LAS VEGAS ENDOCRINOLOGY

Today's Date: _____ Primary Care Provider: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____ Primary language: _____

Allergies to Medications: _____

Primary Insurance Information

Insurance Company: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Social Security #: _____

Policy #: _____ (Check box if SS# is same as above ☐)

Group #: _____

Secondary Insurance Information

Insurance Company: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Social Security #: _____

Policy #: _____ (Check box if SS# is same as above ☐)

Group #: _____

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Las Vegas Endocrinology. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment by your insurance company to Las Vegas Endocrinology. We have an agreement with you, not your insurance company for payment. In the event your insurance denies a claim, you will become responsible for all amounts not covered payable to Las Vegas Endocrinology. Parents/guardians are responsible for services rendered to a minor. I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records if necessary.

Signature: _____ Date: _____

LAS VEGAS ENDOCRINOLOGY

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Yes ☐ No

Use of tobacco/smoking: ☐ Yes ☐ No

Use of illicit drugs: ☐ Yes ☐ No

Medical History (list previous hospitalizations, surgeries, serious injuries, etc.…)

Patient/Family History (Please circle all that apply.)

	Patient		Mother		Father	
Diabetes	Yes	No	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Yes	No
Stroke	Yes	No	Yes	No	Yes	No
Arthritis/Gout	Yes	No	Yes	No	Yes	No
Convulsions/Seizures	Yes	No	Yes	No	Yes	No
Depression	Yes	No	Yes	No	Yes	No
Thyroid Disease	Yes	No	Yes	No	Yes	No

LAS VEGAS ENDOCRINOLOGY

Current Medications/Dose
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Cross Streets: _____

How would you ideally prefer to be contacted regarding the following (check only one for each)?

Medical Issues: ☐ Home Phone ☐ Cell Phone ☐ Email

Appointment Reminders: ☐ Text Message ☐ Email

Medication Recall Notice: ☐ Text Message ☐ Email

May we leave voicemail: ☐ With detail ☐ Without detail

Emergency Contact

Last Name: _____ First Name: _____

Phone #: _____ Relationship to patient: _____

LAS VEGAS ENDOCRINOLOGY

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPPA

I _____ understand that as part of my health care, **Quang Nguyen DO PLLC, dba Las Vegas Endocrinology** originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer(s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that **Quang Nguyen DO PLLC, dba Las Vegas Endocrinology** is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of the organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent **Quang Nguyen DO PLLC, dba Las Vegas Endocrinology** to disclose my protected healthcare information to the following person and/or people:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I fully understand and accept the terms of this consent.

_____ _____

Patient/Legal Guardian Signature Date

LAS VEGAS ENDOCRINOLOGY

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

I authorize the use or disclosure of the following protected health information:

- ✓ Progress Notes
- ✓ Lab/Radiology Reports
- ✓ Medication History
- ✓ Other: _____

RECORDS FROM:	Physician Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

RECORDS TO:	Las Vegas Endocrinology 2865 Siena Heights Drive, Suite 140 Henderson, NV 89052	Phone: 702-605-5750 Fax: 702-605-5751

I understand that by signing this authorization:

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization will expire **1 year** from the date of my signature, unless I revoke the authorization prior to that time.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

MISSED APPOINTMENT FEE POLICY

"NO CALL, NO SHOW"

A patient who fails to attend his/her appointment (without contacting us in advance) will be subject to a **$50.00 missed appointment fee**. Please be aware that patients who have multiple "no shows" or excessive cancellations will be discharged from the practice.

If you are unable to keep your appointment, please notify us by phone immediately. This way we can schedule others who have been patiently waiting for an appointment. Please understand that we are a specialist medical office. We often have patients waiting to be seen.

If a patient show up to his/her appointment more than 15 minutes late, the appointment will have to be rescheduled to the next available appointment time and date. This allows our practice to stay on schedule to the best of our ability.

By signing this policy, you are indicating that you understand and agree to the terms of service explained above. This is our office policy.

Thank you for your understanding and cooperation.

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

FINANCIAL AND COLLECTION POLICY

Please Read the following carefully:

- Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.
- We will bill your insurance as a courtesy, not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time service is rendered.
- Photo ID and Insurance card must be provided for each date of service.
- All outstanding balance must be paid prior to check-in, unless other arrangements have been made.
- If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 60 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collections and court costs.
- Returned checks will be subject to a $35.00 fee.
- There will be a $50.00 No Show fee. Please refer to our MISSED APPOINTMENT FEE POLICY.
- If there is any change of insurance, it is the patient's responsibility to notify Las Vegas Endocrinology of the changes.
- Any refunds will be released once insurance claim has been paid by your insurance carrier. We want to make sure we deduct any copays, coinsurance, deductibles, or any other charges your insurance carrier may apply towards your responsibility. Time frame is 6 to 8 weeks.

We encourage you to communicate any problems/concerns so that we can assist you in the management of your account. We also offer payment arrangements. Please speak with our billing department for further assistance.

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)