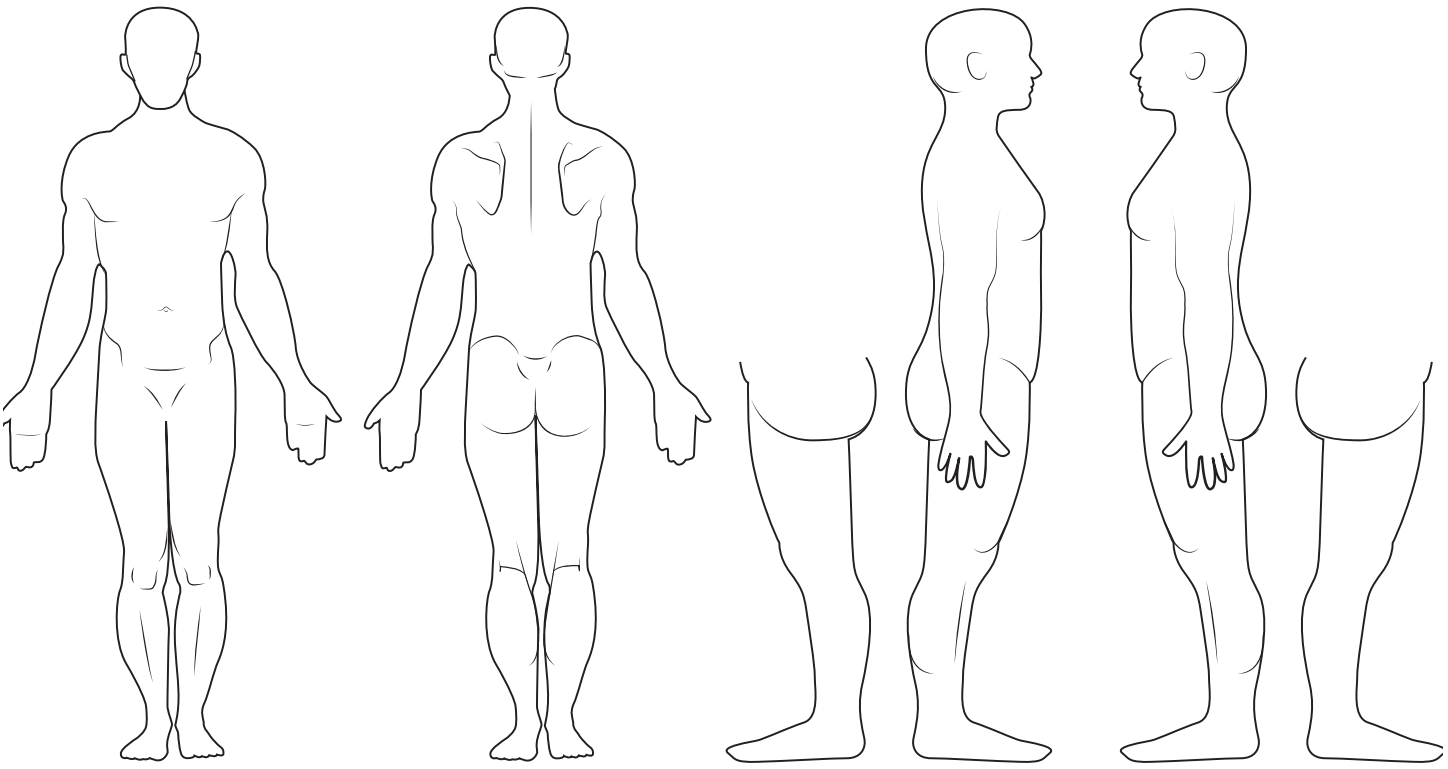
MEDICAL COMPLAINTS SINCE THE INJURY

24

	Location of Pain:	Does the Pain Radiate?	Pain is Worse with:	Pain is Better with:	Type of Pain:
1		☐ Yes ☐ No	☐ Sitting ☐ Standing ☐ Heat ☐ Ice ☐ Bending ☐ Activity ☐ Medicine ☐ Massage ☐ Driving ☐ Working ☐ Relaxation ☐ Other:	☐ Numb ☐ Searing ☐ Dull ☐ Burning ☐ Ache ☐ Sharp ☐ Other:
2		☐ Yes ☐ No	☐ Sitting ☐ Standing ☐ Heat ☐ Ice ☐ Bending ☐ Activity ☐ Medicine ☐ Massage ☐ Driving ☐ Working ☐ Relaxation ☐ Other:	☐ Numb ☐ Searing ☐ Dull ☐ Burning ☐ Ache ☐ Sharp ☐ Other:
3		☐ Yes ☐ No	☐ Sitting ☐ Standing ☐ Heat ☐ Ice ☐ Bending ☐ Activity ☐ Medicine ☐ Massage ☐ Driving ☐ Working ☐ Relaxation ☐ Other:	☐ Numb ☐ Searing ☐ Dull ☐ Burning ☐ Ache ☐ Sharp ☐ Other:

25 Since the injury, please mark on this drawing where you are currently experiencing pain



Anterior Posterior Right Lateral Left Lateral

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Personal Injury INITIAL INTAKE Questionnaire

26 Do you experience pain even at rest such as laying in bed or when you are relaxing? ☐ Yes ☐ No

27 Can you recall if you have ever sought treatment for pain in those body parts prior to this injury? ☐ Yes ☐ No

28 Do you remember ever having had imaging studies such as an X-Ray or MRI of these body parts before this injury?

☐ Yes ☐ No If yes, please indicate: _____

29 Please list the years and City/State in which you have ever had a motor vehicle accident or tramatic injury in the last 20 Years:

Year	City	State	Year	City	State
Year	City	State	Year	City	State

30 Please list the names of all of the medical providers that you have seen for your injuries related to the accident. Please include primary care doctors, massage therapists, physical therapists, chiro-practors, pain doctors, neurologists, neurosurgeons, orthopedic surgeons. If you are unsure of the provider's name, please just list the specialty of the provider:

Specialty	Name of Provider
Specialty	Name of Provider
Specialty	Name of Provider
Specialty	Name of Provider

31 Have you had any "Cortisone" injections since the accident? ☐ Yes ☐ No

If yes, what is the name of the doctor who gave you the injections?

Date of Injections (if known)

Month	Day	Year

32 Have you had any type of surgery since the accident? ☐ Yes ☐ No

