Horizon View Medical Center

Phone # 702 641-8500 Fax # 702 641-8502

www.horizonviewmed.com

PATIENT REGISTRATION

(Please Print Clearly)

Patient's Name:_____
First Name MI Last Name

Social Security Number:_____

Date of Birth:_____Male:_____Female:_____

Single:_____Married:_____Widowed:_____Divorced:_____

Street Address:_____

City/State:_____Zip Code:_____

Home Phone Number: (_____)_____-_____ Cell Phone Number: (_____)_____-_____

Email Address:_____

Spouse's Name: _____

Phone Number: (_____)_____-_____

Parent/Guardian Name:_____

Phone Number: (_____)_____-_____

If patient is a Minor, are the parents:

_____ Married _____ Divorced _____ Custodial Parent

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Custodial Parent's Home Phone Number: (_____) _____-_____

Custodial Parent's Work Phone Number: (_____) _____-_____

Custodial Parent's Social Security Number: (_____) _____-_____

Custodial Parent's Date of Birth: _____

In Case of Emergency, please contact (a person living with you).

Name: _____

Home Phone Number: (_____) _____-_____

Cell Phone Number: (_____) _____-_____

Relationship to Patient:_____

Referring Physician Name:_____

Referring Physician Phone Number: (_____)_____-_____

PLEASE PRESENT INSURANCE CARDS & PHOTO ID FOR COPYING.

PLEASE COMPLETE THE REQUESTED INFORMATION BELOW.

Insurance Company #1:_____

Phone Number: (_____)_____-_____

Primary Insured's Name:_____

Date of Birth:_____

Policy #:_____Group #:_____

Relationship:_____

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Insurance Company #2:_____

Phone Number: (_____)_____-_____

Primary Insured's Name:_____

Date of Birth:_____

Policy #:_____Group #:_____

Relationship:_____

- I hereby authorize the payment of medical benefits to Horizon View Medical Center, for services rendered.
- I understand that I am financially responsible for any services not covered by my insurance carrier.
- I hereby authorize Horizon View Medical Center to release any medical information necessary to complete and process my insurance claims.

Please check which provider:

_____ I authorize **Nouhad Damaj, M.D.** Internal Medicine, to treat me and use my personal health information for healthcare operations.

_____ I authorize **Bipin Saud, M.D.** Gastroenterology, to treat me and use my personal health information for healthcare operations.

_____ I authorize **Stephanie Annillo,** Dietitian, to treat me and use my Personal health information for healthcare operations.

Signature:_____Date:_____

(Patient or Insured's signature, if patient is a Minor must have responsible party sign.)

*How did you hear about us?_____

_____

_____

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You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

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 for the purpose of treatment, payment or healthcare operations. You may also request that nay 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.

Your physician is not required to agree to a restriction you may request. If you physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend 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 a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

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

This notice was published and becomes effective on or before April 14, 2003.

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 the 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 (702) 641-8500.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature:_____**Date**:_____

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HIPPA NOTICE OF PRIVACY PRACTICES

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 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 right 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 or condition and related health care services.

1. 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 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 physicians 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 and management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health care 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 practice. These activities include, but are not limited to, quality assessment activities, employee
review activities, training of medical students, licensing, and conduction 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.

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, Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 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 this 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:
Following is a statement of your rights with respect to your protected health information.

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ATTENTION PATIENTS

IT IS THE RESPONSIBILITY OF THE PATIENT/INSURED TO KNOW WHETHER THE DOCTOR YOU ARE SEEING FOR MEDICAL SERVICES IS A PROVIDER ON YOUR INSURANCE AND TO PROVIDE A REFERRAL (IF NECESSARY) UPON ARRIVAL.

IF NOT, YOUR APPOINTMENT WILL BE RESCHEDULED.

YOU AS THE INSURED, ARE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE OR DEDUCTABLE AT THE TIME OF SERVICE.

IF OUR OFFICE IS NOTIFIED BY YOUR INSURANCE COMPANY FOR INELIGIBILITY OF BENEFITS, OR THAT YOU ARE NO LONGER INSURED, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL**. YOU AS THE PATIENT ARE ALSO RESPONSIBLE TO PAY IN FULL ANY MONEY TOWARDS YOUR DEDUCTIBLE.

