# Patient Encounter Form

**Name:**_____ **DOB:**_____ **Primary Care Physician:**_____

## Current Symptoms/ Sintomas Actuales:

| | | | | | |
|---|---|---|---|---|---|
| Do you have a fever? | Yes | No | Do you have nausea or vomit? | Yes | No |
| Tiene fiebre? | Si | No | Tiene nausea o vomito? | Si | No |

Do you have diarrhea? Yes No Do you have any pain? Yes / No If "yes" rate your level of pain: 1 – 10___
Tiene Diarrea? Si No Tiene dolor? Si / No Si tiene dolor cual es el nivel del 1 – 10 _____

If here for any type of hernia, is it work related? Yes No If yes date of incident _____
Si está aquí para algún tipo de hernia, está relacionado con su trabajo? Si No Fecha de accidente _____

## Current Medications (Including all vitamins and over the counter medications)
## Los medicamentos actuales(Incluyendo todas las vitaminas y medicamentos de venta libre)

☐ None/Ningun medicamento

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

## Past Medical History/Antecedentes Medicos:

| | | | Description--Descripcion |
|---|---|---|---|
| ○ Diabetes/ Diabetes | Yes / Si | No | _____ |
| ○ Thyroid Disease/ Tiroides | Yes / Si | No | _____ |
| ○ Osteoporosis/ Osteoporosis | Yes / Si | No | _____ |
| ○ Heart Disease/ Enfermedad del Corazon | Yes / Si | No | _____ |
| ○ Lung Disease/ Enfermedad del Pulmon | Yes / Si | No | _____ |
| ○ Stroke/derrame cerebral | Yes / Si | No | _____ |
| ○ Kidney Problems/Problemas renales | Yes /Si | No | _____ |
| ○ Eye Problems/Problemas de los ojos | Yes / Si | No | _____ |
| ○ Cancer/ Cancer | Yes / Si | No | _____ |
| ○ High Blood Pressure/ Presion arterial alta | Yes / Si | No | _____ |
| ○ Circulation Problems/ Problemas de circulacion | Yes / Si | No | _____ |
| ○ Other/ Otros | Yes / Si | No | _____ |

*Women only / Solo para Mujeres:* ☐ Pregnant / Embarazada ☐ Breastfeeding / amamantando

**Allergies/ Alergias:** ☐ No known Drug allergies/ Ninguna alergia a medicamentos

_____

**Surgical History/Antecedentes Quirurgicos:** ☐ None/Ninguna cirugia anterior

List all surgeries you have had and date of surgery.
Lista de todas las cirugia(s) que ha tenido y fecha de cirugia(s).

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

**Recent Hospitalization/Hospitalizacion Reciente:** ☐ Yes/Si ☐No /No

If yes, Reason for visit, hospital name, and date(s)/ Encaso de si, la razon, nombre del hospital, y fecha(s):

1. _____

2. _____

**Family History/ Historia Familiar:** ☐Unknown family history/Desconocido historial familiar

| Family Member/Miembro familiar | | Age/Edad | Medical Problems /Problemas medicos |
|---|---|---|---|
| Mother/Madre | | _____ | _____ |
| Father/Padre | | _____ | _____ |
| Brother(s)/Hermano(s) | yes/no | _____ | _____ |
| Sister(s)/Hermana(s) | yes/no | _____ | _____ |
| Children/Hijo(s) | yes/no | _____ | _____ |
| Maternal Grandparent(s)/ Abuelos Maternales | | _____ | _____ |
| Paternal Grandparent(s)/Abuelos Paternales | | _____ | _____ |

**Social History/Historia Social:**

Tobacco use? **Yes** / **No** If yes how often? _____How many?_____ What form of tobacco?_____
Uso de Tabaco? **Si** / **No** En caso de uso, Cual es la frecuencia_____Cuantos?_____ Tipo de tabaco?_____

Drink Alcohol? **Yes** / **No** If yes how often; _____How many? _____
Consume Alcohol? **Si** / **No** En caso de uso, Cual es la frecuencia_____Cantidad que consume?_____

