NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights is available upon request

PREMIER URGENT CARE uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive.

PREMIER URGENT CARE will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

PREMIER URGENT CARE may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

PREMIER URGENT CARE may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request Restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

PREMIER URGENT CARE must maintain the privacy of protected health information (PHI), provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above permitted under law.

If you have any questions or concerns, please contact Vanessa Torres, Privacy and Security Officer, at (702) 623-8810.

Patient Signature: _____ **Date:** _____

PATIENT INFORMATION

Name:_____

Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Home Phone #:(_____)_____ **Cell Phone #**:(_____)_____

Date of Birth:_____ **Sex**: □ Male □ Female

Marital Status: □ Single □ Married □ Divorce □ Separated

Employer:_____ **Phone #**: (_____)_____

Employer Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Name of Spouse:_____ **Phone #**:(_____)_____

Emergency Contact:_____ **Phone #**:(_____)_____

Date of Injury:_____

How were you injured? □ Auto Accident □ Slip & Fall □ Work □ Other:_____

Do you have an attorney? □ Yes □ No If yes, who is your attorney?_____

Attorney's Address:_____ **Phone #**:(_____)_____

I understand that I am responsible for all fees incurred for myself or a dependent regardless of insurance benefits available and that insurance benefits are estimated and billed as a courtesy. Billing my insurance does not guarantee they will pay on my account and does nor release me from payment for unpaid services.

**Signature of Patient or Parent/Guardian of Minor Child*:*_____

DOCTOR'S LIEN

ATTORNEY: _____

PHONE: _____

FAX: _____

E-MAIL: _____

DOCTORS:
Richard Teh, M.D.
Michael Stellmacher, PA-C

Phone: (702) 623-8810
Fax: (702) 926-8822

I do hereby authorize the above doctor(s) to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor(s) such sums as may be due and owing him for medical services rendered to me both, by reason of the accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor(s). And, I hereby further give a lien on my case to said doctor(s) against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor(s) for all medical bills submitted by him for services rendered to me and that this agreement is made solely for said doctor'(s) additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Date:_____ **Patient's Signature**:_____

Date of Injury:_____ **Patient's Printed Name**:_____

The undersigned being attorney of record for the above patient does hereby agree to honor the above lien, and agrees to withhold such sums for any settlement, judgment, or verdict as may be necessary to adequately protect said doctor(s) above named.

Date:_____ **Attorney's Signature**:_____

ATTORNEY: *Please date, sign, and return one copy to doctor(s). Keep one copy for your records.*

PATIENT LIEN

Date:_____

Patient's Name:_____ **Date of Birth:** _____

THIRD PARTY INSURANCE INFORMATION: **CLAIM#** _____

Insurance Company:_____

Adjuster's Name:_____ Phone #:_____

Phone #:_____ Fax #:_____

Address:_____

***YOUR* AUTOMOBILE INSURANCE INFORMATION:** **CLAIM#** _____

Insurance Company:_____

Adjuster's Name:_____ Phone #:_____

Phone #:_____ Fax #:_____

Address:_____

I, _____, agree to have the above involved insurance company pay **PREMIER URGENT CARE** directly upon a settlement being made, for any/all treatment costs that are outstanding, incurred due to a motor vehicle accident/injury on _____(Date of Injury).

If stated arrangement cannot be met, I, _____, agree to pay **PREMIER URGENT CARE** for all treatment costs incurred with regards to the treatment received for and relating to the motor vehicle accident/injuries in which I was involved on _____(Date of Injury).

I agree to start making **monthly payments** on my account **30-60 days following the start of treatment** until a settlement is reached or my account is paid in full, whichever comes first.

I, _____, also understand/agree that if no settlement is reached with an insurance company that I am **ultimately responsible for all outstanding medical bills**, relating to the treatment I receive in a **PREMIER URGENT CARE**. In the event that a settlement is not met, I agree to pay above stated doctor/office for all outstanding medical bills.*

I agree to pay said doctor within 10 days of a settlement being made.

