



Orthopedic & Sports Medicine Institute Of Las Vegas
Randa Bascharon, D.O., Inc.
Ph: 702.947.7790 Fax: 702.947-7792

IMPORTANT INFORMATION FOR OUR PATIENTS

AFTER HOURS INFORMATION:

If you have an emergency dial 911.

If you need to speak to the physician after hours, you can call our office number listed above. Let the answering service know you are one of our regular patients and where you are calling from. You will be directed to the physician on call who will be able to assist you. Our office rotates call with other local orthopedic physicians and there is one on call every day.

APPOINTMENT INFORMATION:

If you arrive late for your scheduled appointment we will need to reschedule your appointment in order to accommodate the patients who are scheduled for that time slot.

FORMS:

We cannot complete forms "on demand". All forms will be processed and completed within a 7 day time period. The fee for each form is \$15.00 to \$50.00, and may not be covered by your insurance. You will be billed for this fee.

CASTING INFORMATION:

Patients with fiberglass casting: **DO NOT GET YOUR CAST WET!**

If this does occur, please contact our office as soon as possible for a cast change. (Splashing a few drops of water on the outside of the cast is not a problem, but the padding against your arm should not become damp or wet).

PRESCRIPTION REFILLS:

If you need **prescription refills**, we ask that you plan at least **48 hours in advance**.

Contact your pharmacy first (the one where the prescription was last filled). Have your prescription information ready for them when you call. The prescription number is helpful, and the name and strength of drug. It is not necessary to call our office first for refills. Please have your pharmacy fax over a refill request to 947-7792. If you are changing your pharmacy, you may have to contact us first as this will then be considered a new prescription. Check with your pharmacy as they may be able to "transfer" the prescription to your new pharmacy of choice.

**** Please keep this document for future reference.**



**ORTHOPEDIC & SPORTS MEDICINE INSTITUTE OF LAS VEGAS
RANDA BASCHARON, D.O., INC.**

PATIENT INFORMATION

PATIENT: LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: (____) _____ CELL PH: (____) _____ WORK PH: (____) _____

SSN _____ SEX: MALE FEMALE DATE OF BIRTH: ____/____/____ AGE _____

EMAIL ADDR _____ DO YOU AGREE TO RECEIVE NEWSLETTERS AND

CORRESPONDENCE FROM OUR OFFICE VIA EMAIL? YES NO

IF PATIENT IS A MINOR: PARENT/GUARDIAN LAST NAME _____ FIRST NAME _____

PATIENTS EMPLOYER _____ ADDR _____ CITY _____ STATE _____ ZIP _____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL: LAST NAME _____ FIRST _____

GUARANTOR ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: (____) _____ WORK PH: (____) _____ CELL PH (____) _____

SSN _____ SEX: MALE FEMALE DATE OF BIRTH: ____/____/____ AGE _____

EMERGENCY CONTACTS

LOCAL FRIEND OR RELATIVE: LAST NAME: _____ FIRST _____ RELATIONSHIP : _____

ADDR: _____ CITY _____ STATE _____ PH: (____) _____ CELL PH(____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO NAME _____ PHONE _____

ADDRESS TO MAIL CLAIMS: _____ CITY _____ STATE _____ ZIP _____

POLICY HOLDER LAST NAME _____ FIRST NAME _____ INITIAL _____

SSN _____ DATE OF BIRTH _____ RELATION TO PATIENT: _____

POLICY/ID# _____ GROUP # _____ EMPLOYER _____ CITY _____ STATE _____

SECOND INSURANCE CO NAME _____ PHONE _____

ADDRESS TO MAIL CLAIMS: _____ CITY _____ STATE _____ ZIP _____

POLICY HOLDER LAST NAME _____ FIRST NAME _____ INITIAL _____

SSN _____ DATE OF BIRTH _____ RELATION TO PATIENT: _____

POLICY/ID# _____ GROUP # _____ EMPLOYER _____ CITY _____ STATE _____

The above information is true to the best of my knowledge. I authorize my insurance benefits or attorney/s settlements to be paid directly to Orthopedic & Sports Medicine Institute of Las Vegas, Dr. Randa Bascharon D.O., Inc. I understand that I am financially responsible for any balance. I also authorize Orthopedic & Sports Medicine Institute of Las Vegas, Dr. Randa Bascharon D.O., Inc. or my insurance company or attorney/s to release any information required to process my claims.

