Family Doctors
MEDICAL CENTER

Last Name:_____ First Name_____ MI_____ SSN: _____

Birthdate:_____ Martial Status: ____Married ____Single ____Other Email: _____

Mailing Address: _____ City:_____ State_____Zip_____

Mobile Phone Number: _____ Home Phone Number:_____

(If under 18 of age please list below Parent(s) or Guardian(S)

Name:_____ Relation: _____ DOB: _____

Emergency Contact:

Name:_____ Relation:_____ Phone Number_____

Insurance Coverage

Primary Insurance:_____

Subscriber Name (If Different):_____

Subscriber ID:_____

Birthdate:_____

Secondary Insurance:_____

Subscriber Name (If Different):_____

Subscriber ID:_____

Birthdate:_____

Please Initial the following and sign at the bottom:

_____ **Financial Policy** (full policy copied on the back): As a courtesy to our patients, Family Doctors Medical Center will bill most U.S. health plans. Deductible, co-pay and/or coinsurance will be collected in full at the time of service. The amount of payment due at the time of visit depends on your insurance plan. We will also collect on any balance due on your account. Signing below indicates that you have read and understand our full Financial policy copied on the back of this form.

_____ **Noncovered Services:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Since your agreement with your insurance carrier is a private one, we do not routinely research whether a service is covered. It is the patient's responsibility to find out if a service is covered prior to service.

_____ **Demographic & Insurance Updates:** All patients are required to update medical history and demographic information on a yearly basis. A copy of the medical insurance card is required on a yearly basis as well in order to ensure proper billing information.

_____ **Missed Appointments:** In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. If you miss three appointments in a 12 month period, you may be dismissed from the practice. **You WILL be charged an $25.00 fee for a missed appointment.**

By signing below, I have read, understand and agree with all of the listed policies:

X_____

Patient Signature or Signature of Legal Guardian if patient is under the age of 18 **Date**

Family Doctors
MEDICAL CENTER

Thank you for choosing Family Doctors Medical Center.

Our aim is to provide you with high-quality medical care provided by a team of compassionate, committed, and friendly medical professionals.

Being “cared for” is the result of a mutually agreeable, voluntary service. It can be terminated at any time by either party.

In order to effectively bill and collect on charges incurred, we require all patients to read and sign the following financial policy. Thank you for your cooperation.

● We accept cash and all major credit cards. Your bill will include office visits, x-rays, procedures performed, fees, lab work, and other charges related to your care.

● As a courtesy to our patients, Family Doctors Medical Center will bill most U.S. health plans. Deductible, co-pay and/or coinsurance will be collected in full at the time of service. The amount of payment due at the time of visit depends on your insurance plan. We will also collect on any balance due on your account.

● Family Doctors Medical Center requires payment in full if an insurance card is not provided before your appointment. Providing correct insurance information and any necessary authorization(s) are your responsibility. You are responsible to pay any charges denied by your insurance because of missing/inaccurate information.

● If you do not have insurance, payment in full is expected at the time of service. Patients who do not have insurance, or choose to file their own insurance and pay in full at the time of service, will receive a 20% discount. Discounts will not be given for DOT, sport, or school physicals.

● Any care not paid for by your existing insurance coverage will require payment in full at the time of service or upon notice of insurance claim denial. We do not routinely research whether a service is covered, so it is up you, the patient, to contact your insurance carrier or employer to determine coverage information.

● If insurance does not pay within 90 days of the service date, Family Doctors Medical Center reserves the right to request payment in full for services from you and transfer the responsibility of obtaining the insurance payment to you. The agreement with your insurance carrier is a legal contract between YOU and your insurance company. Our office is not part of this legal contract. Ultimately, you are responsible for any and all charges incurred at our office.

● Balances are due within 30 days of the first statement. If you are unable to make payment in full, payment plans are available. Payment plans consist of a term rate of no greater than 1 year. If new services are incurred, recurring payments must be adjusted to reflect new balance.

● Accounts past 90 days are considered delinquent, and are subject to review as well as the account being sent to our collection agency, and dismissal from our practice.

● In fairness to other patients and the doctor, we require at least 24 hour notice to cancel an appointment. If you miss three (3) appointments within a 12 month period, you may be dismissed from the practice. A $25 fee may be charged for a missed appointment.

Family Doctors
MEDICAL CENTER

HIPAA

Health Information Portability & Accountability Act

By filing out and signing below, you are authorizing the release of medical information to the following person(s).

Patient Name:_____
DOB:_____

I authorize my medical information to be released to the following person(s) :

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

I authorize Family Doctors Medical Center to release medical information to the following contact information:

Daytime Phone Number:_____

Evening Phone Number:_____

I authorize medical information and or/ newsletters pertaining to the practice to be released by e-mail.