Illicit Drug use? **Yes** / **No** If yes name of illicit drug; _____ How often; _____
Uso ilicito de drogas? **Si** / **No** En caso de uso,Nombre de droga? _____ Cual es la frecuencia? _____

# Desert Surgical Associates

## Patient Registration Form

**PATIENT INFORMATION (PLEASE PRINT)**

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patients Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name _____ (First) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number ___-___-___ ☐ Female ☐ Male Date of Birth___/___/___

E-Mail Address _____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

**Pharmacy Information** Name: _____Address:_____Phone:_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer _____ Occupation_____

**Emergency Contact Name** _____ Phone Number_____

Emergency Contact Relationship to Patient _____

Referring Provider Name _____

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number ___-___-___ ☐ Female ☐ Male Date of Birth___/___/___

E-Mail Address _____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

City, State, ZIP (+4) _____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer _____ Employer Phone Number_____

Patient Relationship to Responsible Party _____

**PRIMARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name _____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number) _____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth ___/___/___ Insured's Social Security Number ___-___-___

Insurance Company Address_____

**SECONDARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name _____

Insurance Company/Phone Number_____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth ___/___/___ Insured's Social Security Number ___-___-___

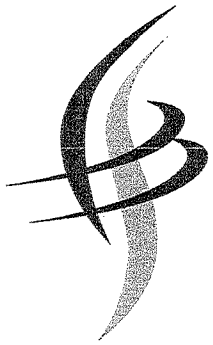
Insurance Company Address_____

---

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

**Patient (or Responsible Party) Signature**_____ **Date**_____

**3131 La Canada Street, Suite 217 – Las Vegas, NV 89169 Tel (702)369-7152 Fax (702-369-7153**



# Medical Records Request

DATE: _____

I hereby authorize the release of some/all of my medical information relating to the treatment I may have received to the person/facility listed below. Please do not release any further information to any other person/facility not listed without my written consent.

RELEASE INFORMATION FROM:

Name of person/facility: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

RELEASE INFORMATION TO:

Name of person/facility: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PATIENT INFORMATION:

PATIENT: _____

DOB: _____ SS#: _____

PATIENT SIGNATURE: _____

This message is a PRIVILEGED AND CONFIDENTIAL communication and may contain information that is exempt from disclosure under applicable law. If you are not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copy of the communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and return the original message via mail. Thank you.

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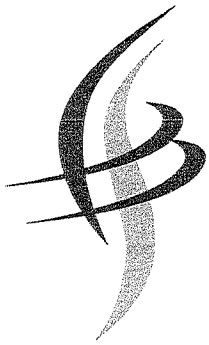

## Release of Information Authorization

Date:_____

Patient: _____DOB:_____SS#:_____

PLEASE LIST ANYONE YOU WOULD LIKE US TO RELEASE ANY MEDICAL INFORMATION (SPOUSE, CHILDREN, PARENT(S), CARE TAKER, FRIEND, ETC.)

WE ARE NOT ALLOWED TO RELEASE ANY INFORMATION TO ANYONE NOT ON THIS LIST. THE PEOPLE LISTED WILL BE ABLE TO INQUIRE ABOUT YOU (TEST RESULTS, LAB RESULTS, OFFICE APPOINTMENTS, ETC). IF AT ANY TIME YOU WISH TO ADD OR REMOVE SOMEONE PLEASE SUBMIT THAT REQUEST IN WRITING OR BY COMING INTO THE OFFICE. UNTIL SUCH TIME, THE PEOPLE ON THIS LIST WILL BE ABLE TO INQUIRE ABOUT YOU.

| NAME | RELATIONSHIP | DOB |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

May we confirm your appointment? Yes No

May we leave a message at your number with a person and or answering machine? Yes No

PATIENT SIGNATURE: _____

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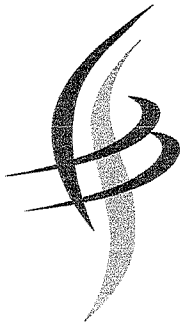

