Welcome to Nevada Neurosurgery:

Nevada Neurosurgery offers the thoughtful and appropriate care of patients with problems of the spine, covering cervical, thoracic and lumbar spine disorders.

We are honored that you have trusted us with your care and will interface with your primary care physicians and any pain physicians, psychiatrists or neurologists you have who are involved in your care. Nevada Neurosurgery will work with these physicians in the community to offer you multidisciplinary care in an organized fashion.

Nevada Neurosurgery prides itself on exhausting conservative options, when appropriate before looking at surgical interventions. A thorough initial assessment is performed before formulating a plan of management that you will have input into. Physical therapy, medications, injections and surgery, when appropriate will all be utilized.

In addition to seeing patients in the office, the physicians of Nevada Neurosurgery must spend many hours at the hospital performing surgery and caring for their hospital patients. They must also be on call 24 hours a day at the emergency rooms to care for trauma cases, which they do on a rotating basis.

Unfortunately, it may require us to make changes in the office schedule for emergency surgeries. We ask for your cooperation and understanding if it becomes necessary for us to reschedule your appointment.

The attached pages are information about the practice and forms that need to be completed prior to your first visit. It is important to be familiar with the information on these forms and ideally, complete them before your visit.

We hope you will be happy with your care with the team at Nevada Neurosurgery. We will strive to reduce your pain, improve your lifestyle and return you to the activities you were doing before your spinal condition affected your lifestyle.

Sincerely

Dr. Sekhon
CIRCLE THE ANSWERS TO THE QUESTIONS BELOW:

Are you on Coumadin/warfarin?  YES/NO

Are you on aspirin/plavix?  YES/NO

Have you ever had Hepatitis B or C?  YES/NO

Do you have HIV?  YES/NO

Are you Diabetic?  YES/NO

Do you have heart problems?  YES/NO

Women: Are you or could you be pregnant:  YES/NO

Do you have religious reasons the prevent you from having blood transfusions?  YES/NO

HOW DID YOU HEAR ABOUT US? (CIRCLE ANSWER)

1. Primary Care Doctor
2. You are a previous patient
3. Recommended by friend or family
4. Saw an ad
5. Internet (Google, Yahoo etc)
Patient Name: ___________________________ DOB: ___________________________

Referring Physician: _______________________________________________________________

Primary Care Physician: _____________________________________________________________

Chief Complaint: _________________________________________________________________

PAST MEDICAL HISTORY:
Check the condition(s) that apply to your past medical history and specify date if known:

CARDIOVASCULAR:
☐ Congestive heart failure
☐ High Blood Pressure
☐ Angina
☐ Arrhythmia
☐ Atrial Fibrillation
☐ High Cholesterol
☐ Blood Clots
☐ Heart Attack
☐ Pacemaker
☐ Heart Disease
☐ Rheumatic Fever
☐ Other: ___________________________

HEMATOLOGICAL
☐ Anemia
☐ Blood Clots/DVT
☐ Other: ___________________________

NEURO/PSYCH
☐ Epilepsy/seizures
☐ Peripheral Nerve Disorder (Carpal Tunnel)
☐ Migraine Headaches
☐ Head Trauma
☐ Headaches
☐ Menigitis
☐ Cerebral Aneuryism
☐ Neuropathy
☐ Polio
☐ PTSD

GASTROINTESTINAL:
☐ Liver Disease
☐ Severe Heartburn
☐ Ulcer
☐ Other: ___________________________

GENITOURINARY:
☐ Kidney Disease
☐ Urinary Disease
☐ Other: ___________________________

MUSCULOSKELETAL
☐ Osteoporosis
☐ Neck Injury
☐ Back Injury
☐ Gout
☐ Arthritis
☐ Back Problems
☐ Spinal Cord Tumor
☐ Fibromyalgia
☐ Rheumatoid Arthritis
☐ Other: ___________________________

