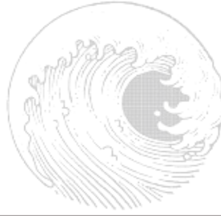
FABITO ANESTHESIA AND PAIN SPECIALIST

1748 W. HORIZON RIDGE PARKWAY HENDERSON, NV 89012
PHONE: 702-982-1300 FAX: 702-728-5661



Today's Date: [Date]	PCP: [PCP]

PATIENT INFORMATION

Last Name:	First:	Middle:	Birth Date:

Marital Status:	Sex:	Race:	Guarantor (if patient is under 18):	Guarantor birth date:

Address: [Address/ P.O Box, City, ST ZIP Code]

SSN:	Home phone no:	Cell phone no:
Occupation:	Employer:	Employer phone no:

Who can we thank for referring you to our office?	Reason for visit:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance CO:	Policy ID# :	Group Number:	Address:
Policy Holder:	Birth Date:	Relationship to patient:	SSN:

Secondary Insurance CO:	Policy ID# :	Group Number:	Address:
Policy Holder:	Birth Date:	Relationship to patient:	SSN:

IN CASE OF EMERGENCY

Who to notify in case of emergency:	Relationship to patient:	Home phone no:	Cell phone no:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _______________ Date _______________

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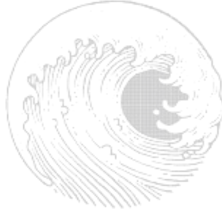

Financial Payment Policy

Effective: January 1, 2019

Thank you for choosing us as your Pain Specialist Providers. 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 any questions that you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **New patient evaluations (for patients without insurance) are $350. Follow-up visits (for patients without insurance) are $100.**
2. **Insurance:** We participate in most insurance plans, including Medicare. If you are insured by a plan that we are not contracted with but don't have an up-to-date insurance card, payment in full for each visit 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. If you are insured by a plan that we are not contracted with, you may be seen only if your plan has Out of Network Benefits or payment in full.

   ______ I understand that if I do not have my insurance card, referral, and/or co-payment, my appointment may be rescheduled until such time that I can provide the required payment or documents.

3. **Co-payments, co-insurance, and deductibles: All co-payments, co-insurance, 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 patient can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

   ______ I understand that Fabito Anesthesia and Pain Specialists will collect all co-payments at the time of the visit, as well as any procedure deductibles.

4. **Non-covered services:** Please be aware that some and perhaps all of the services you receive may not be covered or considered reasonable by Medicare or other insurance companies. **You will be responsible for these services in full at the time of visit.**

   ______ Payment in full and expected co-insurance payment responsibility are determined by the anticipated billing code, details of your insurance benefits, and agreement between Fabito Anesthesia and Pain Specialist and your insurance.

5. **Proof of insurance: All patients must be complete our patient information form before seeing the doctor.** We must obtain a copy of your driver's license and current insurance to provide proof of coverage. 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.

   ______ I understand that it is my responsibility to update my demographics with Fabito Anesthesia and Pain Specialists. I will review my demographics prior to my visit. **It is my responsibility to update any changes to my insurance, residence, or phone number.**

6. **Claims submission:** We will submit your claims and assist you in any way that is reasonable 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 benefits are a contract between you and your insurance company.

   ______ I understand that State Law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services.

7. **Coverage changes:** If your insurance changes, please notify us before your visit so that we can make the appropriate changes. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

   ______ I understand that it is my responsibility to ensure that referrals and/ or authorizations for office visits and procedures are valid. Failure to do so may result in the balance being billed to me.

8. **Nonpayment:** Insurance companies have no more than 60 days to process a claim. Please be aware that if an insurance balance remains unpaid after 90 days, you are then responsible for your balance.

   ______ I understand that I may have the option to participate in a payment plan after 90 days for an unpaid balance. In order to participate in a payment plan, I will have to pay 25% of the balance initially and 10% of the balance monthly until paid in full. Partial payments will not be accepted unless otherwise negotiated.

