LAS VEGAS
CONCIERGE ORTHOPEDICS

Welcome to Las Vegas Concierge Orthopedics.
We are happy you are here!
9260 W. Sunset Road, Suite 200, Las Vegas, NV 89148
Phone: 702-963-1231 Fax: 702-442-9309
Email: lvcorthopedics@gmail.com

PATIENT INFORMATION / *INFORMACIÓN DEL PACIENTE*

Date/*Fecha*: _____ **Name/*Paciente Nombre*:** _____

❑ **Dr.** ❑ **Mr.** ❑ **Mrs.** ❑ **Ms.** **Date of Birth/*Fecha de Nacimiento*:** _____

Cell Phone #/*Teléfono móvil #*: _____ **Home Phone #/*Teléfono de casa #*** _____

Address/*Dirección*: _____ **Apt/*Apto #*:** _____

City/*Ciudad*: _____ **State/*Estado*:** _____

Zip/*Código postal*: _____

Social/*Seguridad* Security #: _____ (required for insurance billing / *requerido para la facturación del seguro*) **Email/*Correo electrónico*:** _____

Referred By/*Referido por*: _____

Marital Status/*Estado civil*:

❑ **Married/*Casado*** ❑ **Single/*Soltero*** ❑ **Divorced/*Divorciado*** ❑ **Widowed/*Viudo***

Emergency Contact Name/*nombre del contacto de emergencia*: _____

Phone Number/*Número de teléfono*: _____

Relationship to patient/*Relación con el pacientet*: _____

Race/*Raza*: American Indian / Alaskan Native / Asian / Black or African American / Native Hawaiian / Pacific Islander / White / Other / Decline

Ethnicity/*Etnicidad*: Hispanic or Latino / NOT Hispanic or Latino / Declined(*Rechazar*)

Do you have an advanced directive?/*¿Tiene usted una directiva anticipada?*: ❑ **Yes/*Sí*** ❑ **No**

If yes, please check mark one of the following / *En caso afirmativo, marque una de las siguientes opciones*:

❑ Do Not Intubate/*No intubar* ❑ Do Not Resuscitate/*No resucitar* ❑ Run Full Code (every measure taken to keep you alive) / *Ejecutar código completo (cada medida tomada para mantenerte vivo)*

Pharmacy Name/*Nombre de la farmacia*: _____

Phone Number/*Número de teléfono*: _____

Pharmacy Address or Cross Streets/*Cruzar las calles*: _____

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INSURANCE INFORMATION / *INFORMACIÓN DEL SEGURO*

Primary Insurance/*Seguro Primario*: _____

Member ID # / *Identificación de miembro #*: _____

Primary Insurance Subscriber/*Suscriptor de seguro primario*: _____

Date of Birth/*Fecha de nacimiento*: _____

Relationship to patient/*Relación con el paciente*:

Self/*Ser* Spouse/*Esposo* Child/*Niño* Partner/Pareja Other/*Otro*

Secondary Insurance/*Seguro secundario*: _____

Member ID# / *Identificación de miembro #*: _____

Secondary Insurance Subscriber/*Suscriptor de seguro secundario*: _____

Date of Birth/*Fecha de nacimiento*: _____

Relationship to patient/*Relación con el paciente*:

Self/*Ser* Spouse/*Esposo* Child/*Niño* Partner/*Pareja* Other/*Otro*

WORKER COMPENSATION INFORMATION

On the Job Injury?/*¿Lesión en el trabajo?* ❑ **Yes/*Sí*** ❑ **No**

Date of Injury/*Fecha de la lesion*: _____

Worker's Comp Adjuster's Name/*Nombre del ajustador*: _____

Phone/*Teléfono*: _____

Insurance Carrier/*Aseguradora*: _____

Claim # / *Afirmar #*: _____

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PATIENT HISTORY / *HISTORIA DEL PACIENTE*

Patient Name/*Nombre del paciente* : _____

Date of Birth/*Fecha de nacimiento*: _____

Current occupation?/*Ocupación actual* _____

Have you seen Dr. Carr before? ❑ No ❑ Yes/Sí: Previous Practice / Hospital: _____

Reason for your visit/*Motivo de tu visita*: What is Injured or what hurts?/*¿Qué está herido o qué duele?*

