Patient Registration Form

TODAY'S DATE_____ **REFERRED BY**:_____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name:_____ First Name:_____ Middle Initial:____

*Address:_____

City:_____ State:_____ Zip:_____

Home Phone #: (_____)_____-_____ Cell Phone #: (_____)_____-_____

*Social Security Number (Last Four Only):_____ *Date Of Birth:_____ Age_____

*Sex: Male___ Female___ Marital Status:_____ Drivers Lic #:_____

Ethnicity: Hispanic_____ Non-Hispanic_____ Race:_____ Preferred Language:_____

*Employer Name/ Address/ Phone #:_____

_____

Emergency Contact Name:_____ Emer. Phone #: (_____)_____-_____

GUARANTOR INFORMATION: (List the person or insured name responsible for bill – use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self___ Spouse___ Parent___ Other:_____

*Last Name:_____ First Name:_____ Middle Initial:_____

*Address_____

City:_____ State:_____ Zip:_____

Home Phone #: (_____)_____-_____ Cell Phone #: (_____)_____-_____

*Social Security Number (Last Four Only):_____ *Date Of Birth:_____ Age_____

*Sex: Male___ Female___

*Employer Name/ Address:_____

_____

Work Phone #: (_____)_____-_____

INSURANCE INFORMATION: **(Please allow receptionist to photocopy your insurance ID cards)**

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

Primary Insurance:

Plan Name:_____ *Insured's Name:_____

*Insured's Social Security #:_____ *Insured's Date of Birth: _____

*Policy/ID#:_____ *Group#:_____ Effective Date:_____

Claims Address & Phone Number:_____

Secondary Insurance:

Plan Name:_____ *Insured's Name:_____

*Insured's Social Security #:_____ *Insured's Date of Birth: _____

*Policy/ID#:_____ *Group#:_____ Effective Date:_____

Claims Address & Phone Number:_____

***REQUIRED FIELDS – PLEASE COMPLETE FOR BILLING *ATTACH COPIES OF INSURANCE CARDS**

Infectious Diseases of Southern Nevada
825 North Gibson Road – Suite 311
Henderson NV 89052
Telephone: (702) 776-8300

Billing Policies

***** Please initial on all lines indicating your understanding of each of our billing policies. It is also necessary to sign and date at the bottom of this page.**

_____ Please note that we bill your insurance as a courtesy. All billing regardless of insurance are **ultimately the patient's responsibility after 90 days**.

_____ Your insurance will be billed one time. If there is no payment within 30 days you will receive a statement. We ask at that you please contact your insurance to check the status of your claim at this time.

_____ Regardless of insurance **All** accounts greater than 90 days past due become due and payable from the patient.

_____ Co-pays and deductibles are due prior to seeing our physicians**. It is the patient's responsibility to know their insurance plan's co-pay and deductible amounts as well as plan provisions.**

_____ Returned Checks (NSF) will be charged a $25.00 administration fee.

Collections:

_____ Accounts more than 120 days past due not paid by either the patient or their insurance will be turned over to a collection agency.

_____ All accounts turned over to collections will be charged a 20% administration fee. This fee is based upon the total owed to Infectious Diseases of Southern Nevada at the time the account is sent to collections.

BY SIGNING THIS FORM I HEREBY ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THESE TERMS AS SET FORTH IN THIS DOCUMENT.

_____ _____

Date **Signature of patient or person acting on behalf of patient**

Patient Name:_____ **Date of Birth**:_____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Infectious Diseases of Southern Nevada. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive is a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of benefits be made directly to Infectious Diseases of Southern Nevada.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have read a copy of the Infectious Diseases of Southern Nevada patient information privacy policy. I hereby authorize Infectious Diseases of Southern Nevada to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services.

AUTHORIZATION TO MAIL OR CALL:

I certify that I understand the privacy risks of the mail and phone calls; I hereby authorize a representative of Infectious Diseases of Southern Nevada or my physician to mail or call me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results.

PERSONS WHO MAY OBTAIN MY MEDICAL INFORMATION:

_____

RELATIONSHIP:_____

_____

RELATIONSHIP:_____

PATIENT SIGNATURE:_____**DATE**:_____

ACKNOWLDEGEMENT FORM

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the **Infectious Diseases of Southern Nevada's Notice Of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____
_____
_____
_____

Further, I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment of benefits apply.

Signed:_____ **Date:**_____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship:_____ **Witnessed by**:_____

IF THE PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

{ } Patient refused to sign this acknowledgment

Date:_____

Time:_____

Employee Name:_____

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CONSENT TO DISCUSS PATENT INFORMATION

PATIENT:_____**CHART #**_____

Nevada State law prevents this office from discussing patient information without express written consent from the patient. If you would like someone other than yourself to be allowed to discuss your care, please list the names of the individuals below. Please keep in mind that you can change this list at any time. Any person on the list must be able to verify your date of birth as an added security.

NAME OF PERSON	RELATIONSHIP TO PATIENT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Patient Signature:_____**Date**:_____

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NOTICE REGARDING INSURANCE FORMS

Due to the increased volume of requests our office receives for completing various forms for insurance purposes, etc., we have unfortunately been forced to initiate a fee of $25.00 for each form.

If you are mailing in a form to be completed, please enclose the fee with the form. If you are dropping off a form, we ask that you pay at that time. Your form will be completed and we will call you when it is ready. For your convenience, you may also call the office and make payment by debit or credit card.

We will be unable to mail or fax forms until payment has been received. Forms will be processed as quickly as possible. Thank you for your understanding regarding this matter.

If you have any questions or concerns, please call our office, 702-776-8300

_____ _____

Signature of Patient or Guardian **Date**

Financial Policy

We would like to welcome you to our office. The following information is provided to avoid any misunderstanding concerning payment of services. Please take a moment to read this information sheet concerning our financial policy.

1. All co-pays and deductibles are due at the time of check-in. Payment for services for cash patients are due "in full" at the time of check-in. For your convenience we accept Cash, Checks, MasterCard, Visa credit cards. **We do not accept American Express.**

2. We bill your insurance as a courtesy. You are responsible for your account until we receive payment from your insurance. If your insurance company changes, you must notify us immediately so we can obtain a copy of your new card and submit claims to the correct address.

3. Your insurance policy is an agreement between you and your insurance company. It is your responsibility to know what is covered and what is not covered. Fees for non-covered services are due at the time service is rendered.

4. If a problem occurs with your claim, we ask that you call your insurance company to help expedite the claim process. You will be required to establish a **written financial agreement** with our office until your insurance problem is resolved.

5. Please help us to better serve you by keeping all scheduled appointments. We require at least 24 hours advance notice for all appointment cancellations. If you miss your appointment or fail to cancel within 24 hours advance notice, our policy is to charge $25 for missed appointments.

6. Returned checks will be subject to a $25 fee

Our practice firmly believes that a good doctor/patient relationship is based on understanding and open communication. We do understand that temporary hardships may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Your signature below indicates that you understand and accept these policies.

Print Name: _____ **Date**: _____

Signature of Parent/Guardian: _____