OLOGYMED

☐ New Patient ☐ Established Patient

Date: _____

Patient Information

Patient Name: _____ _____ _____ _____
First Name M Last Name Suffix

Date of Birth: ___/___/___ **Sex:** ☐ Male ☐ Female ☐ Other: _____

Social Security Number: _____ **(needed for care follow-up)**

Address: _____ _____
Apt./Ste/Unit

_____ _____ _____
City State Zip Code

Mobile: _____ **Home:** _____

Email*: _____

Gives you access to your Patient Chart Portal & Appointment Reminders
Appointment Reminders: Automated text/phone calls will be sent to the mobile number provided

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ Caucasian ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Preferred Pharmacy Name/Cross Streets or Phone: _____

Emergency Contact

First & Last Name: _____ **Phone**: _____

Relationship to Patient: _____

Insurance Information

Primary Insurance Name: _____

Policy #: _____ **Group #:** _____

Under someone else's policy? ☐ Yes ☐ No **If NO, please skip to next section.**

If YES, please fill out below:

Policyholder Name: _____ _____ _____
First M Last

Relationship of Policyholder: _____ Date of Birth: _____

Policyholder SSN: ___ ___ ___ Phone Number: _____
(used to verify insurance)

OLOGYMED

Patient Name: _____

Date of Birth: _____

Secondary Insurance Name: _____

Policy #: _____ **Group #:** _____

Guarantor Contact

First & Last Name: _____ **Phone**: _____

Relationship to Patient: _____

Appointments

Appointments are scheduled according to the treating provider. New patients must arrive 20 minutes prior to their scheduled appointment to fill out the proper paperwork if not completed beforehand. Any special appointment times are to be given directly by the provider.

Referrals

If referrals are required, we will complete the necessary paperwork and submit it to your health plan for authorization. It has been our experience that each health plan varies in its response timeliness.

Financial Policy

Our providers are contracted with traditional insurance health plans. If you have any questions about whether any of our providers are participants in your health plan, please directly call your insurance company. Co-payments/Deductibles are due at the time of service.

Emergency/ Non-Emergency Care

If you believe you have an emergency, please call 911. Your health plan may require that any non-emergency health care received outside of our office also receive prior authorization from your health plan and your physician. If authorization is not obtained, you may be financially responsible for the services rendered.

Billing

Insurance is billed as a courtesy to the patient. Please direct all billing inquiries and account questions to (725) 210-5860. Patients without insurance are required to pay for services in full at the time of service. Power of Attorney verification is expected at the first visit if applicable. Any medical records or test results requested by another physician's office may be sent by fax/mail at no charge. Patients requesting medical records/test results will be charged $.60 per page. Payment is expected prior to the release of records.

ROUTINE PHYSICAL APPOINTMENTS

I understand a routine physical appointment cannot be accompanied by any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed to the provider the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

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. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to doctor. A copy of the signature is as valid as the original.

ABN (Advance Beneficiary Notice of Non-Coverage)

Medicare does not pay for everything, even some care that your health care provider has good reason to think you need. You accept that you may have to pay what Medicare does not pay, including any lab work ordered by your provider. This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-663-4227/TTY: 1-877-486-2048)

_____ _____

Patient Signature / Legal Guardian Signature Date

OLOGYMED

Patient Name: _____

Date of Birth: _____

General Consent to Treat/Patient Authorization/Acknowledgment of Benefits Release

The following are the conditions for services provided by Astrana Care for the patient whose name appears at the top of this page.

ROUTINE PHYSICAL APPOINTMENTS

_____ ***Initials*** I understand a routine physical appointment cannot be accompanied with any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed with the physician the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

LAB DISCLAIMER

_____ ***Initials*** It may be necessary to perform or request lab work (cultures, pap smears, biopsies, lab work, etc.). Our office WILL send you directly to the Lab of your choice. Each test may have more than one fee depending on the complexity. Your insurance carrier may not cover certain tests. It is your responsibility to know your benefits. We cannot change any coding (CPT Procedure Codes or ICD-9 Diagnosis Codes) to conform to your plan's coverage or benefits.

Please **CHECK MARK** the lab your insurance is contracted with. If unknown, staff will choose your preferred lab, per insurance contract.