INFECTIONIOUS DISEASE
☐ Hepatitis B/C
☐ HIV/AIDS
☐ Other: ___________________________

ONCOLOGY
☐ Cancer – Where/What
☐ Other: ___________________________

HOSPITALIZATIONS/SURGICAL HISTORY:

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<th>Surgery/Procedure</th>
<th>Hospital</th>
<th>Date</th>
<th>Surgeon</th>
<th>Comments</th>
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SOCIAL HISTORY

PATIENT NAME: ________________________________ Date: ________________________________

Marital Status: ______________________________ Religion: ______________________________ Preferred Language: ______________________________

Place of Birth: ______________________________ Education: ______________________________ Occupation: ______________________________

Children: ______________________________ Sons ______________________________ Daughters ______________________________

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: American Native or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander Other Race Do Not Wish to Report White

SMOKER: NO YES PACKS PER DAY: _______ # OF YEARS: _______ YEAR QUIT: _______

CHEWING TABACCO: NO YES TIMES PER DAY _______ # OF YEARS: _______ YEAR QUIT: _______

ALCOHOL: NO YES AVG # OF DRINKS/DAY: _______ # OF YEARS: _______ YEAR QUIT: _______

HISTORY OF DRUG ADDICTION: YES NO HISTORY OF STREET DRUG EXPERIENCE: YES NO

Do you have any religious reasons that prevent you from receiving a blood transfusion? Yes No

FAMILY HISTORY: Circle any past family medical history and indicate family member

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>FAMILY MEMBER</th>
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<th>FAMILY MEMBER</th>
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<tbody>
<tr>
<td>Arthritis</td>
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<td>Leukemia</td>
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<td>Cancer</td>
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<td>Muscle Disease</td>
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<td>Kidney Disease</td>
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<td>Heart Disease</td>
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<td>Mental illness</td>
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<td>Hypertension</td>
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<td>Seizure</td>
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<td>Inherited Problem</td>
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<td>Tuberculosis</td>
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<tr>
<td>Stroke</td>
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<td>Bleeding disorder</td>
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</table>

MEDICATION ALLERGIES

Have you ever had an allergic reaction to: (Circle any that apply to you)

Shellfish Tape Adhesive Latex Dye used in x-ray tests such as a CT scan, kidney test (IVP) or myelogram
CURRENT MEDICATIONS

<table>
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<tr>
<th>PRESCRIPTION MEDICATIONS</th>
<th>STRENGTH</th>
<th>HOW OFTEN YOU TAKE</th>
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OVER-THE-COUNTER MEDICATIONS, NUTRITIONAL SUPPLEMENTS, ETC.

Do you take aspirin or anti-inflammatory medications? □ No □ Yes - Please list

Do you take any of the following medications?  Plavix  Coumadin  Warfarin  Pradaxa  Xeralto

Physician who currently prescribes your pain medication: ____________________________
(Check those that apply to your condition currently)

□ Right Handed  □ Ambidextrous

□ Left Handed

□ General:
□ Fever □ Weight loss □ Fatigue □ Loss of appetite
□ Visual loss □ Otorrhea □ Injuiy

□ Hemorrhage □ Ringing □ Dizziness □ Discharge from ear □ Pain in the ears

□ Nose bleeds □ Obstruction □ Discharge

□ Mouth:
□ Toothache

□ Throat:
□ Hoarseness □ Sore throat □ Swallowing difficulty □ Voice changes

□ Cardiovascular:
□ Palpitations □ Rapid heart beat □ Irregular heart beat □ Chest pain □ Leg swelling

□ Respiratory:
□ Wheezing

□ Cough □ Shortness of breath □ Shortness of breath when lying down □ Bloody sputum □ Night sweats □ Sleep Apnea

Have you had the pneumonia vaccine?
□ Yes □ No

□ Gastrointestinal:
□ Abdominal pain or colic □ Vomiting □ Vomiting blood □ Nausea □ Jaundice □ Change in bowel habits