9. **Missed appointments: Please help us to serve you better by keeping your regularly scheduled appointment.**

   ______ I understand that I may be charged a $50 no-show fee for missed appointments and $250 for missed procedures that are not cancelled within 48 hours. These charges will be my responsibility and billed directly to me.

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:

____

Patient Name

______________________________ ________________

Signature of Patient or Responsible Party **Date**

______________________________ ________________

Witness **Date**

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HIPPA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

Fabito Anesthesia and Pain Specialists are committed to complying with HIPPA laws and regulations. Therefore, we require our patients to sign an authorization stating that family, friends, caregiver, and physicians are approved to hear discussion and/or receive medical information regarding the patient's health information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164).

I GIVE FABITO ANESTHESIA AND PAIN SPECIALISTS AND STAFF THE AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY, FRIENDS, CAREGIVER, PHYSICAN, INSURANCE AND/OR SHORT TERM DISABILITY PROVIDER:

NAME: ______________________________ RELATIONSHIP TO PATIENT: ____________________

NAME: ______________________________ RELATIONSHIP TO PATIENT: ____________________

NAME: ______________________________ RELATIONSHIP TO PATIENT: ____________________

NAME: ______________________________ RELATIONSHIP TO PATIENT: ____________________

I authorize the release of my complete health record with the **exception** of the following information:

- o Mental Health
- o Communicable Diseases (including HIV and AIDS)
- o Other (please specify)________________________

✓ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department of Fabito anesthesia and pain specialists .I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment, or healthcare operations. I understand that authorizing the disclosure of this health information is voluntary.

✓ I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can receive further information from my doctor or his staff.

Unless otherwise revoked, this authorization will expire on the following date, and if I fail to specify a date, this authorization will expire one (1) year from the signature on this form.

____
Patient Name

______________________________ ____________________
Patient Signature Date

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and abuse- therefore, they are clearly controlled by the local state and federal government. They are intended to relieve pain or improve function and/or ability to work and not simply to feel good. Because my doctor is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. **I AM RESPONSIBLE FOR MY CONTROLLED SUBSTANCE MEDICATIONS**. If the prescription is lost or stolen, or if use up the medication sooner than it is prescribed, I understand that **it will not be replaced.**

2. I **will not request nor accept controlled substance medication from another physician or individual** while I am receiving such medication from Fabito Anesthesia and Pain Specialists. It is illegal to do so (NRS 453-391) and I may endanger my health. The only exception is if it is prescribed while I am admitted to the hospital.

3. **REFILLS OF CONTROLLED SUBSTANCES:**
   - **A. YOU MUST BE SEEN EVERY MONTH IN OFFICE FOR PRESCRIPTION REFILLS.**
   - **B. REFILLS WILL NOT BE GIVEN IF I RUN OUT OF MEDICAION EARLY. I am responsible for taking medication in the dose prescribed and for keeping track of the amount on hand.**
   - **C. I must keep track of the medication and plan ahead. I will call at least 48 hours ahead of I need assistance with a controlled substance medication prescribed.**

4. **I understand that IF I VIOLATE THE ABOVE CONDITIONS, my controlled substance and/or treatment may be ended immediately.** If there is a violation involved in obtaining controlled substances from another described above, I may also be reported to my primary physician, medical facilities, and other authorities. **I understand that THE MAIN TREATMENT GOAL IS TO IMPROVE MY ABILITY TO FUNCTION AND/OR WORK.** In consideration for this goal, **I AGREE TO HELP MYSELF BY FOLLOWING THE BETTER HEALTH HABITS** specifically involving exercise, weight control, and the use of tobacco and alcohol.

