LAS VEGAS ENDOCRINOLOGY

Today's Date: _____ Referring Physician: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: ☐ M ☐ F Social Security #: _____

Street Address: _____ Home Phone: _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____ Work Phone: _____

Email address: _____ Primary language: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance Information

Insurance Company: _____ Phone: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Social Security #: _____

Address (If Different from Above): _____

Policy/Member ID #: _____ Group #: _____

Secondary Insurance Information

Insurance Company: _____ Phone: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Social Security #: _____

Address (If Different from Above): _____

Policy/Member ID #: _____ Group #: _____

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Quang Nguyen DO PLLC dba Las Vegas Endocrinology. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment by your insurance company to Quang Nguyen DO PLLC, dba Las Vegas Endocrinology. We have an agreement with you, not your insurance company for payment. In the event your insurance denies a claim, you will become responsible for all amounts not covered payable to Quang Nguyen DO PLLC, dba Las Vegas Endocrinology. Parents/guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency to include but not limited to, commissions attorney & court filing fees, or interest rates assigned by the collection agency. I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records if necessary.

Signature: _____ Date: _____

LAS VEGAS ENDOCRINOLOGY

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Yes ☐ No

Use of tobacco/smoking: ☐ Yes ☐ No

Use of illicit drugs: ☐ Yes ☐ No

Medical History (list previous hospitalizations, surgeries, serious injuries, etc.…)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Patient/Family History (Please circle all that apply.)

	Patient		Mother		Father	
Diabetes	Yes	No	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Yes	No
Stroke	Yes	No	Yes	No	Yes	No
Arthritis/Gout	Yes	No	Yes	No	Yes	No
Convulsions/Seizures	Yes	No	Yes	No	Yes	No
Depression	Yes	No	Yes	No	Yes	No
Thyroid Disease	Yes	No	Yes	No	Yes	No

LAS VEGAS ENDOCRINOLOGY

ALLERGIES to Medications: _____

PLEASE LIST ALL MEDICATIONS Medication Name	Dose	Frequency	What is if for?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Cross Streets: _____

Permission to access your medication list from your pharmacy/insurance company? ☐ Yes ☐ No

How would you ideally prefer to be contacted regarding the following (check only one for each)?

Medical Issues: ☐ Phone ☐ Email

Appointment Reminders: ☐ Phone ☐ Email

Medication Recall Notice: ☐ Phone ☐ Email

May we leave voicemail: ☐ With detail ☐ Without detail

LAS VEGAS ENDOCRINOLOGY

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPPA

I _____ understand that as part of my health care, **Quang Nguyen DO PLLC, dba Las Vegas Endocrinology** originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer(s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that **Quang Nguyen DO PLLC, dba Las Vegas Endocrinology** is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of the organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent **Quang Nguyen DO PLLC, dba Las Vegas Endocrinology** to disclose my protected healthcare information to the following person and/or people:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I fully understand and accept the terms of this consent.

_____ _____

Patient/Legal Guardian Signature Date

LAS VEGAS ENDOCRINOLOGY

MEDICAL RECORDS REQUEST FORM

Patient Name: _____ Date of Birth: _____

I hereby request that you release the following protected health information:

- ✓ Progress Notes
- ✓ Lab/Radiology Reports
- ✓ Medication History
- ✓ Other: _____

RECORDS FROM:	Physician Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

RECORDS TO:	Las Vegas Endocrinology 229 North Pecos Road, Suite 100 Henderson, NV 89074	Phone: 702-605-5750 Fax: 702-605-5751

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

FINANCIAL AND COLLECTION POLICY

Please Read the following carefully:

- Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.
- We will bill your insurance as a courtesy, not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not, and to obtain a referral if required by your insurance. Fees for non-covered services are due at the time service is rendered.
- **Photo ID and Insurance card must be provided for each date of service**.
- If Las Vegas Endocrinology cannot verify your insurance at the visit or if you do not bring current proof of insurance to each visit, you agree to pay charges in full prior to your visit or be rescheduled.
- **You agree to pay all insurance deductibles, co-insurances, and/or co-pays, at the time of check in and prior to services being rendered.**
- If your insurance does not pay within 90 days of claim submission, we reserve the right to begin billing you directly and that you contact your insurance carrier for reimbursement of funds that you paid to settle your account.
- Accounts will be considered delinquent 90 days after insurance adjudication. If a delinquent account is submitted to a collection agency, you agree to pay all fees including, but not limited to, both collection agency fee and the account balance. Once an account has gone to collections, we cannot waive the collection agency's fees. Future appointments will be canceled and follow-up appointments will not be scheduled.
- You agree to pay a $35 returned check fee, in addition to the amount on the check, on any of your personal checks which are returned to this office by our bank. Furthermore, if your check is returned once for insufficient funds, we will not accept your personal check as a form of payment.
- **The No Show fee is $50. Please refer to our MISSED APPOINTMENT FEE POLICY.**
- **If there is any change of insurance, it is the patient's responsibility to IMMEDIATELY notify Las Vegas Endocrinology of the changes (ie. policy dates, coordination of benefits).**
- Any refunds will be released once insurance claim has been paid by your insurance carrier. We want to make sure we deduct any copays, coinsurance, deductibles, or any other charges your insurance carrier may apply towards your responsibility.
- Our office bills are for doctor services only. Fees for lab work are billed separately by the appropriate lab. We are not responsible for fees associated with your lab. You will need to communicate with your insurance and/or lab.

We encourage you to communicate any problems/concerns so that we can assist you in the management of your account. We also offer payment arrangements. Please speak with our billing department, email billing@medicalrcm.net and toll-free number 833-865-8273, for further assistance.

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

CODE OF CONDUCT FOR PATIENTS

To provide a safe and healthy environment for staff, visitors, patients and their families, Las Vegas Endocrinology expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or are unhappy with the service received in our office, please contact our office manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the provider at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- **Our practice follows a zero-tolerance policy for disrespectful or aggressive behavior directed by patients against our staff.**
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

• Possessing firearms or any weapon
• Intimidating or harassing staff or other patients
• Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication
• Physically assaulting or threatening to inflict bodily harm
• Making verbal threats to harm another individual or destroy property
• Damaging business equipment or property
• Making menacing or derogatory gestures
• Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Signature: _____ Date: _____
Patient or Legally Authorized Representative

Printed Name: _____
Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

OFFICE POLICIES

Please Read the following carefully:

- MISSED APPOINTMENT FEE POLICY
  - Appointment confirmation is a courtesy act. It is the responsibility of the patient to keep track of his/her appointment date and time and not rely on the clinic to remind him/her. You will receive an email reminder if you provide an email and/or text to confirm your appointment if you provide a cell phone number.
  - If you are unable to keep your appointment, please notify us using the patient portal or by email at lvendocrine@gmail.com. We require at least 24 hours' notice. Please understand that we are a specialty clinic. We often have patients waiting to be scheduled. **We strongly encourage the use of the patient portal to cancel your appointment.**
  - **A patient who fails to attend his/her appointment (without contacting us at least 24 hours in advance) will be subject to a $50.00 missed appointment fee**. Please be aware that patients who have multiple "no shows" or excessive cancellations will be discharged from Las Vegas Endocrinology.
  - **If a patient shows up to his/her appointment more than 15 minutes late, the appointment will have to be rescheduled to the next available appointment time and date.** This allows our practice to stay on schedule to the best of our ability.
- **A minimum of one in-office appointment is required each calendar year**.
- While your appointment may be a specific time, no express or implied guarantee is made that a provider will see you at the exact time. Las Vegas Endocrinology makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. You agree to not hold Las Vegas Endocrinology responsible in any manner for time spent waiting to be seen.
- **ALL medical record requests by patients for pick-up will take 7 business days. A photo ID and payment ($0.65 per page) must be provided during pick-up.**
- **ALL paperwork requests (FMLA, clearance letters, etc.…) will take 10 days. A photo ID and payment ($45 for FMLA paperwork, $25 for non-FMLA paperwork) must be provided during pick-up. We do not complete medical waivers for vaccines nor long-term disability paperwork nor workers' compensation related form(s).**
- If being prescribed a controlled substance (ie. testosterone, phentermine, benzodiazepine), we will follow all state and federal guidelines associated with controlled substances, which includes checking the Prescription Monitoring Program (PMP) and a signed controlled substance consent/agreement. We do NOT prescribe NARCOTICS.
- You agree and understand that you or associated party will be financially responsible for any damages or destruction to Las Vegas Endocrinology facility, equipment or property.
- **Due to space limitations and maintaining infection controls, please limit the number of companions in your party to those involved in your healthcare (MAX of 2 adults). All others will be asked to wait outside of the building**.