❑ **LEFT (*Izquierda)*** ❑ **RIGHT (*Bien)*** ❑ **BILATERAL**

Specify Body Part/*Especificar parte del cuerpo*:_____

Height?/¿Altura? _____ Weight?/¿Peso? _____

Do you have any drug or metal allergies? / *¿Tiene alguna alergia a medicamentos o metales?*

_____

Past Medical History/*Historia médica pasada*: What major illnesses have you had, or do you have at the present time? (Example: High blood pressure, Diabetes, Cancer, Heart Disease, Kidney Disease, Lung Disease, Liver Disease)

¿Qué enfermedades importantes ha tenido o tiene actualmente? (Ejemplo: presión arterial alta, diabetes, cáncer, enfermedades cardíacas, enfermedades renales, enfermedades pulmonares, enfermedades hepáticas)

_____

Past Surgical History/*Historia Quirúrgica Pasada*:

Type of surgery/*Tipo de cirugia*:

_____

_____

_____

Medications/*Medicamentos*:

Current Medication with dose/*Medicación actual con dosis*:

_____

_____

_____

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Social History/*Historia social*:

Have you ever smoked?/*¿Alguna vez has fumado?* ❑ **Yes/*Sí*** ❑ **No**

Do you currently smoke?/*¿Fuma usted actualmente?* ❑ **Yes/*Sí*** ❑ **No**

Number of cigarettes per day/*Número de cigarrillos por día* _____

When did you quit?/*¿Cuándo lo dejaste?*_____

Do you use recreational drugs?/*¿Usas drogas recreativas?* ❑ **Yes/*Sí*** ❑ **No**

If yes, what type?/En caso afirmativo, ¿de qué tipo?:_____

Do you drink alcohol?/*¿Bebes alcohol?* ❑ **Yes/*Sí*** ❑ **No**

How many drinks per occasion?/*¿Cuántas bebidas por ocasión?* _____

How often(check mark)?/*¿Con qué frecuencia (marca de verificación)?*

☐Daily ☐Weekly ☐Monthly ☐Socially

Have you ever received treatment for substance abuse?/*¿Alguna vez ha recibido tratamiento por abuso de sustancias?* ❑ **Yes/*Sí*** ❑ **No**

If yes, what was the treatment?/*En caso afirmativo, ¿cuál fue el tratamiento?*

_____

Have you fallen in the past year?/*¿Te has caído en el último año?* ❑ **Yes/*Sí*** ❑ **No**

If so, how many times?/Si es así, ¿cuántas veces? _____

Were you injured by the fall?/*¿Resultó herido por la caída?* ❑ **Yes/*Sí*** ❑ **No**

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Patient Name/*Nombre del paciente* : _____

Date of Birth/*Fecha de nacimiento*: _____

Do you currently have any of the following? Check ALL that apply/*¿Tiene actualmente alguno de los siguientes? Marque todo lo que corresponda*:

GENERAL

- ❑ Weight Gain/Loss
- ❑ Fevers
- ❑ Chills
- ❑ Night Sweats
- ❑ Fatigue
- ❑ Excessive Sleep
- ❑ Lack of sleep

EYES

- ❑ Vision Loss
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Rapid Change in Vision

ENDOCRINE

- ❑ Stomach Pain
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Excessive Thirst
- ❑ Excessive Hunger
- ❑ Dry Skin

RESPIRATORY

- ❑ Chronic Cough
- ❑ Wheezing
- ❑ Coughing Up Blood

CARDIAC

- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Ankle/Foot Swelling
- ❑ Rapid or Irregular Heartbeat

GASTROINTESTINAL

- ❑ Frequent Constipation
- ❑ Frequent Diarrhea
- ❑ Blood in Stool
- ❑ Vomiting
- ❑ Heartburn

HEMATOLOGIC

- ❑ Easy Bruising
- ❑ Easy Bleeding
- ❑ Frequent Infections
- ❑ Low Blood Counts
- ❑ Prior Transfusion

URINARY

- ❑ Urinary Incontinence
- ❑ Burning on Urination
- ❑ Blood in Urine
- ❑ Decrease of Urine Flow
- ❑ Frequent Urination

MUSCULOSKELETAL

- ❑ Muscle Pain
- ❑ Joint Pain
- ❑ Muscle Cramps
- ❑ Stiffness
- ❑ Rash
- ❑ Change in Skin Color
- ❑ Back Pain
- ❑ Neck Pain

NEUROLOGICAL

- ❑ Seizures
- ❑ Loss of Balance
- ❑ Dizziness
- ❑ Memory Loss
- ❑ Headache
- ❑ Weakness
- ❑ Loss of Grip Strength
- ❑ Numbness/Tingling

