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 ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Street Address	City	State	ZIP Code	Home Phone No.	Cell Phone No.
				( )	( )

Occupation	Employer	Employer Address	Employer Phone No.
			( )

How did you hear about our Office	Reason for your Visit	Email Address

EMERGENCY CONTACT

Name	Phone number	Relationship

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD)

*Person Responsible for Sevices:	Date of Birth:	Address (if different):	Home Phone No.

Occupation:	Employer:	Employer's Address:	Employer Phone No.
			( )

Primary Insurance:	Insurance Phone Number:

Policy Holders Name:	Date of Birth :	Group #	Policy #

Patient's Relationship to Subscriber ❑Self ❑ Spouse Child ❑ Other _____

Secondary Insurance:	Insurance Phone Number:

Policy Holders Name:	Date of Birth:	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑Spouse ❑ Child ❑ Other _____

I, hereby, attest that the above information is complete and accurate. I authorize the necessary care to be provided to me or my child at this office and release of information necessary to file a claim with my insurance company. 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.

_____

Print Patient/Guardian Name (if different) Signature Date

Frontline Medical Group

Last Name: _____ First Name: _____ Date of birth: _____

Insurance & Financial Policy **Initial**

It is your responsibility to ensure that Dr. Sassan Kaveh/Frontline Medical Group, LLC is an in-network provider with your insurance company. I agree that it is my responsibility to provide my current insurance information prior to services being rendered. _____

I agree to pay for any non-covered services by my insurance company if I am out of network with the office. _____

I agree to pay my copay, deductible, and or coinsurance prior to any service being rendered. _____

I acknowledge that the payment I make as part of a copay, deductible or coinsurance is only an estimate of services, I may be billed for any surcharges. _____

I agree to call my insurance company for any COB (Coordination Of Benefits) in case I change my primary insurance. _____

I agree to fill out and return any documents requested from my insurance company for the claims to get processed in a timely manner, otherwise I would be responsible for the bill. _____

I agree that, the authorizations obtained for any kind of procedures done in this office use solely the insurance information provided by me. So, in case my insurance changes either through my employer or myself and I haven't notified the office, I would be responsible for those dates of service's bills. _____

Claims

The office will submit claims to your insurance company and will wait a total of 45 business days for a response from your insurance carrier. If we do not receive a response from your insurance carrier you will receive a statement and we will need you to contact your insurance carrier regarding payment. _____

If a service is not covered by your plan/policy, you are responsible for all non-covered services provided by this office. _____

_____ _____

Signature Date

Frontline Medical Group

PATIENT HISTORY

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Social Security: _____ Age: _____ Sex: M ☐ F ☐

Phone# Home: _____ Work#: _____

Occupation: _____ # of Children: _____

Place of birth (optional) _____ Sexual Orientation: Opposite Sex ☐ Same Sex ☐

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			FAMILY HISTORY		
High Blood Pressure	___Yes	___No	____Date	___Yes	___No	___Relationship
Diabetes Mellitus	___Yes	___No	____Date	___Yes	___No	___Relationship
Heart Attack	___Yes	___No	____Date	___Yes	___No	___Relationship
Congestive Heart Failure	___Yes	___No	____Date	___Yes	___No	___Relationship
High Cholesterol	___Yes	___No	____ Date	___Yes	___No	___Relationship
Blood Clots	___Yes	___No	____Date	___Yes	___No	___Relationship
Stroke	___Yes	___No	____Date	___Yes	___No	___Relationship
Emphysema (COPD)	___Yes	___No	____Date	___Yes	___No	___Relationship
Asthma	___Yes	___No	____Date	___Yes	___No	___Relationship
Hepatitis (A, B, C,)	___Yes	___No	____Date	___Yes	___No	___Relationship
Hypothyroidism (underactive thyroid)	___Yes	___No	____Date	___Yes	___No	___Relationship
Hyperthyroidism (overactive thyroid)	___Yes	___No	____Date	___Yes	___No	___Relationship
Arthritis	___Yes	___No	____Date	___Yes	___No	___Relationship
Cancer	___Yes	___No	____Date	___Yes	___No	___Relationship
What Kind? _____						
Anemia (low blood count)	___Yes	___No	____Date	___Yes	___No	___Relationship
Kidney Stones	___Yes	___No	____Date	___Yes	___No	___Relationship
Stomach Ulcers	___Yes	___No	____Date	___Yes	___No	___Relationship
Irregular Heart Beats	___Yes	___No	____Date	___Yes	___No	___Relationship
TB	___Yes	___No	____Date	___Yes	___No	___Relationship
HIV	___Yes	___No	____Date	___Yes	___No	___Relationship
STD's Type: _____	___Yes	___No	____ Date	___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 PRIMARY CARE PHYSICIANS

Name: _____ Phone # _____

Address: _____

Name: _____ Phone# _____

Address: _____

LIST CURRENT MEDICATIONS OR PROVIDE A LIST

1) _____ Dosage _____ How often _____
2) _____ Dosage _____ How often _____
3) _____ Dosage _____ How often _____
4) _____ Dosage _____ How often _____
5) _____ Dosage _____ How often _____
6) _____ Dosage _____ How often _____
7) _____ Dosage _____ 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 _____
Other _____ 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, skin color, religion, sexual orientation or country of origin.

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 may 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** may 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

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Las Vegas, NV 89128
Phone #: (702)233-6661
Fax #: (702)233-3055
www.alphaveinclinic.com
fmg@alphaveinclinic.com

Frontline Medical Group
Narcotic Contract

Patient's Name: _____ **DOB:** _____

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: _____

Address: _____

Cross St: _____

Phone: _____

#2) Name: _____

Address: _____

Cross St: _____

Phone: _____

Frontline Medical Group

MEDICAL RECORDS RELEASE

Intended for office use only:

I, HEREBY, REQUEST THAT MY MEDICAL RECORDS BE RELEASED

FROM: _____ TO: **Frontline Medical Group**

DATE:_____ **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

For patients to fill out:

*PATIENT NAME: _____

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

*SIGNATURE: _____

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HealtHIE NEVADA

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
- Are you agreeable for us to send you text messages on your phone number for health related matters? ☐ 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.

Name of Patient :_____ Date of Birth:_____ Date: _____

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** Date: _____/_____/_____ Results: □Normal □Abnormal
□ **Fecal Occult Blood Test** Date: _____/_____/_____ 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: _____