DIMURO PAIN MANAGEMENT

Infectious disease and COVID screening

All guest upon arrival are required to:

1) Wash their hands or use alcohol-based hand rub upon entry
2) Please answer the following questions:

Date: _____ DOB: _____ Temperature: _____

Name:_____ Reason for visit: _____

Do you have or feel any of the following symptoms:

Cough or symptoms of upper respiratory infection? ☐ Yes ☐ No

Shortness of breath? ☐ Yes ☐ No

Fever or temperature above 100.4? ☐ Yes ☐ No

Chills and or shaking?	☐ Yes	☐ No	Headache?	☐ Yes	☐ No
Sore throat?	☐ Yes	☐ No	Diarrhea or vomiting?	☐ Yes	☐ No
Skin infection?	☐ Yes	☐ No	New loss of taste or smell?	☐ Yes	☐ No
Muscle pain	☐ Yes	☐ No	Open or draining wound?	☐ Yes	☐ No

Exposure history:

Have you been exposed to anyone with COVID19 or traveled out of the country in the past 30 days (including at home or at work)? ☐ Yes ☐ No

Have you been hospitalized in the last 90 days? ☐ Yes ☐ No

Do you have a history of MRSA or MDRO infection? ☐ Yes ☐ No

Have you taken Acetaminophen or Ibuprofen today? ☐ Yes ☐ No

Are you on Dialysis? ☐ Yes ☐ No

For anyone answering “yes” to any question please exit the building and contact us via telephone to discuss the nature of your visit and how we may help you.

DIMURO PAIN MANAGEMENT

PATIENT ATTESTATION

PLEASE READ THIS SECTION CAREFULLY ALONG WITH THE DOCUMENTS THAT ARE REFERENCED.

Thank you for choosing DiMuro Pain Management. Please make sure you have received all documents listed below. It is important that you carefully read and review these documents before your consultation with our pain management Physician. Please initial your name once you have read, understood, and agreed with each of the documents completely. The documents listed below are used for your benefit to inform you in regards to our policies & procedures.

1. Policy Concerning Advance Directives
I was given information about the organization's *Advance Directives/Consent to Resuscitative Measures* policy. Any questions, concerns, and/or disagreements to these terms will be my responsibility to bring to the attention of appropriate staff.
If you have an Advanced Directive, did you bring a copy with you today? **Yes** ___ **No**___
Initials _____

2. Privacy practices, Privacy Notice and HIPPA compliant release
I was given and have read, understand, and agree with the organization's *Privacy Notice and privacy policies* (this notice is located in the procedure waiting room and on the www.dimuropain.com website). I was given and have read, understand, and agree with the organization's HIPPA compliant release and have completed the release form.
Initials _____

3. Patient's Rights and Responsibilities
I was given and have read, understood, and agree with the organization' patient's rights and responsibilities located in the procedure waiting room and on the website. Included in this information was a list of contact information regarding where and to whom I may be able to express my concerns, complaints, and/or grievances.
Initials _____

4. Medical Lien Agreement/Assignment of Benefits
I was given and have read, understood and agree with the Medical *Lien Agreement/Assignment of Benefits* given to me by the organization. Any questions, concerns, and/or disagreements to these terms will be my responsibility to bring to the attention of the appropriate staff and/or my attorney.
Initials _____

5. Opioid Contract and Patient Medication list
I was given (during the initial consultation), understood, and agree that if I was to violate any of the condition(s) written in the *Opioid Contract*, given to me by the organization, that it may result in dismissal from this practice and the discontinuation of getting any narcotics/controlled substances prescribed to me. I have honestly and completely disclosed any and all medications including prescription, over the counter, supplements and herbal with dosage, frequency, and reason for taking. **Initials** _____

6. General Consent for Treatment and Procedural Consent
I was given and have read, understood, and consent generally and to the procedure for which I am to undergo. The physician has explained and I understand the purpose for and am in agreement. If I have any questions it is my responsibility to ask them prior to the preparation for the procedure.
Initials _____

I understand that me and/or if applicable, my attorney will receive all signed documents included in this packet (see medical lien/assignments of benefits agreement)**.** □ I would like copies □ I do not want copies

Disclosure of Physician Ownership:
I understand that DiMuro Facilities Services LLC is owned 100% by Dr. John DiMuro, DO. Any questions and/or concerns will be my responsibility to address with appropriate staff.
Initials _____

I certify that I have received written documentation of the items list above, prior to my scheduled initial consultation and/or my procedure date. By signing below, I understood and agreed to the above documents, including with regards to DiMuro Pain Management policies and procedures. I am also validating that the initials next to each of the corresponding documents, listed above, were written by me. Furthermore, I have understood that should I have any questions regarding its content, I should contact appropriate management or staff for any clarification.

