momenta
PAIN CARE

PETER N. PIPERIS, MD, DABPM
GRIFFITH F. EVANS, MD
REED JARECKE, PA-C

MOMENTA PAIN CARE, LLC
1805 N. 145 Street
Omaha, NE | 68154
p: 402.991.6559
f: 402.991.3552

APPOINTMENT DETAILS

Our stand-alone building is located on North145th Street, west of (behind) the Railcar Restaurant and Mega Saver, on the southwest corner of 144th and Blondo Street.

1805 North 145th Street

Omaha NE 68154

402-991-6559

NO MEDICATION WILL BE PRESCRIBED DURING THE 1st VISIT

Please arrive 15 minutes prior to your appointment with completed paperwork and the following:

* Photo ID
* Insurance Cards
* Current Medication List

APPOINTMENT DATE: _____ TIME: _____ AM / PM

- ☐ Dr. Peter Piperis, MD, DABPM
- ☐ Dr. Griffith Evans, MD
- ☐ Reed Jarecke, PA-C

www.MomentaPaincare.com

Like us on Facebook!

Regenexx
The Trusted Alternative to Orthopedic Surgery

Peter N. Piperis, MD, DABPM
Griffith F. Evans, MD
Reed Jarecke, PA

MOMENTA PAIN CARE, LLC
1805 North 145 Street
Omaha, NE | 68154
p 402.991.6559
f 402.991.3552

momenta PAIN CARE
Move. Forward.

Regenexx
The Trusted Alternative to Orthopedic Surgery

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER PATIENT DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME: _____ CELL: _____ WORK: _____

EMAIL ADDRESS: _____

PREFERRED CONTACT METHOD: ☐ HOME ☐ WORK ☐ CELL ☐ EMAIL

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE: ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN OR PACIFIC ISLANDER ☐ BLACK ☐ WHITE ☐ DECLINE TO SPECIFY

ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO ☐ DECLINE TO SPECIFY

PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER _____

EMPLOYMENT

☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED ☐ DISABLED

EMPLOYER: _____ OCCUPATION: _____

PHARMACY

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE: _____

EMERGENCY CONTACT

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO THE PATIENT: _____ DOB: _____

ARE WE AUTHORIZED TO DISCUSS YOUR MEDICAL CARE WITH THIS PERSON: ☐ YES ☐ NO

IS THIS PERSON AUTHORIZED TO MAKE MEDICAL DECISIONS ON YOUR BEHALF: ☐ YES ☐ NO

RELEASE OF HEALTH INFORMATION

I AUTHORIZE MOMENTA PAIN CARE TO RELEASE MY HEALTH & BILLING INFORMATION TO:

NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

APPOINTMENT REMINDERS: I AUTHORIZE MOMENTA PAIN CARE TO LEAVE A MESSAGE REGARDING MY APPOINTMENT TIME, CHANGES OR SCHEDULING INFORMATION ON MY VOICEMAIL OR WITH THE PERSON ANSWERING THE PHONE.

PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS OR CHANGES: ☐PHONE ☐EMAIL ☐TEXT ☐OTHER_____

POLICY NOTICE RECEIPT OF ACKNOWLEDGEMENT (INITIAL)

