

Desert Surgical Associates
Forme de Registro para Pacientes

INFORMACION DEL PACIENTE

(Favor de Imprimir)

Dr. Sr. Sra. Srita. Jr. Sr. Otro _____
Nombre del Paciente (Apellido) _____ (Nombre) _____ (Segundo Nombre) _____
También Conocido con el Nombre (apellido) _____ (Nomnre) _____
Estado Civil Casado(a) Soltero(a) Divorciado(a) Viudo(a) Seperado (a) Legalmente Otro
Numero de Seguro Social _____ - _____ - _____ Femenino Male Fecha de Nacimiento ____/____/____
Dirección de E-Mail _____
Números de Teléfonos. Trabajo _____ Día Noche Casa _____ Día Noche
Celular _____ Radio _____
Dirección _____
Ciudad, Estado, CódigoPostal(+4) _____
Condición Empleo Empleado Estudiante Tiempo completo Estudiante tiempo Parcial Jubilado Negocia Propio Desempleado
Compañía que lo Emplea _____ Ocupación _____
Nombre de Contacto para Emergencias _____ Número de teléfono _____
Relación del Paciente con el Contacto para Emergencias _____
Nombre del Proveedor que Lo Recomienda _____

INFORMACION SOBRE LA PERSONA RESPONSABLE

Persona Responsable (Apellido) _____ (Nombre) _____ (Segundo Nombre) _____
También Conocido con el Nombre (apellido) _____ (Nomnre) _____
Numero de Seguro Social _____ - _____ - _____ Femenino Male Fecha de Nacimiento ____/____/____
Dirección de E-Mail _____
Números de Teléfonos. Trabajo _____ Día Noche Casa _____ Día Noche
Dirección _____
Ciudad, Estado, CódigoPostal(+4) _____
Condición Empleo Empleado Estudiante Tiempo completo Estudiante tiempo Parcial Jubilado Negocia Propio Desempleado
Compañía que lo Emplea _____ Ocupación _____
Relación del Paciente con la Persona Responsable _____

INFORMACION SOBRE SEGURO PRINCIPAL (proporcione su tarietà del seguro médico en recepción al momento de anunciarse)

Nombre de la Persona que Proporciona el Seguro Médico _____ Relación con el Paciente _____
Compañía Asegurado/Número de Teléfono _____ (_____) _____
Número ID (Póliza Número) _____ Número ID del Grupo _____ Pago por Consulta _____
Fecha de Validez _____ Fecha de Vencimiento _____ Femenino Masculino
Fecha de Nacimiento del Asegurado ____/____/____ Número de Seguro social del Asegurado _____ - _____ - _____
Dirección de la Compañía Aseguradora _____

INFORMACION SOBRE SEGURO SECUNDARIO (proporcione su tarietà del seguro médico en recepción al momento de anunciarse)

Nombre de la Persona que Proporciona el Seguro Médico _____ Relación con el Paciente _____
Compañía Asegurado/Número de Teléfono _____ (_____) _____
Número ID (Póliza Número) _____ Número ID del Grupo _____ Pago por Consulta _____
Fecha de Validez _____ Fecha de Vencimiento _____ Femenino Masculino
Fecha de Nacimiento del Asegurado ____/____/____ Número de Seguro social del Asegurado _____ - _____ - _____
Dirección de la Compañía Aseguradora _____

De acuerdo a mi mejor conocimiento, la información proporcionada en esta forma es correcta y actualizada.

Paciente (o Responsable) Firma _____ Fecha _____



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: _____

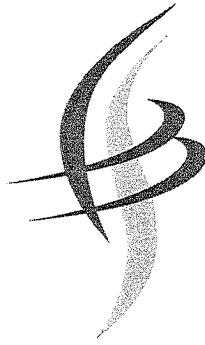
PATIENT INFORMATION:

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.



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: _____

Desert Surgical Associates

Forma de Consentimiento del Paciente

(Favor de Leer y Firmar)

Por medio de la presente, Yo, la persona que firma, doy mi consentimiento para lo siguiente:

- Administración y realización de todos los tratamientos,
- Administración de cualquier anestésico que sea necesario,
- Realización de aquellos procedimientos que sean considerados como necesarios o recomendables para este paciente,
- Uso de medicamentos que sean recetados,
- Realización de procedimientos para diagnóstico,
- El uso y la toma de cultivos,
- Realización de otras pruebas de laboratorio que sean aceptables de acuerdo a recomendaciones medicas, las cuales sean consideradas medicinalmente necesarias, o recomendables, basadas en el juicio del médico asignado o de las personas asignadas por el mismo.

Yo, entiendo que este consentimiento es proporcionado antes de tener un diagnóstico o tratamiento específico.

Mi intención es que la validez de este consentimiento continúe aún después de que se tenga un diagnóstico específico y que se haya recomendado un tratamiento. **Este consentimiento sera válido en su totalidad hasta que indique lo contrario por escrito.**

Yo entiendo que mi consentimiento a **Desert Surgical Associates** incluye a otras oficinas con diferente ubicación y que pertenecen a la misma persona y/o compañía.

