Bone & Joint Specialists

Patient Name: _____
First Middle Last

Cellular: _____

Address: _____ Apt./Sp.#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Social Security #: _____ - ____ - _____ Date of Birth: _____ Age: _____ Male ☐ Female ☐

Race and Ethnicity: _____ Email: _____

Employer: _____ How Long? _____

What type of work do you do? _____ Marital Status: S ☐ M ☐ D ☐ W ☐

Who referred you to our office? _____ Address: _____

★ ★ ★ ★ ★ ***Complete this section only if someone other than the patient is financially responsible*** ★ ★ ★ ★ ★

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

Phone: _____ Date of Birth: _____

Employer: _____ Insured ID # or Social Security #: _____

EMERGENCY CONTACT: *(Name of friend or relative not living with you)*

Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cellular Phone: _____

What body part are we seeing you for? _____ Date of Injury/Onset: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy ID #: _____ Group #: _____

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

Date of Birth: _____ Insured Name: _____

Secondary Insurance: _____ Policy ID #: _____ Group #: _____

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

Date of Birth: _____ Insured Name: _____

Workers' Comp. Name & Address: _____

Workers' Comp. Claim #: _____ Date of Injury: _____

Adjuster's Name: _____ Phone: _____ Fax: _____

Nurse Case Mgr. Name: _____ Phone: _____ Fax: _____

I hereby assign all medical benefits to which I am entitled to Bone & Joint Specialists. I understand I am financially responsible or all charges whether or not paid by said insurance. I hereby authorize said assignee to release any information needed to determine these benefits for related services.

_____ _____
Responsible Party Date

Body part being treated? _____

How did the injury occur & where? _____

_____

Any previous problems with this same body part in the past? Yes ☐ No ☐

If yes, please list: _____

_____

Have you been seen by any other doctor for your present problem? Yes ☐ No ☐

If yes, which doctor and when? _____

Have X-rays or any diagnostic studies been done? (ie: MRI's, CT, Bone Scan and EMG studies)

If yes, Where, When and What body part? _____

_____

List all prescribed medications you are currently taking and the dosage: _____

_____

_____

★ ★ ★ ★ ★ ***Please list name of pharmacy so prescription can be electronically*** ★ ★ ★ ★ ★

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Cross Streets: _____

Allergies to medication: Yes ☐ No ☐

If yes, please list which medication: _____

List **ALL** previous surgeries: _____

_____

List **ALL** Medical Health Problems: _____

_____

Height: _____ Weight: _____

Do you currently smoke? Yes ☐ No ☐ How many packs a day? _____

If you do not currently smoke, have you ever smoked in the past? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐ Socially: Yes ☐ No ☐ Occasionally: Yes ☐ No ☐

Daily: Yes ☐ No ☐ How often? _____

_____ _____

Patient Name Date

DISCLOSURE:
Bone & Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community.

FINANCIAL POLICY:
PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
Our office does verify eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. We will do all we can to assist you with your health insurance claims however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you. Our office will bill a secondary insurance only once as a courtesy to the patient. If the insurance does not pay, then the balance becomes the responsibility of the insured.

If you are scheduled for surgery, we require any deductibles as well as coinsurance amounts paid prior to your date of surgery. In addition to the surgeon's fee, there is a need for an assistant at the time of your surgery. The assistant's fee is in addition to the surgeon's fee.

Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

A returned check charge of $35.00 will be charged to the account for each returned check.

DELINQUENT AND COLLECTION ACCOUNTS:
- An account becomes delinquent when the minimal monthly payment has not been received within 30 days of the statement date.
- An account that has become delinquent for 60 days may become a collections account and may be charged a collections handling fee, court costs and attorney's fees.
- Exemptions from the above are allowed charges under Medicare and Title XIX (Nevada Medicaid) contracts.
- There may be exceptions to all or any part of the account.
- Balances not paid by your insurance plan within 30 days will automatically become the responsibility of the responsible party.

CANCELLATION, NO SHOW AND RESCHEDULING POLICY:
If you fail to provide us with a 24 hour notice of cancellation or rescheduling, or fail to keep your scheduled appointment, there will be a $50 no-show fee.

I understand that Bone & Joint Specialists may not be a provider on my health plan and I will be fully responsible for any outstanding charges that my insurance plan does not cover. A photocopy of this assignment is considered as valid as the original.

In the event that my account becomes a delinquent account or collection account, I agree to pay Bone & Joint Specialists all incurred finance charges, delinquent account handling fees, collection account handling fees and incurred collection costs as set forth above in section 3 of the financial policy.

If it is necessary to forward your account to our collection agency, a collection fee markup of 35% to 50% will be added to the amount owing. Interest will accrue daily at the rate of 1.5% per month or 18% per year.

The markup reflects Bone & Joint Specialists receiving only it's billed charged. The additional money will go to the collection agency.

_____ _____
Signature of Responsible Party Date

Bone & Joint Specialists

BILLING INFORMATION

★ ★ ★ ★ ★ *ONLY COMPLETE THIS SECTION IF MOTOR VEHICLE ACCIDENT* ★ ★ ★ ★ ★

What is the name of the insurance company?_____

Insurance company address:_____

Claim adjuster's name: _____ Phone:_____

DO YOU HAVE AN ATTORNEY FOR YOUR INJURY? Yes ☐ No ☐

Attorney's Name: _____Phone:_____

Attorney's Address: _____

★ ★ ★ ★ ★ *ONLY COMPLETE THIS SECTION IF INJURED ON THE JOB* ★ ★ ★ ★ ★

Did the injury occur at work?

If yes, please explain the injury details: _____

_____

Date the injury occurred: _____

Did you report the injury to a supervisor? Yes ☐ No ☐ Supervisor's Name:_____

Have you had any previous Workers' Compensation injuries in the past? Yes ☐ No ☐

If yes, please explain: _____

_____

_____

_____

_____

_____

_____ _____

Patient's Name Date

Bone & Joint Specialists

SUMMARY OF OUR NOTICE OR PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS
TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact ANNA HOLLAND, OFFICE MANAGER at 702-474-7200.

WHO WILL FOLLOW THIS NOTICE

- Bone & Joint Specialists

This notice describes our privacy practices. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment or health care operation purposes described in this notice.

OUR PLEDGE **REGARDING HEALTH INFORMATION**

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. Theis notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. By coming for care, you give use the right to use your information for treatment, to get reimbursed for your care and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Research**
- **To Provide Information About Organ and Tissue Donation**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**

- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from ANNA HOLLAND, OFFICE MANAGER at 702-474-7200.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact ANNA HOLLAND, OFFICE MANAGER. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

Acknowledgment of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgments will be filed with your records.

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Bone & Joint Specialists

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES FOR BONE & JOINT SPECIALISTS

I here by acknowledge that I have received the Notice of Privacy Practices from Bone & Joint Specialists.

I give permission for my protected health information to be disclosed for purposes or communicating results, findings and care decisions to the family members and others listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature Date

_____
Print Name

Bone & Joint Specialists

2020 Palomino Lane, Suite 110
Las Vegas, NV 89106
702-474-7200
2680 Crimson Canyon Dr.
Las Vegas, NV 89128
702-228-7355

CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medication (narcotics - opioids, tranquilizers, barbiturates, i.e. any drug which induces sleep or stupor) can be very useful but have high potential for misuse and abuse and are, therefore, closely controlled by government agencies. Used properly, some of them can be very effective pain medication. If used excessively, however, they can cause adverse effects, such as impaired judgement, vomiting, constipation, lethargy, organ damage, or even death. To ensure these medications are used properly, I agree to the following conditions.

1. I am RESPONSIBLE for my controlled substance medication. IF THE PRESCRIPTION OR MEDICATION IS LOST, STOLEN OR MISPLACED OR IF I USE IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT MAY NOT BE REPLACED.

2. I will not request or accept narcotic medications from any other physician or individual while I am receiving such medications from my doctor at Bone & Joint Specialists (except if I am in the hospital). Besides being illegal to do so (NRS 453.391), it may endanger my health.

3. **I understand that there will be a 48 hour turnaround time (business hours) for non-narcotic medication refills; therefore, I will not wait until my medication is gone to request more medication. Controlled substances may be obtained only during a scheduled office visit. Refills will not be made at night, on holidays or on weekends.**

4. I understand that if I violate ANY of the above conditions, my controlled substance medication will be **discontinued immediately.**

I am aware of "narcotic effects", including physiological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal may occur if I stop my medications abruptly) and the effects of addiction (psychological dependence), which is less common in patients with true pain. I also understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as an automobile. I must use special care while involved in activities requiring clear thought and concentration.

Effective October 1, 2015, Senate Bill 459 requires when prescribing narcotics, a pharmacy search is made regarding your medication history. By signing this form, I acknowledge and consent to this state mandated inquiry.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness Signature Date

★ ★ ★ ★ ★ ***Patients of Dr. Elkanich understand that they will be subject to random drug testing*** ★ ★ ★ ★ ★