☐ CPL ☐ Lab Corp ☐ Quest ☐ Unknown ☐ Other: _____

CONSENT FOR MEDICAL TREATMENT

I/We voluntarily consent to medical treatment and diagnostic procedures provided by Ologymed and its associated physicians, clinicians, and other personnel. I/We consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis, and testing for drugs if deemed advisable by my physician. I/We am/are aware that the practice of medicine and surgery is not an exact science, and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of application or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/We also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law. I/We fully understand that, as part of a teaching institution, information may be collected from the patient encounter or chart in order to collect data. I/We understand that personal health information may be used or disclosed for the purposes of carrying out treatment, evaluating the quality of services proved and any administrative operations related to treatment or payment. I/We understand that I/we have the right to restrict how the personal health information is used and disclosed for treatment, payment, and administrative operations if I/we submit a written request. I/We understand that each request will be considered for restriction on a case-by-case basis.

ASSIGNMENT OF INSURANCE BENEFITS

I/We guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other fundings to the physician and Ologymed. I/We understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/We understand that Ologymed can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/We have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION

I understand that Nevada Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the NV Code NRS616C.050. I/We authorize Ologymed to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.

OLOGYMED

Patient Name: _____

Date of Birth: _____

CONTROLLED SUSTANCE PRESCRIPTIONS

Ologymed reserves the right not to prescribe narcotic medications. If you take narcotic medications for pain control on a regular basis, you must see a pain management physician. No narcotic prescriptions will be given to a new patient on the initial visit until a complete work up has been performed and old records have been received. Controlled substance medications (narcotics, anti-anxiety, sleeping medications, etc.) are very useful, but have potential for misuse and abuse. These drugs are closely controlled by local, state, and federal government. They are intended to relieve pain, to improve function and/or ability to work, not to simply feel good. If you are prescribed such medications to help manage pain, you are responsible for the controlled substance medication. If the prescription is lost, misplaced, stolen, or used up medication sooner than prescribed, it will not be replaced. You cannot request nor accept substance medication from any other physician or individual while you are receiving this medication from your doctor. Prescription refills of controlled substance cannot be called in to the pharmacy. They must be handwritten, and you must attend your scheduled appointment. You will be informed by your doctor about side effects, including normal psychological effects of tolerance and dependence.

INFORMATION RELEASE

Other Person(s) authorized to discuss any medical information (including appointments, billing, and insurance):

Full Name	Phone Number	Relationship

CONFIDENTIAL COMMUNICATION

You may request to receive confidential communications of Protected Health Information (PHI), i.e. Lab results, imaging results, referral/prior authorization, prescription refills, in the method you prefer.

I authorize Ologymed to leave PHI messages at the following: ***(Please select all that apply)***

- ☐ Mobile Voicemail: _____
- ☐ Home Voicemail: _____
- ☐ Work Voicemail: _____
- ☐ Mobile Patient Portal Web Message (email address required): _____
- ☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN CALL

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/We have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

_____ _____

Patient Signature / Legal Guardian Signature | Date

_____

Printed Name

New Patient Questionnaire

Reason for visit: _____

Primary Care Provider: _____ **Phone:** _____

Other Treating Physicians: _____ **Specialty:** _____

List any medical problems you currently have/reason for being seen:

SURGERIES/OTHER HOSPITALIZATIONS

Date	Reason/Surgery Performed:	Hospital

List of your prescribed drugs and over-the-counter drugs (such as vitamins and inhalers) Continue on back if needed.

Name of Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Circle or List: ◯ Amoxicillin ◯ Penicillin ◯ Aspirin ◯ Ibuprofen

◯ Sulfa drugs ◯ Chemotherapy drugs ◯ Erbitux or Rituxian ◯ HIV drugs (Ziagen, Viramune, etc.)

◯ Insulin ◯ Antiseizure drugs (Lamictal, Tegretol, etc.) ◯ Other: _____

SOCIAL HISTORY

Alcohol?	◯ Yes or No ◯	How many drinks?	# _____ a day or a week
Tobacco?	◯ Yes or No ◯	How many cigarettes?	# _____ a day or a week
Recreational Drugs?	◯ Yes or No ◯	How many?	# _____ a day or a week

FAMILY HISTORY

Family Member	Diagnosis

PATIENT HEALTH QUESTIONNAIRE - 2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by the following? (Circle one)	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down depressed, or hopeless.	0	1	2	3

Total Score: _____

OLOGYMED

Patient Name: _____

Date of Birth: _____

Form Completion Policy

Ologymed requires payment for the completion of forms the patient asks providers to complete on their behalf. We receive many requests which require increased administrative time and financial resources in excess of what is normally needed to complete the medical records.

