



ROSEMAN MEDICAL GROUP

Date: _____

Patient's Name: _____ SSN#: _____

Last name

First Name

Gender: Female Male Gender Identity: Female Male Transgender

D.O.B: _____

(Check one)

(Check one)

mm/dd/yyyy

Marital Status: Single Married Divorce Widow Separated

(Check one)

Home Address: _____

Street

Apt#

City

State

Zip code

Home phone: _____ Cell phone: _____ Work phone: _____

Emergency Contact: _____ Phone Number: _____

E-mail: _____ @gmail.com @yahoo.com @cox.net other: _____

(Circle one)

Insurance Policy Information:

Insurance Name: _____ Phone Number: _____

Claim Address: _____

Member Name: _____

Member I.D.: _____ Group # _____

Policy Holder: _____ Gender: Female / Male (Circle one) D.O.B. _____

Policy Holder Address: _____ mm / dd / yyyy

Employer Name: _____ Phone Number: _____

Secondary Insurance:

Insurance Name: _____ Phone Number: _____

Claim Address: _____

Member Name: _____

Member I.D.: _____ Group # _____

Policy Holder: _____ Gender: Female / Male (Circle one) D.O.B. _____

Policy Holder Address: _____ mm / dd / yyyy

Employer Name: _____ Phone Number: _____

I, the undersigned, certify that the above information is correct and current as of the date below, and that I (or my dependent) have insurance coverage and that I assign directly to **Roseman Medical Group** 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 insurance. I hereby authorized doctor to release all information necessary to secure the payments of benefits.

Sign: _____ Relationship: _____ Date: _____

Roseman Medical Group • 5380 South Rainbow Blvd., Suite #120, Las Vegas, Nevada 89118

Phone: 702-463-4040 • Fax: 702-968-5681 • Monday-Friday 8am-5pm



ROSEMAN MEDICAL GROUP

5380 S. Rainbow Blvd., Suite #120
Las Vegas, Nevada 89118
Phone: 702-463-4040
Fax: 702-968-5681

Assignment of Insurance Benefits and Patient Responsibilities at Roseman Medical Group

Roseman Medical Group (RMG) is a not-for-profit medical practice. We strive to provide you with excellent health care and to charge a reasonable amount for that service. It is still important that RMG gets timely and proper payment for any services provided to you (or your child/guardian). To make that happen more easily for you and for RMG, you must:

- Certify that the insurance information you've given us is accurate, complete and current, and that there is no other coverage or insurance in place now.
• Assign your right to receive payment to RMG. This means that your Health Insurance Plan will pay RMG directly for any authorized benefits.
• Authorize RMG to file an appeal on your behalf if your Health Insurance Plan refuses payment and/or makes some denial related to services and care RMG has given you.
• Agree that, if your Health Insurance Plan will not direct payment to RMG and instead sends payments to you for services and care RMG has given you, you will send those payments to RMG.
• Authorize RMG to release to your (or your child's/guardian's) Health Insurance Plan the information the plan needs to determine what benefits are available for the services RMG provides.

Additionally, you agree that:

- You are responsible for all charges for services provided to you (or your child/guardian) that are not covered by your Health Insurance Plan, and for charges that your plan determines are your responsibility. You also will inform RMG if your Health Insurance Plan changes as soon as possible
• You will pay all charges which are not covered by your Health Insurance Plan and for charges which you are responsible for payment under your Health Insurance Plan. You are aware that you can, if you need to, work out a payment plan with RMG.
• That this form also applies to future appointments at RMG.

Name of Patient (print): _____ Patient Date of Birth: _____

Name of Primary Policy Holder (if different than Patient): _____ Date of Birth: _____

Patient Relationship to Primary Policy Holder: _____

Signature of Patient (or Parent/ Guardian): _____ Date: _____



ROSEMAN MEDICAL GROUP

HIPAA 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 Practices describes how we may use and disclose your protected health information to carry out your treatment, receive payment for the care we provide to you, 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, and future physical or mental health or condition and related health care services. "Demographic information" includes things like your age and address.

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 who 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Additionally, 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 your 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 activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to students who 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. Everyone in our office who may come in contact with your protected health information is fully trained in your rights and how to protect your information, as required by law.

