

Frontline Medical Group

3150 N. Tenaya Way, Suite # 400 Las Vegas, NV 89128

Phone #: (702)233-6661 Fax #: (702)233-3055

PATIENT INFORMATION (ACCORDING TO INSURANCE) (PLEASE PRINT)

Last Name		First	Middle	SSN	
Names used other than above		Date of birth	Age	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Street Address		City	State	ZIP Code	Home Phone No. ()
Occupation		Employer	Employer Address		Cell Phone No. ()
How did you hear about our Office		Reason for your Visit			Employer Phone No. ()
Email Address					

EMERGENCY CONTACT

Name	Relationship	Phone	Address
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INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD)

Person Responsible for Bill		Date of Birth	Address (if different)	Home Phone No.
Occupation	Employer	Employer Address		Employer Phone No. ()
Primary Insurance:			Insurance Phone Number:	
Policy Holders Name		Date of Birth	Group #	Policy #
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	Child <input type="checkbox"/> Other
Secondary Insurance			Insurance Phone Number:	
Policy Holders Name:		Date of Birth	Group #	Policy #
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	Child <input type="checkbox"/> Other

I, hereby, attest that the above information is complete and accurate. I authorize release of information necessary to file a claim with my insurance company and I assign benefits, otherwise payable to me, to the doctor or the group indicated on the claim. All professional services rendered are charged to the patient. I **understand that the patient is responsible for all fees, regardless of insurance coverage.** In the event of collection proceedings due to the lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover the money due to the doctor. If patient is a minor I authorize the above named patient to be seen and treated at this office as deemed necessary.

Print Patient/Guardian Name (if different)

Signature

Date

Frontline Medical Group

PATIENT HISTORY

PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Social Security: _____ Age: _____ Gender: M ☐ F ☐
Phone# Home: _____ Work#: _____
Occupation: _____ # of Children: _____
Place of birth (optional) _____ Sexual Orientation (optional) M ☐ F ☐
Religion (optional) _____ Next of Kin _____
Race: ☐ African American ☐ Am Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

PATIENT HISTORY

High Blood Pressure	___ Yes	___ No	___ Date
Diabetes Mellitus	___ Yes	___ No	___ Date
Heart Attack	___ Yes	___ No	___ Date
Congestive Heart Failure	___ Yes	___ No	___ Date
High Cholesterol	___ Yes	___ No	___ Date
Blood Clots	___ Yes	___ No	___ Date
Stroke	___ Yes	___ No	___ Date
Emphysema (COPD)	___ Yes	___ No	___ Date
Asthma	___ Yes	___ No	___ Date
Hepatitis (A, B, C,)	___ Yes	___ No	___ Date
Hypothyroidism (underactive thyroid)	___ Yes	___ No	___ Date
Hyperthyroidism (overactive thyroid)	___ Yes	___ No	___ Date
Arthritis	___ Yes	___ No	___ Date
Cancer	___ Yes	___ No	___ Date
What Kind? _____			
Anemia (low blood count)	___ Yes	___ No	___ Date
Kidney Stones	___ Yes	___ No	___ Date
Stomach Ulcers	___ Yes	___ No	___ Date
Irregular Heart Beats	___ Yes	___ No	___ Date
TB	___ Yes	___ No	___ Date
HIV	___ Yes	___ No	___ Date
STD's Type: _____	___ Yes	___ No	___ Date

FAMILY HISTORY

___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship
___ Yes	___ No	___ Relationship

Other, Please specify: _____

PAST SURGICAL HISTORY

Have you ever had any of the following? If so, when:

Appendectomy	___ Yes	___ No	___ Year
Tonsillectomy	___ Yes	___ No	___ Year
Gallbladder Removal	___ Yes	___ No	___ Year
Hysterectomy	___ Yes	___ No	___ Year
Bypass Surgery	___ Yes	___ No	___ Year
Cataract Laser	___ Yes	___ No	___ Year
Hemorrhoidectomy	___ Yes	___ No	___ Year
Hernia Repair	___ Yes	___ No	___ Year
Colonoscopy / Sigmoidoscopy	___ Yes	___ No	___ Year
Other, Please specify:			

PREVIOUS PHYSICIANS

Name: _____ Phone # _____

Address: _____

Name: _____ Phone# _____

Address: _____

CURRENT MEDICATIONS

Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____
Medicine _____	Dose (Mg) _____	How often _____

ALLERGIES

Seasonal _____ Yes _____ No

Animals _____ Yes _____ No

Medications, (please list) _____ Yes _____ No

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

Medicine _____ Type of reaction _____

SOCIAL HISTORY

History of Smoking Do/Did you smoke? ☐ Yes ☐ No

How many packs a day? _____ For how many years? _____ If stopped, how long ago? _____

