New Patient

Non-Clinical Information

Your completed intake paperwork helps our Providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. If you have any questions or are unsure about how to complete any section of this form, inquire at our front desk or call (702) 476-9700.

Patient Information

Your Name ______________________________

Driver's License #/State______________________ Social Security Number: ______________________

Date of Birth: ______________________ Age: ____________ Gender: ☐ Male ☐ Female

Street Address: ______________________________

City/State/Zip: ______________________________

Email: ______________________________ Physical Address Same as Mailing? ☐ Yes ☐ No

If not, please list mailing address: ______________________________

Preferred Phone: ______________________________ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: ______________________________ ❑ Home ❑ Mobile ❑ Work

Emergency Contact Name: ______________________________

Phone:______________________________ Relationship: ______________________

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Spanish ❑ Other ______________________________

Referral

Were you referred to our clinic by another physician? If so, whom? ______________________________

How did you hear about us? ❑ Insurance Company ❑ TV ❑ Magazine ❑ Radio ❑ PCP ❑ Family ❑ Friend

❑ Internet ❑ YouTube ❑ Facebook ❑ Twitter ❑ Telephone Message ❑ www.WellnessAndPainCare.com

❑ Other______________________________ ❑ Another Website ______________________

Social Status

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other ______________________

Preferred Pharmacy Information

Pharmacy Name:______________________________ Phone Number: ____________________

Street Address:________________________________ City/State/Zip:__________________

Do you have a Prescription Drug ID card? ☐ Yes, ☐ No Member ID #________________________

RX Bin #________________________ RX Group # ________________________________

☐ Yes ☐ No, I hereby authorize The Center for Wellness and Pain Care of Las Vegas to access my electronic medication history and formulary information

Primary Insurance Plan

Payer (e.g. BC/BS):________________________________ Plan: ______________________

Insurance Policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: ________________________

Policy Holder Name: ____________________________ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth:________________________________ Social Security Number: ______________

Policy/I.D. Number:____________________________ Group Number: ____________________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS):________________________________ Plan: ______________________

Insurance policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: ________________________

Policy Holder Name: ____________________________ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: ________________________________ Social Security Number: ______________

Policy/I.D. Number: ____________________________ Group Number:____________________

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: ____

Agent Name: ____________________________________ State of Injury: ______________

Phone number:__________________________________ Fax number: __________________

Claim Number:___________________________________ Date of initial injury: ____________

Injury Claim

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ☐ Yes ☐ No Date of Injury: ____________

Law Firm:____________________________ Attorney Name: ____________________________

I certify that the above information is accurate, complete and true. I give my consent for CWPC to retrieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature:____________________________________ Date: ____________________

CENTER FOR WELLNESS & PAIN CARE OF LAS VEGAS
"where healing begins..."

CENTER FOR WELLNESS & PAIN CARE OF LAS VEGAS
"where healing begins..."

Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms

Appointments

1. Co-payments. Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, The Center for Wellness and Pain Care of Las Vegas, Inc. reserves the right to reschedule your appointment until a time that you are able to make your copayments. Payment for any outstanding balance is due at your appointment.

2. Procedure Prepayment. The Center for Wellness and Pain Care of Las Vegas, Inc. collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy below. We reserve the right to reschedule your procedure until prepayments has been made.

3. Missed Appointments and Late Arrivals. If you are more than 12 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up for your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $50 charge. Missed procedure, is subject to a $100 charge. These charges are your responsibility and will not be billed to any insurance carrier.

Insurance Payments

4. Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment in full for all medical services provided to you. Any charge not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

5. Coverage Changes and Timely Submission. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time lime within which The Center for Wellness and Pain Care of Las Vegas, Inc. must submit a claim on your behalf to your insurer. If the Center for Wellness and Pain Care of Las Vegas, Inc. is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

6. Self-Pay. If you do not have health insurance, or if your health insurance will not pay for services rendered by The Center for Wellness and Pain Care of Las Vegas, Inc., you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service.

Benefits and Authorization

7. Insurance Plan Participation. We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

8. Referrals. Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by The Center for Wellness and Pain Care of Las Vegas, Inc., it is your responsibility to be aware of this fact, and to obtain this referral.

9. Prior Authorization and Non-Covered Services. The Center for Wellness and Pain Care of Las Vegas, Inc. may provide services that insurance plans exclude or require prior authorization. If insured, it isultimately

your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. The Center for Wellness and Pain Care of Las Vegas, Inc., as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and if so, whether or not prior authorization for treatment is required. If determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

10. Out of Network Payments. If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to The Center for Wellness and Pain Care of Las Vegas, Inc., immediately.

Account Balances and Payments

11. Reassignment of Balances. If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

12. Collection of Unpaid Accounts. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and /or an attorney, which may result in reporting to credit bureaus and /or legal action. The Center for Wellness and Pain Care of Las Vegas, Inc. reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay The Center for Wellness and Pain Care of Las Vegas, Inc. for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection cost.

13. Returned Checks. Returned checks will be subject to a $100 returned check fee.

14. Refunds. Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow for four to six weeks or your request to be processed. Send request to The Center for Wellness and Pain Care of Las Vegas, Inc., Attn Tashi Campbell, 311 North Buffalo Dr. Suttie A, Las Vegas, NV 89145.

15. Statements. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

Form Completion

16. A charge of $50.00 is due before the forms will be completed. (Disability, FMLA, Physician statements, etc.)

Workers Compensation/Auto Liability

17. Our office requires authorization prior to the initial visit. We will do our best to obtain the authorization prior to the visit. You are also required to provide us with Health Insurance coverage in case your workers' comp or auto denies the service. If you do not have health insurance, you may be asked to pay for the service advance. Any claims paid after we have received your payment will be refunded promptly.

