Valley Health
PHYSICIAN ALLIANCE

Patient Registration Form

Patient information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle) M / F	Date of Birth	Marital Status (circle) Divorced - Married - Separated - Single - Widowed - Other	Preferred Language

Race (check all that apply) ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Patient Declined

Ethnicity (check all that apply) ❑ Hispanic or Latino ❑ Multiple ❑ Not Hispanic or Latino ❑ Patient Declined

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Email Address	Primary Physician

Responsible Party/Parent/Guardian (circle one) Check if same as [ ] Patient

Last Name	First Name	Gender (circle) M / F	Date of Birth	What is Patient's relationship to responsible party?

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City/State	Zip code

Insurance Information Check if [ ] Self pay

Primary Insurance:

Insurance Name	Begin date

Subscriber/Member Name	Date of Birth

What is Patient's Relationship to Subscriber?	Gender (circle) M / F

Insurance Mailing Address	City/State	Zip code

Subscriber/Member #	Group #

Secondary Insurance:

Insurance Name	Begin date

Subscriber/Member Name	Date of Birth

What is Patient's Relationship to Subscriber?	Gender (circle) M / F

Insurance Mailing Address	City/State	Zip code

Subscriber/Member #	Group #

Patient Portal

To receive an invitation to register for the patient portal please ensure you have provided an e-mail address above.

Benefits of the patient portal include: 24/7 access online via a computer or smart phone app for yourself or a designated caregiver to view results and visit summaries, request prescription refills, update your demographics, and send secure messages directly to your provider's staff without having to pick up the phone.

To opt out of the patient portal please check one of the options below:

_____ I am not interested in signing up for the portal at this time _____ I do not have an e-mail address

Health Information Exchange (HIE)

I grant ***Independence Physician Management*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***Independence Physician Management*** to search and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***Independence Physician Management***

_____ _____

Patient/Legal Guardian Signature Date Patient/Legal Guardian Print Date

Valley Health
PHYSICIAN ALLIANCE

Patient Name: _____ MRN: _____ Date of Birth: _____
Please Print

Office Policies

Appointments:

We require 24 hour notice if you need to cancel or reschedule your appointment. Your cooperation will allow others that need timely medical care to be scheduled.

A “no-show" is someone who misses an appointment without adequate or no advance notice. A failure to be present for your scheduled appointment will be recorded in your medical record and frequent no-shows may result in dismissal from the practice.

If you arrive 15 minutes or later to your scheduled appointment time, you may be rescheduled so that other patients appointment times will not be impacted.

Financial:

I hereby authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of me and/or dependents. I further expressly agree and acknowledge that my signature in this document authorizes my physician and all necessary parties to submit claims on my behalf. I hereby authorize my insurance company to pay and hereby assign benefits directly to Las Vegas Medical Group (LVMG). I acknowledge that any insurance benefits, when received and paid, will be credited.to my account. Any balance due will be paid by me based on my contractual obligation set forth by Las Vegas Medical Group and my insurance company. Full payment is due at the time of service unless other arrangements have been made or mandated by law. I understand that as a recipient of medical care, or personal representative, I am responsible for all charges regardless of my circumstance for reimbursement.

Privacy (HIPAA):

I hereby give my consent for Las Vegas Medical Group to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and health care operations to a Third Party Organization (TPO). The Notice of Privacy Practices provided by Las Vegas Medical Group describes such uses and disclosures more completely and may be obtained from the medical office upon request. I have the right to place restrictions on the release of my PHI but must do so in writing. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I may have included names on the intake form of people authorized to receive my PHI. I understand that the people I fisted are able to receive my medical information and discuss my health with representatives of Las Vegas Medical Group.

Medications:

We require you to request refills of your prescriptions through your pharmacy 72 hours before needed. The provider my ePrescribe (send the medication directly to the pharmacy through the computer) to assist in you obtaining your prescriptions.

By signing below, you authorize LVMG to send and obtain outside medication history through electronic means.

Controlled Substances:

Nevada State Law is very specific about controlled substances and we comply with all laws. This may include (but not limited to) frequent visits, Controlled Substance Agreement, time sensitive prescriptions and drug testing.

I have read and agree to the above policies.

_____ _____
Signature of Patient or Legal Guardian Patient date of birth

_____ _____
Please print name of Patient or Legal Guardian Today’s Date:

Valley Health
PHYSICIAN ALLIANCE

NOTICE of PRIVACY PRACTICES

A copy of ***Independence Physician Management's*** HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

DISCLOSURE of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

I authorize ***Independence Physician Management*** to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below.

Name: _____ **Relationship** _____

Name: _____ **Relationship**_____

I authorize ***Independence Physician Management*** to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. ☐ Yes ☐ No

Emergency Contact: _____ **Phone number**_____ **Relationship:** _____

Email Address: _____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENT of BENEFITS

Independence Physician Management strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 50% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. ***Independence Physician Management*** will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to ***Independence Physician Management*** of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize ***Independence Physician Management*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize ***Independence Physician Management*** to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ***Independence Physician Management***. Any photographs or other images taken will become part of my medical record. ***Independence Physician Management*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Independence Physician Management*** will provide me with information and forms prior to such procedures. . I grant ***Independence Physician Management*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***Independence Physician Management*** to search and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***Independence Physician Management***.

This form expires three years from today's date.

_____ _____

Patient's Name (Please Print) Signature

_____ _____

Patient Representative (If patient is unable to sign) Signature

Valley Health
PHYSICIAN ALLIANCE

Pharmacy Information

Local Pharmacy

Patient Name:_____ DOB:_____

Pharmacy Name: _____

Pharmacy Phone Number: _____ Fax Number: _____

Pharmacy Address: _____

_____

Major Cross Streets: _____

Mail Order Pharmacy

Do you use a mail order pharmacy? □ Y □ N

If yes, please complete:

Mail Order Pharmacy Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Allergies & Reactions

_____

_____

_____

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PHYSICIAN ALLIANCE

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: **Las Vegas Medical Group- West Henderson Primary Care** **Phone: (702) 551-2079**
866 Seven Hills DR, Suite 201 **Fax: (702) 640-5911**
Henderson, NV 89052

FROM: _____
(Name of Healthcare Provider/Physician/Facility/Medicare Contractor)
_____
Street Address
_____
City, State and Zip Code

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____

_____ I authorize and request the disclosure of all protected information for the purpose of review and evaluation for continuity of care. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- ☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, etc., videos/CDs/films/reels and reports.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: Continuity of Care
_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
Patient or Legally Authorized Representative (Signature) Date
(See 45CFR § 164.508(c)(1)(vi))

_____ _____
Name and Relationship of Legally Witness
Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))