Signature of Patient/Guardian:_____ **Date**:_____

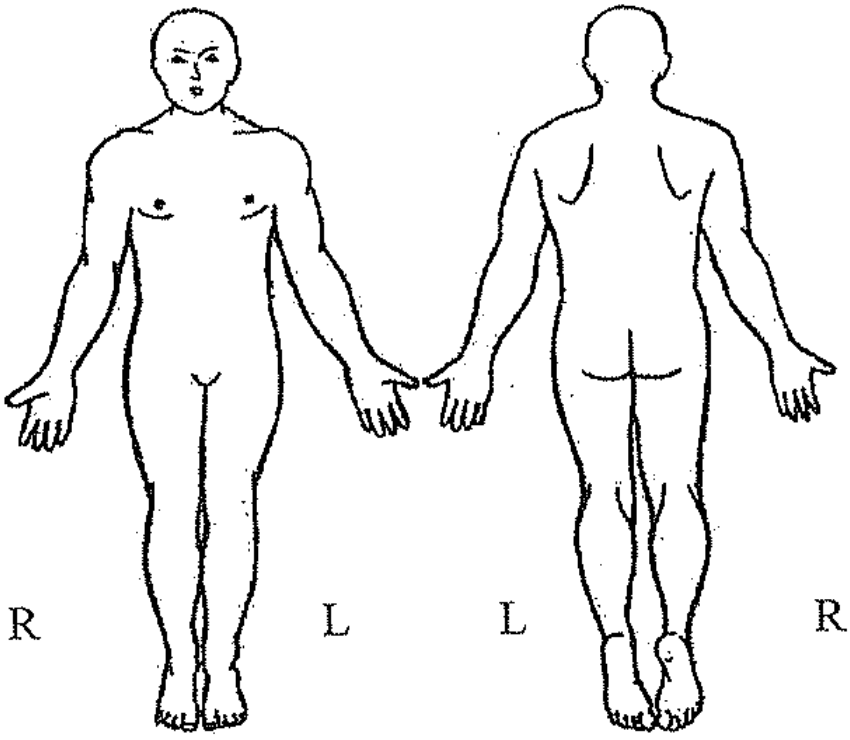
Signature of Witness:_____ **Date**:_____

PAIN DRAWING

Name:_____ **Date**:_____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). **Using the appropriate symbols**, mark areas of pain, include all affected areas, **as you feel right now**. You may draw in the face as well.

NUMBNESS	PINS & NEEDLES	BURNING PAIN	STABBING PAIN	ACHING PAIN
----------	OOOOOOOOO	XXXXXXXXXXX	//////////////	((((((((((((((((



VISUAL ANALOGUE SCALE

Make one mark through the line below to represent your current level of pain, with 0 representing no pain at all and 10 representing the worst possible pain.

_____

0 1 2 3 4 5 6 7 8 9 10

VEHICLE DRAWING

Name:_____ **Date**:_____

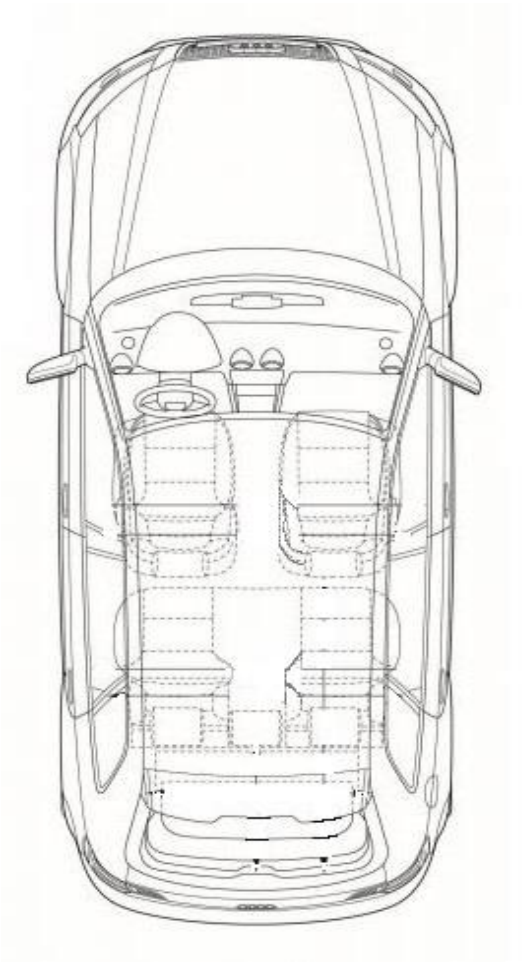
Please be sure to fill this out extremely accurately. Mark the area where you were seated at time of accident. **Using the appropriate symbols**, to mark the area of impact.

