PATIENT INFORMATION RECORD
RURAL SURGICAL ASSOCIATES OF LAS VEGAS

Patient Name _____ M/F _____

Date of Birth _____ Age _____ Social Security # _____

Mailing Address: _____ City/State/**Zip** _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Name of Insured/Guarantor _____ DOB & SS# _____
(REQUIRED FOR TRICARE)

Emergency Contact/Spouse/Guardian _____ Phone Number _____

REFERRING PHYSICIAN _____ Phone Number _____

PRIMARY CARE PHYSICIAN _____ Phone Number _____
(As on your insurance card)

In order to comply with the new healthcare laws we must ask the following questions:

Please Circle

Patient Race: _____ **Patient Ethnicity** **Hispanic or Latino** **Not Hispanic**

Pharmacy Name: _____ **Pharmacy Phone #:** _____

Pharmacy Location: _____

A COPY OF YOUR INSURANCE CARD IS NECESSARY TO ENSURE PROPER FILING*

It is the patient's responsibility to provide our office with the correct insurance information at the time of service. Incorrect insurance information will result in denial of claim payment for which the patient will be completely responsible.

I, _____, herby authorize any physician, medical practioner, hospital, or medical related facility, insurance company, or other institution or persons having any records, charts, x-rays, CTs, MRIs, laboratory work, or similar information or knowledge of me or my health, including, but not limited to, information related to AIDS/HIV/ARCH, to release such information to *RURAL SURGICAL ASSOCIATES OF LAS VEGAS. LLC.* or its authorized representative(s) performing services in connection with my medical care or as lawfully required.

I also authorize *RURAL SURGICAL ASSOCIATES OF LAS VEGAS. LLC.* to release my medical information to *ANY* doctors and other health professionals involved in my medical care. I also authorize *RURAL SURGICAL ASSOCIATES OF LAS VEGAS. LLC.* to release my medical information to *myself.*

I, the undersigned, authorize payment of insurance benefits directly to *RURAL SURGICAL ASSOCIATES OF LAS VEGAS. LLC.* I authorize *RURAL SURGICAL ASSOCIATES OF LAS VEGAS. LLC.* to release any information concerning my (or my dependent's) healthcare, advice, and treatment provided to my insurance company, my employer, and 3rd party payer administrator for the purpose of evaluating and processing my claims. As the responsible party, I agree that I am responsible for co-payments, co-insurance, and/or deductibles in accordance with the terms and conditions of my health insurance policy. **I agree that in the event my insurance company denies payment, or I have no insurance, that I am ultimately responsible for the unpaid balance of my account.**

I am aware that *RURAL SURGICAL ASSOCIATES OF LAS VEGAS. LLC.* charges a fee if I do not call and notify them of my cancellation within twenty-four (24) hours of my appointment.

I acknowledge that I have been given the opportunity to review and/or receive a copy of the **NOTICE OF PRIVACY PRACTICES** on record at *RURAL SURGICAL ASSOCIATES OF LAS VEGAS. LLC.*

Signature of Patient/Responsible Party _____ Date _____

PATIENT EMAIL: _____

*****If this visit is related to a motor vehicle accident, our office requires a Letter of Protection prior to your visit.**

*****If this visit is related to a workers compensation claim, our office requires appropriate billing information and approvals *prior* to your visit. Otherwise, you will be directly responsible for payment.**

PATIENT INFORMATION RECORD - PAGE 2

RURAL SURGICAL ASSOCIATES OF LAS VEGAS

Patient Name _____ Date of Birth _____ Age _____

Height _____ Weight _____ **BMI** _____ **%** **__Normal** **__Above** **__Below**

Care Plan Given:

__Exercise Counseling **__Nutrition/Dietary Counseling** **__BMI Management Provided**

BP _____ Heart Rate _____ **__NORMAL** **__ ABNORMAL**

Care Plan Given:

__Referral to Alternative / PCP **__Physical Activity Recommended** **__Weight Reduction Recommended**

Have you had the following Immunizations this year?

Influenza Immunization: Y N
If Yes please provide approx date: _____
Given by: PCP_____ Other_____

Pneumococcal Immunization: Y N
If Yes please provide approx date: _____
Given by: PCP_____ Other_____

Do you have allergies to medications? If so, what are they and what happens when you take these medications?

_____

_____

Social History

Do you use any of the following?

Tobacco / Cannabis	Y	N	_____ PACKS PER DAY FOR _____ YEARS
Alcohol	Y	N	_____ DRINKS PER DAY

Patient counseled on Smoking: _____ **Date:** _____

Patient counseled on Alcohol use: _____ **Date:** _____

Please list current Medications

NAME OF MEDICATION / DOSAGE	NAME OF MEDICATION / DOSAGE

Preventive Medicine for patients 65 YEARS OR OLDER

Have you had any falls since January of this year? Y N
If yes – How many falls have you had? _____ Was there an injury with the fall? Y N

Assessment Performed
Assessment Not Performed, due to medical reason: _____
Assessment Not Performed, no reason specified: _____
Documented: Y N

_____ _____

Physicians Signature **Date**

RURAL SURGICAL ASSOCIATES OF LAS VEGAS, LLC.

