Andrew M. Cash M.D.
Phone: (702) 630-3472 Fax: (702-946-5115

Would you like access to your medical records through our web portal? Yes _________ No_______
Email: ____

Referring Source: [ ] ___________________________ [ ] ______________________ [ ] ________________________
Physician/health care provider   Friend/ Relative   Insurance book or website

[ ] __________ [ ] __________ [ ] __________ [ ] ______ [ ] ______ [ ] _______ [ ] _____________ [ ]____________
Advertisement   DISC website   DEX Knows   GOOGLE   YAHOO   Phonebook   Hospital/ ER name   ER PHYSICIAN

Patient Name: _______________________________ ________________________ ____________________________
Last   First   Middle

Address: _________________________________ ________________ _______________ ___________ __________
Street   City   State   Zip code   country

Phone: (___)________________ (____)____________ Employer: ___________________________ (___)__________
Home   Cell   Company name   Work phone

<u>Sex:</u> (circle one) <u>Female Male</u> Date of Birth: ___/___/___ Age:____ Social Security Number: ______-_____-_____
Ethnicity: _________________Decline ☐ Race: _____________________ Decline ☐

<u>Primary</u> Insurance Co. Name: __________________ Insured Name: ____________________ Insured DOB:_______

Insured Social Security # ______-_____-______ Policy Id#______________________ Group#___________________

<u>Secondary</u> Insurance Co. Name: ________________ Insured Name: __________________Insured DOB:_______

Insured Social Security # ______-_____-______ Policy Id#______________________ Group#___________________

<u>Notice of Privacy Information Practices</u> of Andrew M. Cash MD policy regarding minimum necessary uses and disclosures of protected health information. ☐**I accept or** ☐**I decline** to receive a copy of privacy practices.

<u>HIPPA PRIVACY AUTHORIZATION FORM</u> *Authorization for use or disclosure of protected health information*

Dr. Andrew Cash at Desert Institute of Spine Care (DISC) is committed to HIPPA regulations. Therefore each patient is required to sign a release for HIPPA regulations. Patients may include companion(s) (family members, friends, etc.) accompanying them to their appointment, schedule or reschedule appointments. Listed individuals are approved to hear discussion regarding the patient's health information.

I authorize the following individuals to be involved in the discussion of my medical health information. I understand, I am responsible for the release of the information provided by (DISC) to the following authorized companion(s)

Name	Relationship	Patient Initials' here
_________________________	_____________________________	_________________
_________________________	_____________________________	_________________
_________________________	_____________________________	_________________

Party Signature:____ Date: ___________________________

By signing this form I hereby consent to and authorize medical treatment, tests, and procedures performed in the office that the physician deems advisable and necessary based on his/her judgment. I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

Insurance revised 08-2011

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X-RAY CONSENT: During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In order to perform x-rays on any patient our office requires the patients consent.

YES_____ I understand that my doctor may need x-rays in order to diagnose my condition. I give permission of all needed diagnostic tests. With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor

NO ______ I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms.

I choose not to have any x-rays at this time and release my Doctor of all liabilities.

YES______I will be responsible for any balances due and owing if payment for x-rays is denied.

- **FEMALES ONLY:** I understand that if I am pregnant and have x-rays taken which expose my lower torso to Radiation, it is possible to injure the fetus. I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.
- With those factors in mind, I am advising my doctor that: (please initial in box)

- Last Menstrual Period __/__/__,
- Are you currently on birth control? ☐Yes ☐No
- I am pregnant _____yes ______no ______ don't know
- I could be pregnant _____yes ______no ______ don't know
- My menstrual period is late _____yes ______no ______ don't know
- I have an IUD _____yes ______no
- I have had a tubal ligation _____yes ______no
- I have had a hysterectomy _____yes ______no
- I have irregular menstrual periods _____yes ______no
- My last menstrual period began _______________
- I have begun menopause ______yes _____ no

____ Date: ___________

Signature Patient/Responsible Party

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NARCOTIC AGREEMENT:

Andrew M. Cash MD is dedicated to providing you the best treatment we possibly can. For Dr. Cash to prescribe you pain medication, we require that you read and follow our narcotic contract. Dr. Cash does not prescribe long term narcotic pain medication, if you have ongoing pain that requires chronic pain medication you will be referred to a pain management specialist for all narcotic medication needs. The following medication policy is intended for the safety of our patients and to limit the chance of drug interactions and abuse.