# PATIENT CONSENT FORM

Please read and sign

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedure/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, authorize **Desert Surgical Associates** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Desert Surgical Associates.**

I acknowledge that I have been given the **Desert Surgical Associates** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

**Patient (or Responsible Party) Signature** **Date**

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**1-Consent to Medical Services**

I consent to laboratory procedures or other services rendered to me as ordered by my physician. This consent includes the testing for blood-borne infectious diseases. Including but not limited to Hepatitis and HIV (Human Immune Deficiency). A physician orders such tests for diagnostic purposes.

**2-Release of Information**

I authorize the facility and any physician or caregiver involved in my care to release information and supporting documentation obtained during my visit to any organization, which is or may be liable or responsible for payment of charge associated with my visit. This authorization specifically includes the release of medical information concerning blood-borne infectious diseases.

**3-Notice of Privacy Practices**

I acknowledge that I have been given the practice's Notice of Privacy Practices. The undersigned certifies that I have read this entire document and that I, the patient, or whoever is duly authorized by or by the law to execute the above agreement, do accept and understand it's terms.

I hereby certify and state that I have read and been given the opportunity to ask questions about this Patient Authorization, I fully understand this Patient Authorization and that I have signed this Patient Authorization knowingly, freely and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any laboratory procedure or other services and I have signed this document without inducement, other that the rendition of services by the healthcare facility and/or facility-based physicians.

X_____

**Patient/Parent/Guardian/Conservator Relation to Patient Date**

X_____**Witness (to signature only)**

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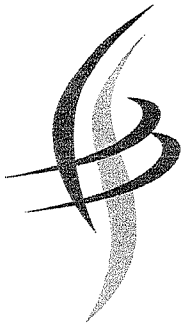

Print Patient Name _____ Date of birth _____

## Assignment of Benefits

I hereby assign to Desert Surgical Associates any insurance or other third-party benefits available for health care services provided to me. I understand that Desert Surgical Associates has the right to refuse or accept assignment of such benefits and these benefits are not assigned to Desert Surgical Associates. I agree to forward to Desert Surgical Associates all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal guardian _____ Date _____

## Medicare Certification for Payment

I certify that the information given to me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf assign the benefits payable for physician or organization furnishing the services or authorized servicing physician or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurance carriers.

Signature of Patient/Legal guardian _____ Date _____

## Authorization

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file to your insurance; however, it is your responsibility to maintain contact with your insurance company to see that Desert Surgical Associates is paid. If your insurance is a managed care plan or out of network with our office, then you will be responsible for all co-pays, deductibles, co-insurance percentage and non-covered services which the insurance company is not liable for on the day of your visit. In the event that your insurance company has not paid within 60 days, you are responsible for the balance due. It is also the patient's responsibility to obtain referral from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable.

For patients who do not have insurance, payment in full is expected at the time services are rendered or, if charges exceed $200.00, a payment plan can be arranged.

I have fully read and understand the above statement of payment policy. I authorize the physicians to administer such treatment. They may deem advisable for my diagnosis and treatment. I certify that I have been made aware of my role and services offered the physician. Physician assistant and/or nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature of Patient/Legal guardian _____ Date _____

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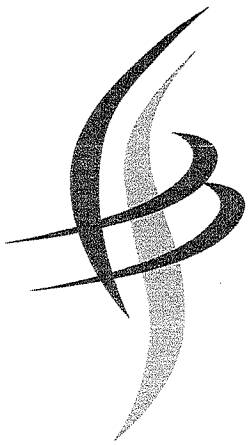

## PATIENT BALANCES

**SELF PAY:**

For patients, who do not have insurance, payment in full is expected at the time services are rendered or, if needed, a payment plan can be arranged.