If yes, on what part of your body did you have the surgery? What was the name of the surgeon?

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Personal Injury INITIAL INTAKE Questionnaire

MEDICAL HISTORY

PAST MEDICAL HISTORY

33 Do you have any medical issues? Please circle all that apply below.

☐ I do not have any known medical problems/I am otherwise healthy

Cardiovascular (Heart):
- ☐ Atrial Fibrillation/Arrythmia
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep vein thrombosis (DVT/blood clot)
- ☐ Heart Attack, when:_____
- ☐ Hypertension (High Blood Pressure)

Endocrine/Metabolic:
- ☐ Diabetes: Type I / Type II
- ☐ Diabetic Neuropathy
- ☐ High Cholesterol
- ☐ Hyperthyroid (High Thyroid)
- ☐ Hypothyroid (Low Thyroid)
- ☐ Obesity

Musculoskeletal:
- ☐ Arthritis/Osteoarthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Gastrointestinal:
- ☐ Gastric Ulcer
- ☐ GERD/Heartburn/Acid Reflex
- ☐ Inflammatory Bowel Disease

Infectious/Integument/Immunity:
- ☐ Herpes Simplex (HSV 1 / 2)
- ☐ Herpes Zoster (Shingles)
- ☐ Hepatitis A / B / C
- ☐ HIV/AIDS
- ☐ Impaired Immunity

Eyes:
- ☐ Glaucoma

Kidney/Urinary:
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones

Respiratory:
- ☐ Asthma
- ☐ COPD/Chronic Bronchitis
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea

Neurologic:
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Parkinson Disease
- ☐ Seizure: Last Seizure_____
- ☐ Stroke/TIA, when_____

Psychiatric:
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Major Depressive Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia

Hematologic:
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clotting Disorder
- ☐ Cancer: Type & Treatment

_____
_____
_____

Other:

_____
_____
_____

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ALLERGIES

34 Do you have any allergies to any medications/food which you are aware of? ☐ Yes ☐ No

If yes, please describe:

_____ _____

MEDICATIONS

35 Are you taking any blood thinners (such as Ibuprofen, Coumadin, Plavix, Naproxen or Asprin)? ☐ Yes ☐ No ☐ Not Sure

36 Are you currently taking any prescription medication? ☐ Yes ☐ No

If yes, please list the names of the medications below. If you are unsure of the name of the medication, please tell us the reason for which you take the medication and the name of the prescribing doctor.