By initialing I agree to the following:

______ **1.** I am currently not abusing prescription or non prescription drugs, and I am not undergoing treatment for addiction or substance abuse.
_______**2.**I certify that I have disclosed to my physician any past diagnoses or treatments of psychiatric conditions, drug or alcohol abuse.
_______**3.**I agree that while I am being treated with narcotic medication I will abstain from alcohol use. I understand the dangers involved in using alcohol while also taking narcotic medications.
_______**4.**I have never been involved in the sale, illegal possession or transport of controlled substance such as narcotic, sleeping pills, pain pills or other illegal substances.
______**5.**I agree to only use one pharmacy for filling of prescriptions, and will supply Dr. Cash with name and number of pharmacy. Pharmacy name: ______________________ Pharmacy phone: _____________
Pharmacy location or major cross streets: ____
_______**6.**I agree to allow Dr. Cash to communicate with referring physicians and pharmacists and the Drug Enforcement Agent (DEA) regarding my medications.
_______**7.**I agree to take my medications as prescribed; I will not alter my dosage or timing of medications without consulting Dr. Cash.
_______**8.**I certify that I am not pregnant, and will stop taking narcotic medications if I become pregnant.
_______**9.**I agree to have a urine or blood test done randomly at my physician's request.
_______**10**. I understand that lost, stolen or misplaced prescriptions or medications will not be replaced unless you provide proof that a police report has been filed.
_______**11.** I understand that narcotic medication may cause drowsiness. If I feel impaired, I will not operate a car or potentially dangerous machinery.
_______**12.** If I deviate from the above guidelines, I understand that I will not receive any more medications from Andrew M. Cash, MD and could result in my termination of care.

____ Date: ___________
Signature Patient/Responsible Party

____ Date: ___________
Signature Witness

I do not agree to the narcotic agreement, therefore I will not receive any medications from Andrew M. Cash MD.

____ Date: ____________
Signature

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Height ______ **Weight _____**

What is your chief complaint? ____________________________________

Use the key below to draw the sensations in the appropriate locations on the body diagram.

Pay attention to front/back and right/left:

