Patient Name _____ SS# _____

Address _____

Street Apt# City State Zip code

DOB _____ Age _____ Sex *M* ☐ *F* ☐ Marital Status *S* ☐ *M* ☐ *W* ☐ *D* ☐

Email _____

Cell phone # _____ Home phone # _____

Please approve the following:

☐ Send mobile text notifications

☐ Send voice notifications

Preferred method of communication:

☐ Email ☐ Mail ☐ Home phone ☐ Mobile phone ☐ Work phone

Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Preferred language:

☐ English

☐ Spanish

***** Please list guarantor/parent employer information if the patient is a minor; otherwise, list the patient's information *****

Employer _____ Occupation _____

Address _____

Work Phone # _____ ext. _____

Emergency Contact _____ Phone # _____

Relationship to patient _____

How were you referred to our office? Dr._____ Phone #_____

Insurance ☐ Online☐ Relative☐ Friend ☐ Other ☐ _____


Hand Center
of Nevada

Health Insurance Information

***** Please fill out the following even if this is a work-related injury *****

Primary Insurance Company _____

Insured's name _____

Member ID # _____ DOB _____

Insured's Employer _____ Relationship to patient _____

***** If the patient is a minor, please list the social security number of the insured on the line below:

_____

Secondary Insurance Company _____

Insured's name _____

Member ID # _____ DOB _____

Insured's Employer _____ Relationship to patient _____

***** If the patient is a minor, please list the social security number of the insured on the line below:

_____

Work Related Injuries

Have you completed a doctor's C-4 form? Yes☐ No☐ Employer: _____

Who is your worker's compensation (MCO) carrier? _____

Date of Injury_____ Claim# _____

Adjuster _____

Phone# _____ Fax# _____

- Hand Center of Nevada shall operate in a manner that does not unlawfully discriminate against people on the basis of race, color, national origin, religion, sex (including pregnancy) age, **sexual orientation** (including **gender identity and expression**), marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law.

  Hand Center of Nevada prohibits retaliation against any person because he or she opposed or complained about discrimination in good faith, assisted in good faith in the investigation of a discrimination complaint, or participated in a discrimination charge or other proceeding under federal, state, or local antidiscrimination law.

Financial Policy and Assignment of Benefits

All fees for medical care are based on the usual, reasonable and customary fee charged in this area by physicians of equal training and experience.

Payment for medical services rendered is due at the time of service unless prior arrangements have been made. All the forms have to be filled out in their entirety.

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your carrier. The patient/responsible party is liable for all co pays/coinsurance/calendar year deductible and non-covered supplies or services.

The exception to the above is for those patients with injuries that are work related and are covered by Worker's Compensation. These patients are not responsible for their bills, unless their claim is denied. This is why we need information about your private insurance, so that the billing process can go smoothly if Worker's Compensation denies your claim.

Prior authorizations obtained for procedures and therapy by this office on your behalf does not guarantee payment but rather based on medical necessity. Claims are subject to policy provisions and your insurance carrier determines final payment. A deposit is required if you are being schedule for surgery. If an assistant is required at the time of surgery to improve the quality of surgical outcome, the assistant's fee is in addition to the surgeon's fee. Furthermore, you will receive and will be obliged to satisfy bills from surgical centers, hospitals and anesthesiologists for surgical procedures independent of our office's billing.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medigap, Veteran's administration or other designated payer of medical benefits to HCON, for clinical, surgical, and/or therapy services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A collection fee will be added to unpaid balances that are sent to collection agency. 1.5% interest accrued monthly. A photocopy of the assignment is considered as valid as the original. Any credit less than $20 will remain on your account unless requested by patient / responsible party. I authorize HCON, to release any information necessary, including medical records, to secure payment for services rendered to me.

I hereby consent to and authorize medical treatment, tests, procedures and/or therapy performed in the office that my physician deems advisable and necessary based on judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

MISSED APPOINTMENTS

Because our practice is extremely busy, please help us to better serve you by keeping all scheduled appointments. We asked that you please cancel or reschedule any appointments you are unable to keep within 24 hours of the scheduled time. **If you do not show for your appointment there is a $25.00 no show fee. If I miss or do not show to 3 of my appointments, I understand that I will be subject to being discharged as a patient.**

COLLECTION POLICY

I agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account. **If referred to a collection service, I understand I will be subject to being discharged as a patient.**

RETURNED CHECKS

There will be a $35.00 fee for all returned checks. If a check is returned, you will be expected to pay by cash, credit card, or money order all subsequent services.

DISABILITY PAPERS

There will be a charge of $35.00 per packet. Any subsequent disability form will be charged an additional $35.00 per packet. Paperwork can take up to 10 business days to complete. Payment is due at the time of form submission. Disability forms will be faxed **1 time** with signed consent. **I understand that it is my responsibility to pick up original forms.**

PRESCRIPTION REQUESTS

Prescription request can take up to 48 business hours to complete from the time the patient has contacted the office.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Our strict adherence to his policy services to enhance our provider/patient relationships.

I have read, understand, and agree to this Financial Policy.

_____ _____

Patient Signature/Legal Representative Date

_____

Printed Name

Medical Records Release Authorization

I hereby authorize and request _____ to release the COMPLETE medical records in your possession concerning my treatment to:

Hand Center of Nevada
8585 S. Eastern Ave. Suite #100
Las Vegas, NV 89123
Phone #: (702) 798-8585
Fax #: (702) 341-0109

Patient Name: _____

Date of birth: _____ **Social Security #:** _____

Patient Address: _____

Cell Phone #: _____ **Home Phone #:** _____

Or

I hereby authorize and request that you release the COMPLETE medical records concerning my treatment at Hand Center of Nevada

Please send records to:

Location: _____

Address: _____

Phone #: _____ **Fax #:** _____

_____ _____
Patient Signature/Legal Representative Date


Hand Center
of Nevada

Patient Record Disclosures

The HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of the PHI by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

***** Please place an X next to all that apply *****

Home Telephone#:

_____ Ok to leave a message with detailed information (Ex: date and time of appointments)
_____ Ok to leave message with callback number **ONLY**

Cellular Phone #:

_____ Ok to leave a message with detailed information (Ex: date and time of appointments)
_____ Ok to leave message with callback number **ONLY**

Work Phone #:

_____ Ok to leave a message with detailed information (Ex: date and time of appointments)
_____ Ok to leave message with callback number **ONLY**

Written Communication:

_____ Ok to email
_____ Ok to mail to home address
_____ Ok to mail to work office address

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests of PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record. **Note: Uses and disclosures for TPO may be permitted without prior consent in case of an emergency.**

I, _____ authorize Hand Center of Nevada to disclose my protected information to: _____, _____, _____, and _____ **(Ex: spouse, child, relative, etc.)**. I am fully aware that once the information is released to the above named person(s), Hand Center of Nevada will not be liable for any misuse of the information given. A copy of the privacy practice is available for review upon request. By signing below, I understand I have the opportunity to read the privacy practice of Hand Center of Nevada.

_____ _____
Patient Signature/Legal Representative Date

_____ _____
Printed Name Date of Birth