Medication	Prescribed by
Medication	Prescribed by
Medication	Prescribed by
Medication	Prescribed by
Medication	Prescribed by
Medication	Prescribed by
Medication	Prescribed by
Medication	Prescribed by

Do you need additional room? Please check here and a second sheet will be provided to you ☐

37 Are you or could you be pregnant? ☐ Yes ☐ No

Date of last menstrual period	Month	Day	Year

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SURGICAL HISTORY

38 Have you ever had surgery? Do you have any metal in your body? ☐ Yes ☐ No

We understand this can be time-consuming to list every surgery and the year in which the surgery was performed, but it is very important information for us to have in the medical record so please do your best to complete this section accurately.

Surgery	Year
Surgery	Year
Surgery	Year
Surgery	Year
Surgery	Year
Surgery	Year

SOCIAL HISTORY

(Needed for a comprehensive profile in your medical record)

39 In what City, State, and Country were you born?

This is a screening question: The purpose is to assist in ruling out diseases that occur endemically in certain regions of the world.

City	State	Country

40 In what City, State, and Country do you currently reside? Since When?

City	State	Country

41 What is your highest level of education completed?

☐ Grade School ☐ High School ☐ College ☐ Graduate Degree

42 Do you smoke/vape or use tobacco-containing products? ☐ Yes ☐ No

43 Do you consume alcohol? ☐ Yes ☐ No

☐ Daily ☐ Weekly ☐ Socially ☐ Rarely ☐ Never

44 Have you ever undergone treatment for any type of substance abuse? ☐ Yes ☐ No

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EMPLOYMENT

45 Are you currently employed? ☐ Yes ☐ No Approximately how many hours per week do you legally work?

46 What is your job title?

47 What is the name of the company for which you are employed?

48 How many years have you been employed by this company?

49 Has your ability to function in your job responsibilities changed since the accident? ☐ Yes ☐ No

If yes, please briefly explain here:

_____

_____

_____

OPIOID RISK TOOL

50 Are you Male or Female? ☐ Male ☐ Female

Please Mark Each Box that Applies:

Family History of Substance Abuse

Alcohol ☐
Illegal Drugs ☐
Rx Drugs ☐

Personal History of Substance Abuse

Alcohol ☐
Illegal Drugs ☐
Rx Drugs ☐

Age Between 16-45 Years ☐

History of Preadolescent Sexual Abuse ☐

Psychological Disease

ADD, OCD, Bipolar, Schizophrenia ☐
Depression ☐

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Request for Medical Records

Pedido de Informacion Medica

Full Legal Name					
Patient Date of Birth			**Date of Appointment**		
Month	Day	Year	Month	Day	Year
Social Security Number			**Date of Injury/Date(s) of Service**		
			Month	Day	Year

I hereby authorize and request you to release to DiMuro Pain Management any and all medical records including but not limited to medical examination, treatment and services rendered, radiographic reports and/or films pertaining to the above-listed date of injury and/or date(s) of service.

Yo autorizo y doy consentimiento que provea ud. a Dimuro Pain Management todos los expedientes medicos que tenga incluyendo, pero no limitado a la examinacio, el tratamiento y los servicios que se me han preveido, reportes radiologicos y/o radiografias que pertenezcan a la fecha lastimadura o de servicios notada arriba.