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Consent for Treatment and Payment

I hereby request treatment by Las Vegas Concierge Orthopedics and consent to care and treatment as ordered by my physician. I authorize the release of information related to my treatment to my referring physician. I authorize LVCO to submit this claim on my behalf for the medical services provided. I hereby authorize my health insurance company to make payment directly to LVCO, for any benefits that I may receive. I understand that I am financially responsible for all charges made to my account whether an insurance company, attorney, or third-party payer is involved with payment. I am responsible for all copayments, deductibles and coinsurance amounts as well as non-covered supplies and services. Payment for services is expected at all time services are rendered. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party. I understand that LVCO does not discriminate against any person based on race, color, religion, gender, gender expression, sexual orientation, age, national origin, disability, or marital status.

Print Patient Name:_____
Signature of Patient _____ Date: _____
Signature of Responsible Party (If patient is a minor) _____ Date: _____

Consentimiento para Tratamiento y Pago

Por la presente solicito tratamiento por parte de Las Vegas Concierge Orthopaedics y doy mi consentimiento para la atención y el tratamiento ordenados por mi médico. Autorizo la divulgación de información relacionada con mi tratamiento a mi médico remitente. Autorizo a LVCO a presentar este reclamo en mi nombre por los servicios médicos brindados. Por la presente autorizo a mi compañía de seguro médico a realizar pagos directamente a LVCO por cualquier beneficio que pueda recibir. Entiendo que soy financieramente responsable de todos los cargos realizados a mi cuenta, ya sea que el pago esté involucrado en una compañía de seguros, un abogado o un tercero pagador. Soy responsable de todos los copagos, deducibles y coseguros, así como de los suministros y servicios no cubiertos. Se espera el pago de los servicios en todo momento en que se presten los servicios. Autorizo la divulgación de cualquier información necesaria para procesar mis reclamos de seguro y facilitar el pago de mi cuenta.por un tercero. Entiendo que LVCO no discrimina a ninguna persona por motivos de raza, color, religión, género, expresión de género, orientación sexual, edad, origen nacional, discapacidad o estado civil.

Imprimir nombre del paciente:_____
Firma del paciente_____ Fecha: _____
Firma del Responsable (Si el paciente es menor de edad) _____ Fecha: _____

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HIPAA Policy

The department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, payment, or health care operations, to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories) and may have to disclose personal information for purposes of treatment, payment or health care operations. The entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your personal health care information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken while relying on that or a previous signed consent. If you have any objections to this form, please let our staff know. Description of the information to be used or disclosed may include patient demographics, insurance or medical records.

Print Patient Name:_____
Signature of Patient _____ Date: _____
Signature of Responsible Party (If patient is a minor) _____ Date: _____

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Política HIPAA

El departamento de Salud y Servicios Humanos ha establecido una "Regla de Privacidad" para ayudar a garantizar que la información personal de atención médica esté protegida por motivos de privacidad. La Regla de Privacidad también se creó para proporcionar un estándar para que ciertos proveedores de atención médica obtengan el consentimiento de sus pacientes para el uso y divulgación de información médica sobre el paciente para llevar a cabo tratamientos, pagos u operaciones de atención médica. Como nuestro paciente, queremos que sepa que respetamos la privacidad de sus registros médicos personales y haremos todo lo posible para asegurar y proteger esa privacidad. Nos esforzamos por tomar siempre precauciones razonables para proteger su privacidad. Cuando es apropiado y necesario, brindamos la información mínima necesaria solo a aquellos que consideramos que necesitan su información de atención médica e información sobre tratamiento, pago u operaciones de atención médica, para brindarle la atención médica que sea mejor para usted. También queremos que sepa que apoyamos su acceso completo a sus registros médicos personales. Es posible que tengamos una relación de tratamiento indirecto con usted (como laboratorios) y es posible que tengamos que revelar información personal con fines de tratamiento, pago u operaciones de atención médica. En la mayoría de los casos, las entidades no están obligadas a obtener el consentimiento del paciente. Puede negarse a dar su consentimiento para el uso de la divulgación de su información personal de atención médica, pero debe hacerlo por escrito. Según esta ley, tenemos derecho a negarnos a tratarlo si usted decide negarse a revelar su información médica personal (PHI). Si usted
Si decide dar su consentimiento en este documento en algún momento futuro, puede solicitar rechazar toda o parte de su PHI. No podrá revocar acciones que ya se hayan realizado basándose en ese consentimiento o en un consentimiento previo firmado. Si tiene alguna objeción a este formulario, comuníqueselo a nuestro personal. La descripción de la información que se utilizará o divulgará puede incluir datos demográficos, seguros o registros médicos del paciente.

