ALGSN
Advanced Laparoscopic & General Surgery of Nevada

Dr. Victor Yoon | Dr. Pankaj Bhatnagar | Dr. Da Yu Yu
6240 N. Durango Drive, Suite 120, Las Vegas, NV 89149
Ph: 702-791-7855 Fax: 702-791-7859

Patient Information – Informacion De Paciente

Patient Name (Last, First, MI) / Nombre de Patiente (Apellido,Nombre,MI)		SSN/Seguro Social	Sex/Sexo	DOB/Fecha De Nacimiento /
Home Phone / Telofone de casa	**Cell Phone / Telofone movil**	**Work Phone / Telefono de trabajo**	Age /Edad	Marital Status / Estado Matrimonial
Patient Address / Direccion		Apt/Space/Unit # / Numero de apartamento/Espacio/Unidad		
City / Ciudad	State / Estado	Zip Code / Zona Postal		
Employer Name and Address / Nombre y Direccion Del Empleador		Employer Telephone / Telefono		
Employer City / Ciudad de Empleador	Employer State / Estado de Empleador	Employer Zip Code / Zona Postal de Empleador		
Guardians Name if a Minor /Power of Attorney /Nombre Del Persona Responsible	Guardians Occupation / Ocupacion	Guardians SSN / Seguro social		
Notify in Case of Emergency / Notifica En Caso De Emergencia	Telephone / Telefono	Relationship to Patient / Relacion		
Emergency Contact Address / Direccion En Caso De Emergencia	City / Ciudad	State / Estado	Zip Code / Zona Postal	

Insurance Information / Aseguranza Informacion

Primary Insurance Company / Primaria Aseguranza		
Policy Holders Name / Nombre De El Asegurado	DOB /Fecha De Nacimiento	SSN / Seguro Social
Relationship to Patient / Relacion Con El Patiente		
Policy Number / Numero De Poliza	Group Number / Numero De Grupo	

Secondary Insurance Information / Aseguranza Segundaria

Secondary Insurance Company / Aseguranza Segundaria		
Policy Holders Name / Nombre De El Asegurado	DOB /Fecha De Nacimiento	SSN / Seguro Social
Relationship to Patient / Relacion Con El Patiente		
Policy Number / Numero De Poliza	Group Number / Numero De Grupo	

The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges rendered regardless of insurance coverage. A copy of the signature is as valid as the original. A $25.00 fee will be charged if I do not call 24 hours prior to my canceling my appointment.

La informacion oblenida es completa y correcta. Po rest mediouested autoriza el desclosameniento de informacion necesaria al hacer reclamos con mi aseguranza. Tanbien asingo benefecios que de otra manera serian pagados a mi doctor o grupo indicado en el reclamo. Yo entiendo de que soy responsible por doctors los cargos relacionados a servicios medicos prestados independientemental tipo de aseguranza. $25 vas a pagar si no llamas 24hr para cancelar su sita.

Patient Signature _____ Date _____

Guarantor's Signature _____ Date _____

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Patient Name _____ DOB _____ Date _____

Home Phone _____ Cell Phone _____

Pharmacy Name _____ Phone Number _____

Current Medication List / Lista de medicación

Medication / Medicación	Dose/Strength / Dosis	Why?/Por Que

Allergies / Alergia

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Please provide the following information:

Name _____ **DOB** _____ **Date** _____

Primary care physician/family doctor: _____ Phone: _____

Cardiologist: _____ Phone: _____

Have you had any of the following in the last 1 year?

Blood Test: (Please Circle) Yes No

If Yes, when and where _____

Radiographic Studies (circle all that apply) Yes No

Upper GI Barium Enema CT Scan Ultrasound Chest X –Ray EKG Echo

If yes, when and where_____

Endoscopic Studies (circle all that apply) Yes No

EGD Colonoscopy Flexible Sigmoidoscopy ERCP

If yes, when and where_____

Recent Hospitalization Yes No

If yes, when and where_____

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Medical Records Release

Date: _____

To: _____

_____

_____

_____

I hereby authorize you to release my medical information to:

Advanced Laparoscopic and General Surgery of Nevada

I hereby authorize you to release the following record of any treatment or examination rendered to me during the period from _____ to _____

Endoscopic Reports _____ Hospital Consultations _____ X-Ray Reports _____

Discharge Summaries _____ Pathology Reports _____ Progress Notes _____

Other : _____

Patient Signature _____ SSN _____

Print Name _____ DOB _____

Witness _____ Title _____

Health Information and Privacy Act
Release of Patient Information
Patient Authorization Form

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I _____ give my authorization for Advanced Laparoscopic and General Surgery of Nevada to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, personal identification number, group of policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use or disclosure obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical and hospital services.

By signing this form you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward written revocation referencing this authorization to our chief privacy officer at Advanced Laparoscopic and General Surgery of Nevada.

We may use or disclose your protected health information in the following situations without authorization. These situations include: as requested by law, public health issues as requested by law, communicable diseases, health oversight abuse or neglect, food and drug administration requirements, legal proceedings, enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, workers compensation, inmates: required uses and disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy with respect to protect health information.

If you choose not to sign this consent, it may be difficult for Advanced Laparoscopic and General Surgery of Nevada to provide treatment. You will be provided with a copy of this signed authorization upon your request.

Signature _____

Printed Name _____

Date _____

Witness _____

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FINANCIAL POLICY

We are committed to providing you with the best possible care. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. **All charges are your responsibility from the date of service.** We realize that insurance companies need processing time; however, all charges will become due and payable if the insurance company does not reimburse Advanced Laparoscopic and General Surgery of Nevada within 90 days or within the guidelines mandated by the Nevada State Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. Many companies require a referral form from the primary care physician. We will attempt to obtain these as a courtesy, however the policy holder must be pro-active in assuring the requirements are met prior to the visit.

If you have medical insurance with whom we are contracted, we will bill your insurance company. All deductibles, co-payments, co-insurance and non-covered items are due at the time of check in.

COLLECTION FEE POLICY:

Patient Name: _____ DOB: _____
I, _____ (parent/guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.
Signature of Patient / Parent / Guardian: _____

RETURNED CHECKS AND NO-SHOW POLICY:

There will be a **$50 charge on all returned checks**. We repost and forward all returned checks to the Clark County District Attorney's Office.

There will be a **$25 No-Show fee** for all appointments not cancelled with 24 hours notice. Your insurance will not cover fees for no-shows.

This office requires 48 hours notice for any surgery cancellations. Failure to cancel your surgery within this time frame will result in a charge of $300.

ALGSN charges $50 for all FMLA paperwork; this fee is payable before the paperwork will be completed.

Please initial to indicate your understanding of each of the policies outlined above: _____

***** Thank you for choosing ALGSN for your surgical care *****

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Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____ Phone: _____

Child(ren) _____ Phone: _____

Other _____ Phone: _____

( ) Information is not to be released to anyone.

Messages

Please call me at: ( ) my home _____ ( ) my work _____ ( ) my cell _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) other: _____

The best time to reach me is (day)_____ between (time)_____.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ___/___/____

Witness:_____ Date: ___/___/_____