_____ / _____

PATIENT OR GUARDIAN SIGNATURE

DATE



**ORTHOPEDICS & SPORTS MEDICINE INSTITUTE OF LAS VEGAS
RANDA BASCHARON, D.O., INC.**

PATIENT NAME: _____ DATE _____

Race: American Indian Asian Black or African American White Alaskan Pacific Islander
 Patient Prohibited Patient Declined Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino
 Patient Prohibited Patient Declined Unknown

Preferred language: _____

Pharmacy Name: _____ Location: _____ PH: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

OTHER PHYSICIAN: FIRST NAME _____ LAST NAME _____

URGENT CARE / EMERG ROOM: NAME FACILITY _____ CITY _____ STATE _____

INSURANCE COMPANY REFERRAL:

NAME OF INS CO _____ AUTH# _____

REPRESENTATIVE NAME _____ PH# _____

LOCAL FRIEND OR RELATIVE: FIRST NAME _____ LAST NAME _____

Are they patients in this practice? YES NO

INTERNET YELLOW PAGES OTHER _____

WHAT ARE WE SEEING YOU FOR TODAY?

BODY PART INVOLVED: 1.) _____ RIGHT LEFT
2.) _____ RIGHT LEFT
3.) _____ RIGHT LEFT
4.) _____ RIGHT LEFT

DATE OF CURRENT INJURY: _____ PLACE INJURY OCCURRED: _____

(If this is a work related injury, stop here and complete work comp patient info only)

HOW DID THE INJURY OCCUR? EXPLAIN IN DETAIL: _____

*IF THIS IS NOT AN INJURY OR ACCIDENT, WHAT IS THE ONSET DATE OF THE PROBLEM/S? _____

WHAT DO YOU THINK MAY HAVE CAUSED IT? _____

AUTO ACCIDENT

WERE YOU: DRIVER PASSENGER FRONT PASSENGER REAR MOTORCYCLE DRIVER MOTORCYCLE PASSENGER

WERE YOU WEARING A SEATBELT AT THE TIME OF ACCIDENT? YES NO

WHAT KIND OF AUTO ACCIDENT? **THE VEHICLE YOU WERE IN WAS:**

IMPACTED BY OTHER VEHICLE: FRONT PASSENGER SIDE DRIVER SIDE REAR

YOUR VEHICLE COLLIDED WITH A STATIONARY OBJECT FRONT PASSENGER SIDE DRIVER SIDE REAR

YOU WERE A PEDESTRIAN STRUCK BY VEHICLE YOU WERE A BICYCLIST STRUCK BY VEHICLE

IS THERE AN AUTO MEDICAL PAYMENT PLAN? YES NO IF YES, LIST INS CO NAME AND PHONE NUMBER OF AGENT/ REPRESENTATIVE

DO YOU HAVE AN ATTORNEY WHO IS REPRESENTING YOU IN THIS CASE? YES NO IF YES LIST NAME, ADDRESS AND PHONE # .

ATTY NAME: _____ ADDR _____ CITY _____ STATE _____ ZIP _____



NEW PATIENT MEDICAL HISTORY

PATIENT NAME _____ DATE TODAY _____

CHIEF COMPLAINT/S: _____

DATE OF INJURY _____ IF NOT INJURY, DATE OF ONSET OF SYMPTOMS: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

DATE OF BIRTH _____ AGE TODAY _____ HEIGHT _____ WEIGHT _____

IS YOUR INJURY/S RELATED TO:

- AUTO ACCIDENT WORK ACCIDENT SCHOOL ACCIDENT ATHLETIC ACCIDENT: WHERE _____
- NO INJURY - ONSET OF SYMPTOMS ONLY OTHER: EXPLAIN _____

