ROSEMAN MEDICAL GROUP

New Patient Registration Form

Patient's Name/DOB: _____
Last name First Name DOB (mm/dd/yyyy)

Gender: Choose one Gender Identity: Choose One Sexual Orientation: Choose One Marital Status: Choose o

Preferred Pronouns: Choose one

Home Address: _____
Street Apt# City State Zip code

Home phone: _____ Cell phone: _____ Work phone: _____
E-mail: _____@gmail.com @yahoo.com @cox.net other: _____

Emergency Contact: _____ Phone Number: _____
Relationship to patient: _____

Please complete this section if patient is a minor (if patient is under the age of 18):
Responsible Party Name: _____ D.O.B: _____
Home Address: _____
Street Apt# City State Zip code

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

Primary Insurance: _____Subscriber's Name: _____D.O.B. _____ Female ○ Male ◉
Mailing address (if different from above): _____
Policy Holder Employer Name: _____Policyholder's Work Phone: _____
Policy # and Group #: _____Customer Service Phone: _____

Secondary Insurance: _____Subscriber's Name: _____D.O.B. _____ Female ◉ Male ○
Mailing address (if different from above): _____
Policy Holder Employer Name: _____Policyholder's Work Phone: _____
Policy # and Group #: _____Customer Service Phone: _____

I, the undersigned, hereby: (a) certify that the above information is correct and current as of the date below, (b) authorize payment directly to Roseman Medical Group and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance; (c) voluntarily consent to treatment for myself and/or dependents; and (d) understand that I am financially responsible for all charges not covered or billed to any insurance or third party payor and/or not paid to Roseman Medical Group, and should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs, and I further understand that a monthly finance charge of 1.5% (18.00% annually) will be assessed on any unpaid balance.

Patient/Guardian Signature_____ Date_____
(If patient is a minor, parent/legal guardian must sign on their behalf)

Relationship to Patient_____

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.

Effective Date of this Notice: January 1, 2021

This Notice of Privacy Practices describes how we (Roseman Medical Group) 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 health professions students and residents, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to trainees who see patients at our office under supervision of licensed healthcare providers. 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 some situations without your authorization. These situations include, but are not limited to: events related to public health issues (for example, reporting of certain communicable diseases); health oversight (including investigations and audits); reporting of abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement purposes; disclosures regarding descendants to coroners and funeral directors; disclosures for organ donations; research (when permitted under the privacy law requirements); in the event of threats to health or safety; military activity and national security; Workers' Compensation disclosures; and any other required permitted uses and disclosures. We will not use and/or disclosure information regarding certain public assistance programs except for certain purposes. 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.

One mission of Roseman Medical Group is to support discovery of new knowledge and treatments that may benefit all patients. Your medical information may be used for research purposes in accordance with state and federal law. Your identity or identifiable information will never be utilized without your authorization and consent on any of the above research opportunities and all research projects are carefully reviewed by an institutional review board to protect the safety, welfare, and confidentiality of our patients. Researchers may look at your information for medical purposes, to plan for future research studies, to identify potential research studies that you may qualify to participate in, or to gather information that may be used for publishing purposes. Your information may be de-identified by Roseman Medical Group or its contractors, and de-identified data may be shared for research or other purposes without your consent.

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 other information which is not a part of the "designated record set" of Roseman Medical Group as defined under HIPAA.

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 be able to restrict certain electronic disclosures of health information. We are not required to agree to your request in most cases. But if we agree to the restriction, we will comply with your request unless the information is needed to provide you emergency treatment. We will agree to restrict disclosure of PHI about an individual to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the PHI pertains solely to a service for which the individual, or a person other than the health plan, has paid us in full. For example, if a patient pays for a service completely out of pocket and asks us not to tell his/her insurance company about it, we will abide by this request. A request for restriction should be made in writing. To request a restriction you must contact us at the following address:

Roseman University of Health Sciences
Attn: Laura Jarrett, Privacy Administration
11 Sunset Way Henderson, NV 89014

We reserve the right to terminate any previously agreed-to restrictions (other than a restriction we are required to agree to by law).

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. (see Disclosure Authorization for more information)

We will inform you of the termination of the agreed-to restriction and such termination will only be effective with respect to PHI created after we inform you of the termination.

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, RMG's CTO/Privacy Administration, Laura Jarrett (702-968-2050), of your complaint.

