



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.

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.



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

- | | | | | | |
|--------------------------------|-------------------------------|-----------------|-------------|---------------|----------------|
| <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | BODY PART _____ | MO/YR _____ | SURGEON _____ | HOSPITAL _____ |
| <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | BODY PART _____ | MO/YR _____ | SURGEON _____ | HOSPITAL _____ |
| <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | BODY PART _____ | MO/YR _____ | SURGEON _____ | HOSPITAL _____ |
| <input type="checkbox"/> RIGHT | <input type="checkbox"/> 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?

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

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 _____
 SMOKER : YRS SMOKED: _____ DRINK ALCOHOL _____ USE ILLICIT DRUGS _____ DRINK CAFFEINE _____
 NON- SMOKER _____ PER DAY _____ DO NOT USE ILLICIT DRUGS _____ PER DAY _____
 FORMER SMOKER _____ OR: PER WEEK _____ 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

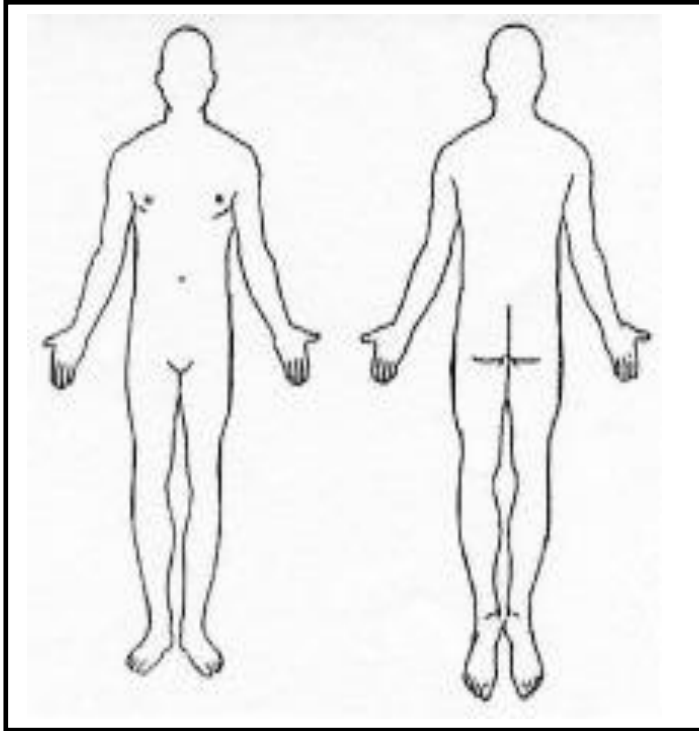
G): REVIEW OF SYSTEMS: HAVE YOU EVER HAD ANY PROBLEMS WITH THE FOLLOWING SYSTEMS: IF YES, EXPLAIN.

- NOSE/THROAT YES NO _____
- EARS/HEARING YES NO _____
- RESPIRATORY YES NO _____
- CARDIOVASCULAR YES NO _____
- GASTROINTESTINAL YES NO _____
- GENITAL/URINARY/ YES NO _____
- GYN YES NO _____
- SKIN YES NO _____
- NEUROLOGICAL YES NO _____
- OPTICAL/ EYE YES NO _____
- EMOTIONAL YES NO _____
- BLOOD DISORDERS YES NO _____
- GLANDS YES NO _____
- BONES/MUSCLES YES 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 & 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: (____) _____ OTHER 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.

X

PATIENT OR GUARDIAN SIGNATURE

DATE



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

PATIENT NAME: _____ DATE _____

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 _____



**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

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.**

FINANCIAL RESPONSIBILITY FORM

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.

INITIAL

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 FORM

(PG 2 of 2)

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

Surgery

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.

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

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

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 or Guardian

Date

(If this form is signed by guardian, state relationship to patient: _____)