A): CHECK BOX FOR ANY DISEASE WITH WHICH YOU WERE PREVIOUSLY DIAGNOSED:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> ALZHEIMERS | <input type="checkbox"/> DRUG ABUSE | <input type="checkbox"/> OSTEOARTHRITIS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> ELEVATED CHOLESTROL | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> EYE DISEASE | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> BLEEDING DISORDERS | <input type="checkbox"/> GI REFLUX (GERDS) | <input type="checkbox"/> SLEEP APNEA |
| <input type="checkbox"/> BLOOD CLOTS | <input type="checkbox"/> GOUT | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> ULCERS |
- ARE YOU: RIGHT HANDED LEFT HANDED AMBIDEXTROUS (BOTH)

B): LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER DRUGS, VITAMINS, SUPPLEMENTS AND THEIR USE

DRUG NAME	DOSE/STRENGTH	FREQUENCY	PRESCRIBING DR	REASON

(*LIST ANY ADDITIONAL MEDICATIONS ON LAST PAGE: ADDITIONAL INFORMATION.)

C): ALLERGIES TO MEDICATION: NONE KNOWN CODEINE PENICILLIN IODINE SULFA DEMEROL

OTHER DRUG ALLERGIES NOT LISTED ABOVE: _____

LIST TYPE OF REACTION TO EACH _____

OTHER ALLERGIES: LATEX ADHESIVE TAPE CATS DOGS HAYFEVER OTHER : PLEASE LIST _____

FOOD ALLERGIES: PEANUTS SOY MILK/DAIRY GLUTEN EGG SEAFOOD OTHERS PLEASE LIST: _____

(*LIST ANY ADDITIONAL ORTHOPEDIC SURGERIES ON LAST PAGE: ADDITIONAL INFORMATION.)

D): ORTHOPEDIC SURGERIES: NO ORTHOPEDIC SURGERIES

- RIGHT LEFT BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____
- RIGHT LEFT BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____
- RIGHT LEFT BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____
- RIGHT LEFT BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____

ORTHOPEDIC REPLACEMENTS: NO ORTHOPEDIC REPLACEMENTS

RIGHT LEFT BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____
 RIGHT LEFT BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____

(LIST ANY ADDITIONAL ORTHOPEDIC SURGERIES ON LAST PAGE: ADDITIONAL INFORMATION.)

OTHER SURGERIES (ANY) : NO OTHER SURGERIES

BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____
BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____
BODY PART _____ MO/YR _____ SURGEON _____ HOSPITAL _____

(LIST ANY ADDITIONAL SURGERIES ON LAST PAGE: ADDITIONAL INFORMATION.)

FRACTURES/BROKEN BONES: NO FRACTURES/BROKEN BONES

BODY PART _____ MO/YR _____ DR: _____ CASTED SURGERY
BODY PART _____ MO/YR _____ DR: _____ CASTED SURGERY
BODY PART _____ MO/YR _____ DR: _____ CASTED SURGERY

(LIST ANY ADDITIONAL FRACTURES ON LAST PAGE: ADDITIONAL INFORMATION.)

E): FAMILY HISTORY: HAVE ANY OF YOUR FAMILY MEMBERS EVER BEEN DIAGNOSES WITH THE FOLLOWING: (INCLUDE: SPOUSE, SON, DAUGHTER, FATHER, MOTHER, SISTER, BROTHER, GRANDFATHER, GRANDMOTHER- LIST PATERNAL OR MATERNAL)

IF YES, WHO?