□ Incontinence □ Blood in your urine

□ Musculoskeletal:
□ Neck pain □ Back Pain □ History of fractures □ Dislocations □ Arthritis □ Muscle pain □ Muscle weakness □ Night cramps □ Joint swelling □ Stiffness

□ Integumentary:
□ Sores that do not heal □ Rash □ Easy bruising

□ Lumps □ Discharge from nipples □ History of breast cancer

□ Neurological:
□ Disturbance of smell □ Facial numbness □ Facial weakness □ Taste disturbance □ Hearing difficulty □ Speech difficulty □ Migraine □ Headaches

□ Loss of consciousness □ Prior head injury or skull fracture □ Involuntary movement □ Seizures, epilepsy □ Gait difficulty □ Incoordination □ Numbness or tingling □ Pain going down arm □ Pain going down leg □ Paraplegic history

□ Psychiatric:
□ Nervous breakdown □ Hallucinations □ Depression

□ Endocrine:
□ Abnormal growth □ Enlarging head, feet, hands □ Unusual hair growth □ Abnormal change in skin color □ Dryness of hair or skin □ Intolerance to heat □ Intolerance to cold □ Excessive thirst

□ Blood & Lymph Systems:
□ Swollen lymph nodes □ Abnormal bleeding

□ Allergy and Immune System:
□ Food allergies

Women: Are you currently pregnant or think you may be pregnant? □ Yes □ No
CURRENT PAIN DESCRIPTION

Patient Name: ___________________ Date: ____________

What does the pain feel like? Circle any that apply:
Pressure    Shooting    Burning    Aching    Stabbing    Stinging
Dull        Throbbing   Cutting    Nagging    Sharp      Electrical

How often do you have pain?
Constant – all day & all night  Part of every day/night  Pain only on certain days

What tends to make your pain worse?
Bending    Sitting    Cough/sneezing    Reaching    Exercise    Lifting    Driving
Lying down   Walking    Other: _______________________

What tends to relieve your pain?

When did you first experience your current pain?

Have you tried any of these forms of conservative therapies?

Interventions                      Other Therapies
Epidural Steroids       Botox       Physical Therapy- # of visits____   Where__________
Radiofrequency           Spinal Cord Stimulator  Acupuncture
Trigger Point Injections Joint Injections  Massage Therapy
Other________________________   Other___________________________

Have you tried any of these medications for your current problem?

Circle it if you think it helped your pain.  Underline it if it didn’t work.

NSAIDS               Muscle relaxants       Benzodiazepines       Opiates (short acting)
Ibuprofen            Flexeril             Valium                Norco/ Hydrocodone
Naproxen             Robaxin              Klonopin              Percocet/Oxycodone
Meloxicam            Zanaflex             Ambien                Dilauidd
Other__________________   Other________________   Other________________

Opiates (long acting)
Methadone
Oxycontin
MS Contin
Other__________________

Antidepressants
Amitriptyline (Elavil)
Cymbalta/ Duloxetine
Wellbutrin
Other__________________

Anticonvulsants
Neurontin/ Gabapentin
Lyrica/ Pregabalin
Topamax
Other__________________

Miscellaneous:       Other Things Tried in The Past That Helped:
Ultram
Lidoderm Patch
Flector Patch
Medical Marijuana
CONSERVATIVE THERAPY

Assistive Devices  (Circle all that apply)
Brace  Cane  Walker  Orthotics  Crutch  Wheelchair

Falls  □ No  □ Yes  How Many/Often: ____________________

Have you missed work for this condition?  □ No  □ Yes  Dates______________________

PAIN DIAGRAM

Mark these drawings according to where you hurt. (If the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.

Numbness

Pins and Needles

Burning

Slabbing

Ache

Right  Left  Left  Right

Please mark with an X on the body form where the pain is worst now.
Please circle the appropriate number below showing how bad your pain is now:
No pain  1  2  3  4  5  6  7  8  9  10  Worst possible pain
(If there are multiple locations of pain, please rate all areas.)

