

XPRESSCARE URGENT & PRIMARY CARE CLINIC OFFICE POLICY/PROCEDURES

It is our intention to provide an environment of safety and respect. Please help us by conforming to our office policies

1. PLEASE REFRAIN FROM USING ABUSIVE LANGUAGE TOWARDS STAFF.
2. PLEASE REFRAIN FROM USING YOUR CELL PHONE IN THE CLINIC.
3. PLEASE CHAPERONE YOUR CHILDREN AT ALL TIMES WHILE IN THE CLINIC.
4. PLEASE BE AWARE OF OUR POSTED TRIAGE POLICY AND REMEMBER THAT WE ARE TRYING TO DO OUR BEST TO TREAT YOU AS CLOSE TO YOUR APPOINTMENT TIME AS POSSIBLE. WITH A GROWING OFFICE. THERE WILL BE LONGER WAIT TIMES. PLEASE BE PATIENT WITH US! WE WILL GET TO YOU AS SOON AS WE CAN.
5. WE RESPECT YOUR PRIVACY AND AS SUCH THE DOCTOR WILL TREAT YOU INDIVIDUALLY IN THE ROOMS. THE DOCTOR WILL SEE ONE PATIENT AT A TIME. THIS INCLUDES ADULT FAMILY MEMBERS.
6. YOUR PRESCRIPTIONS WILL ONLY HAVE 3 REFILLS: FOLLOW-UPS ARE REQUIRED FOR ADDITIONAL REFILLS. NARCOTIC MEDICATIONS WILL NEVER HAVE REFILLS. PATIENTS WILL NEED TO BE SEEN MONTHLY FOR ALL CONTROLLED MEDICATIONS.
7. FORMS FOR FMLA, WORK RELEASE, DISABILITY, ETC...MUST BE PRESENTED AT TIME OF CHECK-IN. WE MAY NEED TO RESCHEDULE YOUR APPOINTMENT IF IT IS PRESENTED ANYTIME AFTER THE APPOINTMENT HAS BEGUN. THERE IS A 25.00 FEE PLUS YOUR OFFICE VISIT FEE/COPAY FOR THE COMPLETION OF FORMS.
8. MONDAYS, FRIDAYS AND SATURDAYS ARE RESERVED FOR WALK-INS. DAY AFTER HOLIDAY IS ALSO RESERVED FOR WALKINS. SCHEDULED APPOINTMENTS WILL BE ON TUESDAYS THROUGH THURSDAYS.

BY SIGNING BELOW, I AGREE TO ABIDE BY THESE POLICIES AND HAVE ASKED ANY QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION.

PATIENT SIGNATURE

(PATIENT PLEASE PRINT NAME)

(DATE)

(PATIENT SIGNATURE)

(PARENT/GUARDIAN SIGNATURE, if applicable)

**XPRESS CARE URGENT & PRIMARY CARE CLINIC
BILLING POLICY/PROCEDURES**

12. WE ARE HMO PROVIDERS AT THIS TIME FOR ONLY BC/BS & AETNA: ANY OTHER NEW HMO PATIENT WILL BE CONSIDERED AS A CASH PATIENT: \$125.00 FOR THE INITIAL VISIT; \$75.00 EACH FOLLOW UP VISIT.
13. THERE IS A FEE STARTING FROM \$25.00 FOR THE COMPLETION OF DOCUMENTS AND FORMS. ALL REQUESTS REQUIRE 5 WORKING DAYS FOR COMPLETION. THE FEE IS PAYABLE UPON PRESENTATION OF THE FORMS.
14. PATIENT'S RECORDS ARE THE PROPERTY OF THE CLINIC. COPIES MAY BE OBTAINED FOR A FEE.
15. THERE IS A \$25.00 FEE FOR RETURNED CHECKS.
16. WE ARE UNABLE TO ACCEPT CHECKS OVER \$50.00.
17. APPOINTMENT CANCELLATION POLICY: THERE IS A \$50.00 NO SHOW FEE FOR ANY APPOINTMENT CANCELLED LESS THAN 24 HOURS PRIOR TO SCHEDULED APPOINTMENT TIME.
18. ANY BILLING INQUIRIES/ CONCERNS THE PATIENT MAY CALL MARIAN (BILLING OFFICE) @ 460-8720 M-F 9:00AM-4PM.