We may use or disclose your protected health information in the following situations without your authorization. The situations include, but are not limited to: as specifically required by law, related to public health issues as required by law, (for example, certain communicable diseases); health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; Coroners, Funeral Directors, and organ donations; research; criminal activity; military activity and national security; Workers' Compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you and the Secretary of the Department of Health and Human Services, when required, to investigate or determine our compliance with Federal requirements.

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 already taken an action based upon this form.

Your Rights

The following is a statement of your rights with respect to your protected health information.

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 any protected health information that is now subject to a 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 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.

Your physician is not required to agree to a restriction that you may request. If a 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 ask that 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 with a copy of any such rebuttal, all of which will be retained in your records.

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 withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services (877-696-6775) 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 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 Administrator.

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

Print Patient's name: _____

Signature of patient: _____ Date: _____

-OR-

Parent /Legal Guardian Name: _____ Signature: _____ Date: _____

(Copy of POA for Health Care must be attached)



ROSEMAN MEDICAL GROUP

Authorization for Release of Information

Patient Name: _____ D.O.B.: _____

I authorize: _____ at
(Name of Physician or authorized facility)

Address: _____
Street City, State Zip

Phone #: _____ Fax #: _____

To release to Roseman Medical Group, the following information from my medical records:

- ___ History and Physical, Consult Reports
___ Discharge Summary
___ Medication Sheet
___ Radiology Reports
___ Echocardiogram Reports
___ Holter Monitoring Reports
___ Coronary Catherization Reports
___ Angiogram Reports
___ Stress Test Reports
___ EKG Reports
___ Laboratory Test Results
___ Microbiology Reports
___ Pathology Reports
___ Colonoscopy Report
___ Mammogram Report
___ Pulmonary Function Test Result
___ Arterial Blood Gases
___ Bronchoscope Report
___ Other
___ Other

Or
___ ALL Medical records

The requested information may be delivered to Roseman Medical Group by mail, facsimile or any other means authorized by me or permitted by law. I understand that I may revoke this consent at any time before the information has been released. This authorization expires one (1) year from the date below.

Any alcohol or substance use information, HIV or AIDS- related information released is protected by Federal Regulations and may not be re-disclosed without an explicit written consent of the undersigned

Patient /Legal Guardian Signature: _____ Date: _____

Signature of Legal Representative: _____
(Copy of POA for Health Care must be attached)

Print Name of Legal Guardian/Representative: _____



ROSEMAN MEDICAL GROUP

5380 S. Rainbow Blvd., Ste. 120|Las Vegas, NV 89118

DISCLOSURE AUTHORIZATION

Patient Name (Printed, Last, First MI) _____ Date of Birth _____

Cell Phone _____

Emergency Contact Name _____

Relationship to Patient _____ Phone _____

A. All patient information is confidential, unless laws or you tell us otherwise. Please list all individuals, if there are any, with whom we may discuss your (or your dependent’s or guardian’s) medical condition, test results, and/or treatment plan. RMG will not disclose personal or medical information to anyone other than those listed below without proper medical release forms on file.

I AUTHORIZE YOU TO DISCUSS MY TREATMENT AT RMG WITH:

- 1) Name Relationship Contact #
2) Name Relationship Contact #
3) Name Relationship Contact #

- B. You may remove this disclosure authorization at any time. If you remove disclosure authorization, we will, from that point on, no longer discuss your conditions/tests/treatments with anyone whose name you’ve removed from the list.
C. Release of Information: Healthcare information may be exchanged verbally among healthcare providers at RMG in order to provide continuity of care.
D. The diagnosis, information discussed, examination notes and dates of services will be recorded in our confidential electronic medical record.
E. None of your information will be released unless you sign a consent form, except as the law may demand.
F. With your signature, you acknowledge that you have read and fully understand the Disclosure Authorization.

Patient Name (Print) and Guardian Name (if appropriate) Patient/Guardian Signature Date/Time



ROSEMAN MEDICAL GROUP

5380 S. Rainbow Blvd., Suite 120
Las Vegas, NV 89118

General Consent for Care and Treatment

As our patient, you have the right to be informed about your condition and any recommended surgical, medical or diagnostic treatment(s) and/or procedure(s) your provider believes you need. You also should know about any risks and hazards that go with those treatments and/or procedures. That way you can decide with us whether or not to undergo them. At this point in your care, no treatment plan has been recommended. This consent form gives us your permission to perform the evaluation necessary to determine if you need any treatments and/or procedures.