_____	_____	_____
Signature	**Printed Name**	**Date**

DIMURO PAIN MANAGEMENT

Advanced Directives Policy and Consent to Resuscitative Measures

Not a Revocation of Advanced Directives or Medical Powers of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based of the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. DPM respects and upholds those rights.

However, unlike in an acute care hospital setting, DPM does not routinely perform "high risk" procedures. While no surgery is without risk, the procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks and expected recovery and care after the procedure.

Therefore, it is our policy, regardless of the contents of and Advanced Directives or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment we will initiate resuscitative or other stabilizing measures and transfer you to a hospital for further evaluation. At the acute care hospital further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we recommend you reschedule the procedure.

Please check the appropriate box:

- ☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.
  - ☐ *I have provided a copy of such document to be part of my medical record.*
  - ☐ *I have **not** provided a copy of such document to be part of my medical record.*
- ☐ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.

I understand that DNR (do not resuscitate) orders will be suspended during the procedure until I completely recover from the effects of anesthesia.

I acknowledge that I have read and understand the contents above and agree to the policy as described:

By:_____ Witnessed By:_____

(Patient's Signature) (Witness Signature)

If other than patient, relationship: _____

Patient's Last Name:	Patient's First Name:	Date:

DIMURO PAIN MANAGEMENT

DEFINITIONS

A. **Agent** – A person appointed to make medical decision for someone else, as in a Durable Power of Attorney for Health Care (also called a surrogate or proxy).

B. **Attending Physician** – The physician selected by or assigned to a patient who has primary responsibility for the treatment and care of the patient. When more than one physician shares such responsibility, any such physician may act as the attending physician.

C. **Advance Directive** – A document in which a person either states choices for medical treatment or designates who should make treatment choices if the person should lose decision-making capacity. Examples of these documents are a Living Will and Durable Power of Attorney for Health Care.

D. **Decision-Making Capacity** – The ability to make choices that reflect an understanding and appreciation of the nature and consequences of one's actions and the patient has not been declared incapacitated by any court nor has a guardian been appointed over his or her person.

E. **Declaration** – An Advance Directive.

F. **Durable Power of Attorney for Health Care (DPAHC)** – An Advance Directive in which an individual names someone else (the "agent" or "proxy") to make health care decisions in the event the individual becomes unable to make them himself or herself. The DPAHC can also include instructions about specific healthcare choices to be made.

G. **Living Will** – A written document executed by the patient directing that should the patient have a terminal condition, life-sustaining procedures will be withheld or withdrawn.

H. **Directive for Final Healthcare** – A written document executed by the patient that combines the Durable Power of Attorney for Health Care and Living Will documents.

DIMURO PAIN MANAGEMENT

DiMuro Professional Services, LLC
DiMuro Facilities Services, LLC

Authorization for Release of Confidential Records and Protected Health Information/ Medical Information- HIPAA Compliant

Patient Name:_____ Date of Accident: _____

Patient Date of Birth:_____ 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 _____("Assignee"), as Assignee 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

_____Communicable 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): _____

DIMURO PAIN MANAGEMENT

DIMURO PROFESSIONAL SERVICES, LLC
DIMURO FACILITIES SERVICES, LLC

Medical Lien Agreement/ Assignment of Benefits

Patient Name:_____ Date of Accident: _____

Patient Date of Birth:_____ Patient Phone Number: _____

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.

Dated:_____ Patient Signature: _____

Patient Name (print):_____

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.

Dated:_____ Attorney Signature: _____

Attorney Name (print): _____

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

DIMURO PAIN MANAGEMENT

OPIOID AGREEMENT FORM

Patient Name: _____

Medical Record Number: _____

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the 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 sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours- Monday through Friday, 9:00AM-5:00 PM.
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.

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

DIMURO PAIN MANAGEMENT

If is see another doctor who gives me a controlled substance medicine (for example, a dentist, 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.

☐ Please check here if you would like a copy of this agreement.

_____ _____

Patient's Signature Date

_____

Patient's printed name

_____

Physician's Signature

Dr. John DiMuro

DIMURO PAIN MANAGEMENT

Patient Home Medication List (As Provided by Patient)

- ☐ No known Allergies
- ☐ Allergies to food, medication (including latex or IV contrast) etc: (Please list each and their reactions)

_____

_____

_____

Please include all medications (including prescription, over the counter, vitamins, supplements, herbal, street drugs etc).

