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

PATIENT INFORMATION

PATIENT: LAST NAME_____FIRST_____MIDDLE_____

ADDRESS_____CITY_____STATE_____ZIP_____
Are you a patient in a skilled nursing facility ? YES NO If yes, facility name? _____Addr: _____
HOME PHONE: _____CELL PH: _____WORK PH: _____

SSN_____ SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH:_____/_____/_____ AGE_____

EMAIL ADDR _____ DO YOU AGREE TO RECEIVE EMAIL REGARDING APPOINTMENTS: ☐YES ☐ NO
DO YOU AGREE TO RECEIVE EMAIL REGARDING YOUR FINANCIAL ACCOUNT WITH OUR OFFICE ? ☐YES ☐ NO
DO YOU AGREE TO RECEIVE NEWLETTERS OR OTHER CORRESPONDENCE FROM OUR OFFICE VIA EMAIL? ☐YES ☐ NO
DO YOU AGREE TO RECEIVE EMAIL REGARDING YOUR APPOINTMENTS ? ☐YES ☐ NO

CONTACT PREFERENCE FOR APPOINTMENT REMINDER: PH HOME PH CELL TEXT EMAIL

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: _____
PharmacyName: _____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_____

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

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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 WITNESSS DATE
(Our office staff will sign in the witness area)

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

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS 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.

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

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

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.
REVOCATION: 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

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

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

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: _____

Orthopedic & Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.
7281 W Sahara Suite #110 Las Vegas, NV 89117
Ph: 702.947.7790 Fax: 702.947.7792

Patient No Show Policy & Procedure

If you are unable to keep your appointment, you are required to provide a 24 hour notice of cancellation.

Failure to cancel your appointment with a 24 hour notice will result in a phone call to the number on file and a "NO SHOW" warning letter mailed to the address on file. To assist you in keeping your appointment, you will receive a reminder call from our automated system.

If there is a subsequent "NO SHOW" appointment, your account may be charged 25.00 for which you are entirely financially responsible. It is not covered by your insurance and will not be billed to insurance. You will need to pay the "NO SHOW" fee in full to obtain any further appointments with our office.

We hope that all of our patients get the care they need and show consideration by notifying us in advance of the inability to keep an appointment so that another patient may have that time slot.

We are very concerned when you miss appointments that you are not receiving the necessary medical care required for your injury or illness.
Please call if you are experiencing any problems. We value you as a patient.

ATTN: **ACCESS TO HEALTHCARE NETWORK** PATIENTS: YOU WILL SIGN BELOW ACKNOWLEDING THAT YOUR AHN MEMBER AGREEMENT REGARDING APPOINTMENT NO SHOW POLICIES WILL SUPERCEDE THIS DOCUMENT. PLEASE REFER TO YOUR AHN AGREEMENT FOR THAT INFORMATION.

_____

Patient printed name Date

_____

Signature of patient/guardian