RSA must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is required that patients who are covered by health insurance provide RSA with your current insurance ID card. It is also *your* responsibility to inform RSA of insurance or insurance ID card changes. If correct insurance information has not been provided, the resulting claim will be denied and ***you* will be responsible for all fees incurred.**

You are responsible and should be fully aware of your own policy *deductibles*, eligible benefits and any referrals/authorizations required. If you are uninsured or do not have your insurance information with you, **payment in full is due at the time of service.** We accept cash, checks, and most major credit cards. **Co-payments are also due at every visit.**

RETURNED CHECK POLICY

Returned checks will automatically be charged to your account along with a $35.00 processing fee. Please note, all future visits must be paid by cash or credit card.

NO SHOW POLICY

RSA requires that if your appointment must be cancelled, it must be done no later than 24 hours prior to your appointment. If you fail to arrive for your scheduled appointment you will be charged a fee ranging from $25-$300 (depending on the services scheduled) which you will be personally responsible. Patient who repeatedly cancel or fail to show for appointments will be released from the care of RSA. You will also be charged a NS fee if you cancel your appointment the same day as your appointment.

COLLECTION POLICY

Balances older than 90 days will automatically be sent to collections. At that point, you, as the patient, will not be seen by RSA providers until your balance has either been paid in full and/or a mutually agreeable payment arrangement has been made with the RSA billing office. Late and/or collection fees ranging from $10-$100 will also be your responsibility. **You will also not be eligible for prescription refills until the collections balance has been paid.**

FORMS, RECORDS, AND LETTERS FEES

RSA does charge anywhere from $45.00 - $90.00 for forms to be filled out and $65.00 - $150.00 for special letters that need to be written by the physicians. The fee will be determined by the physician, based on the detail of the form / letter and time to complete the form / letter. All patients are entitled to **ONE** free copy of their medical records. Any additional copies will require a payment of $25.00. Insurance companies and attorneys are also required to pay the same fees for forms, records, and letters.

I hereby acknowledge that I have read and understand the above policies.

Signature of responsible party: _____ Date: _____

Printed Name of Patient: _____

RURAL SURGICAL ASSOCIATES OF LAS VEGAS, LLC.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____ SS# _____

Date of Birth _____ Phone # _____

I hereby authorize Dr. /Facility _____to release medical records of myself, including any records pertaining to HIV/AIDS, psychiatric/psychological testing, and/or drug and alcohol tests.

Please include the following:

History & Physical Laboratory/Pathology Reports Progress Notes Radiology Reports
Other _____

Date(s) of service for which records are requested: _____

The above described records are to be release to:

Name Address Phone #

For the purpose of:

_____Continuing Care _____Insurance Purposes _____Attorney Use _____Personal Use

I herby release the healthcare provider from all legal responsibility or liability that may arise from the authorization given above. A copy of the authorization shall serve the same purpose as the original. I understand I have the right to examine the information to be disclosed.

Patient/Responsible Party Signature _____Date_____

Relationship to Patient _____

This authorization shall expire in ONE YEAR unless otherwise specified. _____

NOTICE TO RECIPIENT

This information has been disclosed to you from records whose confidentiality is protected by State/Federal Regulations. State/Federal Regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains. or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

The current use and over use of the narcotic analgesics Hydrocodone and Oxycodone are becoming a major problem in medicine and society in general. Whereas these medicines are intended and effective for short term use, their effectiveness in long term use is questionable and the potential for abuse and dependence is significant.

There are certain situations that dictate the long term use of these medicines in order to allow a patient to be functional in his or her daily life. However, these situations are usually the exception, not the rule and other modalities are more desirable.

NO LONG TERM NARCOTICS WILL BE PROVIDED.
SHORT TERM NARCOTIC(S) WILL BE PRESCRIBED FOR POST-OPERATIVE PAIN RELIEF AND ACUTE INJURY ONLY.

After that, it is up to the discretion of the physician whether or not the patient will be referred to a pain management specialist or for another form of medical care. Please be advised that patients requesting or receiving pain medication may be monitored through a pharmacy reporting program which lists all previously prescribed pain medication and the names of the physicians who prescribed them.

This policy may seem harsh to some, but it is in the best interest and welfare to all concerned.

I acknowledge receipt of this information and will adhere to the guidelines.

Signature: _____ **Date:** _____

Authorization to discuss protected information and retrieve written prescriptions

Our clinic is committed to protect our health information. In order to insure we will not withhold information from those with whom you have authorized our staff to discuss your health information on a limited basis, we require a list of persons authorized by you to discuss information on your behalf and those persons authorized to retrieve Prescriptions on your behalf. Those who are authorized will be required to provide picture identification to verify identity. To obtain written records, an **Authorization to Use and Disclose Protected Health Information** form must be completed for each individual instance of request. Please understand that we are required by law to protect your health information and procedures will be strictly enforced by our office staff.

Patient's Printed Name:_____ **DOB:**_____

Persons authorized to discuss health information and retrieve written prescriptions.	**Relationship to patient**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

_____ _____/_____/_____

Patient's Signature **Date**