Name 	Dose	Frequency (How often?)	Reason for Taking	Date of Visit: _____ Last time taken (Date/Time)	C=Continue upon Discharge D=Discontinue upon discharge

Physician Orders:

Discharge Medication	Dosage	Frequency	Comments

Physician/Staff signature:_____Date:_____Time:_____

Patient Signature: _____Date:_____Time:_____

DIMURO PAIN MANAGEMENT

Pre-Procedure Questionnaire

Instruction to Patient: Please print or indicate by a check mark (✓) your answer to each question.

Name_____**Age**_____**Sex**_____**D.O.B.**_____

Height _____**Weight (lbs.)** _____**Right-handed** ☐ **Left-handed** ☐

List all previous surgeries (and when):

_____

_____

_____

Yes	No	
☐	☐	Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?
☐	☐	Have you or your family had any unusual reaction to anesthesia?
☐	☐	Have or are you taking "street" drugs? If yes, last date taken _____
☐	☐	Do you use Medical Marijuana? If yes, last date:_____
☐	☐	Have you had recent weight change (significant amount)?
☐	☐	Are you pregnant?
☐	☐	Do you smoke? If yes, (how many)_____cigarettes per day.
☐	☐	Do you drink alcoholic beverages? If yes, How much_____, last time_____
☐	☐	Have you taken any of the following medications? (Please circle any taken in the last week) Aspirin, Plavix, Coumadin, Anti-inflammatory
☐	☐	Have you ever experienced any reaction to rubber or latex products? If yes, please describe: _____
☐	☐	Do you have any implanted devices (pacemaker, pins, etc.)?

Do you or have you ever had any of the following?

Yes	No		Yes	No	
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	TMJ (dysfunction of temporomandibular joint)	☐	☐	Seizures
☐	☐	Stiff neck or jaw	☐	☐	Blackouts
☐	☐	Shortness of breath	☐	☐	Muscle disease
☐	☐	Asthma	☐	☐	Arthritis
☐	☐	Chronic cough	☐	☐	Diabetes
☐	☐	A cold in the past month	☐	☐	Thyroid problems
☐	☐	Heart attack	☐	☐	Bleeding tendencies
☐	☐	Chest pain; Angina	☐	☐	Sickle Cell Anemia
☐	☐	Palpitations	☐	☐	Blood transfusions
☐	☐	High Blood pressure	☐	☐	Kidney Disease
☐	☐	Hepatitis? If yes, type ☐A ☐B ☐C	☐	☐	Aids/HIV Positive
☐	☐	Hiatal Hernia	☐	☐	Others (please describe)
☐	☐	Rheumatic Fever	_____		
☐	☐	Ulcers	_____		

DIMURO PAIN MANAGEMENT

GENERAL CONSENT FOR TREATMENT

PATIENT NAME: _____ **DOB:** _____
(*Full Legal Name)*

DATE OF INJURY:_____ **ATTORNEY:**_____

Consent to Treatment
I consent to the procedures that may be performed during my stay at DiMuro Pain Management or "DPM" on an outpatient basis, which may include but are not limited to: Laboratory procedures, diagnostic procedures, x-ray examination, anesthesia, medical, or surgical treatment or procedures. Female patients will be tested for pregnancy unless they have not had a menstrual period in 5 years or have had a hysterectomy OR unless pregnancy testing is declined by patient.
Your treating physician is: ☐ Dr. John DiMuro, DO ☐ Other_____

Photography
I understand healthcare providers at DPM may use photographs, films or other recordings for identification, diagnosis, treatment, education, or for any other healthcare purposes. Any other uses will require my authorization. Additionally, I grant authorization by DPM to use any images for educational purposes.

Informed Consent
DR. JOHN DIMURO, anesthesiology and pain medicine is responsible for obtaining my informed consent before any proposed medical services or surgical procedures are performed. If I am unable to consent to treatment, Dr. DiMuro is responsible for obtaining consent from my legal guardian or representative.

Financial Agreement
I understand I am fully liable for the total cost of the care and services that I receive, at the rate effective on the date received, regardless of whether any insurance proceeds or settlement funds are available to pay for them.

I am responsible for payment of any services received for this date of service. I understand that no health insurance is accepted in any way as payment for services received today.