Front
Right Left

Back
Left **Right**

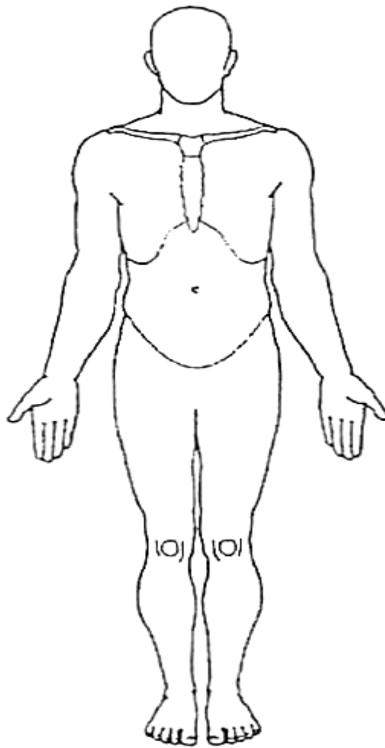
- ***Key***
  ~~~ Ache

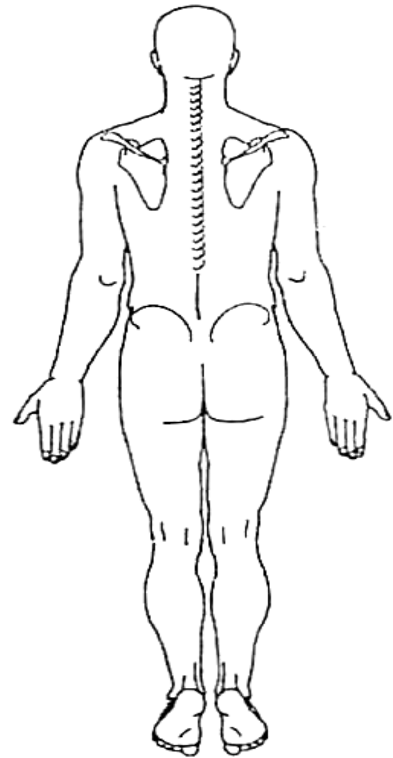
  000 Pins & Needles

  XXX Burning

  /// Stabbing

  === Numbness





When did the problem begin?
____/___/___

How did this problem begin?____

PLEASE LIST ANY AND ALL *PRIOR BODILY INJURIES AND TREATMENTS*:
(This includes ACCIDENTS, WORKERS COMP, INJURIES, CHIROPRACTIC, THERAPY, INJECTIONS)

DATE **BODY PART** **HOW IS HAPPENED?** **TREATMENT**

____
____
____
____

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NECK PAIN: Only complete this page if you have neck pain.
PLEASE CIRCLE THE NUMBER THAT MOST APPLIES TO YOU IN ALL 10 SECTIONS.

NECK DISABILITY INDEX	
SECTION 1: Pain Intensity 0. I have no pain at the moment. 1. The pain is mild at the moment. 2. The pain comes & goes & is moderate. 3. The pain is moderate & does not vary much. 4. The pain is severe but comes & goes. 5. The pain is severe & does not vary much.	SECTION 6: Concentration 0. I can concentrate fully when I want to with no difficulty. 1. I can concentrate fully when I want to with slight difficulty. 2. I have a fair degree of difficulty in concentrating when I want to. 3. I have a lot of difficulty in concentrating when I want to. 4. I have a great deal of difficulty in concentrating when I want to. 5. I cannot concentrate at all.
SECTION 2: Personal Care (Washing, Dressing etc.) 0. I can look after myself without causing extra pain. 1. I can look after myself normally but it causes extra pain. 2. It is painful to look after myself and I am slow & careful. 3. I need some help but manage most of my personal care. 4. I need help every day in most aspects of self-care. 5. I do not get dressed; I wash with difficulty and stay in bed.	SECTION 7: Work 0. I can do as much work as I want to. (0 pts) 1. I can only do my usual work but no more. (1 pt) 2. I can do most of my usual work but no more. (2 pts) 3. I cannot do my usual work. (3 pts) 4. I can hardly do any work at all. (4 pts) 5. I cannot do any work at all. (5 pts)
SECTION 3: Lifting 0. I can lift heavy weights without extra pain. 1. I can lift heavy weights, but it causes extra pain. 2. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table. 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. 4. I can only lift very light weights. 5. I cannot lift or carry anything at all.	SECTION 8: Driving 0. I can drive my car without neck pain. (0 pts) 1. I can drive my car as long as I want with slight pain in my neck. (1 pt) 2. I can drive my car as long as I want with moderate pain in my neck. 3. I cannot drive my car as long as I want because of moderate pain in my neck. (3 pts) 4. I can hardly drive my car at all because of severe pain in my neck. (4p) 5. I cannot drive my car at all. (5 pts)
SECTION 4: Reading 0. I can read as much as I want to with no pain in my neck. 1. I can read as much as I want with slight pain in my neck. 2. I can read as much as I want with moderate pain in my neck. 3. I cannot read as much as I want because of moderate pain in my neck. 4. I cannot read as much as I want because of severe pain in my neck. 5. I cannot read at all because of neck pain.	SECTION 9: Sleeping 0. I have no trouble sleeping. 1. My sleep is slightly disturbed (less than 1 hour sleepless). 2. My sleep is mildly disturbed (1-2 hours sleepless). 3. My sleep is moderately disturbed (2-3 hours sleepless). 4. My sleep is greatly disturbed (3-5 hours sleepless). 5. My sleep is completely disturbed (5-7 hours sleepless).
SECTION 5: Headache 0. I have no headaches at all. 1. I have slight headaches that come infrequently. 2. I have moderate headaches that come in-frequently. 3. I have moderate headaches that come frequently. 4. I have severe headaches that come frequently. 5. I have headaches almost all the time.	SECTION 10: Recreation 0. I am able to engage in all recreational activities with no pain in my neck at all. 1. I am able to engage in all recreational activities with some pain in my neck. 2. I am able to engage in most, but not all, recreational activities because of pain in my neck. 3. I am able to engage in only a few of my usual recreational activities because of pain in my neck. 4. I can hardly do any recreational activities because of pain in my neck. 5. I cannot do any recreational activities at all.

If you are having **NECK** pain please complete the following: **Please circle your pain level** **0 = No Pain, 10 = Worst possible pain**

What is your AVERAGE: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

What makes pain feel worse? (Circle all that apply) Work, sit, stand, walk, lie down, daily activity,________________

What is your WORST: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

How much did these treatments help your **NECK** pain? Physical therapy ____% Chiropractic ____% Injections ____% Surgery ____%

If you have neck AND arm pain, which is worse (or they about equal)?

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BACK PAIN: Only complete this page if you have back pain.