Signature of patient or legal guardian
Firma del paciente o persona responsable

Printed name of patient or legal guardian
Nombre del paciente o persona responsable

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DiMuro Professional Services, LLC
DiMuro Facilities Services, LLC
Authorization for Release of Confidential Records and Protected Health Information/Medical Information - HIPAA Compliant

Full Legal Name					
Patient Date of Birth			Date of Appointment		
Month	Day	Year	Month	Day	Year
Patient Phone Number					
Attorney's Name/Firm Name					

I,_____("Patient") hereby grant permission and authorization for DiMuro Professional Services, LLC ("DCM Professional") and DiMuro Facilities Services, LLC ("DPM Facilities") to disclose to _____("Assignee"), as Asignee of DPM Professional and of DPM Facilities, pursuant to the Medical Lien Agreement/ Assignment of Benefits, and for Assignee to receive, review, inspect, and/or copy, any and all of the following in the possession or control of DPM Professional and DPM Facilities (please initial):

_____ 1. All medical reports, charts, notes, letters, history, physical findings, diagnosis, prognosis, x-rays, MRI films, CT-scans, radiology or other imaging records, pharmacy records, prescriptions, itemized statements of charges, billing and any other medical records, which may include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse;

_____ 2. X-rays, MRI films, CT-Scans, Radiology or other imaging records, only; or,

_____ 3. Only the following items (please specify):

_____

With the exception of the following information:

_____Mental health records
_____Communical diseases (including HIV and AIDS)
_____Alcohol/drug abuse treatment
_____Other (please specify items to be excluded):

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons and/or facility receiving such, and would then no longer be protected by federal privacy regulations:

I may revoke this Authorization by notifying the above office in writing to revoke such. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. This Authorization expires in three (3) years, or upon the resolution of the matter that underlies this authorization, whichever is later. A photocopy of this is to be treated as an original.

Signature of Patient/Client or Claimant or Guardian if a minor:_____
Date:_____ Social Security #:_____

If signed by other than the Patient, select authority and provide documentation:
_____Parent of minor_____Power of Attorney_____Other, (explain):_____

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Opioid Agreement Form

Full Legal Name
Medical Record Number

Agreement for Long Termed Controlled Substance Prescriptions

The use of _____ (Print names of medication(s)) may cause addiction and is only one part of treatment for: _____ (Print name of condition-e.g. pain, inflammation, etc.).

The goals of this medicine are:

to improve my ability to work and function at home
to help my_____(print names of condition-e.g., pain, inflammation, etc.) as much as possible without causing dangerous side effects.

I have been told:

1. if I drink alcohol, marijuana or use street drugs, I may not be able to think clearly, and could become sleepy and risk personal injury.
2. I may get addicted to this medication
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following (please initial):

_____I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.

_____I will not increase my medicine until I speak with my doctor or nurse.

_____My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.

_____I will keep all my appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)

_____I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.

_____I agree to give a blood or urine sampple, if asked, to test for drug use.

_____I understand that any medications necessary for my treatment will be managed through the course of my treatment with the practice. DPM is not currently contracted with any health care plans and DPM does not accept cash pay paments.

Refills

Refills will be made only during regular office hours - Monday through Friday, 9:00AM-5:00PM.
No refills on nights, holiday, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I must keep track of my medications. No early or emergency refills may be made.

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Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my Pharmacy is
Location

Prescription from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to DPM in the original bottle, even if there are no pills left.

Privacy

While I am taking this medication, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medication. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor, and I understand the rules stated in this agreement.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide care for you as needed that may not involve getting controlled medicines from me.

Patient's Signature _____ Date _____

Patient's Printed Name _____

Physician's Signature _____

Dr. John DiMuro

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DiMuro Professional Services, LLC
DiMuro Facilities Services, LLC
Authorization for Release of Confidential Records and Protected Health Information/Medical Information - HIPAA Compliant

Full Legal Name					
Patient Date of Birth			Date of Appointment		
Month	Day	Year	Month	Day	Year
Patient Phone Number					
Attorney's Name/Firm Name					

I, _____("Patient") hereby grant permission and authorization for DiMuro Professional Services, LLC ("DPM Professional") and DiMuro Facilities Services, LLC ("DPM Facilities") to disclose to Medical Services Management LLC ("MSM"), and for MSM to receive, review, inspect, and/or copy, any and all of the following in the possession or control of DPM Professional and DPM Facilities: (please initial)

_____1. All medical reports, charts, notes, letters, history, physical findings, diagnosis, prognosis, x-rays, MRI films, CT-scans, radiology or other imaging records, pharmacy records, prescriptions, itemized statements of charges, billing and any other medical records, which may include records relating to metal healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse:

_____2. X-rays, MRI films, CT-Scans, Radiology or other imaging records, only: or,

_____3. Only the following items (please specify):

_____

With the exception of the following information:

_____Mental health records
_____Communicable diseases (included HIV and AIDS)
_____Alcohol/drug abuse treatment
_____Other (please specify items to be excluded):

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons and/or facility receving such, and would then no longer be protected by federal privacy regulations.