History of Alcohol

How many drinks? _____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

History of Substance Abuse ☐ Yes ☐ No

Type? _____ How much? _____ If stopped, how long ago? _____

Do you exercise regularly? ☐ Yes ☐ No

Are you on any special diet? ☐ Yes ☐ No

Do you need any special assistance? ☐ Yes ☐ No

What Kind? _____

Have you traveled outside the state or country recently? ☐ Yes ☐ No

What Kind? _____

LIVING WILL

Please provide a copy, if possible ☐ Yes ☐ No

DATE

SIGNATURE

Frontline Medical Group

It is the goal of this office to provide the highest quality health care to our patients with the greatest efficiency possible. Hence, we would like to inform all our patients of the following office policies that are put forth to provide a more effective office flow:

No-Discrimination Policy

It is our policy and mission to provide the best medical care we can to every member of our community equally; we will not discriminate against any individual regardless of gender, race, color, religion and sexual orientation.

Missed-Appointment Policy

As a respect to all our patients who may need urgent medical care we follow the American Medical Association Code of Ethics regarding office visits. We ask all our patients to notify the office at least 24 hour prior to any scheduled appointments that they will not be present for. There will be a **\$25.00 fee** for any **missed appointment** or **cancellation** without a **24 hour notice**. Because of limited space and high technical costs involving **ECHO'S** and all **Ultrasounds**, we ask for a **48 hour notice** for any missed appointments or cancellations. Otherwise, a **\$50.00 charge** will apply.

Referral Policy

Please note that all referrals are sent promptly to the respective insurance companies. However, it usually takes about **5-6 business days** to get a response back. We appreciate you being **patient** with us during this waiting period.

Refill Policy

We ask that you allow a minimum of **3 business days** to process all prescription refill requests. I _____ understand and respect the above policy and hereby agree to take financial responsibility as outlined above.

Signature of patient/responsible party

Date

Frontline Medical Group

Narcotic Contract

Patient's Name: _____ DOB: _____ Date: _____

I understand and agree to the following terms regarding any controlled substance prescription(s), whether opiates or sedatives, that I may obtain from Dr. Sassan Kaveh.

- If I am recommended an opiate or sedative for the treatment of an acute or chronic pain condition I would try it after I understand the risks & benefits as well as the alternative therapies.
- I will take my medication only as prescribed and would not take it more often than I am supposed to or share it with anyone else.
- I will promptly notify Dr. Kaveh of any side effects or problems with my medication or if it stops working for me and/or no longer needed.
- I understand that from time to time efforts may be made to taper, change or discontinue the medication in order to optimize my care.
- I agree to meet with Dr. Kaveh regularly to assess my progress with the treatment. I may need to be seen at least once a month or more frequently as necessary.
- I will be responsible for my prescription/medication and will not ask for early refills. Otherwise, an early refill or replacement may not be available until the next scheduled appointment or when a refill is due.
- I agree to obtain narcotic/sedative prescriptions only from one doctor and one pharmacy, unless it is already cleared by Dr. Kaveh.
- I agree to potential and random urine/blood samples to assess my compliance with my treatment.
- If I deviate from these guidelines, obtain opiate medications from other sources, or misuse the medications in any other way, I may have the opiate medication discontinued and/or discharged from the practice.
- I agree to notify Dr. Kaveh of any deviations from above and to allow the office to review my opiate usage with other doctors/pharmacies involved with my care.
- I agree that any violation of State of Nevada Opiate Medication Law may make me subject to a criminal prosecution and discharge from FMG.
- We will regularly check a "Drug Utilization Report" from NV State Board of Pharmacy Prescription Monitoring Program Registration on all our Patients on pain meds.

Patient's Signature: _____ Date: _____

Pharmacy Information

#1) Name: _____ #2) Name: _____

Address: _____ Address: _____

Cross St: _____ Cross St: _____

Phone: _____ Phone: _____

Frontline Medical Group

MEDICAL RECORDS RELEASE

I, HEREBY, REQUEST THAT MY MEDICAL RECORDS BE RELEASED

FROM: _____ TO: **Frontline Medical Group**
Sassan Kaveh, M.D.
Fax: (702)233-3055

PLEASE RELEASE ONLY THE FOLLOWING:

☐ ALL HOSPITAL PHYSICIAN DICTATIONS, TRANSCRIPTIONS AND
RADIOLOGY REPORTS – None OPUS please.

☐ ALL HOSPITAL PROCEDURES & RADIOLOGY REPORTS

☐ ALL PERTINENT OFFICE NOTES

☐ ALL PERTINENT OFFICE PROCEDURES, TESTS & LABS

☐ _____

☐ _____

PLEASE INCLUDE THE ABOVE RECORDS FOR ONLY THE FOLLOWING PERIOD:

LAST: _____ MONTHS _____ YEARS _____ ALL

PATIENT NAME: _____

LAST FOUR OF SS #: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE REQUESTED: _____



For Internal Use Only: MRN _____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME _____
Last First Middle

PREVIOUS NAME(S) _____ GENDER: M ___ F ___

STREET ADDRESS /
P.O. BOX _____

CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ EMAIL _____

DATE OF BIRTH _____ (MM) _____ (DD) _____ (YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

Signature of patient or authorized representative

Date

Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

Name of Authorized Representative (Printed)

Relationship

Date

Time

Address of authorized representative signing this form (please print):

Phone number of authorized representative

FOR INTERNAL USE ONLY

Name of Organization: _____ Name of Witness: _____

As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.

HIPPA Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For Example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting.

We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Frontline Medical Group's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

Requests to copy Protected Health Information

You may generally copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Maryam Kaveh
Frontline Medical Group
3150 N. Tenaya Way #400
Las Vegas, NV 89128

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after 09/19/2013.

Acknowledgement of Notice of Privacy Practices

Frontline Medical Group reserves the right to modify the privacy practices outlined in the previous notice.

Signature

I have reviewed the notice of privacy practices for Frontline Medical Group

Name of Patient

Signature of Patient

Date

Signature of Patient Representative(Required if patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Authorization of Use and Disclosure of Protected Health Information

Are you agreeable to receive your health related records by unencrypted email? ☐ Yes ☐ NO

There may be some level of risk that the information in the email could be read by a third party, due to being unencrypted.

Are you agreeable for us to leave messages on your phone number(s)? ☐ Yes ☐ NO

Do you consent for all CommonWell and Carequality participants to access your electronic health information?

☐ Yes ☐ NO

Persons Authorized to use or disclose Information(i.e. Your spouse, family member, etc.)

Name/Relationship

Name/Relationship

Expiration Date of Authorization

This authorization is effective as of the date of this letter unless revoked or terminated earlier by the patient or the patient's personal representative.

As required by insurance companies, we are obligated to have you complete this questionnaire. We greatly appreciate your cooperation and would like you to know that preventive care is the key to diagnosing medical conditions before they become a problem.

When was your last **Mammogram** for Breast Cancer Screening? **Month:** _____ **Year:** _____
 What was the result? ☐Normal ☐Abnormal ☐Unknown

When was your last **Colorectal Cancer Screening**?
☐ **Colonoscopy** Year: _____ Results: ☐Normal ☐Abnormal
☐ **Fecal Occult Blood Test** Year: _____ Results: ☐Normal ☐Abnormal

When was your last **Influenza Vaccine**? Month/Year: _____
 Location : _____ ☐Allergies ☐N/A ☐Refuse

Fall Risk Assessment Screening Questions (Only answer if you are 65 years of age and older)

Questions	Yes	No
1. Have you fallen in the past year? If yes, how many times? With injuries/ Without injuries		
2. Do you have difficulty rising from a chair?		
3. Do you take any of the following prescription medications? Narcotics for pain; high blood pressure medication; diuretics (water pills); blood thinners, heart medications		
4. Do you feel dizzy when you get up from a bed or chair?		
5. Do you have uncorrected vision problems (glaucoma, cataract, blindness in half of your visual field)?		
6. Are you over 65 years of age?		

If you answered yes to any two (2) of the above questions, you could be at risk of falling.

Depression Screening: PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following:	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Little interest or pleasure in doing things	O	O	O	O
2. Feeling down, depressed, or hopeless?	O	O	O	O
3. Trouble falling or staying asleep, or sleeping too much?	O	O	O	O
4. Feeling tired or having little energy?	O	O	O	O
5. Poor appetite or overeating?	O	O	O	O
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	O	O	O	O
7. Trouble concentrating on things, such as reading the newspaper or watching television?	O	O	O	O
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	O	O	O	O
9. Thoughts that you would be better off dead or of hurting yourself in some way?	O	O	O	O

PHQ-9 Score: _____ + _____ + _____
 Total Score: _____

0-4: Minimal Depression ,5-9: Mild Depression, 10-14: Moderate Depression, 15-19: Moderately Severe Depression, 20-27: Severe Depression