ROSEMAN MEDICAL GROUP

Date: _____

Patient's Name: _____ SSN#: _____
Last name First Name

Gender: ⬡ Female ⬡ Male (Check one) Gender Identity: ⬡ Female ⬡ Male ⬡ Transgender (Check one) D.O.B: _____ mm/dd/yyyy

Marital Status: Single Married Divorce Widow Separated
Circle 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 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 health professions students and residents, 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.

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. 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, to gather information that may be used for publishing purposes. 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.

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. (see Disclosure Authorization for more information)

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: _____

****

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

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. 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, when protecting sensitive information, which includes 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 demand. This described more in the "HIPAA Notice of Privacy Practices" form you have also received. A parent/guardian signature is required to treat or release information for patients younger than 18 years of age 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. I will actively participate in my healthcare and willingly consent to treatment.

_____ _____ _____

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 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**

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 Name Printed: _____ Date: _____

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.

Additionally, I will NOT disclose any personal protected healthcare information via text to my RMG healthcare provider or RMG clinic staff members.

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.

Additionally, I will NOT disclose any personal protected healthcare information via email to my RMG healthcare provider or RMG clinic staff members.

Signature _____ Date_____