Las Vegas Health Services, Inc

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ☐ NEVER DATE:	

Release the following Information:
☐ All Records ☐ Chart Notes ☐ Radiology Reports ☐ Operative Reports ☐ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Las Vegas Health Services, Inc

Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

*** Preferred Pharmacy: PHARMACY:

Allergies

- ☐ NONE/No Known Allergies
- ☐ Dairy Products
- ☐ Sulfa Drugs
- ☐ Adhesive Tape
- ☐ Iodine/Shellfish/Contrast Dye
- ☐ Wheat
- ☐ Anesthesia
- ☐ Latex
- ☐ Aspirin
- ☐ Morphine
- ☐ Codeine
- ☐ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ☐ NONE of the problems listed
- ☐ allergies
- ☐ anemia
- ☐ arthritis conditions
- ☐ asthma
- ☐ arterial fibrillation
- ☐ bleeding problems
- ☐ BPH
- ☐ CAD coronary artery disease
- ☐ cancer
- ☐ cardiac arrest
- ☐ celiac disease
- ☐ chest pain
- ☐ CHF congestive heart failure
- ☐ chronic fatigue syndrome
- ☐ depression
- ☐ diabetes
- ☐ drug/alcohol abuse
- ☐ erectile dysfunction
- ☐ fibromyalgia
- ☐ Gerd
- ☐ heart disease
- ☐ high cholesterol
- ☐ hyperinsulinemia
- ☐ hyperlipidemia
- ☐ hypertension
- ☐ hypogonadism male
- ☐ hypothyroidism
- ☐ infection problems
- ☐ insomnia
- ☐ irritable bowel syndrome
- ☐ kidney problems
- ☐ menopause
- ☐ migraines/headaches
- ☐ neuropathy
- ☐ onychomycosis
- ☐ organ injury
- ☐ osteoporosis
- ☐ pulmonary embolism/blood clot in legs
- ☐ seizure disorders
- ☐ shortness of breath
- ☐ sinus conditions
- ☐ stroke
- ☐ syndrome X
- ☐ tremors
- ☐ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Las Vegas Health Services, Inc.

2600 S. Rainbow Blvd Suite 108 Las Vegas, NV 89146
Phone: 702-655-1400 Fax: 702-655-1417

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USEDE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ 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 purposes 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 (PHI)

Your protected health information may be used an 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 physicians'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. his includes the coordination or management of your health care with a thirds _____ thar provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, ; to obtain payment for you health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare operations. We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited toL

- Quality control
- Licensing
- Employee reviews
- Training of medical students

For example, we may disclose your protected health information to medical students that see patients in 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 to 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 for test results or remind you of your appointment.

We may use or disclose you protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Disease, 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 Law, we must make a disclosure to you when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of the section 164.5000.

HIPAA Notice of Privacy Practices

Other Permitted and Required Uses 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 an action in relation to 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.

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 purpose 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 of for notification purposes as described in this Notice of Privacy Practices. Your request muse state specific restrictions, and whom they apply.

Your physician is not required to agree to a restriction that you may request. If physician believes your restrictions unreasonable and it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from busboy 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 or by fax.

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 the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **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 or 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 privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature:_____ Date:_____

Las Vegas Health Services, Inc.
Financial Policy

Effective November 1, 2009

Thank you for choosing Las Vegas Health Services as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been pit in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that Las Vegas Health Services, Inc. will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and Las Vegas Health Services, Inc. Our office will provide written notification to you detailing anticipated charges. If full deductible is not applied to your claim by your insurance company, we will refund any overpayment to you within 30 days of the date we receive the overpayment.

3. _____ I understand that if my account is not paid in full within 90 days, a $35 collection processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

4. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash)

5. _____ I understand that if I am unable to make a scheduled appointment I need to contact Las Vegas Health Services, Inc. at least 24 hours before my scheduled appointment time. Due to high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need or urgent endoscopic care from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24 -HOUR ADVANCED NOTICE.

6. _____ Las Vegas Health Services, Inc. will allow 60 days from the date of filing for my insurance company to process or pay a claim. Nevada law allows insurance companies operating in the state no more than 60 days to process claims. **It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is all my responsibility to notify Las Vegas Health Services, Inc. if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**

7. _____ ***I have read and I understand the above Financial Policy and I agree to abide to its terms.***

_____ Printed Name of Patient

_____ Signature of Patient/Responsible Person

Las Vegas Health Services Inc.
2600 S. Rainbow Blvd. Suite 108
Las Vegas NV 89146
Phone: 702-655-1400 Fax: 702-655-1417

NO SHOW/LESS THAN 48HR CANCELLATION FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences.

During too high patient demand, and limited availability of appointment we have instituted a ***$75* no show fee**. Effective immediately, you must give a **48hour advanced notice** to cancel appointments. Failure to do so will result in a **$75 fee** charged to your account.

By signing below, I acknowledge that I have read and understand this policy.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

Las Vegas Health Services, Inc.
Zahid Hamid, MD

2600 S. Rainbow Blvd Suite 108
Las Vegas, NV 89146
Phone: 702-655-1400 Fax: 702-655-1417

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

_____

All healthcare information

Definition: Sexually transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, here simplex, human papilloma virus, wart, condyloma, Chlamydia, non - specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus) AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

YES NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

YES NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED