LAS VEGAS CLINIC
Patient Registration

Patient Information

Name:_____ Date of Birth:_____
First MI Last

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

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

Home Phone:_____ Cell Phone:_____

Social Security Number:_____ Gender: Male Female Ethnicity (optional):_____

Marital Status: Single / Married / Domestic Partnership / Divorced / Widowed Preferred Language (optional):_____

Employer:_____ Occupation:_____ Phone:_____

If married or domestic partnership, please provide: Spouse Name:_____ DOB:_____

Spouse's Employer:_____ Phone:_____

Emergency Contact Information

Primary Contact:_____ Phone/Cell:_____ Relationship:_____

Secondary Contact:_____ Phone/Cell:_____ Relationship:_____

Insurance/Billing Information

Will this visit be covered under Workers Compensation or Motor Vehicle/Liability Insurance? (Please Circle) Yes No

Do you have insurance? (Please Circle) Yes No If yes please complete insurance information below:

Primary Insurance Company:_____ ID#_____ Group #_____

Insured Name:_____ SSN:_____ DOB:_____

Relationship to Patient:_____ Deductible Amount:_____ Copay Amount:_____

Secondary Insurance Company:_____ ID#_____ Group #_____

Insured Name:_____ SSN:_____ DOB:_____

Relationship to Patient:_____ Deductible Amount:_____ Copay Amount:_____

How Did You Hear About Us? (Please Circle) Family or Friend / Referral / Other: _____

Authorizations (HIPAA law makes it illegal for information to be released without the Patient's written authorization.)

I authorize Las Vegas Clinic to discuss billing/medical information with the individual(s) listed below:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

I authorize the individual(s) below to be present in the exam room while I am being treated and care is discussed:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____

If signed by someone other than the patient, please state relationship:_____

Las Vegas Clinic provides a patient portal to allow patients to view their records through a secure internet connection. Please provide an email address if you would like to be setup with access to your records.

Email address:_____

Minor Patients (Under Age 18)

The parent or guardian accompanying the minor to the office is responsible for any charges incurred and any payments due at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements for treatment have been made. In the case of multiple guardians (divorce or separation) the financial responsibility becomes that of the guardian who accompanies the patient to their appointment. If insurance coverage is under a guardian not present at the time of service, the information pertaining to that coverage (address, SSN, ID# and group #) is required to bill the insurance.

Parent or Guardian Name:_____ Relationship:_____

Address (if different from above) _____ City:_____ State:_____ Zip:_____

Home Phone: (if different from above) _____ Cell Phone:_____

Social Security Number:_____ DOB:_____ Employer:_____

Other Parent or Guardian Name:_____ Relationship:_____

Address (if different from above) _____ City:_____ State:_____ Zip:_____

Home Phone: (if different from above) _____ Cell Phone:_____

Social Security Number:_____ DOB:_____ Employer:_____

Notice of Privacy Practices / Authorization for Treatment / Billing / Collection Policy

I understand that Las Vegas Clinic may share my health information for treatment, billing and healthcare operations. I have been given a copy of the practice's Notice of Privacy Practices that describes how my health information is used and shared and have had an opportunity to read and ask questions. I understand that Las Vegas Clinic has the right to change this notice at any time. I may obtain a current copy by contacting the office or the Privacy Officer/Practice Manager.

I authorize treatment of the named patient contained in this registration sheet. I have been provided a copy of Las Vegas Clinic's financial policy which outlines their billing/collection procedures and I have had an opportunity to read and ask questions. I authorize all proceeds from insurance to be assigned to this office where applicable. I confirm that the information I have provided is true to the best of my knowledge.

I acknowledge that if I am 10 minutes late for my appointment that the appointment may need to be rescheduled. Scheduled appointment times are generally adhered to, but no guarantee is implied. Unforeseen events may cause rescheduling or cancellation of your appointment. I also understand that if I need to cancel or reschedule an appointment or procedure, I must contact the office at least 24 hours prior to the appointment. If I fail to do so a charge of $40 may incur. If I no show for an appointment a charge of $40 may incur. I also acknowledge that if I no show for a testing appointment a $40 charge plus the cost of medication may incur.

I understand that it is my responsibility to contact my physician regarding any and all results after any testing is performed. I understand and acknowledge that I should request any prescription refills at the time of the office visit.

A monitoring safety net for you has been put into place to help you know when you are either due to see the physician, due for lab tests, or both. You will only receive enough medication to last you until your next physician exam and lab. Refill for medications will only be provided if you have fulfilled the lab and physician exam requirements. **I understand that most prescription refill requests that are initiated from a pharmacy will not be authorized. Prescription refill requests must come directly from the patient. Please do not assume that a pharmacy initiated request will be filled.**

Failure to follow physician's medical treatment or repeatedly missing appointments or procedures may result in the practice to discontinue medical care with Las Vegas Clinic.

_____ _____

Signature Date

If signed by someone other than the patient, please state relationship:_____

LAS VEGAS CLINIC
Medical History Form

In an effort to serve you better, we request you please provide us with the following information.

