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

PERSONAL INJURY/ATTORNEY INFORMATION / *LESIONES PERSONALES/INFORMACIÓN DEL ABOGADO*

Date: _____ Patient Name: _____Date of Birth: _____

Attorney's Name/*Nombre del abogado*: _____

Phone Number / *Número de teléfono:* _____

Date of Accident / *Fecha del accidente:* _____

❑ **Car Accident/*Accidente automovilistico***

❑ **Slip and Fall/*Resbalar y caer***

❑ **Other/*Otro*: _____**

Uninsured Motorist Insurance: ❑ Yes/Sí ❑ No

MedPay Insurance/*Seguro MedPay*: ❑ Yes/Sí ❑ No

Case Manager/*Administrador de casos*: _____

EXECUTED MEDICAL LIEN WILL BE REQUIRED/*SE REQUERIRÁ UN GRAVAMEN MÉDICO EJECUTADO*

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

Date of Accident/Incident/*Fecha del accidente/incidente*: _____

❑ **Car Accident**

Was a police report filed?	❑ No	❑ Yes	• If yes, do you have a copy of the report? ___ • What Police Dept/Agency made the report? _____
Did you go to an emergency room?	❑ No	❑ Yes	• If yes, what hospital? _____ _____ • Do you have your medical records? If you do not have medical records, please sign a medical record release • Were you admitted to the hospital? ___ If yes, for how many days? _____
Were you transported by an ambulance?	❑ No	❑ Yes	
Were you the driver, passenger, or in the back seat?			
Were you wearing a seat belt?	❑ No	❑ Yes	Did you suffer airbag injuries? ___ (i.e. abrasions, burns, internal bleeding) _____
Did the airbags deploy?	❑ No	❑ Yes	• If yes, which airbags? _____ • Did you suffer airbag injuries? (i.e. abrasions, burns, internal bleeding) _____
Estimated amount of damage? Was the car totaled/total loss?	$ _____ (if unknown, give estimate and/or description of damage to determine severity of accident) ❑ No ❑ Yes _____		
Where did the accident occur (street/freeway/city)?	Approximate car speed:		
Please briefly explain how the accident occured.			

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

Date of Accident/Incident/*Fecha del accidente/incidente*: _____

❑ **Slip and Fall / Incident**

Where did the incident occur?			
Was an accident report made on site?	❑ No	❑ Yes	
Did you go to an emergency room?	❑ No	❑ Yes	• If yes, what hospital? _____ • Do you have your medical records? ___ If you do not have medical records, please sign a medical record release • Were you admitted to the hospital? ___ If yes, for how many days? _____
Were you transported by an ambulance?	❑ No	❑ Yes	
Please briefly explain how the incident occurred.			

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

LIEN AGREEMENT FOR MEDICAL SERVICES RENDERED

Law Firms Name

Attorney's Telephone Number

Attorney's Name

Law Firm's Case Manager's Name

Address

Case Manager's Telephone Number

City, State, Zip Code

Re: _____ _____ _____
Patient's Name | Date of Birth | Date of Accident / Incident

I hereby authorize and direct you, my attorney, to pay directly to **Las Vegas Concierge Orthopedics, LLC** such sums as may be due and owing for medical services rendered to me by reason of this accident/incident and for any other bills that may have been incurred. Any settlement, judgment, or verdict shall be withheld if necessary to adequately protect Las Vegas Concierge Orthopedics, LLC I hereby further give a ien on my case to Las Vegas Concierge Orthopedics, LLC against any and all proceeds of any settlement, judgment, or verdict which may be paid to you/your firm or myself as result of the injuries for which I have been treated in connection therewith.

I understand and acknowledge that I may have insurance coverage as member/subscriber of an insurance plan (i.e. HMO, PPO), which would be primarily liable for my medical bills for services rendered. I hereby acknowledge that said insurance plan might be reimbursable pursuant to the terms and conditions of my policy. In the event that repayment is required, I will have a duty to provide repayment out of any legal settlement to my insurance plan for all amounts and funds, which they have expanded on my behalf. I further acknowledge that I understand and agree that any amounts paid to Las Vegas Concierge Orthopedics may not entirely cover my bills and may leave an outstanding balance for which I am personally responsible for pursuant to terms and conditions of this medical lien hereinabove.

I fully understand that I am directly and fully responsible to Las Vegas Concierge Orthopedics for all medical bills submitted by the office for services rendered for me and that this agreement is made solely for the benefit of Las Vegas Concierge Orthopedics, LLC. As additional protection and in consideration of the awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I eventually recover said fee.

Patient's Full Name Printed

Patient Representative's Name and Relationship to Patient

Patient's or Patient Representative Signature

Date

Attorney's Name Printed

Attorney's Signature

Date

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

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is in the intention of the parties that this agreement shall cover all claims or controversies whether in tort. Contract or otherwise, and shall bind all parties whose claims may arise out of or related to treatment or service provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as “Physician”) must be arbitrated including, without limitations, claims for loss of consortium, wrongful death,, emotional distress or punitive damages to a patient, including any spouse or heirs of the patient and any children whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean the mother and the mother’s expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing by U.S. Mail, to all parties, describing the claim against the Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a Nevada superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitrations shall be governed pursuant to Nevada Code, Code of Civil Procedure _____ and the Federal arbitration Act (9 U.S. C. § 1-4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator’s fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed, (including, but not limited to, emergency treatment), but also before it was signed as well.

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

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) if this Arbitration Agreement is declared invalid and/or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DEVIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____

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

_____

Physician's or Authorized Representative's Signature

A signed copy of this document is to be given to Patient. Original is to be filed in Patient's medical records.