DAULAT MEDICAL CENTER

PATIENT INFOMATION

Date _____ Social Security# _____

Name _____

Last Name First Name Middle Initial

Date of Birth _____ Home Phone ( ) _____ CELL ( ) _____

E-Mail Address: _____

Address _____ City _____

State _____ Zip _____

Sex: [] M [] F Age _____ Marital Status _____

Patient Employer _____ Occupation _____

Employer Address _____ Phone ( ) _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone ( ) _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last Name First Name MI

Relation to Patient _____ Birth Date _____ Soc. Sec # _____

Address (If different from patient's) _____ Phone ( ) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? [] Yes [] No

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address (if different from patient's) _____ Phone ( ) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone ( ) _____

Insurance Company _____ Soc. Sec# _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that the above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. A copy of the signature is as valid as original.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

REGISTRATION FORM

DAULAT MEDICAL CENTER **MEDICAL HISTORY**

Date _____ SS/HIC/Patient ID# _____ Date of Birth _____

Patient Name _____

Last Name First Name Middle Initial

Patient Concerns: _____

Date of Last Physical Exam _____

FAMILY MEDICAL HISTORY

	√ if Alive	Age at Death	Present Health or Cause of Death		# Alive	# Deceased	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			

PAST HEALTH HISTORY / HOSPITALIZATIONS / SURGERIES

_____

_____

_____

_____

MEDICATIONS: LIST MEDICATIONS/ VITAMINS/ HREBS/SUPPLEMENTS CURRENTLY TAKING

_____

_____

_____

HAVE YOU EVER SMOKED? _____ **IF YES, FREQUENCY?** _____

ALLERGIES: CHECK IF YOU ARE ALLERGIC TO

ADHESIVE/TAPE ASPIRIN NO KNOWN ALLERGIES

IBUPROFEN IODINE

PENICILLIN SULFA OTHER SPECIFY: _____

_____

_____

_____

OTHER HEALTH CARE PROVIDERS

PRIMARY CARE PROVIDER _____

OB/GYN _____

OTHER _____

PREFERRED PHARMACY

_____

Name

_____

Location

_____

Phone Number

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVES? YES NO

MAY WE HAVE A COPY FOR YOUR CHART? YES NO

CERTIFICATION

I certify that the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

DAULAT MEDICAL CENTER
7106 SMOKE RANCH RD #120
LAS VEGAS, NV 89128

OFFICE POLICY

Controlled Substance will not be called in or faxed to the pharmacy. Patient will need to have a follow up appointment for refills.

Call your pharmacy to send us a request for refill, allow 2 working days.

If you have not been seen in 3 months, re-fill request may be denied until follow up appointment.

Prescriptions given by another physician will not be refill by phone or faxed. Patient must be seen in our office.

There will be no re-fills on Antibiotics without being seen by the doctor.

FORMS: FMLA and work notes and other forms, require an appointment.

Patient Name: _____ Date: _____

Signature: _____

DAULAT MEDICAL CENTER
3416 NORTH BUFFALO DRIVE
LAS VEGAS; NEVADA 89129

PHONE : 702-565-4917
FAX :702-562-8680

MEDICAL RECORDS RELEASE

DATE: _____

FROM:

_____

_____

_____

PHONE:_____FAX:_____

I HEREBY AUTHORIZE YOU TO RELEASE MY MEDICAL INFORMATION TO:

DAULAT MEDICAL CENTER

3416 NORTH BUFFALO DRIVE

LAS VEGAS, NEVADA 89129

PHONE: 702-565-4917 FAX: 702- 562-8680

I AUTHORIZE YOU TO RELEASE RECORDS OF ANY/ALL TREATMENT AND EXAMINATION RENDERED TO ME

SIGNATURE:_____ DATE_____

PRINT NAME:_____ D.O.B:_____

PLEASE SEND ONLY:

H&P DISCHARGE NOTES RADIOLOGY REPORTS

RECENT LABS ONLY CONSULTS

Health Information and Privacy Act
Release of Patient Information
Patient Authorization Form

This notice describes how information about you may be used and disclosed at how you can get access to this information. Please review it carefully.

I _____give my authorization for Daulat Medical Center to use and disclose my protected health information including but not limited to my name of insured's name, name of insurance plan, personal identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use of disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical or hospital services.

By signing this form you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extend that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at Daulat Medical Center.

We may use of disclose your protected health information in the following situations without your authorization. These situation include: as Requested by Law, Public Health issues as requested by law, Communicable Diseases: Health Oversight, Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the Law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you choose not to sign this consent, it may be difficult for Daulat Medical Center to provide treatment. You will be provided with a copy of this signed authorization upon your request.

Signature_____

Printed Name_____

Date _____

Witness _____

Health Insurance Portability and Accountability act of 1996 (42 U.S. Section 1320d et seq.) (45 CFR Subtide A, Subchapter c.)

Acknowledgement of Receipt of Notice of Privacy Practices

Daulat Medical Center reserves the right to modify the privacy practice outlined in the notice, signature.

I have received a copy of the Notice of Privacy Practice for Daulat Medical Center.

_____

Name of Patient/Print or Typed

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative (Required if the Patient is a minor or an adult who is unable to sign)

**********For Office Use Only**********

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practice Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

[ ] The patient was undergoing emergency treatment

[ ] The patient declined to sign the acknowledgement

[ ] Other _____

Signature

_____

Name of Patient (Print or Type)

_____

Name of Staff Member

_____

Date

Daulat Medial Center

Patient Responsibility

It is the responsibility of the patient to be sure that you have at least a six month check up with us, whether reminders are sent out or not. Blood work is to be done on a yearly basis unless otherwise advised by Dr. Daulat.

The office policy for prescription refills is 48 hours on working days. No new prescription will be given unless the physician sees you first. The best way to do a prescription refill is to have your pharmacy contact our office by fax or e-prescribed. Please request your refill at least five working days before it is due to prevent running out of medication.
No Control Substance or Antibiotics will be called in or faxed.

If your laboratory results required follow up the designated personal will instruct you over the phone. You will not be notified of normal laboratory results, you may call for results.

_____ _____

Patient Signature Date

DAULAT MEDICAL CENTER
DR. GAUTAM DAULAT, DO

Financial Policy

We are committed to providing you with the best possible care. **We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract.** All charges are your responsibility from the date of service rendered. We realize that insurance companies need processing time; however, all charges will become due and payable if the insurance company does not reimburse Dr. Daulat in a timely manner as mandated by the NV state Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. All deductibles, co-payments and non-covered items are due at the time of check-in.

Collection Fees Policy: Patient Name: _____.
I, _____ (parent/guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/ legal fees that may be added to my account.

_____ _____
Signature of patient, parent/ Guardian Date

LATE FEE: A late fee of $35 per year on past due accounts will be added.
Initials: _____
Returned Checks: A $25 non-sufficient funds fee will be charges for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's office. **Initials:** _____
No show fees: There is a $25 no-show/late-cancellation fee. All appointments must be cancelled by 3 p.m. of the previous day. Insurance will not cover charges for no-show/late-cancellation. **Initials:** _____