ORTHOPAEDIC SPECIALISTS OF NEVADA

Patient Registration (Please print neatly)

Name: ______________________ Birth Date: ____________ Sex: Female Male

Address: ______________________ Phone: Home ____________ Cell: ____________

City, State, Zip: ______________________ Marital Status: S M W D Email: ____________

Driver's License or ID: State: ________ Number: ____________ Social Security No: ____________

Occupation: ______________________ Employer: ______________________

Work Address: ______________ City, State, Zip: ____________ Work Phone: ____________

Emergency Contact: ______________ Relationship: ____________ Phone: ____________

Insurance Information: (Please provide copy of cards: Front & Back)

Primary Insurance ______________________ ID# ____________

Secondary Insurance ______________________ ID# ____________

Other Information

Who referred you to our practice: ______________________

Is your injury related to an accident: No Yes If yes, was a claim filed: No Yes If yes, Claim No: ____________

Did your injury occur on the job: No Yes If yes, was injury reported to your employer: Yes No

If yes: Name of Worker's Comp Contact Info & Phone: ______________________

Do you have any attorney: No Yes If yes, Name: ______________________ Phone: ____________

Responsible Party Information (if not listed above)

Name: ______________________ Birth Date: ____________ Sex: Female Male

Address: ______________________ Phone: Home ____________ Cell: ____________

City, State, Zip: ______________________ Social Security No.: ____________

Driver's License or ID: State: ________ Number: ____________ Relationship to Patient: ____________

Occupation: ______________________ Employer: ______________________

Work Address: ______________ City, State, Zip: ____________ Work Phone: ____________

______________________ ______________________

Patient / Responsible Party Signature Date

ORTHOPAEDIC SPECIALISTS OF NEVADA

History Form

Name: ______________________ Birth Date: ____________ Today's Date: ____________

Age: ________ Sex: Female Male Height: ____________ Weight: ____________

Medication Allergies: None Yes List: ______________________________

____

Date of Injury: ____________ Injured Body Part: ______________________

Describe Injury/Accident in detail: ______________________________

____

____

Past Medical History

Are you currently or have you had problems with:

	Circle	If yes, describe problem
Eyes	No Yes	
Ears, Nose Throat	No Yes	
Lungs, Breathing	No Yes	
Digestion	No Yes	
Bladder	No Yes	
Diabetes	No Yes	
Heart Disease	No Yes	
High Blood Pressure	No Yes	
Bleeding Problems	No Yes	
Balance Problems	No Yes	
Numbness/tingling	No Yes	
Blackout/fainting	No Yes	
Psychological Problems	No Yes	
Cancer	No Yes	
Arthritis	No Yes	
Polio	No Yes	
Epilepsy	No Yes	
HIV	No Yes	
Hepatitis, Tuberculosis	No Yes	
Other (please describe)	No Yes	

Surgeries / Hospitalizations	Year	Complaint

Have you ever had general anesthesia No Yes

Any problems with Anesthesia: No Yes If yes, describe ______________________

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ORTHOPAEDIC SPECIALISTS OF NEVADA

Name: ______________________________ Birth Date: ______________ Today's Date: ____________

Medications

Medication	Dosage	How Long Taking	Side Effects

Social History

Marital Status: Single Married Divorced Widowed

Do you live alone: No Yes

Children: No Yes, How many: __________

Exercise: No Yes, indicate frequency: daily weekly monthly occasionally rarely

What type of exercise: ____

Are you on a special diet: No Yes, what kind: ______________________________________

History of substance abuse: No Yes, what substance: ______________________________

Do you smoke: No Yes, Packs per day: ________ for ________ years

If you have quit smoking, when did you quit? ______________________________

Do you drink alcohol: No Yes: daily weekly monthly occasionally rarely

Family History

Member	Alive	Age	Health Status / Cause of Death
Father	Yes No		
Mother	Yes No		
Sister / Brother	Yes No		
Sister / Brother	Yes No		
Sister / Brother	Yes No		

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ORTHOPAEDIC SPECIALISTS OF NEVADA
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

ELECTRONIC PRESCRIPTIONS

Our office can now send non-narcotic prescriptions electronically to your pharmacy in accordance with state law. Per state law, narcotic prescriptions will still need to be written out and signed by the physician.

