ASSIGNMENT OF BENEFITS

I hereby assign any and all insurance benefits to be paid directly to Luis L. Diaz, M.D. and not to exceed the outstanding balance on my account.

I understand Luis L. Diaz, M.D. will bill my insurance company as a courtesy to me. I agree to provide any and all information necessary to bill my insurance company (i.e. claim forms, copies of insurance cards, etc.). If payment is not received from the insurance company within a reasonable period of time (i.e. 90 days), I agree that I am directly responsible for any and all outstanding balances.

I understand that every effort will be made to obtain payment form my insurance company. In the event that my insurance does not process the claim for payment the outstanding balance will be due in full.

I understand than any special financial agreements and/or considerations must be approved by the Administrator of this practice.

Should this account be turned over to an outside collection agency, I agree to pay any and all fees incurred to collect this debt (not to exceed 50% of the amount owed).

Should I fail to keep my scheduled appointment or fail to cancel said appointment within 48 hours, I understand that I will be charged a $50.00 fee. I understand that this fee is not paid by Medicare, Medicaid or Commercial Insurance Company and I am solely responsible for payment of the $50.00 charge. I also understand that I will be required to pay this cancellation fee before my next appointment.

Any forms (Ex: FMLA, Disability, Loss of Time, etc..) to be filled out by Dr. Luis L. Diaz, MD or his staff will be subject to a monetary charge up to $150.00 PER PACKET.

Signature _____ DOB _____

Date. _____

CONSENT FOR TREATMENT

I consent for medical treatment rendered to me/the patient by Luis L. Diaz, M.D., staff or under the special instructions of Luis L. Diaz, M.D. I understand that I am responsible for all charges incurred for said treatment.

Signature _____ Date_____

Witness _____ Date_____

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Patient Name: _____

DOB: _____

CONSENT/COMMUNICATION OF MEDICAL INFORMATION

I hereby give my consent for the following designated person(s) to have or request information on my behalf:

- _____
- _____
- _____
- _____

I give my permission to leave messages regarding my appointments or other information to be left on my voicemail or answering machine.

Signature:

_____

Date: _____

Consent to the Use & Disclosure of Health Information for Treatment, Payment of Healthcare Operations

I _____ understand that as part of my healthcare, this practice originates & maintains health records for the last 5 years, after which they may be destroyed, describing my health history, symptoms, examinations, test results, diagnoses, treatment & any plans for future care of treatment. I understand that this information serves as:

1. The basis for my care & treatment.
2. A form of communication between this practice & other healthcare professionals concerning my care.
3. Provides information for applying diagnosis information to my bill & insurance companies.
4. Provides proof of services rendered for third party payors.
5. Provides a tool for healthcare operations in assessing the quality & competence of healthcare professionals.

PLEASE INITIAL EACH OF THE FOLLOWING:

_____ I understand & have been provided/reviewed a Notice of Information & Practices (HIPAA) which gives further clarification of record usage**.**

_____ I understand that I have the right to review the notice prior to signing this consent.

_____ I understand that this practice reserves the right to change their practices and prior to implementation will provide a copy of any revisions to me.

_____ I understand that I have the right to request restrictions as to how my health information may be used in order to carry out treatment and/or payment. This practice is not required to agree to restrictions requested.

_____ I understand that I may revoke this consent in writing, except where this information has already been used.

I wish to have the following restrictions to the use or disclosure of my health information:

Signature: _____

Date: _____

INTAKE AND CONSENT

LUIS L. DIAZ, M.D.

DATE: _____ FULL NAME: _____DOB: _____

SS #: _____ SEX: M / F EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ CELL. WORK. HOME

SECONDARY PHONE: _____ CELL. WORK. HOME

SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED

RETIRED / STUDENT / EMPLOYED- EMPLOYER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE #: _____ CELL WORK. HOME

PRIMARY INSURANCE

NAME OF INSURED: _____ RELATION TO PATIENT: _____

DOB: _____ SS #: _____ EMPLOYER: _____

INSURANCE NAME: _____ MEMBER #: _____

GROUP #: _____

SECONDARY INSURANCE

NAME OF INSURED: _____ RELATION TO PATIENT: _____

DOB: _____ SS #: _____ EMPLOYER: _____

INSURANCE NAME: _____ MEMBER #: _____

GROUP #: _____

AUTHORIZATIONS AND RELEASES:

I HEREBY AUTHORIZE PAYMENT OF **ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO LUIS L. DIAZ, MD**. ANY AND ALL COPAYS, CO-INSURANCES & DEDUCTIBLES FOLLOWING INSURANCE PAYMENTS ARE DUE AND PAYABLE BY MYSELF/LEGAL GUARDIAN. I ALSO REALIZE I AM RESPONSIBLE TO PAY ANY NON-COVERED SERVICES OR INSURANCE DENIALS.

