ROSEMAN MEDICAL GROUP
ROSEMAN UNIVERSITY OF HEALTH SCIENCES

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: _____

Medical History Review

Last Name: First Name: Account:
DOB: Sex:

Roseman Medical Group
5380 S. Rainbow Blvd.
Ste. 120
Las Vegas, NV 891181878
Phone: (702)463-4040
Fax: (702)968-5681

Please review the information below and write in any corrections or missing information.

PATIENT INFORMATION

DOB	**Address**
Age	
Marital Status	**Phone**
Emerg. Contact	**Insurance**
Emerg. Phone	**Policy #**
	Group #

ALLERGIES

Name	Reaction/Severity

MEDICAL HISTORY

Have you been diagnosed with any of the following diseases or had any of the following problems? Please circle Yes or No. Use the notes column to specify when you were diagnosed with that disease or when you last had symptoms.

Name	Yes	No	Notes
Angina	Yes	No	
Aortic Stenosis	Yes	No	
Asthma	Yes	No	
Atrial Fibrillation	Yes	No	
Bipolar Disorder	Yes	No	
Bone Cancer	Yes	No	
Brain Cancer	Yes	No	
Breast Cancer	Yes	No	
COPD	Yes	No	
Chronic Bronchitis	Yes	No	
Chronic Kidney Disease	Yes	No	
Chronic Lower Respiratory Disease	Yes	No	
Colon Cancer	Yes	No	
Congestive Heart Failure	Yes	No	
Depression	Yes	No	
Diabetes	Yes	No	
Eating Disorder	Yes	No	
Emphysema	Yes	No	
Esophageal Cancer	Yes	No	
Gastric Cancer	Yes	No	
Gestational Diabetes	Yes	No	
Hallucinations & Delusions	Yes	No	
Heart Attack	Yes	No	
Heart Disease	Yes	No	
Insomnia	Yes	No	

Kidney Cancer	Yes	No	
Leukemia	Yes	No	
Liver cancer	Yes	No	
Lung Cancer	Yes	No	
Mental Disorder	Yes	No	
Multiple Sclerosis	Yes	No	
Muscle Cancer	Yes	No	
Ovarian Cancer	Yes	No	
Pancreatic cancer	Yes	No	
Panic Disorder	Yes	No	
Personality Disorder	Yes	No	
Post Traumatic Stress Disorder	Yes	No	
Prediabetes	Yes	No	
Prostate Cancer	Yes	No	
Psychosis	Yes	No	
Rectal Cancer	Yes	No	
Restless Leg Syndrome	Yes	No	
Schizophrenia	Yes	No	
Skin Cancer	Yes	No	
Sleep Apnea	Yes	No	
Social Phobia	Yes	No	
Thyroid Cancer	Yes	No	
Type 1 Diabetes	Yes	No	
Type 2 Diabetes	Yes	No	
Uterine Cancer	Yes	No	
_____	Yes		
_____	Yes		
_____	Yes		

FAMILY HISTORY

Has any of your family members been diagnosed with any of the following diseases? Please circle Yes or No. If you answer Yes, please specify which family members were diagnosed with each disease.

Name	Yes	No	Relatives/Notes
Alzheimer's Disease	Yes	No	
Dementia	Yes	No	
Diabetes	Yes	No	
Epilepsy	Yes	No	
Frontotemporal Dementia	Yes	No	
Lewy Body Dementia	Yes	No	
Multiple Sclerosis	Yes	No	
Parkinson's Disease	Yes	No	
Stroke	Yes	No	
Type 1 Diabetes	Yes	No	
Type 2 Diabetes	Yes	No	
_____	Yes		
_____	Yes		
_____	Yes		

SMOKING

Please place a check by the sentence that best describes your smoking status:

I have never smoked: _____ I used to smoke: _____

I currently smoke every day: _____ I currently smoke on some days: _____

SURGICAL/HOSPITALIZATION HISTORY

Please list dates you were hospitalized and the reason for each hospitalization.

Date	Hospitalization Reason/Surgery

CURRENT MEDICATIONS

Please list any medications you are currently taking. Please include the strength of the pill (eg Ibuprofen 250mg). Also list any over-the-counter (OTC) medications you have recently taken.

Drug Name & Strength	Frequency/Instructions	Prescribing Dr

Pharmacy: _____ **Phone:** _____ **Fax:** _____

ROSEMAN MEDICAL GROUP

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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). o 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:_____

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

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DISCLOSURE AUTHORIZATION

Patient Name _____ Date of Birth _____

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 you have authorized in your account.***

B. You may remove this diclosure 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	Patient/Guardian Signature	Date/Time

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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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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/Guardian: _____ Date: _____

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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: _____

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PATIENT EMAIL MESSAGE CONSENT FORM

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_____

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PATIENT 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_____

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INFORMED CONSENT TO PARTICIPATE IN A TELEMEDICINE VISIT/ CONSULTATION

Patient's Name: _____ DOB: _____

1. In an effort to ensure continuity of care and patient safety, I am requesting the opportunity to have a telemedicine visit with a Roseman Medical Group provider.

2. My health care provider has explained to me how the video and/ or audio- conferencing technology will be used to affect such a visit I understand that this visit/consultation will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the video and/or audio-conferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the visit/ consultation other than my health care provider and consulting health care provider in order to operate the video equipment and/or assist in the examination. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

5. I understand that some parts of the exam involving physical exam or testing may need to be conducted by individuals at my location at the direction of the health care provider.

6. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented. There may be a co-pay associated with this telemedicine visit (depending on my insurance).

7. I have read this document carefully and understand the risks and benefits of the video and/or audio-conferencing visit and have had my questions regarding the visit/ consultation explained and I hereby consent to participate in a telemedicine visit under the terms described herein. (annual signature required)

_____ _____

Patient's/parent/guardian signature Date

(Annual updated signature and date required)*

Patient is unable to sign this form, but has verbally attested to this visit/consultation at this time.

_____ _____

Signature of RMG Staff Member Date