Please provide the information listed below:

Patient Name: ______________________________________

DOB: ____________________

Pharmacy Name: ____________________________________

Pharmacy Address: __________________________________

Pharmacy Phone: ____________________

Pharmacy Fax: ______________________

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ORTHOPAEDIC SPECIALISTS OF NEVADA

Financial Policy

Payment, including copays, for medical services rendered are due at the time of service unless prior arrangements have been made. All fees for medical care are based on the usual and customary fees charged in this area by physicians of equal training and experience.

Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will assist you by verifying eligibility and benefits prior to your office visit and or surgery. Any prior authorizations obtained are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company processes your claim. However, verification of eligibility and or benefits does not guarantee payment by your insurance company. If we are unable to verify your eligibility, you will be asked to pay for services rendered.

If you have questions regarding your benefits, please contact your insurance company. This includes questions regarding deductibles, co-pays and or co-insurances for office visits, including x-rays, injections or other office procedures, and surgical procedures.

If you have multiple insurance coverage, it is your responsibility to inform us which insurance is primary and secondary. I agree to respond to requests from my insurance company regarding coordination of benefits in a timely manner. My failure to respond can result in a denial of my claim and I will pay for services rendered.

If I am scheduled for surgery, I agree to pay all patient responsible amounts, including surgery deposits if applicable. I am aware that in addition to the surgeon's fee, there can be an assistant surgeon's fee.

I agree to pay all balances on my account and if I am unable to make payment in full, I will make payment arrangements. Questions regarding your account can be answered by our billing department.

There will be a $25 charge for a missed appointment or for one not cancelled at least 24 hours in advance.

A returned check charge of $25 will be charged to my account for each returned check.

In the event that my account becomes delinquent, I understand that my account will be forwarded to a collection agency. In this event, a collection fee of 35% to 50% can be added to your account balance for collection fees by the collection agency.

Having read the above, I hereby authorize payment by my insurance carrier(s) or other designated payor of medical benefits to Orthopaedic Specialists. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of this assignment is considered as valid as the original.

_______________________________ Signature

_______________________________ Date

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ORTHOPAEDIC SPECIALISTS OF NEVADA

Office Policies

1. Disability Forms, FMLA, Jury Summons & Letters: I understand that there is a fee applied to complete each form presented to the Physician. I acknowledge that the normal completion time is one week and there is a $20 fee per form. If form completion needs to be expedited, a fee of $30 per form will be applied. Payment for forms shall be made when forms are picked up.

2. Co-Pays, Co-Insurance, Outstanding Balances and Supplies:
   a. Collection of co-pays, co-insurance, outstanding balances and supplies issued during office visit shall be made at each office visit. Depending upon your insurance, separate co-pays for xrays, supplies and procedures may apply. If payment cannot be made in full, payment arrangements must be made prior to seeing the Physician.
   b. Please note that if Physical Therapy is ordered by the Physician, separate co-pays may apply.

3. Insurance: I understand that it is my responsibility to provide the proper information and indicate which insurance is primary and secondary. I acknowledge that if insurance cards are not presented at the time of my visit, I will be considered a self pay patient and responsible for the entire balance.

4. Insurance Requests for Information: I understand that it is my responsibility to complete all requests for information from my insurance company including accident details, police reports, third party liability and subrogation forms in a timely manner. Please note that even if your claim is not accident related, you must complete and return all forms. Failure to provide the requested information will result in a denial for claims we have submitted on your behalf. Should we receive a denial of the claim, I understand that I am financially responsible for all balances incurred.