Circle where PATIENT was seated

O

Mark Impact of vehicle

XXXXXXXXXX



Signature of Patient/Guardian:_____ **Date**:_____

AUTO HISTORY

Name:_____ **Date**:_____

Date of Injury:_____

Type of collision: □ Head-on □ Left side impact □ Right side impact □ Rear-end collission

Was your vehicle stopped? □ Yes □ No

Where were you seated in the vehicle? □ Driver □ Passenger □ Front □ Back

List any parts of your body that made contact with the vehicle:_____

_____

_____

Were you knocked unconscious? □ Yes □ No

Did you receive medical care after the accident? □ Yes □ No

Did you got to a hospital or urgent care clinic? □ Yes □ No

If yes, what was the name & location of the hospital/clinic?_____

If you went to a hospital, were you transported by ambulance? □ Yes □ No

Have you seen any other doctors? □ Yes □ No If yes, what is the doctor's name?_____

Were any x-rays taken? □ Yes □ No

Were you given pain medication? □ Yes □ No

Were you given muscle relaxants? □ Yes □ No

Were you given any other treatments? □ Yes □ No If yes, explain:_____

Where do you currently have pain?

□ Neck □ Head □ Mid-back □ Legs □ Arms □ Low back □ Other:_____

_____

CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medications (narcotics and benzodiazepines) may be very useful, but have a high potential for misuse and abuse and are, therefore, closely controlled by the state and federal governments. Used properly, they are very effective medications. If used excessively, however, they may cause adverse effects. To ensure these medications are used properly, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will *not* be replaced.

2. I will not request, nor accept, controlled substance medication from any other provider while I am receiving such medication from my provider **PREMIER URGENT CARE**, except if I am a patient in a hospital. Besides being illegal (NRS 453.391), it may endanger my health.

3. **REFILLS of Controlled Substance medications and tranquilizers will REQUIRE an IN-OFFICE visit during regular office hours of 9AM to 5PM, MONDAY thru FRIDAY.**

4. I understand that if I violate any of the above conditions or decline to take a urine drug test at my provider's request, my controlled substance prescriptions will end immediately. If the violation involves obtaining controlled substance medications from another individual, as described above, I may also be reported to my primary provider (physician, physician assistant, or nurse practitioner), local medical facilities, and other authorities.

I have been informed by my provider about narcotic and tranquilizer effects, including normal physiologic effects of tolerance (need for more medicine to achieve the same pain relief) and dependence (withdrawal will occur if I stop the medicine abruptly) and addiction (abnormal psychological dependence.)

Patient Printed Name	Patient Signature	Date & Time

Witness Printed Name	Witness Signature	Date & Time

ASSIGNMENT OF BENEFITS AGREEMENT

I _____, hereby authorize all insurance payments to be made directly to **PREMIER URGENT CARE** for medical services received. If needed, I also authorize **PREMIER URGENT CARE** to sign my name in the event a check for services rendered is made out to me personally or both parties.

If my insurance company pays me directly, I will immediately forward the check/payment to **PREMIER URGENT CARE**.

I am aware that regardless of my insurance status, I am ultimately responsible for the full charges for any medical care or services rendered by a **PREMIER URGENT CARE** provider.

Patient Name:_____ **Date of Injury**:_____

Insured/Guardian's Name:_____

Patient Signature:_____ **Date**:_____
(Patient or Minor Child Guardian/Parent)

Witness Signature:_____ **Date**:_____

THIRD PARTY ASSIGNMENT OF BENEFITS AGREEMENT

I hereby authorize all insurance payments to be made directly to **PREMIER URGENT CARE**, otherwise payable to me, for medical services received. If needed, I also authorize **PREMIER URGENT CARE** to sign my name in the event a check for services rendered is made out to myself or both parties and I cannot be reached. I am aware that regardless of my insurance status, I am ultimately responsible for the full charges for any medical care or services rendered by a **PREMIER URGENT CARE** provider.

Patient Name: _____

Patient Signature:_____ **Date**:_____
(Patient or Minor Child Guardian/Parent)

Witness Signature:_____ **Date**:_____

REQUEST FOR PATIENT RECORDS

4550 E. Charleston Blvd.
Las Vegas, NV 89104
Phone: (702) 623-8810
Fax: (702) 926-8822

ATTN: MEDICAL RECORDS

Date: _____

Name: _____ **Date of Birth**: _____

Date of Incident: _____

Date(s) Requested:_____/_____/_____**TO PRESENT**

I hereby authorize release of my health information as set forth below. The following individual and/or organization is authorized to make the disclosure:

TO:

_____

Doctor, Hospital, Attorney, Insurance, Self, etc. Phone Number

_____

Address (Street, City, State and Zip) Fax Number

The type and amount of information to be used and disclosed is as follows:

[√] All medical Records [√] History & Physicals [√] Consultation Reports

[√] Discharge Summaries [√] Operative Reports [√] [√] Lab / Pathology Records

[√] Radiology Reports/ Images [√] Emergency Room Records

Date: _____ **Patient Signature**: _____

Printed Name:_____

HEALTH QUESTIONNAIRE

Name: _____**Date:** _____

Past Medical History:

PRE-EXISTING CONDITIONS:

Have you sought care for any health condition in the past 3 years? □ Yes □ No

If yes, what condition(s)?_____

What treatment was administered?_____

_____

Do you take medication for any condition? □ Yes □ No

if yes, what medication(s)?_____

_____

Have you ever had a surgery? □ Yes □ No

If yes, what type of surgery?_____

_____

Social History:

Alcohol: □ Yes □ No If yes: □ Rare □ Social □ Daily

Smoke: □ Yes □ No If yes: How many packs per day _____.

Illicit Drugs: □ Yes □ No If yes:_____.

Family Hisory:

Hypertension: □ Mother □ Father □ Sibling

Diabetes: □ Mother □ Father □ Sibling

Cancer: □ Mother □ Father □ Sibling

Cardiac Issues: □ Mother □ Father □ Sibling

Stroke: □ Mother □ Father □ Sibling

Mental Illness: □ Mother □ Father □ Sibling

Have you had any previous automobile accidents, work injuries, sports injuries, fractures, or other accidents/injuries?

□ **Yes** □ **No**

If yes, give date and describe:_____

_____

_____

SYSTEMATIC REVIEW

GENERAL:
Fever: □ Yes □ No
Unusal Weight Loss: □ Yes □ No
Weakness: □ Yes □ No

HEENT:
Blurred Vision: □ Yes □ No
Double Vision: □ Yes □ No
Glaucoma: □ Yes □ No
Eye Injury: □ Yes □ No
Eye Disease: □ Yes □ No

NECK:
Stiffness: □ Yes □ No
Pain: □ Yes □ No
Thyroid Disorder: □ Yes □ No
Enlarged Glands: □ Yes □ No

CARDIO VASCULAR:
Chest Pain: □ Yes □ No
Shortness of Breath: □ Yes □ No
High Blood Pressure: □ Yes □ No
Conjestive Heart Failure: □ Yes □ No
Heart Murmor: □ Yes □ No
A-Fib: □ Yes □ No
Pacemaker: □ Yes □ No

GASTROINTESTINAL:
Nausea: □ Yes □ No
Vomiting: □ Yes □ No
Diarrhea: □ Yes □ No
Constipation: □ Yes □ No
Blood in stool: □ Yes □ No
Heartburn: □ Yes □ No
Gallbladder disease: □ Yes □ No
Liver Disease: □ Yes □ No
Hepititis: □ Yes □ No

SKIN:
Abnormal pigmentation: □ Yes □ No
Urticaria (Hives): □ Yes □ No
Eczema: □ Yes □ No
Rash: □ Yes □ No
Ecchymosis □ Yes □ No

RESPIRATORY:
Chronic Cough: □ Yes □ No
Asthma: □ Yes □ No
Wheezing: □ Yes □ No
Pleurisy: □ Yes □ No
Pneumonia: □ Yes □ No
Shortness of breath: □ Yes □ No

NEUROLOGICAL:
Headaches: □ Yes □ No
Confusion: □ Yes □ No
Dysarthria: □ Yes □ No
Weakness: □ Yes □ No
Numbness: □ Yes □ No

PSYCHOLOGICAL:
Anxiety: □ Yes □ No
Depression: □ Yes □ No
Mood Changes: □ Yes □ No

ALLERGIES:
Allergies to Medication: □ Yes □ No
If yes, which Medication:_____
_____

HEMATOLOGICAL:
Are you slow to heal
after cuts?: □ Yes □ No
Blood disease: □ Yes □ No
Anemia: □ Yes □ No
Phlebitis: □ Yes □ No
Have you had any abnormal
bruising of bleeding?: □ Yes □ No

Signature of Patient or Parent/Guardian of Minor Child:_____