Yo, la persona que firma, autorizo que: **Desert Surgical Associates** utilice y entregue mi información con propósito de tratamiento, pagos, y funciones relacionadas con el cuidado de la salud.

El **tratamiento** incluye pero no está limitado a: la administración y realización de todos los tratamientos, la administración de cualquier anestésico que sea necesario, el uso de medicamentos que sean recetados; la realización de aquellos procedimientos que sean determinados como necesarios o recomendables durante el tratamiento de este paciente, como son procedimientos de diagnóstico, la toma y utilización de cultivos y otras pruebas de laboratorio que sean medicinalmente aceptables, todos los cuales sean considerados como necesarios y recomendables medicinalmente, por el médico que lo atiende o las personas asignadas.

El **Pago** incluye pero no está limitado a: la autorización del pago directo a: **Desert Surgical Associates** de la cobertura de prestaciones que de otra forma son pagados a mí mismo. Por medio de la presente autorizo la entrega de mi información médica a terceras partes aseguradoras, o personas autorizadas a quienes les sea necesario mi consentimiento para establecer cobrar una cuota por los servicios proporcionados, como son la facturación y cobro por servicios, los pagadores de compañías aseguradoras, las aseguradoras de accidentes para automóviles, o para heridas relacionadas con mi trabajo, a la compañía que me emplea o a la persona asignada.

Yo entiendo que soy financieramente responsable de los cargos que no estén cubiertos. O entiendo que la información del paciente puede ser almacenada electrónicamente y puede estar disponible a través de redes de computo.

Operaciones relacionadas con el Cuidado de la Salud incluyen pero no están limitadas a: La entrega de información médica a cualquiera de mis doctores y sus oficinas o las compañías de seguros que participan en el cuidado, el tratamiento de mi salud y la calidad de dicho tratamiento.

Yo, entiendo que este consentimiento es proporcionado antes de tener un diagnóstico o tratamiento específico. Mi intención es que la validez de este consentimiento continúe aún después de que tenga un diagnóstico específico y que se haya recomendado un tratamiento. **Este consentimiento sera válido en su totalidad hasta que indique lo contrario por escrito.** Este consentimiento incluye específicamente la entrega de cualquier información médica que involucre condiciones relacionadas con drogas, alcoholismo, condiciones psicológicas, condiciones psiquiátricas y/o enfermedades infecciosas que incluyan pero que no están limitadas a enfermedades que son transmitidas por contacto con sangre.

Una fotocopia de este consentimiento deberá de ser tan válida como el original.

(OPCIONAL) En caso de que exista una exposición, y el paciente resultó positivo, el medico que lo atiende notificará al paciente, cualquier persona que haya sido expuesta, y al _____ Health Department (Departamento de Salud) y le serán proporcionadas las recomendaciones adecuadas.

(OPCIONAL) **PACIENTES con seguro por parte de MEDICARE:** Yo, autorizo proporcionar mi información médica que sea necesaria a la Social Security Administration (Administración de Seguro Social) o sus intermediarias para mi cobertura con Medicare. Estoy el pago de los servicios a Desert Surgical Associates.

Yo reconozco que el: Desert Surgical Associates ha proporcionado una Notice of Privacy Practices (Notificación de la Privacidad para Consultorios). Yo, entiendo que si tengo preguntas o reclamos que tengo que contactar al Oficial de Privacidad. Iniciales del Paciente: _____

Yo, declare que he leído y entendido completamente los párrafos anteriores y doy mi consentimiento total y voluntario para que se lleven a cabo.

Firma del Paciente (o Parte Responsable) _____

Fecha _____



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.

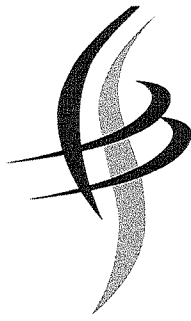
3-Notice of Privacy Practices

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 than 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)



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



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

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

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.dea.diversion.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



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

<input type="radio"/> Diabetes/ Diabetes	Yes / Si	No	_____
<input type="radio"/> Thyroid Disease/ Tiroides	Yes / Si	No	_____
<input type="radio"/> Osteoporosis/ Osteoporosis	Yes / Si	No	_____
<input type="radio"/> Heart Disease/ Enfermedad del Corazon	Yes / Si	No	_____
<input type="radio"/> Lung Disease/ Enfermedad del Pulmon	Yes / Si	No	_____
<input type="radio"/> Stroke/derrame cerebral	Yes / Si	No	_____
<input type="radio"/> Kidney Problems/Problemas renales	Yes /Si	No	_____
<input type="radio"/> Eye Problems/Problemas de los ojos	Yes / Si	No	_____
<input type="radio"/> Cancer/ Cancer	Yes / Si	No	_____
<input type="radio"/> High Blood Pressure/ Presion arterial alta	Yes / Si	No	_____
<input type="radio"/> Circulation Problems/ Problemas de circulacion	Yes / Si	No	_____
<input type="radio"/> Other/ Otros	Yes / Si	No	_____

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