SIGNED:_____DATE:_____

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PATIENT NAME: _____

DOB: _____ AGE: _____ SEX: _____

FAMILY MEDICAL HISTORY

Please check all that apply, include date of onset	Mother	Father	Brother	Sister	Children
DEMENTIA					
ANEURYSM					
BLOOD CLOTS					
CANCER Type:					
COLITIS					
EPILEPSY/ SEIZURES					
HEART DISEASE					
HIGH BLOOD PRESSURE					
HIGH CHOLESTEROL					
KIDNEY DISEASE					
LUNG DISEASE/ ASTHMA					
COPD					
OSTEOPOROSIS					
PSYCHIATRIC DISORDER/ DEPRESSION					
STROKE					
THYROID DISORDER					
ANXIETY					

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PATIENT NAME: _____

DOB: _____ AGE: _____ SEX: _____

PAST MEDICAL HISTORY

Have you ever had?	YES	NO
ANEMIA		
ANXIETY		
ASTHMA		
ATRIAL FIBRILLATION		
CANCER, Type:		
CARDIAC PACER		
HEART FAILURE		
COLITIS		
COPD/EMPHYSEMA		
CVA/STROKE		
DEPRESSION		
DIABETES		
EPILEPSY		
GASTRIC ULCER		
GERD		
GLAUCOMA		
HEART DISEASE		
HYPERLIPIDEMIA		
HYPERTENSION		
HYPOTHYROIDISM		
KIDNEY DISEASE		
KIDNEY STONE		
LIVER DISEASE		
MIGRAINE		
OSTEOARTHRITIS		
OSTEOPOROSIS		
RHEUMATOID ARTHRITIS		

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PATIENT NAME: _____

DOB: _____ AGE: _____ SEX: _____

Have you ever had?	YES	NO	If yes, please explain
Have you ever had serious illness or accident?			
Have you ever had a blood transfusion?			When: _____
Have you ever been hospitalized or been under medical care for very long?			

SOCIAL HISTORY

Check one-- Single: _____ Married: _____ Widowed: _____ Divorced: _____

Lives With: _____

HISTORY	YES	NO	Order	Specifics
TOBACCO USE			Type Frequency Quit Date	Cigarettes ____ Cigars ____ Chewing Tobacco ____ Other:
ILLICIT DRUG USE			Type Frequency Duration Quit Date	Specific Type(s)

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PATIENT NAME: _____

DOB: _____ AGE: _____ SEX: _____

Please list any ***SURGERIES* that you've had in the past.**

_____

_____

_____

HISTORY	YES	NO	Order	Specifics
Alcohol Use			Type: Frequency: Quit Date:	Beer____ Wine ____ Hard Liquor _____ Other _____
Sexually Active				
History of Sexually Transmitted Disease				Type
Work History			Occupation:_____ _____ _____ Hazardous Exposure:_____ _____ _____	Yes ___ or No ____ If Yes, Pls. explain

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PATIENT NAME: _____

DOB: _____ AGE: _____ SEX: _____

Please List Your Medication

Name	Dose	Frequency

Please Indicate The DATE of your Last…

FLU VACCINE	EYE EXAM	PSA Screening (Male Pts. Ony)
PNEUMONIA VACCINE	MAMMOGRAM	COLONOSCOPY

ADDRESS: 6850 North Durango Drive, Suite #301, Las Vegas, Nevada 89149
Phone: 702-641-8500 • Fax: 702-641-8502

STAT

MEDICAL RECORDS REQUEST

To: _____ _____

_____ _____

_____ _____

_____ _____

I _____**, do hereby request and authorize you to send all of my progress notes, labs, x-rays or other test and hospital discharge summaries that are in my medical records.**

Reason why the information is being disclosed (e.g. New PCP, Physician Referral):

_____

Please send this information to: Horizon View Medical Center

6850 N. Durango Dr. Ste. 301, Las Vegas, NV 89149

Phone No. (702) 6418500 **Fax No. (702) 6418502**

☐ **Dr. Nouhad B Damaj, M.D** ☐ **Dr. Bipin M. Saud, M.D.**

. ☐ **Stephanie Annillo, R.D.**

_____ _____

Signature of Patient **Date**

_____ _____

Printed Name **Date of Birth**

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702.641.8500
We're Looking Beyond The Horizon

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RELEASE OF MEDICAL INFORMATION

I _____ , am giving permission to the following individual(s)/doctor's office/facility:

_____ _____

_____ _____

_____ _____

_____ _____

to obtain access to all medical records, test results and information pertaining to my health and welfare.

_____ _____ _____

PRINT NAME **SIGNATURE** **DATE**

_____ _____ _____

WITNESS - PRINT NAME **SIGNATURE** **DATE**