Agreement and Assignment of Benefits

I have read and understand the financial policy of The Center for Wellness and Pain Care of Las Vegas, Inc., and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to The Center for Wellness and Pain Care of Las Vegas, Inc. I understand that I am financially responsible for all serviced I received from The Center for Wellness and Pain Care of Las Vegas, Inc. This financial policy is binding upon you and your estate, executor and /or administrators, if applicable.

Signature: ______________________________

Print Name: ______________________________

Date: ________________

AUTHORIZATION TO RELEASE RECORDS TO THE CENTER FOR WELLNESS AND PAIN CARE

Patient Name:____ **Date of Birth:** ____________________

I hereby authorize ____

Phone:____ Fax: ____

or its agent(s) to disclose my health information as described in this authorization to:

Center for Wellness and Pain Care of Las Vegas

311 N. Buffalo Dr., Suite A Las Vegas, NV 89145	6930 S. Cimarron RD, Suite 260 Las Vegas, NV 89113	1701 N Green Valley Parkway #7B Henderson, NV 89074

P: 702-476-9700 **F: 702-476-9138**

Health information to be disclosed: (Check Appropriate Box)

❑ 2 years prior from last date seen by the healthcare provider ❑ The following health information (be specific): ____________________

The health information is being disclosed for the following purpose: (check appropriate line):

❑ Change of Insurance or Physician ❑ Continuation of Care

If no date, event or condition is written, this authorization will expire 1 year from the date signed.

A photocopy of this Authorization will be considered effective and valid as original.

❑ I understand I may revoke this Authorization at any time by sending written notice of my revocation to The Center for Wellness and Pain Care. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event or condition: ____________________________________

❑ I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV related diseases and communicable disease-related information.

❑ I understand that The Center for Wellness and Pain Care may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal Privacy Regulations.

I have read the Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions

____ ____________________

Signature of Patient** **or Parent/Guardian or Authorize Representative ***Date***

(Guardian or Authorized Representative must attach documentation of such status)

____ ____________________

Printed name and Telephone number ***Relationship***

AUTHORIZATION FOR THE CENTER FOR WELLNESS AND PAIN CARE TO DISCLOSE HEALTH INFORMATION

Patient Name:____ DOB:____________ Phone number: ____________________________

I authorize the Center for Wellness and Pain Care to disclose the following health information of mine to the following recipient:

Health information to be disclosed: (check appropriate box)

☑ 2 years' prior form last date seen by this office

☐ The following health information (be specific): ____

Recipient of health information:

If the recipient is intended to be the undersigned patient (yourself), please specify how you would like to receive records

Name:____Phone_______________________Fax to ______________________________

Mail to Address:____City________________________State_______Zip_________________

I will pick them up from the office: ☐ Yes ☐ No

Please note requests with incomplete information may not be processed

The health information is being disclosed for the following purpose: (check appropriate box):

☐ Change of Insurance or Physician

☐ At the undersigned Patient's request

☐ Continuation of Care

☐ For the following purpose (be specific) ____

☐ I understand I may revoke this Authorization at any time by sending written notice of my revocation to The Center for Wellness and Pain Care (CWPC). I understand that my revocation will not be effective to the extent the CWPC has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event, or condition_____________. If no date, event, or condition is written, this authorization will expire 1 year from the date signed A photocopy of this Authorization will be considered effective and valid as the original

☐ I understand that the health information authorized to be disclosed under this Authorization may include information regarding drugs or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

☐ I understand that CWPC many do not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the recipient may re-disclose the records and that the records may no longer be protected by Federal Privacy Regulations.

I HAVE READ THIS AUTHORIZATION AND I ACKNOWLEDGE THAT I AM FAMILIAR WITH AND FULLY UNDERSTAND ITS TERMS AND CONDITIONS

______________________________________	_______________	________________________
Signature of Patient or Parent/ Guardian Authorized Representative	Date	Telephone

______________________________________	______________________________________
Printed Name of Authorized Representative	Relationship Capacity of Patient

Patient Authorization for Use and Disclosure of Protected Health Information

The Center for Wellness and Pain Care takes your privacy seriously. We will not disclose your medical records (Protected Heath Information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes The Center for Wellness and Pain Care to release your medical records to parties indicated.

Your Name________________________________**Date of Birth** _________**Today's Date** _________

Authorized Parties

By signing below, I authorize The Center for Wellness and Pain Care, its agents and employee's ("Provider"), to use and /or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients")

PARTY	RELATIONSHIP

Authorization to Disclose Protected Health Information Including HIV & AIDS Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility of benefits on whether I sign this Authorization. In addition, I understand that Recipient may disclose the Records and that the Records may no longer be protected by the Federal Privacy Regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV related diseases and communicable disease related information.

With respect to any communicable disease related information protected by State Confidentiality Rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal Confidentiality rules (42.C.F.R Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42.C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this

purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Right of Refusal

I acknowledge that I have had the opportunity to review The Center for Wellness and Pain Care Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at The Center for Wellness and Pain Care. When my information is used, or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

Privacy Officer
311 N. Buffalo Ave., Suite A **Las Vegas, NV 89145** **P: 702-476-9700 F: 702-476-9138**

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date of authorization expires (if any):____________________________

Signature

Signed By ____ **Date** ____________________________

Signature of Patient or Legal Guardian

Relationship to Patient ____________________________________