_____ I ACKNOWLEDGE THAT I WAS OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.
INITIAL

***PLEASE BRING YOUR INSURANCE CARD(S) AND ID ON THE DAY OF YOUR APPOINTMENT AND ARRIVE 15 MINUTES EARLY**

INSURANCE

CARRIER: _____ ADDRESS: _____

POLICY #:_____ ACCOUNT #_____

BENEFIT CODE: _____ EFFECTIVE DATE: _____

PRECERTIFICATION REQUIRED? ☐ YES ☐ NO CONTACT: _____

POLICY HOLDER (IF DIFFERENT THAN PATIENT): _____ DATE OF BIRTH: _____

INSURED THROUGH EMPLOYMENT? ☐ YES ☐ NO

YES, EMPLOYER NAME: _____

SECONDARY INSURANCE

CARRIER: _____ ADDRESS: _____

POLICY # _____ ACCOUNT #_____

BENEFIT CODE: _____ EFFECTIVE DATE: _____

PRECERTIFICATION REQUIRED? ☐ YES ☐ NO

CONTACT: _____

POLICY HOLDER (IF DIFFERENT THAN PATIENT) _____ DATE OF BIRTH: _____

INSURED THROUGH EMPLOYMENT? ☐ YES ☐ NO

IF YES, EMPLOYER NAME: _____

Peter N. Piperis, MD, DABPM
Griffith F. Evans, MD
Reed Jarecke, PA

1805 North 145 Street | Omaha, NE | 68154
p 402.991.6559 | f 402.991.3552

Patient Medical History

Patient Name:_____ Today's Date: _____

Family Physician: _____ Referring Physician: _____

Patient Date Of Birth:_____ Age: _____ Height: _____ Weight: _____

Date That Your Symptoms Began Or Date Of Your Injury: _____

Have You Had Any Previous Problems? ☐ Yes ☐ No | If Yes, When? _____

Is The Current Problem A Result Of: ☐ Work Related Accident ☐ Motor Vehicle Accident

If This Is A Work-Related Injury, Is Your Visit Today Related To A Workers Compensation Claim? ☐ Yes ☐ No

How Did The Injury Occur Or Symptoms Begin? (Please Give A Brief Explanation):

_____

_____

_____

If Currently Working, Is The Pain Affecting Your Work? If Yes, How? _____

Please List Any Other Activities Limited By Your Pain: _____

How Would You Describe Your Pain?

- ☐ Continuous
- ☐ Intermittent
- ☐ Dull
- ☐ Aching
- ☐ Heavy
- ☐ Throbbing
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Tender
- ☐ Gnawing
- ☐ Pressure
- ☐ Burning/Hot
- ☐ Cramping
- ☐ Tingling | Exhausting
- ☐ Sickening
- ☐ Fearful
- ☐ Punishing | Cruel

Please List Any Other Areas Of Pain: _____

_____

_____

Rate Your Pain: 0 = No Pain | 10 = Worst Pain Imaginable

Currently: _____

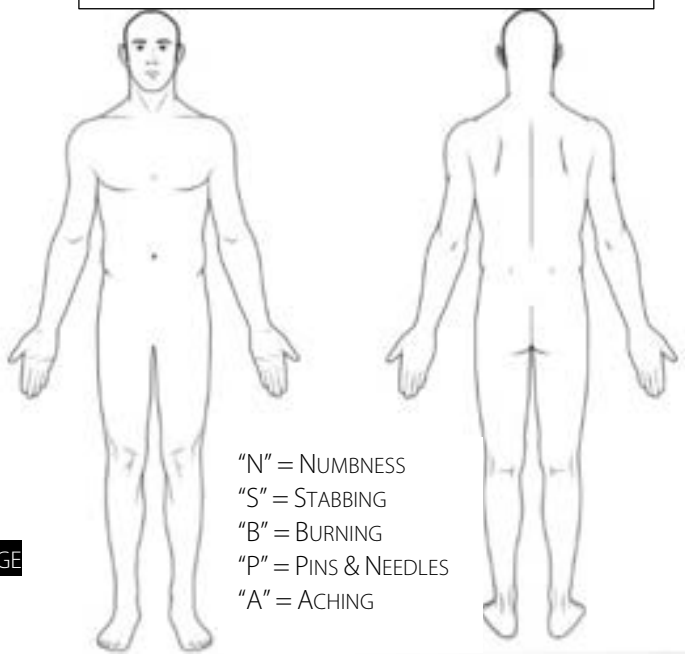
At Your Best: _____

At Your Worst: _____

How Do The Following Activities Affect Your Pain?

	Increases Pain	Decreases Pain	No Change
Resting	☐	☐	☐
Lying Down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Bending	☐	☐	☐
Walking	☐	☐	☐
Changing Positions	☐	☐	☐
Working	☐	☐	☐
Coughing/Sneezing/Straining	☐	☐	☐
Lifting	☐	☐	☐
Prolonged Position	☐	☐	☐

Please Draw The Location Of Your Pain Using The Key Below:



"N" = Numbness
"S" = Stabbing
"B" = Burning
"P" = Pins & Needles
"A" = Aching

Are You Experiencing:

- ☐ Numbness |Tingling Where?_____
- ☐ Weakness
- ☐ Loss Of Bowel/Bladder Control?
  Explain:_____
- ☐ Sleep Disturbance
- ☐ Anxiety
- ☐ Depression