**INSURANCE COVERAGE:**

For patients who have insurance, we will file all charges to your insurance company as a courtesy to you. However, **YOU** are responsible for these charges and should maintain contact with your insurance company to see that Desert Surgical Associates is paid. If your insurance company does not pay within 60 days after billing, the charges will be considered self-pay and you will be responsible for paying the balance. If your insurance is managed care or **out of network** with our office, then you will be responsible for all co-pays, deductibles and non-covered services. For example, many insurance pay 80% after the deductible is met. In that case, we will request that you pay 20% of the charges as services are rendered.

I have read and understand the above policies of Desert Surgical Associates, regarding patient balances.

_____ _____

Signature Date

_____ _____

Witness Date

**3131 La Canada Street Ste 217– Las Vegas, NV 89169 Tel (702)369-7152 Fax (702)369-7153**

# DESERT SURGICAL ASSOCIATES
## Controlled Substances Informed Consent

Treatment with controlled substance medications including opiates (narcotics) is dangerous and can lead to physical dependence and addiction. Taking these may lead to serious health problems, accidental overdose, and even death.

**Risks & Benefits**
- Accidental overdose can and frequently occurs. Death is possible from respiratory depression (slow breathing).
- Even taking these medications for a short duration have been demonstrated to cause physical dependence.
- There may be forms of medications available that deter certain types of abuse. Ask your doctor for more information.
- Women who are pregnant, plan to become pregnant, or could become pregnant, have the added risk of fetal and newborn baby drug addiction, and neonatal abstinence syndrome, a dangerous type of drug withdrawal.

**Proper use**
- Take your medications as prescribed. Do not take more pills or capsules than are prescribed, or more often than prescribed.
- Notify your provider of all other medications, supplements, and over-the-counter medications you are taking.
- Do not start new medications while on these medications without discussing with your healthcare provider.

**Storage & Disposal**
- These medications are for your use only.
- Do not share your medications with others and do not sell your medication.
- Ensure safe storage of your medications in their original containers and out of the reach of others.
- Take unused medications to a Drug Enforcement Administration public disposal location (https://apps.deadiversion.usdoj.gov/pubdispsearch/)
- If disposal services are unavailable, mix medication with used coffee grounds or kitty litter, seal in a bag and place in the trash.

**Refills**
- New medication refills will only be authorized after being seen by your healthcare provider.
- No telephone or internet refills will be given.

**Minors**
- Those under 18 have special risks including interfering with brain development.
- Warning signs include mood or personality changes, behavior changes including doing poorly in school, social isolation, or a sudden change of friends. Please see https://drugfree.org/article/spotting-drug-use/ for more info.

- Constipation is highly likely with opiate treatment, and can cause nausea, vomiting, and can lead bowel blockage and death.
- Opiate medication overdose can be reversed with a medication called naloxone (Narcan). Some pharmacies in Nevada allow you to purchase naloxone without a prescription, and the law in Nevada allows for healthcare providers to prescribe naloxone to a patient's family or other acquaintances.
- *Opiate pain medications do not treat the underlying cause of your pain. They only mask your pain.*
- Your pain level may be reduced while taking these medications, and the intent is to restore normal function and enable you to perform daily tasks. You may never reach a "zero" pain level, even with proper usage.

**Alternatives**
- Non-narcotic medications may be effective in treating your pain. These include NSAIDs (e.g. ibuprofen, Motrin) and acetaminophen (e.g. Tylenol, Excedrin). Please discuss with your healthcare provider to see if you may be a candidate for this type of pain control.
- Some people treat pain without medications. Heating pads and ice may be just as effective for pain.
- Other treatments could include physical therapy, massage, cognitive behavioral therapy, or acupuncture.

*This is not an exhaustive list of risks, benefits, alternatives, or instructions.*
If you have any questions regarding your medications please speak with a member of your care team.

By signing below, I acknowledge my healthcare provider has discussed the risks and benefits of controlled substances, my specific treatment plan, and I agree to treatment with these medications. I understand I can withdraw my consent to treatment with these medications at any time.

| Signature | DOB | Date |
|---|---|---|
| Relationship to patient | | Witness |