Imprimir nombre del paciente:_____
Firma del paciente_____ Fecha: _____
Firma del Responsable (Si el paciente es menor de edad) _____ Fecha: _____

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Payment Policy

Thank you for choosing LVCO as your Orthopedic provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance** - We participate in most insurance plans, including Medicare. But not some Medicare Advantage plans so PLEASE be sure to give us all your insurance plan information. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles** - All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services** - Please be aware that some- and perhaps all - of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance** - All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission** - We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes** - If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment** - If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and the additional collection charges will be charged on your account and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Patient Name:_____
Signature: _____ Date: _____

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Política de pago

Gracias por elegir a LVCO como su proveedor de servicios ortopédicos. Nos comprometemos a brindarle atención médica de calidad y asequible. Debido a que algunos de nuestros pacientes han tenido preguntas sobre la responsabilidad del paciente y del seguro por los servicios prestados, se nos ha recomendado desarrollar esta política de pago. Léala, háganos las preguntas que pueda tener y firme en el espacio provisto. Se le proporcionará una copia si la solicita.

1. **Seguro**: participamos en la mayoría de los planes de seguro, incluido Medicare. Pero no en algunos planes Medicare Advantage, por lo que POR FAVOR asegúrese de brindarnos toda la información de su plan de seguro. Si no está asegurado por un plan con el que trabajamos, se espera el pago total en cada visita. Si está asegurado por un plan con el que trabajamos, pero no tiene una tarjeta de seguro actualizada, se requiere el pago total en cada visita hasta que podamos verificar su cobertura. Conocer sus beneficios de seguro es su responsabilidad. Comuníquese con su compañía de seguros si tiene alguna pregunta sobre su cobertura.

2. **Copagos y deducibles**: todos los copagos y deducibles deben pagarse al momento del servicio. Este acuerdo es parte de su contrato con su compañía de seguros. El incumplimiento de nuestra parte de cobrar copagos y deducibles a los pacientes puede considerarse fraude. Ayúdenos a hacer cumplir la ley pagando su copago en cada visita.

3. **Servicios no cubiertos**: tenga en cuenta que algunos (o quizás todos) los servicios que recibe pueden no estar cubiertos o no considerarse razonables o necesarios por Medicare u otras aseguradoras. Debe pagar estos servicios en su totalidad al momento de la visita.

4. **Comprobante de seguro**: todos los pacientes deben completar nuestro formulario de información del paciente antes de ver al médico. Debemos obtener una copia de su licencia de conducir y seguro válido actual para proporcionar un comprobante de seguro. Si no nos proporciona la información correcta del seguro de manera oportuna, puede ser responsable del saldo de un reclamo.

5. **Presentación de reclamos**: presentaremos sus reclamos y lo ayudaremos de cualquier manera que podamos razonablemente para ayudarlo a que se paguen sus reclamos. Es posible que su compañía de seguros le pida que le proporcione cierta información directamente. Es su responsabilidad cumplir con su solicitud. Tenga en cuenta que el saldo de su reclamación es su responsabilidad, independientemente de que su compañía de seguros pague o no su reclamación. Su beneficio de seguro es un contrato entre usted y su compañía de seguros; nosotros no somos parte de ese contrato.

6. **Cambios en la cobertura**: si su seguro cambia, notifíquenos antes de su próxima visita para que podamos hacer los cambios apropiados para ayudarlo a recibir sus máximos beneficios. Si su compañía de seguros no paga su reclamación en 45 días, se le facturará automáticamente el saldo.

7. **Falta de pago**: si su cuenta tiene más de 90 días de atraso, recibirá una carta indicando que tiene 20 días para pagar su cuenta en su totalidad. No se aceptarán pagos parciales a menos que se negocie lo contrario. Tenga en cuenta que si queda un saldo sin pagar, podemos remitir su cuenta a una agencia de cobranzas y se le cobrarán los cargos de cobranza adicionales en su cuenta y es posible que lo despidan de esta práctica. Si esto ocurre, se le notificará por correo postal y certificado que tiene 30 días para buscar atención médica alternativa. Durante ese período de 30 días, nuestro médico solo podrá tratarlo en caso de emergencia.