E-Mail Address:_____

Family Doctors Medical Center, Utilizes third party agencies (i.e labs, pharmacies, other physicians offices, radiology facilities, etc.) to help obtain authorization for various treatments and coverage of medications. These agencies have more knowledge in the process in dealing with your insurance carriers. This is beneficial for you the patient to better enhance our ability to provide you with the best care possible. Signing below authorizes us to release only pertinent medical records to these third-party agencies for the purposes of better coverage for radiology testing, medication coverage, and other services requiring authorization.

By signing below, I have read, understood and agreed with all of the listed above.

X_____

Patient Signature or Signature of Legal Guardian if patient is under the age of 18 **Date**

Family Doctors
MEDICAL CENTER

HIPAA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ DOB:_____

For Office Use Only:

Authorizing Release From

Name of Doctor of Facility:_____

Address:_____

Phone:_____ Fax:_____

Authorizing Release To:
Family Doctors Medical Center
291 N. Pecos Road—Henderson, NV 89074
1901 S. Jones Blvd—Las Vegas, NV 89030
1703 Civic Center Dr Ste 6—North Las Vegas, NV 89030
Phone (702) 616-9471 Fax (702) 616-9681

Information to be released: ☐ Entire Record ☐ Office ☐ Results ☐ Procedure Reports ☐ OTHER

Purpose of disclosure:_____

Risk of Disclosure: I understand that if the person(S) and or organization(S) listed above are not health care providers, health plan or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be disclosed without my authorization.

Patients rights and authorizations: 1.) I understand that this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2.) I understand if written revocation is not received this authorization will be considered valid for a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "Authorizes" person above. 3.) I understand a photocopy of this authorization is to be considered as valid as the original. 4.) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by federal law. 5.) I understand that I have the right to refused to sign this authorization, I am signing voluntarily, and the treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6.) I have the right to receive a copy of this authorization and any records obtained with its use. 7.) I understand this consent includes disclosure of : Alcohol, drug abuse and / or psychiatric records, sexually transmitted disease and HIV/AIDS information. 8.) I have the right to inspect or copy health information I have authorized to be used or disclosed by the authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the privacy officer.

Expiration Date: It is understood that a photocopy of this authorization shall be considered as effective as the original. This authorization shall remain in full force and effect until the following date(s) _____ or for one year from the date signed.

By signing below, I have read, understand and agree with the content of this authorization form. I am confirming that it accurately reflects my wishes for a period of 1 year from the date signed.

X_____

Patient Signature or Signature of Legal Guardian if patient is under the age of 18 **Date**

Family Doctors
MEDICAL CENTER

Telemedicine Consent/ Telemedicine Care and Treatment Form

Introduction: Telemedicine involves the use of electronic communications, both audio and video, to enable your provider at Family Doctors Medical Center to evaluate, diagnose, and treat you from a remote location.

Benefits: The benefits of a telemedicine are to improve access to medical care by enabling a patient to remain in his/her home while accessing the medical provider at Family Doctors of Green Valley to access medical expertise quickly, efficiently, and without travel.

By electronically signing below I understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine visits, and that no information obtained in the use of telemedicine will be disclosed to researchers or other entities without my written consent.
2. I understand the alternatives to telemedicine consultation such as an on-site visit, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests/touch may be not be conducted.
3. I understand that I may expect the anticipated benefits from the use of telemedicine with my care, but that no results can be guaranteed or assured.
4. I understand if the telemedicine provider determines that telemedicine services do not adequately address my medical needs, the telemedicine providers will refer me for an on-site medical evaluation at a Family Doctors Medical Center location.
5. I understand if after the telemedicine services, I experience an urgent or emergent matter, or if the telemedicine session is interrupted due to a technological or equipment failure, it is my responsibility to seek alternatives to my care such as, but not limited to, a physical visit at a Family Doctors Medical Center location.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider. The above mentioned person will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) ask non-medical personnel to leave the telemedicine examination room; and/or (2) terminate the consultation at any time.
7. I understand this telemedicine consultation will be billed for services rendered, I understand and agree to pay all professional charges not covered by insurance. I also agree to pay all collection fees necessary for this telemedicine on the date of service rendered.

Duration of Consent: I understand and agree this consent for telemedicine with Family Doctors Medical Center. Care and Treatment is valid from the date present and future visits for one year from the date of signature below unless I revoke the consent prior to that time.

By electronically signing below I have read and understand the information in this Consent for telemedicine care and treatment form.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____