A Las Vegas Medical Group
4043 E. Sunset Road
Henderson, NV 89014
Phone (702) 733-0744
Fax (702) 796-8262
www.alasvegasmedicalgroup.com

A Las Vegas Medical Group
Medical History Form

A Las Vegas Medical Group requests this confidential information for the purpose of providing patient care. Persons outside this medical practice are not provided this information without the patient's written consent.

DEMOGRAPHIC INFORMATION

Last Name ___________________________________ **First Name** ______________________________

Birthdate _____/_____/_____ **Sex:** ____ **M** ____ **F** **Place of Birth** ____________________________

Home Address ____
Street *City* *State* *Zip*

Home Phone ______________________________ **Cell Phone** _______________________________

Email Address _____________________________ **SSN:**_____________________________________

MAY WE COMMUNICATE MEDICAL/BILLING INFORMATION VIA TEXT? **YES** **NO**

In case of emergency, please contact:

Contact Name ____

Relationship ______________________________ **Contact Phone** _______________________________

INSURANCE INFORMATION

You will be asked to provide a copy of your Insurance and Identification cards.

(1) Name of Insured _________________________________ **Relationship to Patient** ______________

Effective Date _____/_____/_____ ☐ **Primary** ☐**Secondary** **Phone** __________________________

Claims Address ____

Policy Number or SSN ____________________________ **Group Number** ___________________________

(2) Name of Insured _________________________________ **Relationship to Patient** ______________

Effective Date _____/_____/_____ ☐ **Primary** ☐**Secondary** **Phone** __________________________

Claims Address ____

Policy Number or SSN ____________________________ **Group Number** ___________________________

TREATMENT AUTHORIZATION

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I authorize A Las Vegas Medical Group to provide any emergency care deemed necessary by medical staff in the event of a medical emergency while on the A Las Vegas Medical Group property.

Patient Name ______________________________________ **Date of Birth** _________________

Signature ____ **Date** ________________________

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Signature:____ **Date:**____________________

INSURANCE ASSIGNMENT & MEDICAL RELEASE

I, the undersigned, do hereby authorize my insurance carrier(s) to pay A Las Vegas Medical Group directly, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges NOT covered by the said insurance carrier(s), including co-pay and/or deductible amounts. I also undersign that I give my permission to A Las Vegas Medical Group to furnish any and all necessary medical records to any entity for emergencies or payment of claims.

Patient Name ______________________________________ **Date of Birth** _________________

Signature ____ **Date** ________________________

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A Las Vegas Medical Group Financial Policy

The goal of A Las Vegas Medical Group is to provide you with the best quality care at a reasonable cost. In order to achieve these goals, your assistance is needed in understanding your insurance policy and benefits. Although, we do verify eligibility and get a brief summary of benefits from your insurance company, ***it is very important that you read and understand your benefits***.

If your insurance company cannot be contacted to verify eligibility, you will be asked to pay for the visit via cash, credit, or debit at the time of service, until the eligibility can be verified.

Payment is due at the time of service and includes all co-pays and deductibles per your insurance company and their contract with our facility.

A charge of $25 will be applied to your account for FMLA, disability forms, and any other forms requiring a provider's signature but not completed at the time of a scheduled appointment.

A charge of $25 may be applied to your account for missed or cancelled appointments without 24-hours advance notice.

A charge of $30 will be applied to your account for all returned checks. This fee, plus the amount of your check must be paid in cash or money order within 24-hours of notification unless prior arrangements have been made.

Should your account become delinquent, all late fees, collection fees, and court fees will become your responsibility.

A Las Vegas Medical Group requests that you respond to all inquiries from your insurance company on your pending claims in a timely manner. We appreciate your continued cooperation and assistance in dealing with your insurance company.

By signing this agreement, I understand and agree to abide with the policies of A Las Vegas Medical Group. I also understand that I am financially responsible for any charges not covered by my insurance carrier. I also authorize A Las Vegas Medical Group to release my medical information to my insurance company in connection with my medical claims.

Patient Name ______________________________________ **Date of Birth** _________________

Signature ____ **Date** ________________________

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In an effort to maximize the time your physician spends with you and minimize your wait time, please be aware of our No Show / Late Arrival Policy:

NO SHOW POLICY

This policy applies to all patients who do not keep a scheduled appointment or who cancel an appointment with less than 24-hours notice.

- ***First Occurrence*** – Patient will receive a phone call advising of our policy and offering to reschedule the missed appointment.
- ***Second Occurrence*** – Patient will receive a certified letter and may be subject to a $25.00 No Show Fee.
- ***Third and Subsequent Occurrences*** – May result in dismissal from practice and/or an additional $25 No Show Fee for each occurrence.

LATE ARRIVAL POLICY

Any patient arriving late for their appointment may be subject to reschedule or cancellation.