SIGNATURE OF PATIENT/GUARDIAN: _____ RELATION: _____ DATE: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY HEALTHCARE AND ANY **MEDICAL RECORDS REQUESTED** BY PHYSICIANS REGARDING MY HEALTH ADVICE, AND TREATMENT FOR THE PURPOSE OF **CONTINUING CARE.**

SIGNATURE OF PATIENT/GUARDIAN: _____ RELATION: _____ DATE: _____

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NOTICE OF INFORMATION PRACTICES Luis L. Diaz, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Understanding your health record & Information

Each time you visit a physician or other healthcare provider, a record of your visit is made. Usually this record contains your symptoms, examinations, test results, diagnoses, treatment and a plan for future care of treatment. This information, often referred to as you as health or medical record serve as a:

- Basis for planning your care and treatment
- Means of communicating among the healthcare professionals connected with your care
- Legal documentation describing the care you received
- Means by which your insurance carrier can verify the services you received
- A tool in educating healthcare professionals
- A source of information for medical research
- Understanding your health information & how it is used helps you to:
  1. Ensure its accuracy
  2. To better understand who & why others may have access to your health information
  3. Make more informed decisions when authorizing access to others
- Per chapter 629 of NRS- records may be destroyed by shredding after 5 years

Your Health Information Rights

Although your health record is the physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction as to certain uses & disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record
- Amend your health record
- Obtain a record of your healthcare disclosures
- Request information about your medical record by alternative means
- Revoke your authorization to use or disclose your health information, except where it has already been used.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information (medical records)
- Provide you with a notice of our legal duties & privacy practices with respect to information we collect & maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide you with a revised notice.
We will not use or disclose your health information without your authorization, except as described in this notice.

To Report a Problem

If you believe your privacy rights have been violated, you can file a complaint with the directors of health information management or with the Secretary of Health & Human Services. There will be no retaliation for filing a complaint.

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Medication/Vitamin List

Date _____ Drug Allergies_____

Patient Name _____DOB _____

PCP_____Referring Dr. _____

Medication Name	Dosage	Frequency

Luis L. Diaz, M.D.

Patient Name: _____

Patient Date of Birth: _____

PATIENT HISTORY QUESTIONNAIRE

Do you NOW or HAVE HAD any of the following:

__ **Chest Pain**
__ **Shortness of Breath**
__ **Asthma**
__ **High Blood Pressure/HTN**
__ **Rapid Heart Beat**
__ **Diabetes**
__ **Arthritis**
__ **Rheumatic Fever**
__ **Heart Disease**
__ **Hyperactivity**
__ **Insomnia**
__ **Headaches**
__ **Migraines**
__ **Fainting/Syncope**
__ **Seizures**
__ **Concussion/Head Injury**
__ **Double Vision**
__ **Dizziness**
__ **Numbness/Tingling**
__ **Memory Lapse/Memory Loss**
__ **Depression**
__ **Anxiety**

Have you or any of your family/friends had or have been exposed to COVID-19?

_____ YES _____ NO Date of Exposure _____

Please mark if you presently have any of the following symptoms:

__ **Cold** **_____ Stuffy/Runny Nose**
__ **Flu** **_____ Nausea/Vomiting**
__ **Coughing** **_____ Sneezing**
__ **No, I don't have any of these symptoms.**
__ **Fever**
__ **Diarrhea**

Did you get the COVID-19 Vaccine? YES _____ NO _____

Pfizer _____ Moderna _____ Johnson & Johnson _____

1st Shot Date _____ 2nd Shot Date_____ Booster Date _____

Signature: _____Date: _____

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PHARMACY INFORMATION

DATE: _____

Patient Name:_____DOB: _____

PRIMARY PHARMACY NAME:

_____

ADDRESS:

_____

PHONE #: _____

SECONDARY PHARMACY NAME:

_____

ADDRESS:

_____

PHONE #: _____