This consent gives us (Roseman Medical Group) your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you also agree that (1) this consent will continue, even if a specific diagnosis is made and treatment is recommended; and (2) you agree to care at this office or any other satellite office of Roseman Medical Group (RMG). The consent will be in place until you tell this office in a written message that you no longer want it. You have the right at any time to stop receiving services from RMG.

You have the right to discuss the treatment plan with your provider or members of his or her team to learn more about the purpose, potential risks and benefits of any test, treatment or procedure recommended for you. If you have any concerns, we encourage you to ask questions.

By signing this, you agree that you are voluntarily requesting your provider (or his or her designees) to perform reasonable and necessary medical examinations, testing and treatment for the reasons that brought you to this office. You also agree that you understand that if additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

You are also aware that Roseman Medical Group is a place where future health care providers are taught and that a learner may be present and participate in your care. Your provider will always tell you when a learner is present, and what that learner will be doing. You can refuse, if you wish, to have a learner present.

You are also aware that there is a Federal Law known as HIPAA, and you have signed a separate form for that. Finally, you are aware that a bill for services you receive from RMG will be provided. RMG will work with your medical insurance plan to be paid. RMG also has the right to bill you directly for services, depending on your coverage.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

I authorize RMG personnel to provide medical/surgical care, including examinations, treatments, immunizations and the like for my child/person under my guardianship. In the event of serious disease or injury, I understand that reasonable efforts will be made to contact me, but the failure to make contact will not prevent emergency treatment to help preserve life or health.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

Printed Name of Witness

Employee Job Title

Signature of Witness

Date



ROSEMAN MEDICAL GROUP

5380 S. Rainbow Blvd., Suite 120
Las Vegas, NV 89118

NO SHOW & FORM COMPLETION FEES

In order to meet the appointment scheduling needs of our growing patient population, Roseman Medical Group (RMG) has established a no show fee for missed appointments. A missed appointment occurs when a patient with a scheduled appointment fails to show up and does not cancel the appointment at least 24 hours prior to the appointment. (For Monday appointments or appointments which occur after a Holiday, appointments must be cancelled by NOON on the the previous business day).

The NO SHOW FEES are as follows and must be paid in full PRIOR to the next scheduled appointment:

PROVIDER APPOINTMENTS:

- No Show PRIMARY CARE VISIT FEE: \$30
- No Show NEUROLOGY VISIT FEE: \$50

SCHEDULED PROCEDURES:

- No Show ELECTROMYOGRAPHY (EMG): \$300
- No Show ELECTROENCEPHALOGRAM (EEG): \$150
- No Show DEEP BRAIN STIMULATION (DBS): \$150
- No Show BOTOX TREATMENT: \$50

If you are requesting an RMG provider to fill out any needed complex forms/documentation (ie: FMLA, disability forms) you must do ONE of the following:

- Schedule a dedicated appointment to complete forms with your provider OR
- Pay a \$30 processing fee for the form to be completed by the provider outside of a scheduled visit.

I have reviewed and understand the above patient scheduling and fee responsibilities.

Patient (or Guardian) signature: _____ Date: _____



ROSEMAN MEDICAL GROUP

5380 S. Rainbow Blvd., Suite 120
Las Vegas, NV 89118

PATIENT TEXT AND EMAIL MESSAGE CONSENT FORM

TEXT MESSAGE CONSENT

I hereby give my consent for the practice to send Text Messages to my mobile phone for the purpose of general health information (excluding any HIPAA protected information) and appointment reminders. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession.

Should I not be able to keep an appointment I will contact the Roseman Medical Group office to cancel my appointment at least 24 hours in advance as per RMG no show policy.

Printed Signature _____ Date _____

EMAIL MESSAGE CONSENT

I hereby give my consent for the practice to send email messages to me for the purpose of general health information (excluding any HIPAA protected information) and appointment reminders. I will ensure that I keep the practice informed of my most up to date email.

Should I not be able to keep an appointment I will contact the Roseman Medical Group office to cancel my appointment at least 24 hours in advance as per RMG no show policy.

Signature _____ Date _____