Nuestro consultorio se compromete a brindar el mejor tratamiento a nuestros pacientes. Nuestros precios son representativos de los cargos habituales y habituales de nuestra área. Gracias por comprender nuestra política de pago. Háganos saber si tiene alguna pregunta o inquietud.

He leído y comprendo la política de pago y acepto cumplir con sus pautas:

Imprimir nombre del paciente:_____

Firma: _____ Fecha: _____

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CONSENT TO TREAT

I hereby consent **LAS VEGAS CONCIERGE ORTHOPEDICS, LLC** to the administration and performance of any and all diagnostic procedures and treatments, which in the judgment of my physician may be considered necessary or advisable.

EMAIL/PHONE/TEXT/TELEHEALTH

LAS VEGAS CONCIERGE ORTHOPEDICS, LLC may send information that may contain protected, privileged, and highly confidential medical, Personal and Health Information (PHI), which may include but not limited to labs, imaging, handouts, and/or legal information via email. It may also be discussed over a Telehealth appointment. While we do our best to use a HIPAA compliant email, please understand that there is no guarantee and information communicated may not be entirely secure.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

My signature below authorizes the office of **LAS VEGAS CONCIERGE ORTHOPEDICS, LLC** to bill my insurance and assign all medical benefits to be paid directly to LAS VEGAS CONCIERGE ORTHOPEDICS, LLC for services and supplies rendered. I consent and understand that LAS VEGAS CONCIERGE ORTHOPEDICS, LLC, will share my Protected Health Information (PHI) according to the federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices.

MEDICARE PATIENTS: I authorize payment to be made on my behalf to LAS VEGAS CONCIERGE ORTHOPEDICS, LLC for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits. I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

A copy of this authorization is as valid as the original document. I hereby authorize **LAS VEGAS CONCIERGE ORTHOPEDICS, LLC** to release all information necessary to process claims and secure payment of benefits. I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all servi es provided to me. I authorize **LAS VEGAS CONCIERGE ORTHOPEDICS, LLC** to deposit checks received on my account when made out in my name.

INSURANCE STATUS

Patient is responsible to inform **LAS VEGAS CONCIERGE ORTHOPEDICS, LLC** of any changes in his/her insurance plan, to obtain authorization from their insurance company/IPA if necessary, to be aware of co-pays, deductibles and any other benefit details regarding insurance coverage. If the patient is aware of changes in insurance coverage or termination of coverage, **LAS VEGAS CONCIERGE ORTHOPEDICS, LLC** reserves the right to collect any dues directly from the patient at the time of service.

_____ _____

Patient's Full Name | Patient Representative's Name and Relationship to Patient

_____ _____

Patient's or Patient Representative Signature | Date

_____ _____

Physician's or Authorized Representative's Full Name | Date

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MEDICAL RELEASE FORM

HIPAA Compliant Authorization

Authorization for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. (Parts 160 and 164)

I _____ _____ authorize the following:
First and Last Name Date of Birth

❑Primary _____ Phone #: _____ Fax #: _____
❑Specialist _____ Phone #: _____ Fax #: _____
❑Hospital/UC/ER _____ Phone #: _____ Fax #: _____

To use and disclose the protected health information described below to Las Vegas Concierge Orthopedics.

This protected health information includes information contained in my medical records, which may include, and may not be limited to my medical hisotyr, laboratory results, radiology results, and muy physician's diagnosis for treatment. I understand the information to be released or disclosed may include information relating sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychiatric disorders/mental health and alcohol and drug abuse.

I authorize the release or disclosure of this type of information.

This authorization shall be in full force and effect for 180 days at which time this Authorization for Use and Disclosure of Protected Health Information expires.

The person I authorize to receive this information may use this medical information as I may direct for medical treatment, consultation, billing, claims payment, or other purposes.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treamtnet, payment, enrollment, or eligibility for benefits will not be conditions on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipent and may no longer be protected by federal or state law.

PLEASE EMAIL: LVCORTHOPEDICS@GMAIL.COM

or

FAX to the Office of Las Vegas Concierge Orthopedics: (702) 442-9309

☐ All Medical Records ☐ Imaging ☐ Labs ☐ Other _____

_____ _____
Patient's Full Name Patient Representative's Name and Relationship to Patient

_____ _____
Patient's or Patient Representative Signature Date