5. **I am subject to random drug testing. FAILURE TO COMPLY MAY RESULT IN DISCHARGE FROM THE PRACTICE.**

______________________	______________________
Pharmacy	Pharmacy Phone Number
______________________	______________________
Patient Name	Patient Signature
______________________	______________________
Date	Witness Signature

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PATIENT NAME:____DOB:____________DATE:____________

CURRENT MEDICATION LIST: PLEASE LIST ANY AND ALL MEDICATIONS THAT ARE CURRENTLY PRESCRIBED TO YOU BY A PHYSICIAN

MEDICATION	DOSAGE	FREQUENCY

ALLERGIES: PLEASE LIST ANY MEDICATION YOU HAVE OR MAY HAVE HAD A REACTION TO

____

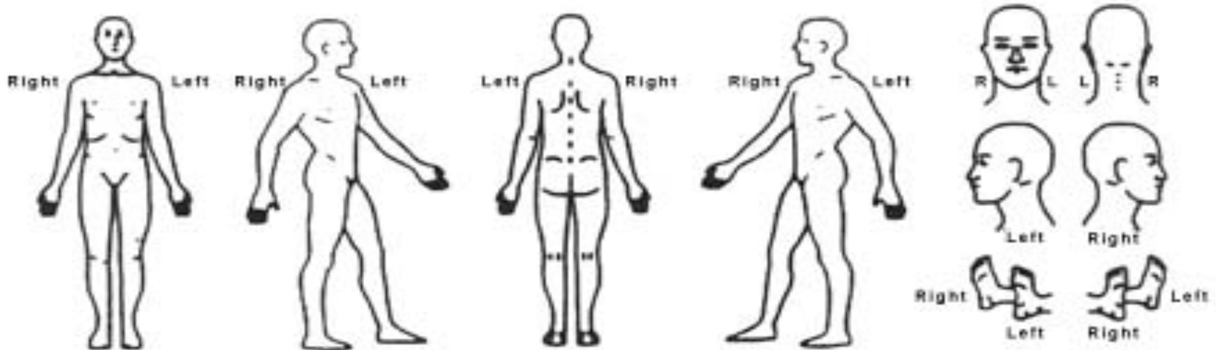
PAST MEDICAL HISTORY: PLEASE LIST ANY PHYSICIAN DIAGNOSED MEDICAL ISSUES (EXAMPLE: HIGH BLOOD PRESSURE, HEART DISEASE)

____

____

SURGICAL HISTORY: ____

LOCATION: PLEASE MARK PAIN WITH AN X AND NUMBNESS AND TINGLING WITH AN O



PLEASE DESCRIBE YOUR PAIN LEVEL ON A 0-10 SCALE (10 BEING THE WORST AND 0 BEING NO PAIN)

PAIN LEVEL RIGHT AT THIS MOMENT ___PAIN LEVEL AT ITS WORST___ PAIN LEVEL AT ITS BEST___ ACCEPTABLE LEVEL OF PAIN___

QUALITY: PLEASE DESCRIBE YOUR PAIN IN YOUR OWN WORDS (EXAMPLE: NUMB, SHARP, SHOOTING, STINGING, THROBBING, BURNING, AND ACHING)

____

ONSET OF PAIN: ____

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PATIENT NAME:____DOB:___________DATE:___________

WAS THERE AN ACCIDENT OR INJURY THAT CAUSED PAIN? YES NO

IF YES, PLEASE DESCRIBE THE ACCIDENT OR INJURY: ____

ASSOCIATED SYMPTOMS: PLEASE CIRCLE ALL THAT APPLY

NUMBNESS/ TINGLING/BURNING/ PINS/ NEEDLES/ DIFFICULTY SLEEPING DUE TO PAIN/DIFFICULTY SITTING/ DIFFICULTY STANDING/ DIFFICULTY WALKING/ URINARY INCONTINENCE/ BOWEL INCONTINENCE/ WEAKNESS/ FATIGUE/ DEPRESSION/ ANXIETY/ SUICIDAL OR HOMICIDAL THOUGHTS OR INTENTIONS/ LOSS OF APPETITE/ NAUSEA/ VOMITING

OTHER:____

PREVIOUS TREATMENT: PLEASE CIRCLE ALL THAT APPLY

ACUPUNCTURE/ INJECTION THERAPY/ CHIROPRACTIC THERAPY/ MEDITATION/ PHYSICAL THERAPY/ HERBAL MEDICATION/ EXERCISE/

OTHER: ____

PLEASE LIST ANY TESTING THAT YOU MAY HAVE HAD AND WHERE IT WAS COMPLETED:

MRI, CT, XRAYS: ____

EMG (NERVE TESTING):____

OTHER: ____