Pain Treatment History

Treatment

☐ I Have Had No Treatment For My Symptoms To Date

Please Select All Of The Following Treatments That You Have Used For Pain Relief:

	Helped Pain	Worsened Pain	No Change	Dates Of Visit
Acupuncture				
Biofeedback				
Brace Support				
Chiropractic				
Electrical Stimulation				
Hot/Cold Packs				
Injection Therapy				
Massage Therapy				
Medications				
Physical Therapy				
Tens Units				
Traction				

Pain Medications

☐ I Have Not Tried Any Medications Including Over The Counter Medications

Please List All Pain Medications That You Have Been On At Any Point For Your Current Pain, Including Over The Counter Medications:

Medication Name	Dose	Frequency	Helped	No Help

Pain Clinic

☐ I Have Not Been Treated By Another Pain Physician Or Clinic

Please List The Names Of Other Pain Physicians You Have Seen, Along With A Brief Description Of Therapy Received:

Facility | Physician	Description Of Therapy	Dates

Psychological | Behavioral Therapy

☐ I Have Not Been Treated For Psychological health

Please List The Names Of Physicians You Have Seen, Along With A Brief Description Of Therapy Received:

Facility | Physician	Description Of Therapy	Dates

Steroid Injections

☐ I Have Not Had Any Injections

If You Have Had Any Injections, Please Provide The Information Below:

Date	Location (Low Back, Neck?)	Performed By MD Or CRNA?	X-Ray Guided? Y Or N	Relief? No Or Mild	Relief? Temporary Or Long Lasting ?	Made Symptoms Worse? Y Or N

Spine Surgery

☐ I Have Not Had Spine Surgery

If You Have Had Spine Surgery In The Past, Please Provide The Information Below:

Date	Location (Low Back, Neck?)	Name Of Surgeon	Relief? No Or Mild	Relief? Temporary Or Long Lasting ?	Made Symptoms Worse? Y Or N

Diagnostics Tests And Imaging

☐ I Have Not Had Any Diagnostic Tests Performed For My Current Pain Complaints

Please Provide Information For All Of The Following Tests You Have Had That Are Related To Your Current Pain Complaints:

Test	Of The (Neck, Back)	Date	Facility
MRI			
X-RAY			
CT			
EMG			
MYELOGRAM			
OTHER:			

Current Medications | Vitamins & Supplements:

Please List All Medications That You Are Currently Taking, Including Vitamins and Supplements:

Medication Name	Dose	Frequency

Surgical History

☐ I Have Never Had Any Surgical Procedures Performed

Please List Any Surgical Procedures You Have Done In The Past, Including The Date:

Surgical Procedure	Dates

Did You Experience An Adverse Reaction To The Anesthesia? ☐ Yes ☐ No

If Yes, Please Explain:

_____

_____

Past Medical History

Select The Conditions That You Have Been Treated For In The Past:

General Medical| Diagnosed Conditions

☐ Cancer – Type_____

☐ Cancer – Type_____

Cardiovascular/Hematologic

☐ Anemia
☐ Stroke/Tia
☐ Heart Valve Disorders
☐ Peripheral Vascular Disease
☐ Heart Murmur
☐ Heart Attack
☐ Coronary Artery Disease

Urological

☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Gastrointestinal

☐ Gerd (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ Constipation

Neurologic

☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures

Behavioral

☐ Depression
☐ Anxiety

Head/Ears/Eyes/Nose/Throat

☐ Headaches
☐ Migraines
☐ Head Injury
☐ Glaucoma

Endocrine

☐ Hyperthyroidism
☐ Hypothyroidism
☐ Diabetes – Type_____

Respiratory

☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Emphysema/Copd

Musculoskeletal/Rheumatologic

☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Other Conditions

☐
☐
☐

ALLERGIES

DO YOU HAVE ANY DRUG/MEDICATION ALLERGIES? ☐ YES ☐ NO

IF SO, PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

MEDICATION NAME	ALLERGIC REACTION

TOPICAL ALLERGIES: ☐ LATEX ☐ IODINE ☐ TAPE ☐ IV CONTRAST

FAMILY HISTORY

☐ UNKNOWN

PLEASE SELECT ALL THE APPROPRIATE DIAGNOSES AS THEY PERTAIN TO YOUR FIRST-DEGREE RELATIVES:

DIAGNOSIS	MOTHER	FATHER	BROTHER	SISTER	CHILD
ARTHRITIS					
HEADACHES/ MIGRAINES					
BRACE SUPPORT					
LIVER PROBLEMS					
SEIZURES					
CANCER					
HIGH BLOOD PRESSURE					
OSTEOPOROSIS					
STROKE					
DIABETES					
KIDNEY PROBLEMS					
RHEUMATOID ARTHRITIS					
BACK PROBLEMS					
HEART PROBLEMS					
DECEASED					

☐ OTHER MEDICAL PROBLEMS:_____

_____

SOCIAL HISTORY

OCCUPATION: _____ EMPLOYER: _____

ARE YOU CURRENTLY WORKING? ☐ YES ☐ NO ☐ RETIRED ☐ DISABLED ☐ UNEMPLOYED

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EDUCATION: ☐ ELEMENTARY SCHOOL ☐ HIGH SCHOOL DIPLOMA ☐ GED ☐ SOME COLLEGE ☐ COLLEGE DEGREE ☐ TRADE SCHOOL

DO YOU EXERCISE? ☐ YES ☐ NO IF YES, WHAT TYPE OF EXERCISE? _____

HOBBIES | INTERESTS: _____

ALCOHOL USE: ☐ YES ☐ NO AMOUNT: _____

TOBACCO USE: ☐ YES ☐ NO AMOUNT: _____ E-CIGARETTE USE: _____

ILLICIT/RECREATIONAL DRUG USE:

☐ DENIES ANY ILLICIT/RECREATIONAL DRUG USE ☐ CURRENTLY USES ILLICIT/RECREATIONAL DRUGS

☐ FORMERLY USED ILLICIT/RECREATIONAL DRUGS (NOT CURRENTLY USING)

HAVE YOU EVER ABUSED NARCOTIC OR PRESCRIPTION MEDICATIONS? ☐ YES ☐ NO

REVIEW OF SYSTEMS

PLEASE SELECT ANY OF THE FOLLOWING SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING:

CONSTITUTIONAL: ☐ FEVER ☐ CHILLS ☐ NIGHT SWEATS ☐ WEIGHT LOSS
☐ WEIGHT GAIN ☐ DECREASED ENERGY ☐ LOSS OF APPETITE

HEENT: ☐ RUNNY NOSE ☐ NOSE BLEEDS ☐ SINUS CONGESTION ☐ HEARING LOSS
☐ VISION CHANGES

SKIN: ☐ RASH ☐ NON-HEALING SKIN LESIONS

NEUROLOGIC: ☐ SEIZURE DISORDER ☐ TREMORS ☐ DIZZINESS/FAINTING ☐ WEAKNESS IN EXTREMITY
☐ PARALYSIS ☐ LOSS OF BALANCE

CARDIAC: ☐ CHEST PAIN/ANGINA ☐ HEART PALPITATIONS ☐ RAPID HEART RATE ☐ SWELLING IN EXTREMITIES

RESPIRATORY: ☐ WHEEZING ☐ BLOOD STAINED SPUTUM ☐ SLEEP APNEA ☐ COUGH
☐ UPPER RESPIRATORY INFECTION

GASTROINTESTINAL: ☐ ABDOMINAL PAIN ☐ VOMITING ☐ HEARTBURN ☐ CONSTIPATION
☐ BLOODY STOOLS ☐ DIARRHEA

GU/NEPHRO: ☐ DYSURIA ☐ HEMATURIA ☐ CHRONIC RENAL FAILURE

ENDOCRINE: ☐ DIABETES ☐ HEAT INTOLERANCE ☐ COLD INTOLERANCE ☐ THYROID PROBLEMS
☐ EXCESSIVE THIRST ☐ EXCESSIVE URINATION

GENITOURINARY: ☐ URINARY INCONTINENCE ☐ PAIN WITH URINATION ☐ PROSTATE PROBLEMS ☐ POST-HYSTERECTOMY
☐ POST-MENOPAUSAL ☐ URINARY TRACT INFECTION ☐ BLOOD IN URINE ☐ KIDNEY STONES