I understand that if care and services are received as a result of an injury for which I receive a monetary award, settlement or verdict and that if the amount I receive will not pay the balance on the account, that DiMuro Professional Services, LLC and DiMuro Facilities Services, LLC, DBA DiMuro Pain Management or "DPM" will accept the amount I receive as a partial payment and that acceptance of a partial payment will not discharge my financial obligation for the remaining balance.

Retention
DPM, will retain the financial details of my account for the period required by law. Medical records of patients over the age of 18 will be destroyed after 5 years. Medical records of patients under the age of 18 will be destroyed 5 years after the patient reaches the age of 18.

Assignment of Benefits
I assign to DPM, all applicable benefits otherwise payable to me not to exceed the established charges for the services provided. I except financial responsibility for any charges not paid by the assignment.

Release of Information
I acknowledge that DPM, the physicians and other health professionals involved in my care will share healthcare information necessary for treatment, payment or healthcare operations as allowed by law. Information may be released to any person or entity liable for payment on my behalf to verify coverage, answer payment questions or for any other purpose related to benefit payment.

Communications about my health

DIMURO PAIN MANAGEMENT

Unless I request privacy restrictions, I understand my healthcare information may be disclosed for purposes of communicating results, findings and care decisions to my family members and others responsible for my care as designated by me. My name, location and condition will be available to them by visits from medical personnel, phone calls, or other directory services.

Other acknowledgement

I understand that providers furnishing services may be independent contractors and not employees or agents of DPM. Independent contractors are responsible for their own actions and DPM is not liable for the acts or omissions of any independent contractor. Independent contractors may bill separately for their services. I understand physicians or other healthcare professionals may be called upon to provide care or services to me on my half, but I may not actually see or be examined by such physicians or healthcare professionals participating in my care. For example, I may not see physicians providing anesthesiology or radiology services.

Personal Valuables

I understand DPM, maintains lockers for the safe keeping of money and valuables for patients who are admitted to the procedure center. DPM is not responsible for the loss or damage to any money, jewelry, glasses, dentures, or any other item that would be considered a loss if misplaced, and not deposited within their designated locker for specifics of safe keeping. I agree to reclaim any property in custody of this entity within 60 days of discharge. If I am unable to sign for the release of said property, my personal representative may reclaim the property.

Patient printed name: _____ Date: _____ Time:_____

Patient Signature: _____

Witness printed name: _____ Date: _____ Time:_____

Witness Signature: _____

WILLIAM AZZOLI, M.D.
Authorization for Release of Confidential Records and Protected Health Information/ Medical Information- HIPAA Compliant

Patient Name: _____ Date of Accident: _____

Patient Date of Birth: _____Patient Phone Number: _____

Attorney's Name/ Firm Name: _____

I, _____ ("Patient") hereby grant permission and authorization for William Azzoli, M.D. ("WA") 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 William Azzoli, M.D.:

_____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
_____ Communicable 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

3970 West Ann Road, Suite 100
North Las Vegas, NV 89031
Tel: 702-747-4799 Fax: 702-747-4667

WILLIAM AZZOLI M.D.

Medical Lien Agreement/ Assignment of Benefits

Patient Name: _____ Date of Accident: _____

Patient Date of Birth: _____ Patient Phone Number: _____

Attorney's Name/ Firm Name: _____

Attorney's Phone Number: _____ Attorney's Fax Number: _____

I, the above referenced Patient ("Patient" or "Me")) of William Azzoli M.D. ("WA") hereby authorize and direct you, my attorney ("Attorney") or insurance company, to pay directly to William Azzoli M.D. (Referred to as "WA") such sums as may be due and owing for medical goods and services rendered to me by WA, 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 WA. I hereby further give a Medical Lien on my claim and/or lawsuit related to the Accident to WA against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my Attorney, or to myself, or by you 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 WA 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 WA for all medical bills and invoices submitted by WA 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 WA's additional protection and in consideration of WA awaiting payment. I further understand and agree that full payment to WA 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 WA should WA 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 WA, 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 WA 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 WA 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 WA 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 WA deems appropriate, and to any third party assignee of WA'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

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treatment, goods, services, and/or procedures rendered to Patient.

Patient hereby authorizes WA to release any and all of the Patient's medical and billing records to Assignee, as well as to WA'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 WA 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 WA, 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 WA 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 WA 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 WA 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, WA 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 WA's interest as outlined herein, WA 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 WA'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.

Dated: _____ Patient Signature: _____

Patient Name (print):_____

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 WA or Assignee. Receipt of this notice, regardless of written affirmation thereof, will create in me a duty to protect the interests of WA 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.

Dated: _____ Attorney Signature: _____

Attorney Name (print): _____

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

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