LAS VEGAS ENDOCRINOLOGY

Today's Date: _____ Primary Care Provider: _____

Patient Information

Last Name: _____ First Name: _____ MI:_____

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

Street Address:_____ Home Phone: _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____ Work Phone: _____

Email address: _____ Primary language: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance Information

Insurance Company: _____ Phone: _____

Policy Holder's Name: _____

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

Address (If Different From Above): _____

Policy #: _____ Group #: _____

Secondary Insurance Information

Insurance Company: _____ Phone: _____

Policy Holder's Name: _____

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

Address (If Different From Above): _____

Group #: _____ 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 Quang Nguyen DO PLLC dba 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 Quang Nguyen DO PLLC, dba 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 Quang Nguyen DO PLLC, dba Las Vegas Endocrinology. Parents/guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency to include but not limited to, commissions attorney & court filing fees, or interest rates assigned by the collection agency. 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: _____

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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

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Allergies to Medications: _____

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

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Cross Streets: _____

Permission to access your medication list from your pharmacy/insurance company? ☐ Yes ☐ No

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

Medical Issues: ☐ Phone ☐ Email

Appointment Reminders: ☐ Phone ☐ Email

Medication Recall Notice: ☐ Phone ☐ Email

May we leave voicemail: ☐ With detail ☐ Without detail

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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

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MEDICAL RECORDS REQUEST FORM

Patient Name: _____ Date of Birth: _____

I hereby request that you release 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
229 North Pecos Road, Suite 100
Henderson, NV 89074

Phone: 702-605-5750
Fax: 702-605-5751

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

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MISSED APPOINTMENT FEE POLICY

"NO CALL, NO SHOW"

Appointment confirmation is a courtesy act. It is the responsibility of the patient to keep track of his/her appointment date and time and not rely on the clinic to remind him/her. We will always call at least 2 to 3 business days before the appointment, but if we are not able to get a hold of you, it is not our responsibility to follow up.

If you are unable to keep your appointment, please notify us using the patient portal or by email at lvendocrine@gmail.com. We require at least 24 hours' notice. Please understand that we are a specialty clinic. We often have patients waiting to be scheduled. If you choose to cancel by phone, the cancellation MUST BE CONFIRMED by our staff. Leaving a phone message will not suffice. We strongly encourage the use of email to cancel your appointment.

A patient who fails to attend his/her appointment (without contacting us at least 24 hours 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 Las Vegas Endocrinology.

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 below, you are indicating that you understand and agree to our MISSED APPOINTMENT FEE (No Show) policy. 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)

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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 balances 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)

LAS VEGAS ENDOCRINOLOGY

ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

Quang Nguyen DO PLLC, dba Las Vegas Endocrinology ("Practice") and Patient herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and all electronic communications may be utilized between the Practice and Patient that includes Patient's Personal Health Information ("PHI"). The Patient agrees to inform the Practice of any changes to Patient's authorized email address. Patient acknowledges that should Patient email exchange with the Practice from another email address, Patient authorizes the Practice to use that email address for communicating PHI as well.
2. For all other services, the Practice and the Patient may use telephone (landline or mobile), facsimile, mail, or in-person office visits.
3. Under no circumstances shall email or electronic communications be used by the Patient or the Practice in emergency or time-sensitive situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.
4. The Practice values and appreciates the Patient's privacy and takes security measures such as encrypting the Patient's data, password-protected data files, and other authentication techniques to protect the Patient's privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient's explicit consent to certain communication amenities.
5. The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient's information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this PHI Agreement. The Patient shall hold harmless any and all demands, claims and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or causes by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.
6. The Practice will obtain the Patient's express consent in the event that the Practice is required or requested to forward the Patient's identifiable information to any third party, other than as specified in the Practice's Notice of Privacy Practice's, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all Responsible Parties.
7. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Practice terminating the email and electronic communications relationship, and may lead to the termination of the Patient's agreement for Practice services.
8. The Patient hereby consents to engaging in electronic and after-hours communications referenced above regarding the Patient's PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.
9. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate with the Patient regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient's PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgment.
10. The Patient shall have the right to request from the Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronics information. However, the Patient's PHR Support subscription fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive) the Practice's actual supply costs for such equipment may be charged to the Patient.
11. This Agreement will remain in effect until the Patient provides written notice to the Practice that the Patient revokes this Agreement or otherwise revokes consent to communicate electronically with the Practice. The Patient may revoke this Agreement at any time, and agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communication database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment, but will preclude the Direct Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all present and future purposes.

ACKNOWLEDGMENT OF RECEIPT FOR AGREEMENT FOR PERSONAL HEALTH INFORMATION

I acknowledge that I have received a copy of the Practice's Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

Signature: _____ Date: _____

Printed Name: _____