PLEASE CIRCLE THE NUMBER THAT MOST APPLIES TO YOU IN ALL 10 SECTIONS.

BACK DISABILITY INDEX	
SECTION 1: Pain Intensity 0. I have no pain at the moment. 1. The pain is mild at the moment. 2. The pain comes & goes & is moderate. 3. The pain is moderate & does not vary much. 4. The pain is severe but comes & goes. (5. The pain is severe & does not vary much.	SECTION 6: Standing 0. I can stand as long as I want without pain. 1. I have some pain on standing but it does not increase with time. 2. I cannot stand for longer than 1 hour without increasing pain. 3. I cannot stand for longer than 1/2 hour without increasing pain. 4. I cannot stand for longer than 10 minutes without increasing pain. 5. I avoid standing because it increases the pain immediately.
SECTION 2: Personal Care (Washing, Dressing etc.) 0. I can look after myself without causing extra pain. 1. I can look after myself normally but it causes extra pain. 2. It is painful to look after myself and I am slow & careful. 3. I need some help but manage most of my personal care. 4. I need help every day in most aspects of self-care. 5. I do not get dressed; I wash with difficulty and stay in bed.	SECTION 7: Social life 0. My social life is normal and gives me no pain. 1. My social life is normal but it increases the degree of pain. 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, for example, dancing, etc.. 3. Pain has restricted my social life and I do not go out very often. 4. Pain has restricted my social life to my home. 5. I have hardly any social life because of pain.
SECTION 3: Lifting 0. I can lift heavy weights without extra pain. 1. I can lift heavy weights, but it causes extra pain. 2. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table. 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. 4. I can only lift very light weights. 5. I cannot lift or carry anything at all.	SECTION 8: Driving 0. I get no pain when traveling. 1. I get some pain when traveling but none of my usual forms of travel make it any worse. 2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel. 3. I get extra pain while traveling which compels me to seek alternate forms of travel. 4. Pain restricts me to short necessary journeys under ½ hour. 5. Pain restricts all forms of travel.
SECTION 4: Walking 0. I have no pain on walking. 1. I have some pain on walking but it does not increase with distance. 2. I cannot walk more than 1 mile without increasing pain. 3. I cannot walk more than 1/2 mile without increasing pain 4. I cannot walk more than 1/4 mile without increasing pain 5. I cannot walk at all without increasing pain.	SECTION 9: Sleeping 0. I have no trouble sleeping. 1. My sleep is slightly disturbed (less than 1 hour sleepless). 2. My sleep is mildly disturbed (1-2 hours sleepless). 3. My sleep is moderately disturbed (2-3 hours sleepless). 4. My sleep is greatly disturbed (3-5 hours sleepless). 5. My sleep is completely disturbed (5-7 hours sleepless).
SECTION 5: Sitting 0. I can sit in any chair as long as I like. 1. I can sit only in my favorite chair as long as I like. 2. Pain prevents me from sitting more than 1 hour. 3. Pain prevents me from sitting more than 1/2 hour. 4. Pain prevents me from sitting more than 10 minutes. 5. I avoid sitting because it increases pain immediately.	SECTION 10: Recreation 0. My pain is rapidly getting better. 1. My pain fluctuates but is definitely getting better. 2. My pain seems to be getting better but improvement is slow. 3. My pain is neither getting better or worse. 4. My pain is gradually worsening. 5. My pain is rapidly worsening.

If you are having **BACK** pain please complete the following: **Please circle your pain level** **0 = No Pain, 10 = Worst possible pain**

What is your AVERAGE: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

What makes pain feel worse? (Circle all that apply) Work, sit, stand, walk, lie down, daily activity,________________

What is your WORST: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

How much did these treatments help your **BACK** pain? Physical therapy ____% Chiropractic ____% Injections ____% Surgery ____%
If you have back AND leg pain, which is worse (or they about equal) ________________________________

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Allergies: List all medications/foods you are allergic to, **include the type of reaction** from this medication:
NAME ___________________ Reaction: _________________________
NAME ___________________ Reaction: _________________________
NAME ___________________ Reaction: _________________________

Medications: List all medications you are currently taking, **include dosage** and **frequency** and **reason**:
If you have a **complete** list that we can photocopy, you do not have to complete this section.
NAME ___________________dosage:____________________frequency:__________reason:____________________
NAME ___________________dosage:____________________frequency:__________reason:____________________
NAME ___________________dosage:____________________frequency:__________reason:____________________