I may revoke this Authorization by notifying the above office in writing to revoke such. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. This Authorization expires in three (3) years, or upon the resolution of the matter that underlies this authorization, whichever is later. A photocopy of this is to be treated as an original.

Signature of Patient/Client or Claimant or Guardian if a minor			
Date			Social Security Number
Month	Day	Year	

If signed by other than the Patient, select authority and provide documentation:
_____Parent of minor _____Power of Attorney _____Other_____

File #:

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DiMuro Professional Services, LLC
DiMuro Facilities Services, LLC
Medical Lien Agreement/ Assignment of Benefits

Full Legal Name	Best Phone Number to Contact Patient or Patient Representative

Patient Date of Birth			Date of Appointment		
Month	Day	Year	Month	Day	Year

Attorney's Name/Firm Name	
Attorney's Phone Number	Attorney's Fax Number

I, the above referenced Patient ("Patient" or "Me")) of DiMuro Professional Services, LLC ("DPM Professional") and DiMuro Facilities Services, LLC ("DPM Facilities") hereby authorize and direct you, my attorney ("Attorney") or insurance company, to pay directly to DPM Professional and/or DiMuro DPM Facilities (collectively referred to as "DPM") such sums as may be due and owing for medical goods and services rendered to me by DPM, related in any way to the accident or incident noted above (the "Accident") and by reason of any bills or invoices for medical goods and/or services rendered to me. I further authorize and direct you to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate DPM. I hereby further give a Medical Lien on my claim and/or lawsuit related to the Accident to DPM against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my Attorney, or to myself, or by your insurance company, as the result of the injuries for which I have been treated and/or injuries in connection therewith. I hereby direct my Attorney or insurance company to render payment to DPM in accordance with governing Nevada law and rules of ethics, and no later than to any and all other individuals and/or entities with an interest therein.

I understand that I am directly and fully responsible to DPM for all medical bills and invoices submitted by DPM for goods and services rendered to me, regardless of any amounts recovered in my claim/ lawsuit, if any. I understand and agree that this Medical Lien Agreement ("Agreement") is made solely for DPM's additional protection and in consideration of DPM awaiting payment. I further understand and agree that full payment to DPM is not contingent on any settlement, judgment or verdict related to my claim and/or lawsuit by which I may eventually recover payment for such medical bills and invoices. I also direct the appropriate insurance carrier to make available a separate check payable to DPM should DPM make such a request.

As additional security for Patient's obligations to pay for medical services and costs and as security for the Patient's performance on any and all other obligations with respect to DPM, either now existing or arising in the future, including any extensions, renewals, or other modifications of Patient's duties regarding medical treatment, Patient hereby grants to DPM a security interest in the following property:

1. That certain tort claim and/or lawsuit that arose out of the Accident.
2. All proceeds that arise out of or that are related to said tort claim described above.
3. Payment intangibles related to said tort claim described above. These include any and all contractual obligations that now exist or that come into being in the future that obligate any person or entity to pay money to the Patient and/or his/her attorney as a result of the Accident.

I further authorize DPM or its assignee to file a UCC 1 financing statement in order to perfect its security interest in this collateral, though it is not required to do so.

Patient and Attorney acknowledge and agree that DPM reserves the right to sell and assign its rights under this Agreement, and the underlying bills, invoices, and accounts receivable, at any rate or for any consideration that DPM deems appropriate, and to any third party assignee of DPM's choosing ("Assignee"). Patient and Attorney shall continue to be bound by this Agreement to Assignee as if Assignee is the original party to this Agreement. Further, Patient agrees to remain liable to Assignee for the full billed/invoiced charges for any and all medical treatment, goods, services, and/or

procedures rendered to Patient.