Average pain score over the last 7 days: ____________________

Pain Interferes with: (Circle all that apply)
Walking  Jogging  Personal Hygiene  Rising from chair
Standing  Sleeping  Driving  Eating  Toileting  Dressing/Undressing

The above information is accurate to the best of my knowledge.
Patient/Guardian Signature: ____________________ Date: ____________________
I have reviewed the above information with the patient today.
Physician Signature: ____________________ Date: ____________________
AGREEMENT FOR PRESCRIPTION REQUESTS AND USE OF CONTROLLED SUBSTANCES

As a Neurosurgical practice our treatment is directed towards a neurosurgical solution. Part of your treatment may involve the prescription of analgesic (pain relieving) medications. Treatment for pain is done for the acute period. This period should be expected to be 4-6 weeks only. If you have been on analgesic pain medication for 3 months or longer you may require formal pain management and may be referred to a pain management specialist. Although the majority of patients control their medications well, and follow their doctor’s orders very strictly, there are some patients that are prone to harmful medication dependency or addiction. Because of this, the State and Federal government carefully regulate many pain medications. This means that the use of these medications involves mutual responsibility between the patient and physician.

IT IS VERY IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING POLICIES AND PROCEDURES. THEY MUST BE FOLLOWED FOR YOUR PHYSICIAN TO PRESCRIBE AND TREAT YOU SAFELY AND EFFECTIVELY.

1. Medication must be used as prescribed and directed unless discussed with your physician. It is life threatening to chew or take a partial tablet of a long acting medication. Increasing your dose without close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and death.
2. If you have a reaction to your medication DO NOT FLUSH IT OR THROW IT AWAY. You may be required to bring the remainder to the office to replace with a new prescription.
3. Per the Board of Medical Examiners Regulations, Sec. 1 Chapter 630 and our office policy, controlled substance medications are to be obtained from only one physician. It is a FELONY to knowingly obtain controlled medications from one practitioner without disclosing this fact to all prescribing practitioners.
4. You should discuss any medication changes with your physicians at your appointments and inform them of any new medication allergies.
5. ALLOW FOR 3 WORKING DAYS FOR PREPARATION OF A WRITTEN PRESCRIPTION FOR PICK UP. ALLOW 48 HOURS FOR ALL CALL IN RX’S. IF SOMEONE IS TO PICK UP YOUR RX IN YOUR PLACE, THEY MUST BE ON YOUR HIPAA RELEASE OR BE ACCOMPANIED BY A NOTE SIGNED BY YOU. **Please Initial here that you have read and understand line #5**
6. Lost, stolen or misplaced prescriptions or medications may not be replaced. Early requests for refills will not be provided unless you have called and discussed this prior to running out of medication. Selling medication or sharing medication with family, friends, or any other person is illegal and will not be tolerated. You should protect and care for your medication as you would any extremely valuable possession. If you run out of your medication, either because of poor planning or because of taking in excess of what was prescribed, you are responsible for the consequences, including poor pain control and any withdrawal symptoms.
7. PRESCRIPTION REQUESTS WILL BE ADDRESSED MONDAY THROUGH THURSDAY, 9-5 ONLY. Prescriptions are not available Friday, weekends, holidays or after office hours. The on-call physician is on-call for neurosurgical emergencies only.
8. Notify your physician if you are pregnant.
9. The use of alcohol or recreational drugs while on opioids is not allowed. Our office will not provide medications under these circumstances.

We expect you to take the above patient responsibilities seriously.

______________________________      ______________________________
Patient Name                      Patient Signature

Lali Sekhon
MD, PhD, FRACS, FACS, FAANS
Controlled Substances Informed Consent

Treatment with controlled substance medications including opiates (narcotics) is dangerous and can lead to physical dependence and addiction. Taking these may lead to serious health problems, accidental overdose, and even death.

