Dear Patient:

Welcome to The DOCS. Thank you for allowing us the opportunity to assist you with your healthcare needs. We value all our patients and are committed to providing you with high-quality, healthcare services.

This packet includes all the patient forms that will need to be completed in for us to assist you with your care.

1. Intake Form
2. Office Policies
3. HIPAA Brochure
4. HIPAA Acknowledgement
5. Authorization for Use and Disclosure of PHI

Please take a few moments prior to your appointment to review and complete the registration forms. We ask that you bring the completed forms to your appointment along with your insurance card.

Please arrive 20 minutes early for your appointment. The physicians and the staff at The DOCS look forward to assisting you with your health care needs. If you have any questions, please call the numbers below and someone will be happy to help you.

The DOCS Intake Form

Date: _____

First Name: _____ MI_____ Last Name: _____

Mailing Address:_____Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

Primary Phone ☐ Cell ☐ Home:_____Secondary Phone ☐ Cell ☐ Home: _____

SSN:_____ Date of Birth:_____ Marital Status: M S D W

Sex: F or M Identifying As: F or M Employer's Name:_____Work Phone: _____

Email:_____Web Enable: Y or N (for our patient portal)

Race:_____(optional) Ethnicity:_____(optional) Language: _____

Emergency Contact Name:_____Phone#:_____Relation: _____

Who referred you? _____

Preferred Pharmacy Name:_____Phone:_____Cross Streets: _____

Health Insurance Information (ALL FIELDS ARE REQUIRED)

Primary Insurance Name:_____Customer Service Phone: _____

Policy Holder Name:_____SSN:_____Date of Birth: _____

Phone:_____Policy Holder Employer: _____

ID Number:_____Group/Policy #: _____

Secondary Insurance Name:_____Customer Service Phone: _____

Policy Holder Name:_____SSN:_____Date of Birth: _____

Phone:_____Policy Holder Employer: _____

ID Number:_____Group/Policy #: _____

- The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits to be payable to The DOCS.

Signature:_____ **Relationship to Patient:**_____**Date:** _____

8352 W Warm Springs rd Suite 300 Las Vegas NV 89113
(702)-851-7286

Financial Policy

1. All co-payments are due at the time of visit, every visit to include but not limited to new appointments, follow up appointments, studies, pre-op visits, post-op visits, scans etc. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a violation of the contract you have with your insurance company. Our office accepts cash, checks (post-dated checks are not accepted), credit and debit cards.

2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.

3. You are ultimately responsible for payment of charges for services you receive from our office.

4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.

5. It is your responsibility to ensure that our physicians are in your insurance network.

6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.

7. Payment is due for rendered services 10 days from receipt of your billing statement. Outstanding balances must be paid in full prior to any additional visit unless arrangements have been made with our billing department.

8. There is a service fee of $35 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee.

9. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery and in-office procedures must be received at least 5 days prior to the scheduled surgery date and time.

10. Patients who fail to keep or fail to cancel a scheduled appointment may be charged a $50.00 No Show Fee. There is a $500.00 cancellation fee for scheduled surgeries or in-office procedures that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.

11. Medical records requests must be received in writing at least 72 hours prior to the date needed.

12. Administrative Services: There is a $50.00 charge for each required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative items not covered by insurance.

13. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.

14. **SELF-PAY**: Payment in full is due at the time of service if you do not have health insurance coverage.

Name of Individual/Legal Representative **(Print) Signature of Individual/Legal Representative** **Date**

8352 W Warm Springs rd Suite 300 Las Vegas NV 89113

HIPAA PRIVACY INFORMATION

UNDERSTANDING YOUR HEALTH RECORD:

Each time you visit our office(s), a record of your visit and notes are recorded.

Typically, this record contains your symptoms, examination/test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among health professionals who contribute to your care.
- Legal document describing care you received.
- Means by which you or a payer can verify that services billed were provided.
- A source of data for medical research.
- A source of information for public health officials to help improve the health of the nation.
- A Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of our offices as we compiled the information, the information itself belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and request copies of your health record as provided for in 45 CFR 164.524
- Obtain accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations.
- Revoke our authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

Our offices are required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

APPOINTMENT REMINDERS:

We may call or write to remind you of scheduled appointments or inform you that you need to make another appointment. We may also call, write, or email to notify you of other services available at our offices that may be of interest to you. Unless you tell us otherwise, we may leave a message on your answering machine or voicemail, or with someone who answers your phone if you are not available.

We will not make any other uses or disclosures of your information unless you sign a written "authorization form." Federal law mandates the content of an "authorization form." In all situations, other than those described above, we will ask you for your written authorization before using or disclosing your information. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. Revocations must be in writing.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS:

We routinely use your information for these purposes without any special permission, the most common reasons being for treatment payment or health care operations.

Examples of how we use or disclose information for treatment purposes are setting up appointments, testing or examination (including labs), prescribing medications (including pharmacies), referring you to another provider for care, or getting copies of your health information from another facility that you may have seen or are currently seeing. We may also disclose information to your insurance company for billing, other payors' payments, and our outside collections service for outstanding accounts. Rarely, we may also have to disclose information for financial or billing audits, internal quality assurance, or outside professional or academic programs.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

In some limited situations, the law allows or requires us to use or disclose your information without your permission. Examples of such uses are:

- When a state or federal law mandates that certain information be reported for a specific purpose.
- To governmental authorities about victims of suspected abuses, neglect, or domestic violence.
- For health oversight activities, such as the licensing of professionals, for audits for payors, or for investigation of possible violations of health care laws.
- For health-related research.
- To prevent a serious threat to health or safety.
- Of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures are an avoidable byproduct of permitted uses or disclosures.
- For legal purposes, such as subpoenas or court orders.
- For law enforcement purposes, such as information pertaining to a victim of a crime; or to report a crime.
- To a medical examiner, or to funeral directors, or to organizations that handle organ or tissue donations.
- For specialized government functions, such as intelligence activities, disaster relief activities, or other national security activities authorized by law.
- For public health purposes, such as contagious disease reporting, investigation and surveillance, and notices to and from the FDA or devices of de-identified information.
- Relating to worker's compensation programs.
- To "business associates" who provide services for us and who commit to respect the privacy of your information.
- Unless you object, we will also share relevant information about your care with your family or other caregivers who are helping with your medical needs.

Patient HIPAA Acknowledgement and Consent Form

Patient Name (Printed):_____ **Date of Birth:** _____

Notice of Privacy Practices.

_____(Patient/Representative initials) I acknowledge that I have received The DOCS Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in The DOCS Notice of Privacy Practices.

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the The DOCS Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize The DOCS to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

Patient Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of The DOCS Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply with the policies stated.

Patient Initials: _____

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize The DOCS to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at The DOCS and it may include prescriptions back in time for several years.

Patient Initials: _____

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by The DOCS, encompassing routine care, diagnostic procedures, examination, and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by The DOCS Podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to The DOCS all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33 1/3% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions.

Patient Initials: _____

The DOCS may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

DISCLOSURE OF SERVICES

I understand that The DOCS are provided for patient convenience. During my course of treatment, products and/or services from The DOCS may be recommended. I understand that I am under no obligation to patron these businesses and that I may find alternate sources to purchase these products and/or services.

Patient Initials: _____

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name:_____ **Patient DOB:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:** _____

I authorize the use or disclosure of the above-named individual's PHI to be released as follows:
__All Medical Records __Lab/X-ray _Other_____
Reason for Request:
__Medical Care _Personal Insurance __Attorney____Other_____

This authorization is given and to remain in force for the specified period:
__From_____to_____
__For the period of 1 year beginning on: _____

The following named individuals are granted permission to access my medical information and communicate on my behalf:

Name:_____Relationship:_____
Name:_____Relationship: _____

Transfer Records From:
Name: _____
Address:_____City:_____State:_____
Phone Number:_____Fax Number: _____

Send Records To:
Name: _____
Address:_____City:_____State:_
_____Zip: _____
Phone Number:_____Fax Number: _____

Signature of Patient, Parent, Guardian, or Personal Representative:
Signature:_____Date: _____
Print name of above:_____
Relationship to Patient: _____

Controlled Substance Acknowledgment

The Providers at The DOCS **DO NOT** prescribe controlled substances on an initial visit.

Printed Name	Signature	Date