SOUTHERN NEVADA FAMILY MEDICINE
Board Certified in Family Medicine

Dr. Amir K. Nicknam, M.D. Ron
Meagan Hill, APRN

Ludwiszewski, PA-C
Yaw-Jong Tsai, PA-C

PATIENT INFORMATION

Today's Date: ____/____/_____ Patient's Name: _____
Address: _____
Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work: _____-_____-_____
Social Security Number: _____-_____-_____ Date of Birth: ____/____/_____ Gender: Male Female

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Ethnicity:
- ☐ White
- ☐ African-American
- ☐ Latino
- ☐ Other: _____

Primary Language: _____
Spouse's Name: _____ Spouse's Phone Number: _____-_____-_____
Spouse's Social Security Number: _____-_____-_____ Spouse's Date of Birth: _____/_____/_____
Emergency Contact Name: _____ Phone Number: _____-_____-_____
E-mail Address: _____
How did you hear about us? _____

EMPLOYMENT INFORMATION AND STATUS

Are you or your spouse currently employed? Yes No If yes, complete below:
Patient's employer: _____ Work Phone: ___-____-____
Address: _____
Spouse's Employer: _____ Work Phone: ___-____-____
Address: _____

PRIMARY INSURANCE INFORMATION

Name of primary insured: _____ Date of Birth: ___/____/_____
Relationship to insured: Self Spouse Parent Guardian Other: _____
Insurance Carrier: _____ Social Security Number: _____-_____-_____
Member ID Number: _____ Group Number: _____
Address: _____

SECOUNDARY INSURANCE INFORMATION

Name of primary insured: _____ Date of Birth: ____/____/_____
Relationship to insured: Self Spouse Parent Guardian Other: _____
Insurance Carrier: _____ Social Security Number: ____-____-_____
Member ID Number: _____ Group Number: _____
Address: _____

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PATIENT HISTORY

Patient's Name: _____ DOB: _____/_____/_____
Pharmacy:_____ Location(cross streets, phone numbe)r: _____
What is the reason for your visit? _____

Please list any hospitalizations and/or operations you have or had in the past with approximate dates:

1. _____
2. _____
3. _____
4. _____

Please list any medications you take daily, including over- the – counter medication:

MEDICATION	DOSAGE	HOW OFTEN

***** If you take additional medications you take daily, please list them on the back of this paper*****

Are you allergic to any medications? Yes No
If yes please list all allergies and reactions below:

_____

Last colonoscopy: _____ **Last eye exam:** _____
Last DEXA Bone scan_____ **Last pap smear:** _____ **Last Mammogram:** _____

Family Health History

Relative	Current Age	Health Status	Deceased		Age of Death	Cause of death
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		

SOCIAL HISTORY

Do you currently smoke? Yes No How many packs per day? _____ How many years? _____
If no, have you smoked in the past? Yes No What year did you quit? _____How many packs did you smoke? _____
Do you drink? Yes No Daily Weekly Monthly How many drinks? _____
Do you do recreational drugs? Yes No What drugs do you use? _____

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Patient's Name: _____ Today's Date: ____/____/_____

AUTHORIZATION TO REALSE MEDICAL RECORDS AND INFORMATION

I _____ hereby authorize Southern Nevada Family Medicine to obtain my medical records and information from the following physician(s)/ facility

_____

I _____ hereby authorize Southern Nevada Family Medicine to disclose my health and/ or billing information relevant to my care to my following family members(s), personal representatives or other persons listed below.

1. _____ 3. _____

2. _____ 4. _____

PLEASE INITIAL BELOW IF YOU AGREE TO THE FOLLOWING:

_____ I give Southern Nevada Family Medicine permission to send the above information electronically by fax or mail

_____ I give Southern Nevada Family Medicine permission to leave a message on my answering machine or voicemail

_____ I give Southern Nevada Family Medicine permission on the event they cannot get in contact with me, Southern Nevada Family Medicine may leave a message with my contacts of family members listed below

1. _____ 2. _____

PLEASE NOTE UNLESS THIS AUTHORIZATION IS REVOKED BY THE PATIENT, IN WRITING, THIS AUTHORIZATION REALEASE SHALL REMAIN IN EFFECT INDEFINITELY

PRINT PATIENT'S NAME PATIENT'S SIGNATURE TODAY'S DATE

CONSENT OF TREATMENT

I _____ consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or medically necessary in the judgement of Dr. Amir Nicknam.

PRINT PATIENT'S NAME PATIENT'S SIGNATURE TODAY'S DATE

HEALTH INFORMATION PORTABLITY AND ACCOUNTABILITY ACT (HIPPA)

I have read and received a copy of the Health Information Portability and Accountability Act (HIPPA)

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FINANCIAL POLICY

Southern Nevada Family Medicine (SNFM) appreciates the opportunity to participate in your medical care. The services you may receive from Dr. Nicknam have been chosen to correctly diagnose and maintain your health condition. We recognize the need for an understanding between patient and physician regarding financial agreements for your medical care.

PLEASE READ AND INITIAL ALL STATEMENTS BELOW

_____ All copayments are due at the **time of service**. These payments are collected prior to seeing the physician.

_____ SNFM will submit a claim to your insurance carrier. Upon receipt of payment, SNFM will then bill your secondary and/or tertiary insurance (if applicable) for any remaining balance based on the explanation of benefits received from your primary and/or secondary insurance company.

_____ Your insurance carrier(s) may not cover all the services determined by Dr. Nicknam as medically necessary. Please refer to your insurance policy for further clarification and verification of coverage and benefits. Fees for non-covered services are the responsibility of the patient or guarantor.

_____ SNFM will attempt to appeal what my insurance does not pay. In the event of a denied appeal and once all measures to overturn an appeal or denied, I must then submit an appeal to the decision with my insurance carrier.

_____ If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and recommend that you contact your insurance carrier(s) to follow up on the payment status. Any accounts left unpaid will be placed with a private collection agency. All accounts will be subject to the costs associated with the collection process.

_____ **I agree that I am responsible for all charges incurred in the office. You as the insured are responsible to pay for any outstanding coinsurance or deductible amounts determined by your insurance carrier. If my insurance carrier does not provide full benefits, I agree to pay the remaining balance.**

_____ If any part of your insurance carrier(s) changes, **it is you responsibility to notify SNFM** so that we can bill your claims properly**. You must provide us with a copy of the new insurance card immediately.** Failure to inform us of any new changes may affect obtaining pre-authorization prior to future appointments and obtaining a future appointment itself with our office.

_____ If your address or telephone number should change at any time, you must notify the SNFM billing department of such change. Please contact the billing department at 702-733-6622.

_____ Returned checks and will be subject to a $25.00 fee

_____ No shows are subject to a $40.00 fee

I authorize the release of any information necessary, including medical history, physical findings and treatment rendered as allowed by HIPPA to determine liability for payment and to obtain reimbursement on my medical claims. I request that payment of authorized payments be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurances, and other health plan to SNFM. The assignment of benefits will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original. I understand that I am fully responsible for all charges whether paid by insurance carrier (s).

I have read, understood and agree to the above financial policy.

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SOUTHERN NEVADA FAMILY MEDIICNE OFFICE POLICIES

- Patients are requested to come in five (5) minutes prior to tgeir assigfned appointment. For new patirrnts that have not pre-registered online, please come in (15) minutes before your appointed tme so you can fill our intake form properly.
- We will require some form of **picture ID** and your **insurance card** during registration. Please be advised we cannot properly bill your insurance **without this information**.
- Please do not ask to waive your payments for ofice visits. Office copays, outstanding deductibles, out of pocket balances nd coinsurance balances remaining from your insurance campany are to be paid at the TIME OF SERVICE. We are obligated by our insurance contract to collect your cost or share. If you are unable to pay this amount for any reason, please bring it to the office staff's attention **immediately** or ask to speak to our billing manager.
- We accept cash, debit, Visa, Mastercard and American Express.
- We charge **$0.60** per page fee for any copies you may need.
- We charge a minimum of **$45.00+** and up for forms that require our physicians to complete.
- Your prescription refill request would be best served within **24 to 48 hours**.
- We will try to secure your authorization for the procedures you require within **7 to 10** business days, which is also subject to the response time your insurance company.
- **Cancellation/ No Show Policy** for Doctor Appoiontment: We undestand that there are times when you must miss an appointment due tgo emergencies or obligatiopns for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. A **$40.00** cancellation fee will be charged to patient account for new or existing patients if a **24hr** notice is not given.

Our staff will best serve your needs in the best serve your needs in the best way they posibly can. We highly believe in extending respct to everyone. We ask that you extend them the same courtesy while in our facility. We will not tolerate abusive patients.

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