Risks & Benefits

• Accidental overdose can and frequently occurs. Death is possible from respiratory depression (slow breathing).
• Even taking these medications for a short duration have been demonstrated to cause physical dependence.
• There may be forms of medications available that deter certain types of abuse. Ask your doctor for more information.
• Women who are pregnant, plan to become pregnant, or could become pregnant, have the added risk of fetal and newborn baby drug addiction, and neonatal abstinence syndrome, a dangerous type of drug withdrawal.

Proper use

• Take your medications as prescribed. Do not take more pills or capsules than are prescribed, or more often than prescribed.
• Notify your provider of all other medications, supplements, and over-the-counter medications you are taking.
• Do not start new medications while on these medications without discussing with your healthcare provider.

Storage & Disposal

• These medications are for your use only.
• Do not share your medications with others and do not sell your medication.
• Ensure safe storage of your medications in their original containers and out of the reach of others.
• Take unused medications to a Drug Enforcement Administration public disposal location (https://apps.deadiversion.usdoj.gov/pubdispsearch/)
• If disposal services are unavailable, mix medication with used coffee grounds or kitty litter, seal in a bag and place in the trash.

Minors

• Those under 18 have special risks including interfering with brain development.
• Warning signs include mood or personality changes, behavior changes including doing poorly in school, social isolation, or a sudden change of friends. Please see https://drugfree.org/article/spotting-drug-use/ for more info.

• Constipation is highly likely with opiate treatment, and can cause nausea, vomiting, and can lead bowel blockage and death.
• Opiate medication overdose can be reversed with a medication called naloxone (Narcan). Some pharmacies in Nevada allow you to purchase naloxone without a prescription, and the law in Nevada allows for healthcare providers to prescribe naloxone to a patient’s family or other acquaintances.
• Opiate pain medications do not treat the underlying cause of your pain. They only mask your pain.
• Your pain level may be reduced while taking these medications, and the intent is to restore normal function and enable you to perform daily tasks. You may never reach a “zero” pain level, even with proper usage.
Alternatives

• Non-narcotic medications may be effective in treating your pain. These include NSAIDs (e.g. ibuprofen, Motrin) and acetaminophen (e.g. Tylenol, Excedrin). Please discuss with your healthcare provider to see if you may be a candidate for this type of pain control.
• Some people treat pain without medications. Heating pads and ice may be just as effective for pain.
• Other treatments could include physical therapy, massage, cognitive behavioral therapy, or acupuncture.

This is not an exhaustive list of risks, benefits, alternatives, or instructions.

If you have any questions regarding your medications please talk with a member of your care team.

By signing below, I acknowledge my healthcare provider has discussed the risks and benefits of controlled substances, my specific treatment plan, and I agree to treatment with these medications. I understand I can withdraw my consent to treatment with these medications at any time.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood and accepted these terms on both pages of the agreement. No narcotic or otherwise habit-forming medications will be prescribed without the acceptance of this agreement.

_________________________     _______________________              ___________
Patient Name                   Patient Signature              Today’s Date

________________________________     ______________________________
Pharmacy Name                                      Pharmacy Telephone Number
PROVIDERS' INFORMATION

Please list the names, specialties, and phone numbers of your other healthcare providers:

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<th>Provider Name</th>
<th>Specialty</th>
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____________________________________

Patient Name ___________________________ Today’s Date ______________
**Welcome To Our Office**