By signing below, you are indicating that you understand and agree to our office polices. Thank you for your understanding and cooperation.

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

Quang Nguyen DO PLLC, dba Las Vegas Endocrinology ("Practice") and Patient herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and all electronic communications may be utilized between the Practice and Patient that includes Patient's Personal Health Information ("PHI"). The Patient agrees to inform the Practice of any changes to Patient's authorized email address. Patient acknowledges that should Patient email exchange with the Practice from another email address, Patient authorizes the Practice to use that email address for communicating PHI as well.
2. For all other services, the Practice and the Patient may use telephone (landline or mobile), facsimile, mail, or in-person office visits.
3. Under no circumstances shall email or electronic communications be used by the Patient or the Practice in emergency or time-sensitive situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.
4. The Practice values and appreciates the Patient's privacy and takes security measures such as encrypting the Patient's data, password-protected data files, and other authentication techniques to protect the Patient's privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient's explicit consent to certain communication amenities.
5. The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient's information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this PHI Agreement. The Patient shall hold harmless any and all demands, claims and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or causes by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.
6. The Practice will obtain the Patient's express consent in the event that the Practice is required or requested to forward the Patient's identifiable information to any third party, other than as specified in the Practice's Notice of Privacy Practice's, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all Responsible Parties.
7. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Practice terminating the email and electronic communications relationship, and may lead to the termination of the Patient's agreement for Practice services.
8. The Patient hereby consents to engaging in electronic and after-hours communications referenced above regarding the Patient's PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.
9. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate with the Patient regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient's PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgment.
10. The Patient shall have the right to request from the Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronics information. However, the Patient's PHR Support subscription fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive) the Practice's actual supply costs for such equipment may be charged to the Patient.
11. This Agreement will remain in effect until the Patient provides written notice to the Practice that the Patient revokes this Agreement or otherwise revokes consent to communicate electronically with the Practice. The Patient may revoke this Agreement at any time, and agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communication database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment, but will preclude the Direct Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all present and future purposes.

ACKNOWLEDGMENT OF RECEIPT FOR AGREEMENT FOR PERSONAL HEALTH INFORMATION

I acknowledge that I have received a copy of the Practice's Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

Signature: _____ Date: _____

Printed Name: _____

LAS VEGAS ENDOCRINOLOGY

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Las Vegas Endocrinology Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices for Las Vegas Endocrinology.

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

NON-CONTRACTED INSURANCES

Listed below are the insurances that our practice is **NOT** contracted with. By signing this form, you are acknowledging this list and are aware that if you **DO** have any one of these insurances and continue to proceed with care from our facility, you will be responsible for all charges for that date of service.

