
DR. CARR
CONCIERGE ORTHOPEDICS

**Welcome to Las Vegas Concierge Orthopedics. We are happy you are here.**
9260 W. Sunset Road, Suite 309, Las Vegas, NV 89148
702-963-1231 Fax 702-442-9309 email: LVCOrthopedics@gmail.com

## PATIENT INFORMATION

**Date:** _____ **Patient Name:** _____ □ **Dr.** □ **Mr.** □ **Mrs.** □**Ms.**

**Date of Birth:** _____ **Cell Phone #**_____**Home Phone #**_____

**Address:** _____**Apt #**_____

**City**_____**State**_____**Zip**_____

**SS #**_____ **(required for insurance billing) Email:** _____

**Marital Status:** □**Married** □**Single** □**Divorced** □**Widowed**

Race: American Indian/Alaskan Native/Asian/Black or African American/Native Hawaiian/Pacific Islander/White/Other/Declined

Ethnicity: Declined / Hispanic or Latino / NOT Hispanic or Latino

**Pharmacy Name:** _____ Phone number_____
Pharmacy address or cross streets: _____
**Referred by:** _____

Emergency Contact Name: _____ Phone #_____
Relationship to Patient: _____

**PRIMARY INSURANCE INFORMATION** (must be completed by patient even if cards provided)

**Primary Insurance:** _____ Member ID#_____

Primary Insurance Subscriber: _____ Date of Birth_____

Relationship to patient: Self Spouse Child Partner Other

**Secondary Insurance:** _____ Member ID#_____

Primary Insurance Subscriber: _____ Date of Birth_____

Relationship to patient: Self Spouse Child Partner Other

**WORKER COMPENSATION INFORMATION**
Were you injured on the job? □ No or □ Yes? Date of Injury_____ Adjusters Name_____
Insurance Carrier_____Phone Number_____ Claim #_____

I hereby sign to Las Vegas Concierge Orthopedics/Dr Carr all benefits for medical and surgical care payable under the policy of the practice. I also authorize the release of information under the same policy. I understand that I am financially responsible for any charges not covered by my insurance.

_____ _____ _____
Patient Name (Parent if Minor) Signature Date

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Patient Name : _____ Date of Birth : _____

Have you seen Dr. Carr Previously? **No** **Yes**: Previous Practice or Hospital

**Reason for your visit:** What is Injured or what hurts? **LEFT** **RIGHT** **BILATERAL**

**Specify Body Part:**_____

**What is your height?** _____ **What is your current weight?** _____

**What is your current occupation?** _____

**Do you have any drug or metal allergies?**

_____

**Past Medical Illness:** What major illnesses have you had, or do you have at the present time? (Example: High blood pressure, Diabetes, Cancer, Heart Disease, Kidney Disease, Lung Disease, Liver Disease)

_____

**Past Surgical History:**

Date_____ Type of surgery:_____

Date_____ Type of surgery:_____

Date_____ Type of surgery:_____

**Medications:**

Current Medication with dose:

_____

_____

_____

**Social History:**

Have you ever smoked? **Y N** Do you currently smoke? **Y N** # of cigarettes per day _____ When did you quit?_____

Do you use recreational drugs? **Y N** type: _____

Do you drink alcohol? **Y N** How many drinks per occasion? _____ How often? __Daily __Weekly __Monthly __Socially

Have you ever received treatment for substance abuse? **Y N** If yes what was the treatment? _____


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Patient Name : _____ Date of Birth : _____

Do you currently have any of the following? Check ALL that apply:

**GENERAL**
- ☐ Weight Gain/Loss
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Excessive Sleep
- ☐ Lack of sleep

**EYES**
- ☐ Vision Loss
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Rapid Change in Vision

**RESPIRATORY**
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Coughing Up Blood

**CARDIAC**
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Ankle/Foot Swelling
- ☐ Rapid or Irregular Heartbeat

**GASTROINTESTINAL**
- ☐ Frequent Constipation
- ☐ Frequent Diarrhea
- ☐ Blood in Stool
- ☐ Vomiting
- ☐ Heartburn

**URINARY**
- ☐ Urinary Incontinence
- ☐ Burning on Urination
- ☐ Blood in Urine
- ☐ Decrease of Urine Flow
- ☐ Frequent Urination at Night

**MUSCULOSKELETAL**
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Muscle Cramps
- ☐ Stiffness
- ☐ Rash
- ☐ Change in Skin Color
- ☐ Back Pain
- ☐ Neck Pain

**NEUROLOGICAL**
- ☐ Seizures
- ☐ Loss of Balance
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Headache
- ☐ Weakness
- ☐ Loss of Grip Strength
- ☐ Numbness/Tingling

**HEMATOLOGIC**
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Frequent Infections
- ☐ Low Blood Counts
- ☐ Prior Transfusion

**ENDOCRINE**
- ☐ Stomach Pain
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Dry Skin

**PSYCHOLOGICAL**
- ☐ Depression
- ☐ Frequent or Severe Anxiety
- ☐ Hallucination

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Consent for Treatment and Payment

I hereby request treatment by Las Vegas Concierge Orthopedics and consent to care and treatment as ordered by my physician. I authorize the release of information related to my treatment to my referring physician. I authorize LVCO to submit this claim on my behalf for the medical services provided. I hereby authorize my health insurance company to make payment directly to LVCO, for any benefits that I may receive. I understand that I am financially responsible for all charges made to my account whether an insurance company, attorney, or third-party payer is involved with payment. I am responsible for all copayments, deductibles and coinsurance amounts as well as non-covered supplies and services. Payment for services is expected at all time services are rendered. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party. I understand that LVCO does not discriminate against any person based on race, color, religion, gender, gender expression, sexual orientation, age, national origin, disability, or marital status.

Print Patient Name: _____

Signature of Patient _____ Date: _____

Signature of Responsible Party (If patient is a minor) _____ Date: _____

HIPAA Policy

The department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, payment, or health care operations, to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories) and may have to disclose personal information for purposes of treatment, payment or heal care operations. The entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health care information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken while relied on that or a previous signed consent. If you have any objections to this form, please let our staff know.

Description of the information to be used or disclosed may include patient demographics, insurance or medical records.

Print Patient Name: _____

Signature of Patient _____ Date: _____

Signature of Responsible Party (If patient is a minor) _____ Date: _____

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Payment Policy

Thank you for choosing LVCO as your Orthopedic provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. But not some Medicare Advantage plans so PLEASE be sure to give us all your insurance plan information. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and the additional collection charges will be charged on your account and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date