We are required by law to maintain the privacy of patient records, and to 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.

HealthIE Nevada Patient Notification

Roseman Medical Group endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HealthIE Nevada HIE, or cancel an opt-out choice, at any time.

ROSEMAN MEDICAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____ Date of Birth _____

I acknowledge that I have received a copy of the Roseman Medical Group's Notice of Privacy Practices:

Signature of Patient/Personal Representative _____ Date_____

Documentation of Good Faith Efforts

To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices
(For use when acknowledgment cannot be obtained)

The patient present to the office/hospital on _____ (date) and was provided with a copy of the Roseman Medical Group's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

____Patient refused to sign

____Patient was unable to sign or initial because: _____
_____

____Patient had a medical emergency, and an attempt to obtain the Acknowledgement will be made at the next available opportunity

____Other reason. Describe:_____
_____

Signature of Employee Completing Form_____ Date _____

Roseman Medical Group • 5380 South Rainbow Blvd., Suite # 120 • Las Vegas, Nevada 89118
Office: 702-463-4040 • Fax: 702-968-5681

ROSEMAN MEDICAL GROUP

Transfer of Medical Records

Reason for Release:

☐ **Moving**: ☐ Out of State ☐ Within Nevada
☐ **Provider Retiring / No longer at New West**
☐ **Dissatisfaction with practice / provider**
☐ **Insurance** ☐ **Continuity of Care**
☐ **Other**: _____

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Release From:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Release To:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

I request and authorize this transfer and release of my medical record to and from the medical practice listed above. I understand that this documentation includes all forms of Protected Health Information (PHI) and is also applicable to the electronic transfer of records if the if the requested recipient is able to accept and access encrypted information from the Roseman Medical Group's Electronic Medical Record. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

☐ **ENTIRE RECORD - OR:** ☐ **Laboratory Reports** ☐ **Diagnoses**
☐ **Doctor's Notes** ☐ **Diagnostic Studies** ☐ **Other**
☐ **Pathology Reports** ☐ **Medications**
☐ **X-Ray Reports**

Due to the sensitivity of the following information, please check off and initial if you would like the following information to be released:

☐ Notes and reports related to STDs including HIV/AIDS ___ Initial
☐ Psychiatry/Mental Health Notes ___ Initial
☐ Notes related to Drug/Alcohol Abuse ____ Initial

I understand that Roseman Medical Group will no longer be responsible for the protection of the PHI except in its original format in their records. I understand that my health information may be subject to re-disclosure by the recipient and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations. This authorization will expire one year from the date I sign it. I understand the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present the written revocation to Roseman Medical Group. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

PLEASE NOTE: THERE MAY BE A CHARGE FOR THE COPYING OF RECORDS

In accordance with NRS 629.061, the cost of this information cannot exceed $0.60 per page and a reasonable cost for copies of any x-ray photographs and other health care records produced by similar processes. Actual postage or shipping costs and applicable sales tax, if any, may be charged. We will not be able to process your request until the following payment is received.

Patient /Legal Guardian Signature_____ Date_____

(If patient is a minor, parent/legal guardian must sign on their behalf)
(If patient is adult, attach copy of Durable Power of Attorney)

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Nondiscrimination Notice and Access to Communication Services

Roseman Medical Group does not discriminate on the basis of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us. Such as, letters in other languages, or in other formats like large print. Or, you can ask for an interpreter. To ask for help, please call the number **702-463-4040**.
If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Administrator
10530 Discovery Drive
Las Vegas, NV 89135

If you need help with your complaint, please call the toll-free number **702-802-2878**. You must send the complaint within 60 days of when you found out about the issue.

You can also file a complaint with the U.S. Dept. of Health and Human services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ROSEMAN MEDICAL GROUP

Disclosure Authorization

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

Cell Phone_____

Emergency Contact Name_____

Relationship to Patient _____ Emergency Contact Phone_____

A. All patient information is confidential, unless applicable 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. If you wish to remove any above-named person(s) from your disclosure list, a new updated Disclosure Authorization form must be completed.
C. Release of Information: Healthcare information may be exchanged verbally among healthcare providers at RMG in order to provide continuity of care. RMG will follow state and federal laws, including HIPAA and 42 CFR Part 2, where applicable, when protecting sensitive information, which may include medical, behavioral health, social or psychological records, including drug and alcohol abuse, addiction data, or HIV/sexually transmitted infections information.
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 permit or demand. See the "HIPAA Notice of Privacy Practices" for more information. A parent/guardian signature is required to treat or release information for minors or for those who are legally found not to be competent to make their own decisions.
F. With your signature, you acknowledge that you have read and fully understand the Disclosure Authorization.