- Aetna CVS HMO
- Anthem BRONZE X HMO
- Anthem MediBlue Diabetes care HMO
- Anthem MediBlue HMO
- Friday
- Health Plan of Nevada – HMO, POS, PPO, Balance Plans
    - Accepted but only as out-of-network benefits.
- P3 (ACCEPTED ONLY THROUGH INTERMOUNTAIN)
- Railroad Medicare
- Select Health (ACCEPTED ONLY THROUGH INTERMOUNTAIN)

Signature: _____ Date: _____

Patient or Legally Authorized Representative

Printed Name: _____

Patient or Legally Authorized Representative (Relationship to Patient)

LAS VEGAS ENDOCRINOLOGY

PATIENT QUESTIONNAIRE FOR SYMPTOMS SUGGESTIVE OF AUTONOMIC DYSFUNCTION

QUESTION	YES	NO
1. Do you have diabetes? **If YES, answer questions 2 and 3; if NO, skip to question 4		
2. Have you had low blood sugar (with or without fainting) and not been aware of it?		
3. Do you sweat when you eat, even if the food is not spicy, or do you have dry skin on your hands or feet?		
4. Do you have pain, tingling, burning, numbness, or electrical shocks in your feet? Circle which symptom(s) you have		
5. Do the bedsheets or your socks bother or hurt your feet?		
6. Do you have pain, tingling, burning, numbness or electrical shocks in your hands? Circle which symptom(s) you have		
7. Do you have trouble driving or seeing at night?		
8. Do you feel dizzy or faint when you stand up too quickly?		
9. Do you feel bloated or full after the first few bites of food?		
10. Do you get tired as soon as you start to exercise?		
11. Do you have diarrhea at night?		
12. Do you have urinary incontinence?		
13. Men only: do you have difficulty with erections that has not improved with medications like Viagra, Cialis, or Levitra?		

As part of your care, your provider requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a user-friendly home sleep test. The home sleep test will determine if you have a sleep breathing disorder. Sleep breathing disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Sleep Assessment Form

Name: _____ Date of Birth_____

Insurance: _____ HT: _____ WT: _____ O2 Use: *Yes or No*

1. Have you ever been given a CPAP device?..... Yes ___ No___
2. If you have been given any form of CPAP, do you use it nightly?..... Yes ___ No___
3. Are you comfortable with your CPAP and satisfied with its use?..... Yes___ No___

If the answer is "Yes" to all three questions, YOU ARE DONE!

If your answer is **"No"** to any of the above questions, please continue to ***Part 1***.

Part 1 ***Epworth Sleepiness Scale***

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more. …….. 0 1 2 3
2. Sitting and talking to someone…… 0 1 2 3
3. Sitting and reading…….. 0 1 2 3
4. Watching TV…….... 0 1 2 3 Score: ____
5. Sitting inactive in a public place……. 0 1 2 3
6. Lying down to rest in the afternoon……..... 0 1 2 3
7. Sitting quietly after lunch without alcohol…….. 0 1 2 3
8. In a car, while stopped for a few minutes in traffic……. 0 1 2 3

Total ESS: ____

Part 2

1. Have you been told that you snore?..... Yes___ No___
2. Does your family have a history of premature death in sleep?..... Yes___ No___
3. Do you have diabetes?..... Yes___ No___ Score: ____
4. Have you ever been told you have coronary artery disease?..... Yes___ No___
5. Do you have high blood pressure?..... Yes___ No___
6. Have you ever experienced irregular heart rhythms?..... Yes___ No___

Part 3

1. Have you ever been diagnosed with sleep apnea? …….. Yes___ No___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes___ No___
3. Has anyone said that you seem to stop breathing while sleeping? .. Yes___ No___
4. Is your neck size larger than 15" (female) or 16.5'' (male)……. Yes___ No___
5. Have you ever had a stroke?..... Yes___ No___
6. Have you ever been told you have congestive heart failure?..... Yes___ No___
7. Do you have or did you ever have atrial fibrillation?..... Yes___ No___

Actual Neck Size: _____

Score: ____

Patient Signature: _____ Date: _____

****Our sleep coordinator will contact you if further testing is recommended.****

SA Score: _____ Home Sleep Apnea Test High:_____ Low: _____