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV _____ | <input type="checkbox"/> DEPRESSION _____ | <input type="checkbox"/> HYPERTENSION _____ |
| <input type="checkbox"/> ALCOHOLISM _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> KIDNEY DISEASE _____ |
| <input type="checkbox"/> ALZHEIMERS _____ | <input type="checkbox"/> DRUG ABUSE _____ | <input type="checkbox"/> OSTEOARTHRITIS _____ |
| <input type="checkbox"/> ANEMIA _____ | <input type="checkbox"/> ELEVATED CHOLESTROL _____ | <input type="checkbox"/> OSTEOPOROSIS _____ |
| <input type="checkbox"/> ARTHRITIS _____ | <input type="checkbox"/> EYE DISEASE _____ | <input type="checkbox"/> PACEMAKER _____ |
| <input type="checkbox"/> ASTHMA _____ | <input type="checkbox"/> FIBROMYALGIA _____ | <input type="checkbox"/> SEIZURES _____ |
| <input type="checkbox"/> BLEEDING DISORDERS _____ | <input type="checkbox"/> GI REFLUX (GERDS) _____ | <input type="checkbox"/> SLEEP APNEA _____ |
| <input type="checkbox"/> BLOOD CLOTS _____ | <input type="checkbox"/> GOUT _____ | <input type="checkbox"/> STROKE _____ |
| <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> HEART DISEASE _____ | <input type="checkbox"/> THYROID DISEASE _____ |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> HEPATITIS _____ | <input type="checkbox"/> ULCERS _____ |
| <input type="checkbox"/> LUPUS _____ | <input type="checkbox"/> OTHER AUTO IMMUNE DISORDER _____ | |

DO YOU HAVE CHILDREN? YES NO AGES AND SEX _____

F): SOCIAL HISTORY:

OCCUPATION: _____ EMPLOYER _____
WORK: FULL TIME PART TIME MORE THAN ONE JOB RETIRED : YEAR _____ DISABLED : YEAR _____
MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED SEPARATED PREGNANT? YES NO

TOBACCO :	ALCOHOL	ILLICIT DRUGS	CAFFEINE
<input type="checkbox"/> SMOKER : YRS SMOKED: _____	<input type="checkbox"/> DRINK ALCOHOL	<input type="checkbox"/> USE ILLICIT DRUGS	<input type="checkbox"/> DRINK CAFFEINE
<input type="checkbox"/> NON- SMOKER	PER DAY _____	<input type="checkbox"/> DO NOT USE ILLICIT DRUGS	PER DAY _____
<input type="checkbox"/> FORMER SMOKER	OR: PER WEEK _____	<input type="checkbox"/> FORMER USER	OR: PER WEEK: _____
YRS SMOKED _____ YEAR QUIT _____	OR: PER MONTH _____		OR: PER MONTH _____

LIFESTYLE:

ACTIVITY LEVEL: SEDENTARY MODERATE VIGOROUS
EXERCISE FREQUENCY: DAILY 1-2 TIMES PER WEEK 3-4 TIMES PER WEEK OCCASIONAL NEVER

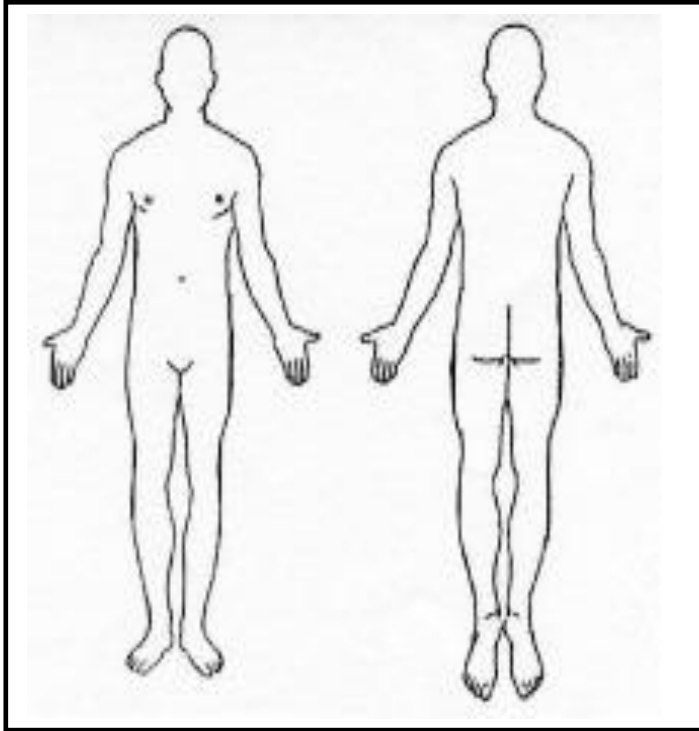
G): REVIEW OF SYSTEMS: HAVE YOU EVER HAD ANY PROBLEMS WITH THE FOLLOWING SYSTEMS: IF YES, EXPLAIN.