By signing below, I agree to abide by these policies and have asked any questions which have been answered to my satisfaction.

PATIENT SIGNATURE

(PATIENT PLEASE PRINT NAME)

(DATE)

(PATIENT SIGNATURE)

(PARENT/ GUARDIAN SIGNATURE, if applicable)

**XPRESS CARE URGENT & PRIMARY CARE CLINIC
BILLING POLICY/PROCEDURES**

1. CURRENT PATIENT IDENTIFICATION & INSURANCE CARD ARE REQUIRED IN ORDER TO BE SEEN.
2. INSURANCES WILL BE VERIFIED AND SUBMITTED ON BEHALF OF PATIENTS.
3. PATIENT WILL BE INFORMED OF CO-PAYS AND DEDUCTIBLES WHICH ARE PAYABLE UPON CHECK-IN BEFORE SERVICES ARE RENDERED.
4. VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF CLAIM PAYMENTS. PATIENT IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE.
5. WORKMAN'S COMP CLAIMS MUST BE IDENTIFIED AT FIRST VISIT WITH A COMPLETED C-3 FORM TO BE PROCESSED AS SUCH. IF WORKMAN'S COMP IS NOT IDENTIFIED AT THAT TIME, IT IS THE PATIENT'S RESPONSIBILITY TO PAY IF CLAIMS ARE DENIED.
6. **NEW PATIENTS:** IF YOU HAVE A DEDUCTIBLE THAT HAS NOT BEEN MET; THERE WILL BE A \$50.00 CHARGE PLUS CO-PAY UNTIL THE DEDUCTIBLE IS MET. AS A COURTESY, THE OFFICE WILL BILL YOUR INSURANCE CLAIM AND THEN BILL THE PATIENT FOR ANY OUT-OF-POCKET EXPENSES NOT PAID AT TIME OF SERVICE.
7. PATIENTS MUST PAY THEIR CO-PAY AT EACH OFFICE VISIT.
8. REFUNDS ARE NOT ISSUED FOR NON-SURGICAL COSMETIC SERVICES: INCLUDING BUT NOT LIMITED TO WEIGHT LOSS, MESO-THERAPY, BOTOX, ETC.
9. **CASH PATIENTS:** FOR THOSE PATIENTS WHO ARE NOT COVERED UNDER ANY MEDICAL INSURANCE OR WHO PREFER TO PAY ON A CASH FEE FOR SERVICE BASIS, THERE IS A \$125.00 OFFICE CHARGE FOR THE INITIAL VISIT. ANY CHARGES INCURRED ABOVE THE PHYSICIANS MEDICAL SCREENING EXAM, WILL BE COURTESY BILLED. THIS MAY INCLUDE LAB TESTING, X-RAY, EKG, ETC. THESE COSTS ARE IN ADDITION TO THE REGULAR OFFICE VISIT FEE. FOLLOW-UP VISITS ARE \$75.00, ALSO NON-INCLUSIVE OF ANY ADDITIONAL FEES AS DESCRIBED ABOVE.
10. **AFTER HOURS NEW PATIENTS:** WE WILL BE UNABLE TO VERIFY THE INSURANCE UNTIL THE NEXT BUSINESS DAY. THEREFORE THERE WILL BE A MINIMUM DEPOSIT OF \$50.00 UNTIL THE INSURANCE IS VERIFIED. ONCE THE INSURANCE HAS BEEN VERIFIED, AND THERE IS NO OUTSTANDING DEDUCTIBLE WITH YOUR INSURANCE; BILLING DEPT WILL **REFUND** OVERPAYMENT AFTER RECEIVING NOTIFICATION FROM YOUR INSURANCE COMPANY.
11. EVERY PATIENT MAKING A PAYMENT WILL RECEIVE A HAND WRITTEN RECEIPT.



