Southern Nevada Family Medicine
Southern Nevada Occupation Health Center

Board Certified in Family Medicine

Amir Nicknam, MD., MPH, CIME, FACOEM

Chief Medical Officer

PATIENT INFORMATION

Today's Date ___ /___ / ___

Patient Name: ______________________________ Date of Birth: ___ / ___ / ___ Gender: Male Female

Address: ____

Street Unit /Apt # City State Zip Code

Home Phone: _____ -_____ -________ Cell Phone: _____ -_____ -________ Work Phone: _____ -_____ -________

Language Preference: __________________ Race: White African-American Latino/Hispanic Other

Social Security Number: _____ -_____ -_____ Marital Status: S M Other

Email: (For appointment Reminders, Patient Portal, Medical Records Access) ______________________________

Spouse's Name: ______________________________ Spouse's Phone Number:_____ -_____ -________

Emergency Contact: ______________________________ Contact's Phone Number: _____ -_____ -________

How did you hear about us? Friend Relative Insurance Online Other

EMPLOYMENT INFORMATION

Are you employed? Yes No If yes, employer's name: ______________________________

Address: ______________________________ Phone Number:_____ -_____ -________

Is your spouse employed? Yes No If yes, employer's name: ______________________________

Address: ______________________________ Phone Number:_____ -_____ -________

INSURANCE INFORMATION

Primary Insurance

Insurance Carrier: ______________________ Member ID: ______________________ Group Number: ________________

Phone Number:_____-_____-________ Address: ______________________________

Are you the primary? Yes No - If no, relationship to insured: Spouse Parent Guardian Other: ______________________

Name of Primary Insured:______________________ Date of Birth ___ / ___ / ___ Social Security Number ___ - ___ - ___

Secondary Insurance

Insurance Carrier:______________________ Member ID:______________________ Group Number: ________________

Phone Number:_____-_____-________ Address: ______________________________

Are you the primary? Yes No - If no, relationship to insured: Spouse Parent Guardian Other:______________________

Name of Primary Insured: ______________________ Date of Birth ___ / ___ / ___ Social Security Number ___ - ___ - ___

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Patient Name:______________________________ Date of Birth: ____ / ____ / ____

Pharmacy name:______________________ Location: (cross streets, phone number) ______________________

Reason for today's visit? ____

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

1 ______________________________ 2 ______________________________

3 ______________________________ 4 ______________________________

Please list any medications you take daily, including over the counter medicines :

	MEDICATION	DOSAGE	HOW OFTEN
1			
2			
3			
4			
5			

*** If you take additional medications, 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:

FAMILY HEALTH HISTORY

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

SOCIAL HISTORY

**Do you currently smoke? Y N How many packs per day do you smoke? _____ How many years have you smoked for? _____

If no, have you smoked in the past? Y N What year did you quit? ___________ How many packs per day did you smoke? _____

**Do you drink? Y N Daily Weekly Monthly How many drinks?_________

**Do you do recreational drugs? Y N What drugs do you use? ______________________________

SNOHC: 4060 N Martin Luther King Blvd Ste l0lA, North Las Vegas, NV 89032 Phone: (702) 380-1712 Fax 877-361-1165 www.snohc.com
SNFM: 1765 Village Center Cir. Ste 100, Las Vegas, NV 89134 Phone: (702) 733-6622 Fax 877-361-1165 www.snfamilymedicine.com

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AUTHORIZATION TO RELEASE MEDICAL RECORDS & INFORMATION

Patient Name ____ Date of Birth: ___ / ___ / ___

I hereby authorize SNFM / SNOHC to disclose my health and/or billing information relevant to my care to my following family member(s), personal representative or other persons listed below

1 ____________________________________ 2 ____________________________________

3 ____________________________________ 4 ____________________________________

PLEASE INITIAL BELOW ON YOUR PREFERENCE

_____ I give SNFM/SNOHC permission to send the above information electronically by fax or mail

_____ I give SNFM/SNOHC permission to leave a message on my answering machine or voicemail

_____ In the event that SNFM/SNOHC cannot get in contact with me, I give them permission to leave a message with my contacts

1 ____________________________________ 2 ____________________________________

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

__________________________ __________________________ ____/____/____

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

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

__________________________ __________________________ ____/____/____

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

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<u>OFFICE POLICIES</u>

- Patients are requested to come in fifteen (15) minutes prior to their appointment to update their records.
- ID and insurance card(s) are required **every time** you come in for your appointment.
- Patient needs to be scheduled monthly for any controlled substance prescription.
- Copays, outstanding deductibles, out of pocket balances and co-insurance balances remaining from your insurance company 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 your current balance, please bring it to the office staff's attention immediately or ask to speak to our billing manager.
- A payment contract will be set up for any balance over $100.
- We accept cash, Visa, MasterCard and American Express. **NO checks**.
- If you need your medical records, there will be a fee of $0.60 per page and may take up to 10 business days to complete.
- There is a $45 fee at the time of the request for any forms completed by our physicians, ex: FMLA, disability, letters, etc. (Except for patients with Culinary Health Fund Insurance)
- FMLA paperwork may take 7 - 14 business days to complete.
- Your prescription refill request may take 24 - 48 business hours if calling our prescription line.
- We will try to secure your authorization for the procedures you require within 7-10 business days, which is also subject to the response time of your insurance company.
- We send courtesy reminders for appointments, you must confirm your appointment via email, phone call or text.
- If you leave a message, we will return your call within 24 business hours.
- No bill over $50 will be accepted as form of payment.

NAME: ______________________________ SIGNATURE: ______________________________ DATE: __ /__ /__

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FINANCIAL POLICY

Patient Name: ____

SNFM/SNOHC 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 copays are due at the time of service, these payments are collected prior to seeing the physician.

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

_______ My insurance carrier(s) may not cover all the services determined by Dr. Nicknam as medically necessary. I will refer to my insurance policy for further clarification of coverage and benefits. Fees for non-covered services are my responsibility.

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

_______ If my insurance company does not pay within 60 days, SNFM/SNOHC reserves the right to begin billing me directly and recommend that I contact my insurance carrier(s) to follow up on the payment status. Any accounts left unpaid will be placed with a private collection agency and subject to the costs associated with the collection process.

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

_______ If any part of my insurance carrier(s) changes, it is my responsibility to notify SNFM/SNOHC so that my claims can be billed to my insurance. I must provide a copy of the new insurance card immediately.

_______ If my address / telephone number should change at any time, I must notify the front office immediately at 702-733-6622.

_______ If I do not CANCEL/RESCHEDULE my appointment at least 24 hours in advance or NO SHOW to my appointment, there will be a $50 fee that is not covered under my insurance.

I authorize the release of any info necessary, including medical history, physical findings and treatment rendered as allowed by HIPAA 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 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 my insurance carrier(s). I have read, understood and agree to the above financial policy.

NAME: ________________________________ SIGNATURE: ________________________________ DATE: __ /__ /__

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Southern Nevada Family Medicine. When you schedule an appointment with Southern Nevada Family Medicine we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

^ Effective May 26, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee**.

^ Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee**.

^ If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from SNFM Family Practice.

^ Any new patient who fails to show for their initial visit will not be rescheduled.

^ The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

^ As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Southern Nevada Family Medicine 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. Messages left at either location are acceptable.

Southern Nevada Family Medicine - MLK (702) 380-1712
Southern Nevada Family Medicine - Summerlin (702) 733-6622

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

______________________________ ______________________________
Signature (Parent/Legal Guardian) Relationship to Patient

______________________________ ______________________________
Printed Name Date