- | | | |
|------------------|--|-------|
| NOSE/THROAT | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| EARS/HEARING | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| RESPIRATORY | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| CARDIOVASCULAR | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| GASTROINTESTINAL | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| GENITAL/URINARY/ | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| GYN | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| SKIN | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| NEUROLOGICAL | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| OPTICAL/ EYE | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| EMOTIONAL | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| BLOOD DISORDERS | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| GLANDS | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| BONES/MUSCLES | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |

BODY PART INVOLVED: 1.) _____ RIGHT LEFT
 2.) _____ RIGHT LEFT
 3.) _____ RIGHT LEFT
 4.) _____ RIGHT LEFT

PAIN DIAGRAM:

HOW LONG HAVE YOU BEEN EXPERIENCING PAIN? _____ YEARS _____ MONTHS _____ WEEKS _____ DAYS
 ON THE DIAGRAM BELOW, PLEASE MARK WHERE YOU ARE CURRENTLY EXPERIENCING PAIN OR OTHER SYMPTOMS
 A= ACHE B= BURNING N = NUMBNESS P= PINS & NEEDLES S= STABBING O= OTHER



WHAT IS YOUR CURRENT PAIN LEVEL ON A SCALE OF?
 1 TO 10?
 (WITH 1 BEING: NO PAIN AND 10 BEING: EXCRUCIATING PAIN)

1 2 3 4 5 6 7 8 9 10

QUALITY

DULL SHARP BURNING ACHING

OCCURRENCE

CONSTANT INTERMITTENT RARE

MADE WORSE BY _____

MADE BETTER BY: _____

HAVE YOU HAD ANY PREVIOUS TREATMENT FOR THIS PAIN/PROBLEM? _____

PHYSICAL THERAPY? WHEN? _____

BRACING _____

INJECTIONS? _____

SURGERY? _____

ADDITIONAL INFORMATION FROM PREVIOUS SECTIONS:

LIST THE SECTION LETTER FIRST AND THEN THE ADDITIONAL INFORMATION:



**Orthopedic and Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.**

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

(Page 1 of 3)

Thank you for choosing our practice! We are committed to the success of your Medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or our Practice Manager.

How may I pay?

We accept payment by cash, check, ATM with Visa or MasterCard logo, VISA, & MasterCard. Please be advised Returned checks are subject to an additional fee of \$25.00.

Do I need a referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, your appointment will need to be rescheduled.

Which Plans Do You Contract With?

Your insurance policy is a contract between you and your insurance company. We accept assignment of Insurance benefits. However, it is your responsibility to call your insurance company prior to your first office visit to determine your benefits, your co-payment, co-insurance, deductible or if you require an authorization to see a specialist. We do contract with many insurance companies. However this changes frequently.

What Is My Financial Responsibility For Services?

Patients are responsible for all charges from the date they are charged. Patients who have insurance companies with whom we are contracted specialists will be responsible for all insurance directed copays, deductibles and co-insurance as per your contract.

What If I require forms to be filled out by the physician (FMLA, disability, insurance company forms, and DMV forms) what is the process and is there a fee?

We cannot complete forms "on demand". All forms will be processed and completed within a 7 day period of time. The fee for each form is \$15.00 to \$50.00, and may not be covered by your insurance. You will be billed for this fee.

What if I do not have insurance?

Patients who do not have insurance are required to speak to management prior to receiving treatment and on a case by case basis may be offered a payment structure.

Copays, Deductible and Co-insurance: All insurance copays, deductibles and co-insurances are due at the time of service.