Patient /Legal Guardian Signature_____ Date_____
(If patient is a minor, parent/legal guardian must sign on their behalf)

Relationship to Patient_____

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ROSEMAN MEDICAL GROUP

General Consent for Care and Treatment

Patient Name _____ Date of Birth _____

To the Patient: You have the right, as a patient, to be informed about your condition and any recommended surgical, medical or diagnostic treatment(s) and/or procedure(s) your provider believes you need. to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the potential risks involved. At this point in your care, no specific treatment plan has been recommended.

The purpose of this consent is to obtain your permission to perform reasonable and necessary medical examinations, testing and treatment. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Roseman Medical Group. This consent will remain fully effective until it is revoked in writing.

I agree to provide accurate and complete information about my health history, condition(s) and presenting complaint, to agree upon a treatment plan and follow that plan.

I understand that I have the right to discuss the treatment plan with my 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. I have the right to ask questions.

I agree that I am 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 may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I am 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. My provider will always tell you when a learner is present, and what that learner will be doing. I can refuse, if I wish, to have a learner present.

I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed at Roseman Medical Group.

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

Patient /Legal Guardian Signature_____ Date_____
(If patient is a minor, parent/legal guardian must sign on their behalf)

Relationship to Patient_____

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ROSEMAN MEDICAL GROUP

Financial Policy of Roseman Medical Group

Insurance

While our office participates in most health plans, the following are reminders:

- It is your responsibility to verify that Roseman Medical Group (RMG) participates with your health plan prior to scheduling your visit.
- It is your responsibility to verify what services (lab, diagnostic testing and preventative) are covered under your health plan
- Bring your insurance card with you to each visit and be prepared to update your health information.
- Be prepared to pay your insurance co-pay at the time of your visit as well as any previous, outstanding balance on your account.

Co-Payments

- Commercial Plans with Established Co-Pays – The co-pay amount listed on your insurance card is due in full at time of service. If a co-pay is not listed, contact your insurance plan prior to your visit to determine the amount due at time of service.

Self-Pay Patients

- Patients Without Insurance - The estimated charges of the visit are due at the time of service. RMG has a separate cash pay services rate that includes applicable discounts.

No Shows and Cancellations

In order to meet the appointment scheduling needs of our growing patient population, 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 previous business day).

- Primary Care Visit: $30
- Neurology Visit: $50
- Electromyography (EMG): $300
- Electroencephalogram (EEG): $150
- Deep Brain Stimulation (DBS): $150
- Botox Treatment: $50

If you are requesting an RMG provider to fill out any needed complex forms/documentation (i.e.: 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 Financial Policy of RMG and agree to its terms.

Patient /Legal Guardian Signature_____ Date_____
(If patient is a minor, parent/legal guardian must sign on their behalf)

Relationship to Patient_____

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ROSEMAN MEDICAL GROUP

Consent to Contact

Patient Name _____ Date of Birth _____

At times Roseman Medical Group may need to contact you. By filling out the information below we will better be able to serve you. If you want to allow us to leave messages and/or to speak with a trusted individual regarding your medical care we need written authorization in order to do so.

Please indicate if we have your permission or not to leave phone messages regarding your medical care:

_____ I authorize Roseman Medical Group to leave phone messages containing my Personal Health Information on the following telephone number(s):

Phone Number_____
Phone Number_____

__ No, I do not authorize Roseman Medical Group to leave phone messages containing Personal Health Information on any of my telephone number(s).

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present the written revocation to Roseman Medical Group. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

This authorization will expire one year from the date I sign it. I understand that my information may be subject to redisclosure by the recipient and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations. I release Roseman Medical Group from any and all liability and claims of any nature pertaining to the disclosure of requested information once a disclosure takes place.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to allow Roseman Medical Group to contact me.

Patient Signature_____ Date_____

Personal Representative_____ Relationship_____

Staff Signature_____ Date_____

If patient is unable to sign, please document reason_____

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