Dear Patient:

Welcome to The DOCS. Thank you for allowing us the opportunity to assist you with your healthcare needs. We value all our patients and are committed to providing you with high-quality, healthcare services.

This packet includes all the patient forms that will need to be completed in for us to assist you with your care.

1. Intake Form
2. Office Policies
3. HIPAA Brochure
4. HIPAA Acknowledgement
5. Authorization for Use and Disclosure of PHI
6. Twistle

Please take a few moments prior to your appointment to review and complete the registration forms. We ask that you bring the completed forms to your appointment along with your insurance card.

Please arrive 20 minutes early to your appointment. The physicians and the staff at The DOCS are looking forward to assisting you with your health care needs. If you have any questions, please call the numbers below and someone will be happy to help you.

Sincerely,

The DOCS

8352 W. Warmsprings Rd., 3rd Floor, Las Vegas, NV 89113
Office: (702)851-7287 Fax: (702)851-7286

The DOCS Intake Form

Date: _____

Patient First Name: _____MI _____ Last Name: _____

Mailing Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip: _____

Primary Phone ☐Cell ☐ Home: _____Secondary Phone☐ Cell ☐Home: _____

SSN: _____ Date of Birth: _____ Marital Status: M S D W

Sex: F M Identifying As: F M Employer's Name: _____ Work Phone: _____

Email Address: _____ Web Enable: Y or N (for our patient portal and/or Twistle)

Race: _____(optional) Ethnicity: _____(optional) Language: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

Referring Physician Name:_____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Preferred Pharmacy Name: _____ Phone: _____ Cross Streets: _____

Health Insurance Information (ALL FIELDS ARE REQUIRED)

Primary Insurance Name: _____Customer Service Phone: _____

Policy Holder Name: _____ SSN: _____Date of Birth: _____

Phone: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

Secondary Insurance Name: _____ Customer Service Phone: _____

Policy Holder Name: _____ SSN: _____ Date of Birth: _____

Phone: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

- The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to be payable to The DOCS.

Signature: _____ Relationship to Patient: _____Date: _____

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Required for Each Visit

- **THE PATIENT**
- Current insurance card(s)
- Driver's License or other state/government issued picture ID
- Co-pay for the day's visit (cash, Visa, Mastercard or Discover)
- Deductible that may be due for the day's visit
- Payment for any existing balance from previous billing
- List of/or current medications
- Any pump or meter device you use (should upload online prior to arrival)
- Any recent lab or testing results
- Referral if we do not have one on file and your insurance requires it

Walk in Appointments

We will not disrupt our regularly scheduled patients to accommodate a walk-in appointment, unless it is a true emergency. Call the office and speak to our staff if you feel you or your child needs to come to the office that same day.

Late Appointments

Because of our physicians' schedules, we may ask you to reschedule if you arrive to the office more than 15 minutes past your appointment time. Late arrivals cause appointments arriving on time to be late. Continuous late arrivals may result in discharge from the practice.

Cancellation and Missed Appointments

If it is necessary to cancel your appointment, we require that you cancel **AT LEAST 24 HOURS** prior to the appointment time. Failure to cancel the appointment with sufficient notice will result in a $50 fee for office visits. As a courtesy we provide appointment reminders, however, **you are still responsible for the cancellation even if you did not receive a reminder.** We reserve the right to discharge you from the practice for missing appointments frequently.

After Hours Calls

Our physicians are available on call 245 hours/day-365 days/year for calls of a truly urgent nature. Since our practice is charged per call for after hours calls to the nurse advice line, non-urgent calls made after hours may be charged $15.00 per call.

Prescription Refill/Prior Authorization

We require regular office visits for **ALL** our patients taking prescription medication. It is recommended to ask for refills if necessary during the visit with your physician. If you do not and therefore call back later with your requests or your pharmacy submits a request on your behalf, **please allow 24-48 hours**

to complete the request. However, if prior authorization is required, please allow 7-10 business days. Keep in mind that we cannot control how long it may take for you insurance to grant approval and we cannot guarantee that approval will be granted at all. In some cases the process can take several weeks and still result in us needing to change your medication due to your insurance companies formulary or policies. Also, if you are overdue for follow up, and or lab testing, your request may be denied or only partially filled until you complete the testing and follow up**. It is your responsibility to give us you current preferred pharmacy information at each visit.**

Social Media

In an effort to ensure fair and honest patient feedback, and to prevent the publishing of libelous content in any form, by accepting and signing this clause, you agree not to post any complaint or negative review to any platform of social media without allowing us 90 days from the day of service to resolve any issue pertaining to any service, including but not limited to: billing issues, medication requests, consultation issues, laboratory tests, clinical procedures, problems with attending physicians or any problems with clinic staff. Should you violate these terms, you will be provided a seventy-two (72) hour opportunity to retract the content in question. If the content remains, in whole or in part, it is hereby agreed that the dispute shall be referred for binding arbitration.

Insurance, Billing and Patient Responsibility

The DOCS understands that insurance information can be confusing and overwhelming. Every plan is different, and it is critical to know what services your plan will cover and what services will become your responsibility. We recommend that you read and understand the "Summary of Benefits and Coverage Guide," provided by your health plan or contact your health insurance provider and/or your HR department at work to assist you with this. **We have provided the following definitions to help you:**

- **Deductible:** the amount you owe for health care services before your health insurance plan begins to pay.
- **Coinsurance:** Your share of the costs of health care service, calculated as a percentage (for example, 20%) of the total cost. This generally is in addition to your assigned co-pay.
- **Co-Pay:** A fixed amount (for example, $15) you pay each time you see a physician. Your insurance requires you to have payed this fee prior to them covering the associated service.
- **Podiatry Surgery:** There is a **$150.00** minimum surgery deposit at time of scheduling, depending on your Insurance/Deductibles, more may be required: certain elective surgical procedures will require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery. It is the patient's responsibility to cancel an unwanted surgery ***within one week before surgery***. If the patient fails to do so, ***the patient will be charged a $500.00 cancellation fee.***
- **Cardiology:** If you need to cancel or reschedule your appointment, please do so 24 hours prior to your test. If appointment is cancelled the day of the test or no show occurs, ***patient will be charged for a cancellation/no show fee for isotope waste of $600.00.***

We are contractually obligated by your insurance company to collect your co-pay at the time of service.

Your co-pay is also required at each follow up visit. If we have information that you have not met your deductible at the time of service, **we will collect any applicable deductible amount at the time of service.**

As a courtesy to our patients, The DOCS will bill your primary and secondary insurance companies. Please remember that **your insurance is a contract between you and the insurance company, not the doctor.** You are responsible for balances after primary insurance has paid and payment in full is due within 60 days of receipt of the statement. We participate with **most** plans, but if we do not accept your insurance, you will be responsible for the entirety of the visit charges.

Your insurance may require that you receive a referral from your primary care provider. If this is the case, please make sure that your doctor sends that over to our office, so that your visit will be covered. If we do not receive this information, we will bill the visit directly to you. It is not our responsibility to obtain the referral.

If you are uninsured, we do offer "cash-pay discount prices" on our services. Feel free to ask our staff for details.

We accept cash, Mastercard, Visa and Discover. **We do not accept American Express or personal checks at check-in. If paying cash, please come prepared with bills no larger than $20.**

If your account balance is not paid in full after 60 days following receipt of the statement, your account by be referred to collections:

Should my account be referred for collection to an attorney, collection agency or another collection service, I agree to pay the costs of collection, including but not limited to attorney fees, court costs and other reasonable collection fees as may be assigned. Additionally, an interest rate of 10% monthly or 10% annually may be charged until my financial obligation is paid in full. Furthermore, I understand that until my account is paid in full that the total amount owed may increase due to interest assessed.

By signing below, the responsible party acknowledges that he or she has read and understood the financial policy of The DOCS and is bound by the terms and conditions set forth therein. You also understand that failing to sign this agreement may result in discharge from the practice.

Signed _____ Date_____

Patient Name _____ Date of Birth_____

HIPAA PRIVACY INFORMATION

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit our office(s), a record of your visit and notes are recorded.

Typically, this record contains your symptoms, examination/test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among health professionals who contribute to your care.
- Legal document describing care you received.
- Means by which you or a payer can verify that services billed were provided.
- A source of data for medical research.
- A source of information for public health officials to help improve health of the nation.
- A Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of our offices as we compiled the information, the information itself belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and request copies of your health record as provided for in 45 CFR 164.524
- Obtain accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations.
- Revoke our authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Our offices are required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or inform you that you need to make another appointment. We may also call, write, or email to notify you of other services available at our offices that may be of interest to you. Unless you tell us otherwise, we may leave a message on your answering machine or voicemail, or with someone who answers you phone if you are not available.

We will not make any other uses or disclosures of your information unless you sign a written "authorization form". Federal law mandates the content of an "authorization form". In all situations, other than those described above, we will ask you for your written authorization before using or disclosing your information. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. Revocations must me in writing.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We routinely use your information for these purposes without any special permission, the most common reasons being for treatment payment or health care operations.

Examples of how we use or disclose information for treatment purposes are setting up appointments, testing or examination (including labs), prescribing medications (including pharmacies), referring you to another provider for care, or getting copies of your health information from another facility that you may have seen or are currently seeing. We may also disclose information to your insurance company for billing, other payors payments, and our outside collections service for outstanding accounts. Rarely, we may also have to disclose information for financial or billing audits, internal quality assurance, or outside professional or academic programs.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

In some limited situations, the law allows or requires us to use or disclose you information without your permission. Examples of such uses are:

- When a state or federal law mandates that certain information be reported for a specific purpose.
- To governmental authorities about victims of suspected abuses, neglect, or domestic violence.
- For health oversight activities, such as the licensing of professionals, for audits for payors, or for investigation of possible violations of health care laws.
- For health related research.
- To prevent a serious threat to health or safety.
- Of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an avoidable byproduct of permitted uses or disclosures.
- For legal purposes, such as subpoenas or court orders.
- For law enforcement purposes, such as information pertaining to a victim of a crime; or to report a crime.
- To a medical examiner, or to funeral directors, or to organizations that handle organ or tissue donations.
- For specialized government functions, such as intelligence activities, disaster relief activities, or other national security activities authorized by law.
- For public health purposes, such as contagious disease reporting, investigation and surveillance, and notices to and from the FDA or devices of de-identified information.
- Relating to worker's compensation programs.
- To "business associates" who provide services for us and who commit to respect the privacy of your information.
- Unless you object, we will also share relevant information about your care with your family or other caregivers who are helping with your medical needs.

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Patient HIPAA Acknowledgement and Consent Form

Patient Name (Printed): _____Date of Birth: _____

Notice of Privacy Practices.

_____ (Patient/Representative initials) I acknowledge that I have received The DOCS Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in The DOCS Notice of Privacy Practices.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION/ATTEND OFFICE VISITS? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

We want to stay connected with our patients. Patients in our practice may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an

automatic dialing device), text messaging and/or Twistle to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time (see next page).The practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is**_____.

I authorize to receive messages and share medical information via **Twistle.**

-OR-

I decline _____ (Patient/ Representative Initials) to receive communication via text.

I decline _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.

I decline _____ (Patient/ Representative Initials) to receive communication via email.

I decline _____ (Patient/ Representative Initials) to receive messages and share information via Twistle.

Note: *This clinic uses an Electronic Health Record and all your demographics and consent information will be updated to what you provide us.*

Release of Information.

I hereby permit The DOCS and the physicians or other health professionals involved in patient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Pick-up. There may be times when you need a friend or family member to pick-up a prescription (script). In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** _____ (Patient/Representative Initials) to designate the following individual to pick up a prescription on my behalf:
    - Name: _____ Date: _____
    - Name: _____ Date: _____
- ***I do not want*** _____ (Patient/Representative Initials) to designate anyone to pick-up my prescription order.

Notifications Request Change Form

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*

*_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **via cellular telephone call**.*

*_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____ Date: _____

Time: _____

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Welcome to The DOCS free, secure HIPAA compliant messaging platform used to ease the communication between you the patient an our office care teams and other health providers in a secure manner.

The communication tool can be used for: copies of lab results (to have lab values reviewed, please schedule an appointment with your provider), prescription requests, pump uploads, scheduling changes, and insurance/billing inquiries. Please allow 24 to 48 business hours upon receipt of your request for a staff member to process and complete the request. Twistle is NOT a substitute for emergent situations. Twistle hours of operation remain the same as clinical operations hours: 7:30am to 5:00 PM.

How to Twistle:

1. Please give the preferred email address/smart phone number to our office staff.
2. You will get an invite to Twistle in your email or through text message. Click on the 'Join' Button.
3. You will be brought to the 'Join' screen. Create your Twistle Account.
4. You are now at the welcome screen for Medical Queries.
5. You will subsequently get invites to each of the other clinical areas or groups. You should accept all of them for better communication
6. Now you are ready to communicate. To send a message click on the blue pencil at the top
7. You can select the group that you wish to communicate with; you can include other groups as well.
8. If you wish to include an attachment, look for the paperclip near the "send button".

We hope that this streamlines communication for you. Your time is precious, and we seek to make communication faster, easier, secure and more efficient. Thank you.

Sincerely,

The DOCS care team.

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Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name: _____Patient DOB:_____
Address: _____City: _____ State: _____Zip: _____

I authorize the use or disclosure of the above named individual's PHI to be released as follows:
__All Medical Records __ Lab/X-ray __Other_____
Reason for Request:
__Medical Care __Personal Insurance __Attorney ___Other_____

This authorization is given and to remain in force for the specified period:
__From _____to_____
__For the period of 1 year beginning on: _____

The following named individuals are granted permission to access my medical information and communicate on my behalf:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

There will be a "Fee of 60 cents per page plus postage if applicable when releasing records directly to parent or patient".

Transfer Records From:
Name: _____
Address: _____City: _____State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

Send Records To:
Name: _____
Address: _____City: _____State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

Signature of Parent, Guardian or Personal Representative:
Signature: _____ Date: _____
Print name of above: _____ Relationship to Patient: _____

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