NAME ___________________dosage:____________________frequency:__________reason:____________________
NAME ___________________dosage:____________________frequency:__________reason:____________________
NAME ___________________dosage:____________________frequency:__________reason:____________________

Medical History: Please mark any conditions that apply to you: ☐Diabetes☐ High blood pressure ☐Heart Disease ☐Hepatitis ☐Asthma ☐Cancer ☐AIDS ☐Emphysema/Bronchitis ☐Epilepsy/Seizures ☐Arthritis ☐Gout ☐Hearing Loss ☐Dizziness/Fainting ☐Depression ☐Chemical Dependency
☐Psych Problems(Which type: __________) Other:___________

Surgical History: List any surgeries or other conditions for which you have been hospitalized:
Date Surgery/Hospitalization Reason
____
____
____
____

Social History: Marital Status: ☐Married ☐Single ☐Divorced ☐Widow
Education Level: ☐H.S. ☐College/University ☐Vocational
Occupation: ________________ Employer Name: _______________ Are you currently working? ☐Yes ☐No.
Last day worked: ___/___/___ Are you disabled? ☐Yes ☐No, if so who deemed you disabled and when?

How much tobacco do you use per day? ________________________ How much alcohol do you drink? ______________
Do you use illegal substances? ☐No/☐Yes, which ones? ______________________________________

Family History: Has anyone in your immediate family (Parents, Brothers, Sisters) ever been treated for any of the following? ☐Arthritis ☐Cancer ☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Kidney Disease ☐Stroke ☐Tuberculosis ☐Mental Disorder (type:______________) ☐Other: ___________________

Do you have any siblings? ☐ Yes ☐ No If yes how many? __________ What is your birth order? ________

Review of Systems: Do you now or have you had any problems related to any of the following systems?
☐Night Sweats ☐Fevers ☐Chills ☐Pain wakes you up ☐unexplained weight loss ☐ Chest Pain ☐Headaches ☐Visual Changes ☐Hearing Loss ☐Dizziness ☐Swelling in Legs ☐Shortness of breath ☐Cough ☐Abdominal Pain ☐Nausea ☐Vomiting ☐Heartburn ☐Constipation ☐Diarrhea ☐Incontinence

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Financial Policy, Assignment of Benefits, HIPAA, and Medication Policy Signature Form

I, the undersigned patient, assign payment (s) directly to Desert Institute of Spine Care or DISC; Dr. Andrew Cash. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance. Certain tests may be ordered by Dr. Cash such as X-rays and or toxicology screens. I agree to be financially responsible for these services should they be considered "non-covered", "out of network" or not medically indicated by my insurance company. If my treatment is involved in a lien, it is my responsibility to notify the office if there are any changes in legal representation. If my treatment is involved with a work related injury and Dr. Cash is to file Workman's Compensation claims on my behalf, I authorize the doctors and staff to discuss plan of treatment, care and appointment information with claims payers and/or case workers. There will be a charge of **$50.00** for **All NO Show Appointments or cancellations less than 24 hours prior to the scheduled appointment time.** There will be a charge of **$50.00 for all returned checks**. If my account becomes delinquent and referred to a collection agency, I will be responsible for the costs of collection and/or legal fees. There will be an interest charge of **$50.00** for all delinquent payments at time of service.________ **(initial)** I hereby assign Andrew M. Cash MD, their Physician Assistants, and surgical technologists any or all benefits for surgical and medical care. I also authorize release of information to secure payment. A photocopy of this assignment is to be considered as valid as the original. ________ **(initial)**

_______________ _______________ _______________ _______________

Print Last Name, First Name Patient signature Date

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean ___________________________. "Physician" Andrew M. Cash M.D. Desert Institute of Spine Care. Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I __________________________ (patient name) and/or my representative agree to use American Board of Orthopaedic Surgery (ABOS) board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the ***Clark County Medical Society.*** Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the ***North American Spine Society and American Academy of Orthopaedic Surgeons.***

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the ***North American Spine Society and American Academy of Orthopaedic Surgeons*** and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members **Clark County Medical Society.** In further consideration for this, Physician agrees to the same stipulations. Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief, in addition to monetary damages.

______________________________ ______________________

Patient or responsible party signature Date

______________________________ ______________________

Physician signature Effective date of treatment