Instructions:

- Submit forms requested in advance. The provider will attempt to complete the forms as quickly as possible; however, in order to properly address each form, providers need adequate time to review the patient's records.
- If applicable, patient must complete their section of the form prior to giving it to the provider.

Providers will make every effort to complete these forms within 7-10 business days; however, we cannot make any assurance of completion with the patient's time frame(s). Payment is required prior to completion of all forms.

$30 fee for completion of the following forms:

- FMLA/Disability
- Letter of Condition
- Misc. patient request

$20 fee for the completion of the following forms:

- DMV Disability Placard
- Physical Forms

Late & No-Show Policy

It is the policy of Ologymed that patients arrive on time for their scheduled appointments. We honor a 15 minute grace period before offering a rescheduled appointment time. In the event that a patient is unable to make their scheduled appointment the patient **must give 24 hours advance notice by calling the office**.

Failure to attend a scheduled appointment without prior notice limits access to care for other patients and results in unused provider time. A no-show fee is therefore applied to help ensure appointment availability and fairness to all patients. If patient does not notify the office prior to their appointment time a there will be a $50.00 No show fee.

There will be a "NO SHOW" fee of $50.00.

New patients must arrive 20 minutes prior to their scheduled appointment to fill out the proper paperwork. Existing Patients must arrive 10 minutes prior to their scheduled appointment. A patient who fails to keep 3 or more appointments in a twelve-month period without prior notice of cancellation may be discharged from the practice at the discretion of the patient's physician.

By signing below, I attest that I have read and understood the above mentioned. A copy of this form is provided in your patient portal, if you would like a paper copy of this form, you may request a copy from an office staff member.

_____ _____

Patient Signature / Legal Guardian Signature | Date

_____

Printed Name

OLOGYMED

Patient Name: _____

Date of Birth: _____

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY OLOGYMED MULTISPECIALTY GROUP AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI):
Understanding what is in your health records and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI) we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act, 45CFR Part 464.The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations, and other specific purposes explained on the next page. This Includes contacting you for appointment reminders and follow-up care.

YOUR HEATH INFORMATION RIGHTS: You have the right to:
Request a restriction of the use sand disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction. Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record fora fee of $.60 per page and the actual cost of postage per NRS 629.061, except that you are not entitled to access to, or to obtain a copy of psychotherapy notes and information compiled for legal proceedings. Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the request amendment. Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions. Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax and/or telephone. Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES: The Law requires us to:
Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI. Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your protected health information, including information obtained prior to the change. Post notice of any changes in our Privacy Policy in the lobby and make a copy available to you upon request. Use or disclose your health information only with your authorization except as described in this notice. Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your health information.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the designated Privacy Officer Kim Grana, at 2621 W. Horizon Ridge Pkwy., Ste 110, Henderson, NV 89052, 725-220-3863. If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

Treatment: e.g. we will use, and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

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Patient Name: _____

Date of Birth: _____

NOTICE OF PRIVACY PRACTICE CONTINUED

Payment: e.g. we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment.
Health Care Operations: e.g. members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.
Other uses and disclosures not requiring authorization.
Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
Notification: We may disclose limited health information to friends or family members identified by you as being involved in your care of assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
Legally Required Disclosures, Public Health & Law Enforcement: We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, though in such circumstance you will not be personally identified), to an employer to evaluate whether an employee bas a work related injury, and to public officials to report births and deaths. We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of a crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
Information Regarding Decedents: We may disclose health information regarding a deceased person to: I) Coroners and Medical Examiners to identify cause of death or other duties; 2) Funeral Directors for their required duties; and 3) to procurement organizations for purposes of organ and tissue donation.
Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
Marketing: We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also contact you as part of a fund-raising effort.
Directory Information: We may disclose limited information regarding your name and location for directory purposes to those persons who as for you by name or to members of the clergy. You may request that we not include your name in the directory.
Disclosures requiring authorization.
All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.

By signing I acknowledge and understand that I did receive a copy of the Notice of Privacy Practices for Ologymed.

_____ _____

Patient Signature / Legal Guardian Signature Date

_____

Printed Name

Ologymed: Multispecialty Group
2621 W Horizon Ridge Pkwy, Suite 110
Henderson, NV 89052
P: (725) 220-3863
F: (725) 228-6427

OLOGYMED

STAT FAX REQUEST

DATE:_____

To: _____ From: _____

Fax: _____ Fax: _____

Phone:_____ Phone:_____

Print Patient Name	Date of Birth

I, _____ allow Ologymed to receive/send any and all
SIGN

information/records including previous/current notes, test results, imaging, labs, etc.

Notes: