ANTHEM HILLS MEDICAL CENTER

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2540 Horizon Ridge Parkway
Henderson, NV 89052
Phone: 702-385-7001 F: 702-385-7002

Patient Information

First Name: _____ Middle Initial: _____Last Name: _____

DOB: _____ Soc. Sec. #: _____ Gender (circle one)**: Male Female**

Marital Status: _____ Race/Ethnicity: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell Phone: _____ Work: _____

Email: _____ Patient Portal Access? ☐Yes (Preferred) ☐No

Occupation: _____ Employer: _____

Emergency Contact Name: _____Relationship to Patient: _____

Phone number: _____

Insurance Information (Enter if we do not have copy of card yet)

Primary Insurance: _____ ID Number: _____

Policy Holder: _____Policy Holder DOB: _____ Relationship_____

Secondary Insurance: **_____ ID Number: _____**

Policy Holder: _____Policy Holder DOB: _____ Relationship_____

Assignment and Release

I Certify that I, and/or my dependent (s), have Insurance coverage with _____ and assign Anthem Hills Medical Center all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information. The above-named physician may use my health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative **Date**

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Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child (ren) _____

[ ] Other _____

[ ] Information is not to be release to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call [ ] my home [ ] my work [ ] my cell Number: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

AHMC Financial Policy

We participate in most PPO insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of a claim.

All co-pays and deductibles are due at the time of check in. We accept cash, checks, Visa, and MasterCard. We will submit an insurance claim on your behalf if we have a provider contract with your insurance company.

Please read the following carefully:

- Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.
- Not all services are covered by your insurance company; please refer to your insurance policy for clarification and verification of covered serves. Fees for non-covered services are due at the time service is rendered.
- If you have Managed Care Insurance, please make sure you have contacted them and named us as your primary care physician.
- If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and recommend that you contact your insurance carrier to follow up on payment status. Accounts are delinquent after 90 days and will be placed with a private collection agency and subject to all reasonable collection and court costs.
- Returned checks will be subject to a $25 fee.
- Our policy is to charge $40 for appointments not canceled within 24 hours. Please help us to serve you better by keeping your regularly scheduled appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.
- We offer a reasonable office visit cost to patient without insurance or with an insurance we are not in network with. We are not able to process referrals and authorizations for insurances we are not in network with due to insurance company restrictions.
- Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

We do understand that, temporary hardships may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, and other health plans to the practice named above. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance.

_____ _____

Signature of Patient/Authorized Representative **Date**

_____ _____

Print Name of Patient/Authorized Representative **Date**

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

With my consent, Anthem Hills Medical Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (PHO). Please refer to Anthem Hills Medical Center Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notices of Privacy Practices prior to signing this consent; Anthem Hills Medical Center reserves the right to revise Notices of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by submitting a written request to:

Anthem Hills Medical Center
HIPAA Privacy Office
2540 W Horizon Ridge Pkwy
Henderson, NV 89052

With my consent, Anthem Hills Medical Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out PHO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Anthem Hills Medical Center may mail to my home or other designated location any terms that assist Anthem Hills Medical Center in carrying out PHO, such as appointment reminder cards and patient statements as longs as they are marked Personal and Confidential. **We do not mail out any Medical Records to patients home due to protected health information**.

By signing this form, I am consenting to Anthem Hills Medical Center using and disclosing protected health information (PHI) about me to carry out treatment, payment and healthcare operations (PHO).

I may revoke my consent in writing except to the extent that Anthem Hills Medical Center has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Anthem Hills Medical Center may decline to provide treatment to me.

Print Name of Patient or Representative: _____

Signature of Patient or Representative: _____

Date: _____

Acknowledgment of Privacy Practices

I acknowledge that the Notice of Privacy Practices of Anthem Hills Medical Center is available upon request.

Print Name of Patient or Representative: _____

Signature of Patient or Representative: _____

Witness Signature: _____

Date: _____

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Authorization for the Release of Protected Health Information (PHI)

Date: _____ Phone: _____ Fax: _____

I, hereby authorize _____ and its affiliates, its employees and agents, to release to _____ my personal information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, SSN, Member ID number). I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/ organization and may no longer be protected by applicable federal and state privacy laws.

_____I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ (date).
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for coverage of services.

Please complete bottom portion only

Patient Name: (Please Print)_____

_____
Address **City/ State** **Zip Code**

_____
Telephone Number **Date of Birth**

Information to be Released:

__ All Records (2 years' worth) **__ Most Recent Records (notes/labs/radiology)** **__Hospital Records**

__ Other _____

The purpose of this disclosure is: ___ Continuation of care **___My Request** (patient/representative)

Please send records by FAX or MAIL (paper). NO CD'S

***Signature: X*_____**
Patient or Representative

_____
Relationship to Patient

AHMC Review of Systems ‖ Patient Name _____

Any?	Yes	No	If Yes Please Explain	Any?	Yes	No	If Yes Please Explain
Fever				Anxiety			
Chills				Memory Loss			
Sweats				Suicidal Ideations			
Fatigue				Hallucinations			
Weight Loss				Insomnia			
Blurring of Vision				Depression			
Sensitivity to light				Cough			
Eye Pain				Shortness of breath			
Vision Loss				Excessive Sputum			
Eye Discharge				Coughing up blood			
Eye Irritation				Wheezing			
Seeing Double				Nausea			
Date of Last Eye Exam:				Vomiting			
Ear Pain or Discharge				Diarrhea			
Swallowing Difficulties				Constipation			
Hoarseness				Abdominal Pain			
Sore throat				Bloody Stools			
Nosebleeds				Jaundice			
Nasal Discharge				Painful Urination			
Chronic Nasal Congestion				Blood In Urine			
Decreased hearing				Discharge			
Ringing in ears				Loss of Urine Control			
Date of Last Ear Exam:				Genital Sores			
Chest Pains				Date of Last Prostate Exam:			
Heart Palpitations				Cold Intolerance			
Passing Out				Heat Intolerance			
Shortness of breath on exertion				Thirsty all the time			
Sleeping with more than 2Pillows				Drinking large volumes of fluids			
Night time shortness of breath				Always hungry			
Persistent Infections				Weight Change			
Problems with Erection/Ejaculation				**Allergies to Medications:**			

ADVANCED DIRECTIVE: ☐Surrogate Decision Maker (Family/Friend) : ☐Non-Surrogate Decision Maker (Self) : ☐Living Will : ☐Living Trust : ☐Power Of Attorney : ☐Do Not Resuscitate :

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

Date of Last Pneumonia Shot: _____ Date of Last Influenza "Flu" Shot _____

FEMALES ONLY: Date of Last Period: _____ Number of Pregnancies: _____ Number of Children: ____

Date of Last Pap smear: _____ Date of Last Mammogram: _____

Patients Name: _____Date: _____