Name:_____ DOB:_____ Date:_____

Preferred Pharmacy:_____

Name of Primary Care Physician:_____

If you do not have a Primary Care Physician, would you like to establish primary care with Las Vegas Clinic? Yes No

What is the main medical condition or symptom you are being seen for today?

_____

Please list all prior and current medical conditions:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list prior surgeries and date(s):

_____ _____
_____ _____
_____ _____
_____ _____

Please list all allergies to medications: Are you allergic to latex? (Please circle) Yes No

_____ _____
_____ _____
_____ _____

Do you currently smoke cigarettes or use other forms of tobacco? (Please circle) Yes No
If **yes**, packs per day _____, total number of years you have smoked _____

If no to above question, have you ever smoke cigarettes or used other forms of tobacco? (Please circle) Yes No
If **yes**, number of years smoked _____ Average number of packs per day _____

Do you currently use, or have you previously used recreational drugs? (Please circle) Yes No

Marital status: (Please circle) Single Married Domestic Partnership Divorced Widowed

Occupation:_____ **OR** (circle) student unemployed disabled retired

What medical conditions are present in your family, especially parents, siblings and children?

_____

Any autoimmune disorder(s) in the family? (Please circle) Yes No
If **Yes**, please list disorder(s)_____

Any neurological disorder(s) in the family? (Please circle) Yes No
If **Yes**, please list disorder(s)_____

Has any member of your family been diagnosed with Cancer? (Please circle) Yes No
If **yes**, what type _____

Have you had a colonoscopy? (Please circle) Yes No If yes, date:_____

Have you had a flu shot? (Please circle) Yes No

Female Patient: Date of last pap? _____ or date of hysterectomy _____
Date of last mammogram? _____

Male Patient: Have you had a PSA test? (Please circle) Yes No If yes, date:_____

Medication List

Name: _____ Date of Birth: _____

Current Medications	Strength (mg)	# of times per day

Las Vegas Clinic
Review of Systems-Neurology

Name: _____ Date of Birth: _____

Please check 'yes' or 'no' to any symptoms you are experiencing:

YES	NO		YES	NO	
☐	☐	Fevers	☐	☐	Bloody urine
☐	☐	Chills	☐	☐	Painful urination
☐	☐	Weight loss	☐	☐	Loss of control of urine
☐	☐	Weight gain	☐	☐	Joint pain
☐	☐	Night sweats	☐	☐	Back pain
☐	☐	Headaches	☐	☐	Depression
☐	☐	Visual loss	☐	☐	Anxiety
☐	☐	Double vision	☐	☐	Thoughts of suicide
☐	☐	Blurry vision	☐	☐	Have you ever been treated by a psychiatrist?
☐	☐	Hearing loss	☐	☐	Numbness
☐	☐	Trouble swallowing	☐	☐	Tingling
☐	☐	Trouble speaking	☐	☐	Weakness
☐	☐	Choking	☐	☐	Arm pain
☐	☐	Shortness of breath	☐	☐	Leg pain
☐	☐	Coughing	☐	☐	Trouble walking
☐	☐	Chest pain	☐	☐	Falls
☐	☐	Palpitations	☐	☐	Stroke
☐	☐	Swelling of extremities	☐	☐	Blood clots
☐	☐	Abdominal pain	☐	☐	Cancer or tumors (specify)_____
☐	☐	Diarrhea			
☐	☐	Constipation			
☐	☐	Loss of control of bowels			

Las Vegas Clinic
Review of Systems-Rheumatology

Name: _____ Date of Birth: _____

Please check 'yes' or 'no' to any symptoms you are experiencing:

YES	NO		YES	NO	
☐	☐	Fevers	☐	☐	Painful urination
☐	☐	Chills	☐	☐	Joint pain
☐	☐	Weight loss	☐	☐	Back pain
☐	☐	Night sweats	☐	☐	Depression
☐	☐	Headaches	☐	☐	Anxiety
☐	☐	Visual loss	☐	☐	Thoughts of suicide
☐	☐	Double vision	☐	☐	Have you ever been treated by a psychiatrist?
☐	☐	Blurry vision	☐	☐	Numbness
☐	☐	Hearing loss	☐	☐	Tingling
☐	☐	Trouble swallowing	☐	☐	Muscle weakness
☐	☐	Shortness of breath	☐	☐	Sores in mouth or nose
☐	☐	Coughing/Coughing up blood	☐	☐	Face or body rash
☐	☐	Chest pain	☐	☐	Hair loss
☐	☐	Palpitations	☐	☐	Frequent pneumonia
☐	☐	Swelling of extremities	☐	☐	Sinus infections
☐	☐	Abdominal pain	☐	☐	Blood clots
☐	☐	Diarrhea	☐	☐	Miscarriages
☐	☐	Bloody bowel movement	☐	☐	Cancer or tumors (specify)_____
☐	☐	Bloody urine			

LAS VEGAS CLINIC

Financial Policy/Practice Agreement

Welcome to our practice. As you may know, health care is becoming more complicated every day. We would like to take this opportunity to advise you of your patient responsibilities and Las Vegas Clinic's financial policy. While many patients do not understand the billing of insurance and the processing of claims, it is a courtesy that we extend to our patients.
The following information outlines financial responsibilities related to payment for professional services provided by our physicians and staff. If you have any questions or concerns, please do not hesitate to ask a member of our staff for clarification. We believe a clear understanding of our financial policy is essential to our professional relationship. Additionally, your commitment to your account is just as significant as your participation with your health care.