**Date:** ____________________

**Name:** ____________________ **Nickname:** ____________________

**SSN:** ____________________ **Birthdate:** ____________________ **Age:** ______ **Sex:** ______

**Physical Address:** ____________________

**City:** ____________________ **State:** ____________________ **Zip:** ____________________

**Mailing Address (if different from above):** ____________________

**City:** ____________________ **State:** ____________________ **Zip:** ____________________

**Home Telephone:** (______) ____________ **Cell Phone:** (______) ____________

**Marital Status:** ____________________

**Email Address:** ____________________ **May we send information to your e-mail?** ☐ Yes ☐ No

**Occupation:** ____________________

**Employer:** ____________________ **Years Employed:** ______

**Employer’s Address:** ____________________

**City:** ____________________ **State:** ____________________ **Zip:** ____________________

**Work Phone:** (______) ____________ **May we contact you at work?** ☐ Yes ☐ No

**Name of Spouse:** ____________________ **Birthdate:** ____________________

**SSN:** ____________________ **Employer:** ____________________

**Occupation:** ____________________ **Work Phone:** (______) ____________

---

**COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE**

**Responsible Party:** ____________________ **Relationship to Patient:** ____________________

**Home Address:** ________________________________________________________________

**City:** ____________________ **State:** ____________________ **Zip:** ____________________

**Telephone:** (______) ____________ **DOB:** ____________________ **Age:** ______

**SSN:** ____________________ **Employer:** ____________________

**Occupation:** ____________________ **Work Phone:** (______) ____________

**Referring Physician:** ____________________ **Phone Number:** ____________________

**Primary Care Physician:** ____________________ **Phone Number:** ____________________

**How did you hear about our office?** ____________________

**In case of emergency, contact:** ____________________

**Relationship:** ____________________ **Phone:** (______) ____________
Insurance Information

[Primary Insurance] Name of Insurance Company: 

______________________________________________________________________________________________

Address: ____________________________________________________

City: ____________________________ State: _______ Zip: _______

Insured’s Name: __________________________________________ Insured’s DOB: _______________________

Policy ID Number: __________________ Group Number: _______________ Group Name: ______________

[Secondary Insurance] Name of Insurance Company: 

______________________________________________________________________________________________

Address: ____________________________________________________

City: ____________________________ State: _______ Zip: _______

Insured’s Name: __________________________________________ Insured’s DOB: _______________________

Policy ID Number: __________________ Group Number: _______________ Group Name: ______________

Name of Workers Compensation Carrier: 

______________________________________________________________________________________________

Address: ____________________________________________________

City: ____________________________ State: _______ Zip: _______

Date of Injury: ____________________________ Claim Number: _______________

Adjuster’s Name: ____________________________ Phone Number: (____) __________

Litigation? □ Yes □ No Name of Attorney: ____________________________

Nurse Case Manager: ____________________________ Phone Number: (____) __________

Our office will file insurance claims for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays and non-covered service amounts.

See our complete financial policy for details.

**Assignment of Benefits

I hereby assign all right, title, and interest of my primary and secondary insurance to Nevada Neurosurgery for the treatment of my medical services.

Patient Signature _______________________________ Date __________________________

(Parent/Guardian if minor)
NEVADA NEUROSURGERY CANCELLATION POLICY

To gain the most benefit from our office and to ensure that other patients receive the highest level of care, it is essential to keep all your scheduled appointments.

If you are more than 10 minutes late for an appointment, you may not be seen that day. We try to keep to our schedule and your being late will affect the next patient.

We understand the need at times to cancel your appointment. If you must cancel your appointment, please give us at least 24 hours notice. There are other patients requiring our care and your appointment can be given to someone else with enough notice.

If you fail to attend without calling or give less than 12 hours notice of cancellation, you will be charged $40.00. This is not covered by insurance and this amount will have to be paid before scheduling another appointment.

If you cancel 3 appointments or miss 2 appointments, you will be discharged from our care.

Thank you for helping us provide the best care possible.

I have read and understand Nevada Neurosurgery's cancellation policy.

_____________________________  __________________
Name                      Date
Dr. Sekhon's main office location is at 75 Pringle Way, Suite 701. It is on the Renown Campus (enter for Advanced Medicine C). If you find the Starbucks coffee shop in the hospital, take the elevators across from this. Parking is via 2nd Street.