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# ANTHEM HILLS MEDICAL CENTER

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2540 Horizon Ridge Parkway  
Henderson, NV 89052  
Phone: 702-385-7001 F: 702-385-7002 F:725-204-8893

## 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 or copay, deductible, and/or coinsurance responsibility. 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 services. Fees for non-covered services are due at the time service is rendered.
- ⤴ If you have Managed Care Insurance (Aetna HMO plan), please make sure you have contacted them and named us as your primary care physician. For HMO insurances, we only take Aetna, and only some of those plans.
- ⤴ 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 \$50 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 discharge from our practice.
- ⤴ We offer a reasonable office visit cost to patients without insurance or with out-of-network insurances. Any procedures, testing, or injections performed during this office visit may incur an additional self-pay fee. Extended visits may also incur a higher charge. Please see Self-Pay/Insurance Waiver Document.
- ⤴ We are not able to process referrals and authorizations for insurances we are not in network with due to insurance company restrictions. You may be able to bill your insurance directly.
- ⤴ We are not able to see patients with Commercial Medicaid plans. We are not able to process claims if we are not in network with a patient's primary insurance provider.
- ⤴ 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.
- ⤴ Anthem Hills Medical Center does not treat patients for nor complete forms/documents for Workman's Comp or Work Injuries, Personal Injury Third-Party claims/liens (MVA's / Accidents) or Long-Term Disability.

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. Our billing department can set up payment plans.

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.

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**Signature of Patient/Authorized Representative**

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**Date**

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**Print Name of Patient/Authorized Representative**

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**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 long 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
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				<b>Allergies to Medications:</b>		

**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:** \_\_\_\_\_