HEMATOLOGIC: ☐ ANEMIA ☐ SWOLLEN LYMPH NODES ☐ ABNORMAL BRUISING/BLEEDING

MUSCULOSKELETAL: ☐ JOINT PAIN ☐ BACK PAIN ☐ NECK PAIN ☐ MUSCLE PAIN
☐ JOINT RESTRICTIONS

PSYCHIATRIC: ☐ DEPRESSION ☐ ANXIETY ☐ DRUG USE ☐ STRESS
☐ SLEEP DISTURBANCE ☐ MOOD CHANGES

IMMUNOLOGIC: ☐ HIV/AIDS ☐ COVID

Regenexx
The Trusted Alternative to Orthopedic Surgery

momenta
PAIN CARE

Peter N. Piperis, MD, DABPM
Griffith F. Evans, MD | Reed Jarecke, PA
1805 N 145 St | Omaha, NE | 68154
p 402.991.6559 | f 402.991.3552

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date of Appointment: _____

Gender: ☐ Male ☐ Female ☐ Other Patient Date Of Birth:_____ Age: _____

Over The Last 2 Weeks, How Often Have You Been Bothered By Any Of The Following Problems? (Circle the number to indicate your answer)

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Please Add Totals				

Final Score _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult ☐

Check Yes Or No And Enter Date	Yes	No	Date (Month/Year)
Covid Vaccine			
Flu Vaccine			
Pneumonia Vaccine			
Tobacco use			
Alcohol use			
Urinary Incontinence			
Colonoscopy			
Females: Mammogram			
Females: Dexa Scan (Bone Scan)			

Staff Use Only

Patient Insurance
Traditional Medicare: ☐
Medicare Advantage: ☐
Other: ☐

BMI:_____ PHQ-9:_____

Review Of Current Medication List Completed By: _____

Regenexx
The Trusted Alternative to Orthopedic Surgery

momenta
PAIN CARE

Peter N. Piperis, MD, DABPM
Griffith F. Evans, MD | Reed Jarecke, PA
1805 N 145 St | Omaha, NE | 68154
p 402.991.6559 | f 402.991.3552

Opiod Risk Tool Test

Patient Name: _____ Date of Appointment: _____

Gender: ☐ Male ☐ Female ☐ Other Patient Date Of Birth:_____ Age: _____

Please check the first box if it applies, and circle the corresponding number in relationship of either being male or female.
If it does not apply, please leave it blank.

Mark Each Box That Applies	Female	Male
Family History of Substance Abuse		
☐ Alcohol	1	3
☐ Illegal Drugs	2	3
☐ Rx Drugs	4	4
Personal History of Substance Abuse		
☐ Alcohol	3	3
☐ Illegal Drugs	4	4
☐ Rx Drugs	5	5
Ages Between 16-45		
☐ YES	1	1
☐ NO	0	0
History of Preadolescent Sexual Abuse		
☐ YES	3	0
☐ NO	0	0
Psychological Disease		
☐ Attention Deficit Disorder (ADD)	2	2
☐ Obsessive Compulsive Disorder	2	2
☐ Bipolar Disorder	2	2
☐ Schizophrenia	2	2
☐ Depression	1	1
Scoring Totals		

Total Score Risk Category: 0 – 3: Low Risk | 4 – 7: Moderate Risk | >8: High Risk

momenta PAIN CARE

PETER N. PIPERIS, MD, DABPM
GRIFFITH F. EVANS, MD
REED JARECKE, PA-C
1805 NORTH 145 STREET
OMAHA, NE | 68154
p: 402.991.6559 f: 402.991.3552

Regenexx™

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

momenta PAIN CARE

PETER N. PIPERIS, MD, DABPM
GRIFFITH F. EVANS, MD
REED JARECKE, PA-C
1805 NORTH 145 STREET
OMAHA, NE | 68154
p: 402.991.6559 f: 402.991.3552

Regenexx

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures will be made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

momenta PAIN CARE

PETER N. PIPERIS, MD, DABPM
GRIFFITH F. EVANS, MD
REED JARECKE, PA-C
1805 NORTH 145 STREET
OMAHA, NE | 68154
p: 402.991.6559 f: 402.991.3552

Regenexx™

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.