Patient hereby authorizes DPM to release any and all of the Patient's medical and billing records to Assignee, as well as to DPM's management company, Medical Services Management LLC ("MSM"), as needed to enforce payment of any bills, invoices, accounts receivable related to goods and services rendered by DPM to Patient.

Patient hereby authorizes his Attorney, including any attorney he/she retains in the future with regard to the Accident, to disclose any information pertaining to the status of Patient's personal injury claim and/or lawsuit to DPM, MSM or Assignee. Patient further directs Attorney to do everything necessary to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Patient hereby understands that if health insurance information is not presented at the time of service and a request to use that health insurance is not made at that time, Patient will not later claim that health insurance should have covered the service provided, nor shall Patient seek a discount from DPM or its Assignee so as to pay an amount that an insurance payor would have purportedly paid if health insurance information had been initially furnished.

I agree to promptly notify DPM of any change or addition of attorney(s) used by me in connection with this Accident, and I instruct my current attorney to do the same and to promptly deliver a copy of this Agreement to any such substituted or added attorney(s). I understand and agree that if I do not keep DPM updated on the name and contact information of the attorney for my claim/ lawsuit related to the Accident, or pursue my claim/ lawsuit related to the Accident without an attorney for whatever reason, or drop my claim/ lawsuit related to the Accident, DPM or Assignee reserve their right to consider all invoices/ bills/ accounts receivable due and payable immediately and in full by Me.

I acknowledge that I have been given an opportunity to consult with an attorney of my choosing prior to signing this Agreement. I agree to be bound by this Agreement by signing below. I have been advised that if my Attorney does not wish to cooperate in protecting DPM's interest as outlined herein, DPM will not await payment, and may declare the entire balance due and payable immediately and in full by Me. By signing below, Patient promises to abide by the terms of this Agreement and acknowledges that DPM's rights hereunder may be assigned to a third-party Assignee, as outlined above. In the event of such assignment, patient and Attorney shall continue to be bound by this Agreement as if Assignee is the original party to this Agreement. In the event this Agreement is litigated, the laws of the State of Nevada will be controlling, and the prevailing party will be entitled to attorneys' fees and costs.

Patient's Signature _____ Dated _____

Patient's Printed Name _____

The undersigned being attorney for the above Patient does hereby agree to observe all of the terms outlined above, without modification, and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate DPM or Assignee. Receipt of this notice, regardless of written affirmation thereof, will create in me a duty to protect the interests of DPM or Assignee, pursuant to relevant Nevada law. Attorney further agrees that in the event this Agreement is litigated, the laws of the State of Nevada will be controlling, and the prevailing party will be entitled to attorneys' fees and costs.

Attorney Signature _____ Dated _____

Attorney Name (print) _____

Please date, sign and return one copy to DPM. Keep a copy for your records.

File #:

DPM
DIMURO PAIN MANAGEMENT

(702) 747-4799 (702) 747-4667

North Office 3970 W. Ann Road., Suite 100, North Las Vegas, 89031
Central Office 5550 W. Flamingo, Suite A-2, Las Vegas, NV 89103
South Office 8475 S. Eastern Ave. Suite 203, Henderson, NV 89123

Patient Authorization/Emergency Contact Form

Authorization to Release Information to Family Members

- Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic/test results and/or financial information released to any family members you must sign this form.
- You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent

I authorize DiMuro Pain Management (DPM) to release my records and any information requested to the following individuals:

1	Name	Relationship to Patient
2	Name	Relationship to Patient
3	Name	Relationship to Patient

Authorization Regarding Messages

(Please Check all that Apply)

- ☐ I authorize DPM to leave a detailed message on my home or cell number regarding appointments.
- ☐ I authorize DPM to leave a detailed message on my home or cell number regarding medical treatment, care, test/diagnostic results, or financial information.
- ☐ I authorize DPM to leave a message with anyone who answers the phone.
- ☐ Messages may only be left with _____

Emergency Contact Form

1	Name			
Phone Number		Relationship to Patient		
Address	City	State	ZIP Code	

2	Name			
Phone Number		Relationship to Patient		
Address	City	State	ZIP Code	

Patient's Signature _____ Date _____

Patient's Printed Name _____

File #:

DPM
DIMURO PAIN MANAGEMENT

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