Insurance Billing and Balances: Your insurance is a contract between you & your insurance company. We may bill your insurance for you. It is our goal to help you receive the maximum allowable benefits. Not all services are a "covered" benefit. It is your responsibility to be familiar with the benefits and restrictions provided by your plan. Contact your insurance carrier or consult your plan coverage and Provider directory to be familiar with your coverage and Providers of care. You will receive a statement from our office once a month, regardless of insurance/patient balance. All charges are patient responsibility from the day of charge. Please contact your insurance company when claims have not been processed within 30 days. We will gladly discuss your proposed treatment plan and answer questions related to charges for those services.

INITIAL



**Orthopedic and Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.**

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

(PG 2 of 3)

Collection processes: Accounts with unpaid balances after 90 days may be turned over to a Collection Agency for assistance in collection. If this occurs, you will be responsible for all agency fees, legal fees and court costs incurred as a result.

INITIAL

Authorization for Use or Disclosure of Health Information Relating to Payment for Services Rendered by Dr. Randa Bascharon, DBA: Orthopedic & Sports Medicine Institute of Las Vegas.

I hereby authorize Dr. Randa Bascharon,(*Medical Provider) DBA: Orthopedic & Sports Medicine Institute of Las Vegas, and its vendors and service providers involved in collection and processing of payments for services delivered to me by Medical Provider (*Vendors") to disclose health information (including my name and financial account information) records concerning:

Patient name Patient address, city state zip

TO: Any and all vendors or subcontractors to Vendors that assist in the collection and processing of payments for services provided by Medical Provider to Patient.

FOR THE PURPOSE OF: Collection and processing of payment for services provided by Medical Provider to Patient.

REVOCAION: I understand that I may revoke this authorization at any time by notifying Medical Provider in writing at 7281 W Sahara Ave. Ste 110, Las Vegas, NV 89117. I understand that my revocation will not affect actions taken by Medical Provider or any Vendor prior to its receipt.

I understand that I have a right to receive a copy of this authorization.

Patient/Guarantor signature

Date

Time

Surgery & Outside referrals (including but not limited to: Hospitals & surgery centers, Other physicians/specialists, Physical therapy, Radiology services & Laboratories.

If your physician recommends surgery, you will be referred to his/her surgery coordinator. The surgery coordinator will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. The surgery coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the surgery coordinator or billing specialist. If your physician refers you to an outside facility for services that may include, but are not limited to: surgery, any therapy, another physician, labs, or x-ray, we may be required to provide demographic and /or medical information to that facility prior to your appointment with them.

I authorize the release of any medical or demographic information necessary to complete the process of the referral to any outside Medical service.

Signature of patient/guardian

Date

Dispensing of Durable Medical Equipment: Durable Medical Equipment may be billed by this office or an outside service. I authorize the release of any medical information necessary to process the health insurance claim for this service. I request direct payment be made to Randa Bascharon, D.O., Orthopedic and Sports Medicine Institute of Las Vegas, or other vendor who may supply & bill for the DME.

Signature of patient/guardian

Date

Automobile Accident: I, the undersigned patient/guardian, hereby direct my Auto Insurance medical payments, Personal Injury Protection and/or Health Insurance benefits carrier/s to make payment for medical supplies and services directly to Randa Bascharon, D.O, Inc, Orthopedic and Sports Medicine Institute of Las Vegas.

Signature of patient/guardian

Date



**Orthopedic and Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.**

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

(PG 3 of 3)

Dispensing of Prescriptions in our office: Prescriptions and "Medical Foods" may be billed by this office or an outside service. I authorize the release of any medical information necessary to process the health insurance claim for these services. I request direct payment be made to Randa Bascharon, D.O., Orthopedic and Sports Medicine Institute of Las Vegas, or other vendor who may supply & bill for the prescription or "Medical Food".

Signature of patient/guardian

Date

Authorization to View Medication Information/history: Our office is currently utilizing an electronic system for prescribing, refilling and tracking medications called: "SureScripts". It is a community database for accessing and adding patient prescription and medication information and history. SureScripts is a valuable tool for helping to ensure that your medications are effective and do not have interactions with other medications being prescribed. Your prescription will be electronically prescribed to a SureScript pharmacy and should be ready for pick up by the time you leave our office.

Please be aware that some medications will still have hand written requirements and therefore will not be eligible for this new electronic method.