CURTIS BAZEMORE, M.D., LTD

PERSONAL DATA

PATIENT HISTORY - Pg. 1

Name: _____ Date of Birth: _____
 Social Security: _____ Age: _____
 Phone Number (Home): _____ Marital Status: _____
 Occupation: _____ Work#: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

PATIENT HISTORY

FAMILY HISTORY

High Blood Pressure	___ Yes	___ No	___ Yes	___ No
Diabetes Mellitus (sugar)	___ Yes	___ No	___ Yes	___ No
Angina Pectoris	___ Yes	___ No	___ Yes	___ No
Heart Attack	___ Yes	___ No	___ Yes	___ No
High Cholesterol	___ Yes	___ No	___ Yes	___ No
Blood Clots	___ Yes	___ No	___ Yes	___ No
Stroke	___ Yes	___ No	___ Yes	___ No
Emphysema (breathing problems)	___ Yes	___ No	___ Yes	___ No
Asthma	___ Yes	___ No	___ Yes	___ No
Hepatitis	___ Yes	___ No	___ Yes	___ No
Hypothyroidism (low thyroid)	___ Yes	___ No	___ Yes	___ No
Arthritis	___ Yes	___ No	___ Yes	___ No
Cancer	___ Yes	___ No	___ Yes	___ No
Anemia (low blood count)	___ Yes	___ No	___ Yes	___ No
Kidney Stones	___ Yes	___ No	___ Yes	___ No
Rheumatic Fever	___ Yes	___ No	___ Yes	___ No
Ulcers (Bleeding)	___ Yes	___ No	___ Yes	___ No
Cataract	___ Yes	___ No	___ Yes	___ No
Irregular Heart Beats	___ Yes	___ No	___ Yes	___ No
TB	___ Yes	___ No	___ Yes	___ No
Hypertension	___ Yes	___ No	___ Yes	___ No
Epilepsy/Convulsions	___ Yes	___ No	___ Yes	___ No
Mental Illness	___ Yes	___ No	___ Yes	___ No
Others, please specify:				

Cancer ___ Yes ___ No
 What kind? _____ When? _____
 What kind? _____ When? _____

PAST SURGICAL HISTORY

Have you ever had any of the following operations? If so, when:

Appendectomy	___ Yes	___ No	___ Year
Tonsillectomy	___ Yes	___ No	___ Year
Gallbladder Removal	___ Yes	___ No	___ Year
Hysterectomy	___ Yes	___ No	___ Year
Bypass Surgery	___ Yes	___ No	___ Year
Cataract Laser	___ Yes	___ No	___ Year
Hemorrhoidectomy	___ Yes	___ No	___ Year
Hernia Repair	___ Yes	___ No	___ Year
Colonoscopy/Sigmoidoscopy	___ Yes	___ No	___ Year

Others, please specify:

PREVIOUS PHYSICIANS

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

CURRENT MEDICATIONS

Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____

ALLERGIES

Seasonal ___ Yes ___ No

Animals ___ Yes ___ No

Medications ___ Yes ___ No

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e....electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 313-7878.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____





6525 N. Buffalo Drive, Suite 130 • Las Vegas, Nevada 89131-4040 • Ph. (702) 313-7878 • Fax (702) 313-7879

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician in whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law 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 disclosures 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 164.500.

Other Permitted and Required Uses and Disclosures Will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

THIS IS TO REQUEST AND AUTHORIZE:

(Name of Doctor you are to release information)

Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Fax: _____

TO RELEASE THE FOLLOWING INFORMATION FOR THE PURPOSE OF:

(For what purpose may the information be used)

RELEASE INFORMATION TO: _____
(Name of Doctor, Lawyer, Insurance Co., or Individual)

Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Fax: _____

(CHECK RECORDS TO BE RELEASED)

All Medical Records _____ X-rays _____ Lab Work _____

Operative Reports _____ Other _____

I REALIZE THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION:

(Signature of Patient or Responsible Party)

(Relationship)

(Witness)

(Date)