Patient Name ______________________________________ **Date of Birth** _________________

Signature ____ **Date** _________________________

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PERSONAL MEDICAL HISTORY

Please indicate if you have or have had any of the following:

Have you had or do you currently have:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Anxiety			Ear/Nose/Throat Problems			Recurrent diarrhea		
Asthma			Frequent Indigestion			Recurrent headaches		
Allergies			Gallbladder Problems			Seizure disorder		
Anemia			Hay Fever			Shortness of Breath		
Arthritis			Head injury			Sickle Cell/Sickle Cell Trait		
Alcohol Abuse			Heat Illness			Sinusitis		
Back Pain			Heart murmur			Stomach/Intestinal trouble		
Cancer			Heart palpitation			Trouble sleeping		
Chest pain			High/Low Blood Pressure			Tuberculosis		
Communicable Diseases (e.g. Chickenpox or Shingles)			High Cholesterol			Urinary Tract Infections		
Chronic cough			Hepatitis / Jaundice			Sexually Transmitted Infection		
Diabetes			Thyroid Problems			Weakness: paralysis		
Dizziness			Joint Pain/Injury			**WOMEN ONLY:**		
Drug Abuse			Kidney Disease			Irregular periods		
Depression			Mental Health Disorder			Severe cramps		
Eating Disorder			Pneumonia			Excessive flow		
Eye Trouble			Recurrent colds			Pregnancy		

Please explain any "yes" answers:

____
____
____
____
____

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Have you had any illness/injury/surgery which required hospitalization? ☐ Yes ☐ No

____

At any time have any of your activities been restricted due to illness, injury, etc.? ☐ Yes ☐ No

____

Have you ever experienced any personal or emotional difficulties which required professional attention? ☐ Yes ☐ No

Would you like more information about mental health services? ☐ Yes ☐ No

Please list all medications (including vitamins and herbal supplements) you are currently taking:

Name of Medication	Dosage	How Often	Reason

Please list any allergies (including medications, food, and environmental):

Allergy	Reaction	Allergy	Reaction

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FAMILY MEDICAL HISTORY

Father: Age _____ Occupation ___________________________________ ☐Living☐Deceased

Mother: Age _____ Occupation ___________________________________ ☐Living☐Deceased

Sibling: Male / Female Age _____ Occupation ______________________ ☐Living☐Deceased

Sibling: Male / Female Age _____ Occupation ______________________ ☐Living☐Deceased

Sibling: Male / Female Age _____ Occupation ______________________ ☐Living☐Deceased

Please indicate if any of your immediate family members have or have had any of the following:

Have your relatives had or currently have:	**Yes**	**No**		**Yes**	**No**
Arthritis			High Blood Pressure		
Asthma / Hay Fever			Kidney Disease		
Cancer			Mental Health Disorder		
Depression			Sickle Cell Anemia/Trait		
Diabetes			Substance Abuse		
Heart Disease			Tuberculosis		

Explain any "yes" answers above:____

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MEDICATION REFILL POLICY

It is the responsibility of the patient to contact the office at least **FIVE (5) DAYS IN ADVANCE** of the medication running out. For your convenience, you may leave a voicemail on the "refills" option when you contact the main office.

THE PRACTICE WILL NOT DO SAME DAY REFILLS UNLESS IT IS DURING AN OFFICE VISIT

I, ____, have read the medication refill policy above and understand that I have to contact the office FIVE (5) DAYS IN ADVANCE for any medication refills. I also understand that the office WILL NOT DO SAME DAY REFILLS.

Patient Name:____

Patient Signature:_______________________________**PatientDOB:**______________**Date:**______________

FORMS POLICY

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at A Las Vegas Medical Group will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow **7-10 BUSINESS DAYS FOR COMPLETION** of requested forms/letters. Also, note that a $25 fee may be applied for the completion of forms.

I, ________________________________, understand that completion of forms may take 7-10 business days. I also understand that **SAME DAY OR NEXT DAY FORM COMPLETION WILL NOT OCCUR**. As such, I understand it is my responsibility to turn in forms with enough time before their due date in order to be completed. I also understand a $25 fee may be applied for completion of forms.

____ ___________

Patient/Responsible Party signature Date

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MEDICAL RECORDS REQUEST

A complete medical record is essential for quality care. Please list healthcare providers that may have pertinent medical records. A copy of a medical release form is included in this packet. Additional forms may be requested from the front office staff.

PROVIDER OR FACILITY	PHONE NUMBER	FAX NUMBER	SPECIALTY	PREVIOUS OR CURRENT

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth
Address	

I, or my authorized representative(s), request that health information regarding my or my child's care and treatment as set forth on this form:

In accordance with Nevada State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV related information only if I choose the option below. In the event the health information described below includes any of these types of information, and I choose the option below, I specifically authorize release of such information to the person(s) indicated below.
2. I have the right to revoke this authorization at any time by writing to A Las Vegas Medical Group. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. I understand that signing this authorization is voluntary. My or my child's treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
4. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT AUTHORIZE A LAS VEGAS MEDICAL GROUP TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE INDIVIDUALS/AGENCIES SPECIFIED BELOW:**

Name and address of health provider or entity to release this information:	
Names of Individuals/Agencies authorized to receive my OR my child's Protected Health Information (PHI):	
Specific information to be released: ☐ Medical Record from (insert date) _____________________________ to (insert date) ____ ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to A Las Vegas Medical Group by other health care providers. □ Other ____	
Reason for release of information: □ At request of patient OR Parent/Guardian □ Other: ____	Date or event on which this authorization will expire
Printed name Patient OR Parent/Guardian	Relationship to patient

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____ Date ____

Signature of Patient OR Parent/Guardian

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Medical Information Release Form
(HIPAA Release Form)

Name: ___________________________________ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)____

[ ] Other____

[ ] Information is not to be released to anyone.
This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ____

Text message communication: ____YES _____NO

Signed: _______________________________________ Date: ____/____/_____

Witness:_______________________________________ Date: ___/____/______