Financial Responsibility
Las Vegas Clinic requires a copy of any insurance information and photo identification prior to treatment. This office will attempt to verify your benefits on each visit. It is our goal to provide you with the most accurate information in regard to authorizations, deductibles, co-pays and co-insurance responsibilities. You, the patient or guardian, are ultimately responsible for all charges associated with your care regardless of insurance coverage. If you have insurance, please remember your insurance policy is a contract between you and your insurance company and that you have final responsibility for payment of your bill. For your convenience, our office accepts cash, check, Visa and Mastercard. Please be advised you will receive a statement from this office as long as there is a balance on your account. A statement is not always a demand for patient payment. If your account balance falls in the 60 day or older category, noted at the bottom of your statement, please contact our billing office at 702-505-4230, extension 107.

Self Pay
If you do not have insurance, payment in full is expected at the time of service. If you are unable to pay in full at the time of service, arrangements will need to be made with our staff prior to treatment.

Contracted Insurance
Payment of any unmet deductible, co-insurance and/or co-pay is due at the time of service. You will receive a bill for any further portions due after your carrier processes your claim.

Non-Contracted Insurance As a courtesy, we will bill **most** insurance companies. Payment of any unmet deductible, co-insurance and/or co-pay is due at the time of service. You will receive a bill for any further portions due after your carrier processes your claim.
Please be aware your insurance company may not cover all the services provided. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination of "usual and customary" rates by your insurance carrier.

Medicare
Las Vegas Clinic participates in the Medicare program; therefore, we will bill Medicare and accept assignment of benefits. If you have a secondary insurance plan, we will not require co-payment at the time of service. However, if you only have Medicare, we will collect 20% of the Medicare allowable at the time of service. Please be aware some services are not covered by Medicare and is the patient responsibility. You will receive a bill for any further portions due after Medicare processes your claim.

VA Administration
Las Vegas Clinic accepts VA as a form of payment. Patients must have prior approval from VA BEFORE the office visit.

Finance Charges/Collection Fees
Las Vegas Clinic assesses finance charges on any account balance not paid within 90 days from the date of service. The finance charge will be computed at the rate of 1.5%. Any expense incurred collecting delinquent accounts is added to the account balance. A fee of $25 is charged for any returned checks or invalid credit card transactions.

Appointment Cancellation and No Call No Show Fees
Las Vegas Clinic requires 24 hour notice for appointment cancellations. Failure to provide adequate notice will result in the following fees being charged to your account - $40 for Physician appointments and $40 for procedures (EMG, EEG etc.)

Signature_____ **Date**_____

LAS VEGAS CLINIC

Jonathan McKinnon, Md
Neurology

Naya McKinnon, MD
Rheumatology

351 N. Buffalo Drive, Suite B, Las Vegas, NV 89145 Phone 702-505-4230 Fax 702-505-4231

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
MEDICAL RECORDS RELEASE

Patient Name:_____ DOB:_____

I authorize release
of my records TO:_____

FROM:_____

For the following reason: ___ Continued care with another physician ___ Legal reasons _____
___ Personal copy of my treatment records ___ Other:_____

Please note there is no charge for the first copy of your records. Copy fees may be assessed for additional copies and must be paid in advance.

I request my records be provided in the following format (check one):

___ Paper copy

___ Faxed to #:_____

___ Mailed to:_____

___ Electronic copy (This is available thru our Patient Portal.) E-mail Address:_____

PLEASE NOTE: Access to your protected health information can be provided through our secure patient portal. You must provide us with a valid email address. Once you are set up, you will receive a temporary pin number. Protected Health Information can then be viewed and printed.

___ E-mailed to:_____

PLEASE NOTE: E-mail is not a secure method of sending protected health information and Las Vegas Clinic cannot guarantee the privacy of your health information or the delivery of your information. Documents that are produced for e-mail transmission may not be compatible with your computer. I understand that my protected health information will not be secure and I am voluntarily choosing to have my records e-mailed to the address provided. Initial _____.

_____ / _____ _____

Signature of Patient/Guardian/Legal Representative Date ID Verification: Document and Number

This authorization will automatically expire in six (6) months from the date signed. I understand that I may revoke this consent at any time and that revocation will not apply to information that has already been released as a result of this authorization. If I revoke this authorization, I must do so in writing and send it to the attention of the Privacy Officer. I understand that authorizing the disclosure of this health information is voluntary and that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may no longer be protected by federal confidentiality rules. Las Vegas Clinic does not guarantee the completeness or accuracy of outside records; therefore, we will not be held responsible for the contents of the outside records that you receive.

FOR LAS VEGAS CLINIC USE ONLY

Records processed by Employee Initials and Date:_____

Records: ___ Faxed ___ Mailed ___ E-mailed ___ Picked Up (ID verified by:_____)