By signing below, you are aware and are authorizing our office personnel to view your medication history available through the SureScript database or any other electronic database being utilized by our practice.

Signature of patient/ guardian

Date

Financial Agreement and Authorization:

I have read, understand, and agree to the above Financial Policy. I understand that all charges, including applicable co-payments, co-insurances and deductibles, are my responsibility. I agree that any balance not paid by insurance will be paid by me.

I agree to pay for all attorney's fees, court costs and filing fees, including charges that may be assessed by our collection agency to pursue collection of my account.

I authorize my insurance benefits, auto medical payments or attorney settlement be paid directly to Randa Bascharon, D.O. Inc, Orthopedic & Sport Medicine Institute of Las Vegas.

I authorize Randa Bascharon, D.O. Inc, Orthopedic & Sport Medicine Institute of Las Vegas, to release pertinent medical information to my insurance company, automobile medical insurance company or attorney when requested to facilitate payment of a claim. A photocopy of this executed document shall be sufficient in law as any original.

Signature of Patient or Guardian

Printed Name of Patient

Date

Printed Name of Guardian _____ Guardians relationship to patient: _____

HIPAA Notice of Privacy Practices

Effective as of March/1/2010



Orthopedic & Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.
Ph: 702.947.7790 Fax: 702.947.7792

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.



Orthopedic and Sports Medicine Institute Of Las Vegas
Randa Bascharon, D.O., Inc.
Ph: 702.947.7790 Fax: 702.947-7792

HIPAA NOTICE OF PRIVACY PRACTICES

(This page will be retained in your medical records at Orthopedic and Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O. Inc.)

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Orthopedic & Sports Medicine Institute, Dr. Randa Bascharon's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

OUR MEDICARE COMPLIANCE PLEDGE

Our office is fully committed to compliance with all Medicare laws, rules and regulations. If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Compliance Officer.

PRINT PATIENT NAME

SIGNATURE PATIENT/GUARDIAN

DATE _____



Orthopedic and Sports Medicine Institute Of Las Vegas
Randa Bascharon, D.O., Inc.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
TO FAMILY AND/OR CAREGIVERS

PATIENT NAME: _____

NAME OF PARENT/GUARDIAN (IF PATIENT IS MINOR)_____

In the event Orthopedic & Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O., Inc. may need to give your test results or medical information, may we.....

Check all that apply.

_____Leave detailed message on an answering machine

_____Leave a message with my spouse or family member

_____Call you on your cellular phone, the phone number is:_____

_____Call you at work, the phone number is:_____

I, _____whose date of birth is:_____, hereby give

Orthopedics and Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O., Inc. and staff, the authorization to disclose my protected health information to the following family, friends, and/or caregiver:

- Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department of Orthopedic and Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O., Inc.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment, or healthcare operations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can receive further information from my doctor or his staff.

Unless otherwise revoked this authorization will expire on the following date, event, or condition: _____

If I fail to specify a date, this authorization will expire one (1) year from the signature on this form.

_____/_____
SIGNATURE OF PATIENT DATE

_____/_____
SIGNATURE OF PARENT/GUARDIAN (IF PATIENT IS A MINOR) DATE

_____/_____/_____
NAME OF WITNESS SIGNATURE OF WITNESS DATE



Orthopedic & Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.
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Ph: 702.947.7790 Fax: 702.947.7792

Authorization to View Medication Information

Our office is currently utilizing an electronic system for prescribing, refilling and tracking medications called : "SureScripts". It is a community database for accessing and adding patient prescription and medication information and history. SureScripts is a valuable tool for helping to ensure that your medications are effective and do not have interactions with other medications being prescribed. Your prescription will be electronically prescribed to a SureScript pharmacy and should be ready for pick up by the time you leave our office. Please be aware that some medications will still have hand written requirements and therefore will not be eligible for this new electronic method.

By signing below, you are aware and are authorizing our office personnel to view your medication history available through the SureScript or any other electronic database being utilized by our office.

Patient name:

Date of Birth:

Signature of patient/ guardian

Date

Printed Name if guardian/responsible party is signing for patient.

Relationship to patient