5. An insurance claim will be submitted for each date of service for all services rendered to your insurance carrier(s). You are financially responsible for all deductibles, co-pay, co-insurance and non-covered service amounts as provided by the explanation of benefits. See Financial Policy for details.

6. I authorize and consent to medical treatment, testing and procedures that my physician deems advisable and necessary based on his/her judgment.

7. Prescription requests and refills require a 48 hour turnaround time. Please note narcotic refills will not be authorized after 4 pm on Thursday. Please plan accordingly.

8. Appointments missed or not cancelled at least 24 hours in advance is subject for a $25 fee.

9. I hereby acknowledge that I have received a Notice of Privacy Practices from Orthopaedic Specialists. Upon my request, I will be provided with a copy of the Notice of Privacy Practices.

By signing below, you are accepting your responsibility for the items detailed above.

______________________________ ____________________

Signature Date

ORTHOPAEDIC SPECIALISTS OF NEVADA

Contract for Controlled Substances

Controlled substance medication (narcotics-opiods, tranquilizers, barbiturates, i.e. any drug which induces sleep or stupor) can be very useful but have high potential for misuse and abuse and are, therefore, closely controlled by government agencies. Used properly, some of them can be very effective pain medication. If used excessively, however, they can cause adverse effects, such as impaired judgment, vomiting, constipation, lethargy, organ damage or even death. To ensure these medications are used properly, I agree to the following conditions:

1. I am RESPONSIBLE for my controlled substance medication. IF THE PRESCRIPTION OR MEDICATION IS LOST, STOLEN OR MISPLACE OR IF I USE IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT WILL NOT BE REPLACED.

2. I will not request or accept narcotic medications from any other physician or individual while I am receiving such medications from my doctor at Orthopaedic Specialists (except if I am in the hospital). Besides being illegal to do so (NRS 453.391), it may endanger my health.

3. I understand that there will be a 24-48 hour turnaround time for non-narcotic medical refills: I will not wait until my medication is gone to request more medication. Controlled substances may be obtained only during a scheduled office visit. Refills will not be made at night, on weekends or on holidays.

4. I understand that if I violate ANY of the above conditions my controlled substance medication may be discontinued immediately.

I am aware of "narcotic effects", including physiological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal may occur if I stop my medications abruptly) and the effects of addiction (psychological dependence), which is less common in patients with true pain. I also understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as an automobile. I shall use special care while involved in activities requiring clear thought and concentration.

__________________________________ ____________________

Signature Date

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

Article 6: **Condition of Treatment:** I understand that signing this arbitration agreement is not a condition of my receiving medical treatment.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

________ ***INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."***

By: [signature] 7/1/2011
Physician or Duly Authorized Representative Signature (Date)

By: G. MARK SYLVAIN, M.D.
Print or Stamp Name of Physician, Medical Group or Association Name

By: ________
Signature of Translator (if applicable) (Date)

____
Print Name of Translator

By: ________
Patient's Signature (Date)

____
Print Patient's Name

By: ________
Patient's Representative's Signature (if applicable) (Date)

____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records

PREMIER PHYSICIANS
INSURANCE COMPANY

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After the arbitration hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of the doctor is bound.

What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially *reversed* ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and have an attorney of your choice, at your expense. This agreement generally helps to lower litigation time and costs for both patients and physicians. Further, both parties are spared the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

ORTHOPAEDIC SPECIALISTS
SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP), which is posted in our office. If you have any questions about this notice, please contact our Privacy Officer at (702) 388-1008.

WHO WILL FOLLOW THIS NOTICE:

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization. There are also various other ways in which we may use or disclose your information:

- Research
- To Allow Oversight of the Quality of the Healthcare We Provide
- To Allow Workers' Compensation Claims
- As Required by Subpoena in Lawsuits and Disputes
- Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper Copy of This Notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from the Policy Officer at (702) 388-1008.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.