NexusCare

Dr. Brian Citro MD MBA FACS

PATIENT INFORMATION

Name: _____ DOB: _____

Street: _____ City _____

State: _____ Zip: _____ Gender: _____

Mobile#: _____ Work#: _____ Home#: _____

SSN: Email:

INSURANCE INFORMATION

Primary Insurance:

Insurance: _____ ID# _____

Insured's Name: _____

Relationship: ☐ Self ☐ Spouse ☐ Dependent DOB: _____

Employer: _____ Work#: _____

Secondary Insurance:

Insurance: _____ ID# _____

Insured's Name: _____

Relationship: ☐ Self ☐ Spouse ☐ Dependent DOB: _____

Employer: _____ Work#: _____

EMERGENCY CONTACT

Name: _____

Phone: Relationship:

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

_____ *(initial)* I hereby authorize Nexus Care and it's providers to provide medical treatment for the above named patient and fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to Nexus Care, for any fees not covered by insurance. I further authorize Nexus Care to release any and all pertinent medical records necessary to facilitate insurance billing or medical care, and authorize the creditor or higher agent to make any employment, or insurance verification and release of all information needed to process claims. I hereby authorize benefits to pay directly to Nexus Care and understand that payment for services rendered is ultimately my responsibility.

_____ *(initial)* I understand that my insurance will be billed as a courtesy to me. I also understand that it is my responsibility to follow up with my insurance company 30 days from the date of service, to make sure they are processing my claims. Any claims not paid within 90 days will be my responsibility.

_____ *(initial)* I also understand that in the event of default on any payments due to Nexus Care, I agree to pay costs of collection, including attorney fees.

Signature: _____ **Date:** _____

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MEDICAL HISTORY

Name: _____ DOB: _____

Referred by: _____ Reason for visit: _____

Medical Conditions: ☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ Heartburn ☐ Chronic pain

Other:

Medical Conditions of close relatives: ☐ Breast cancer ☐ Colon cancer ☐ Ovarian cancer ☐ Uterine Cancer

☐ Bowel disease ☐ Heart disease ☐ Other:

Current Medications (list): _____

Medication Allergies: _____

Marital Status: ☐ Married ☐ Single Number of Children: _____

Smoker: ☐ Yes ☐ No ☐ Quit How much? _____ /day

When Started: _____ When Quit: _____

Marijuana Use: ☐ Yes ☐ No ☐ Quit Other Drugs: _____

Alcohol Use: ☐ None ☐ Rare ☐ Monthly ☐ Weekly ☐ Daily ☐ Recovering alcoholic

List All Previous Operations: _____

Have you or any family member had a reaction to anesthesia? ☐ Yes ☐ No

Have you or any family member had bleeding problems? ☐ Yes ☐ No

Females Only

Are you Pregnant? ☐ Yes ☐ No Due Date? _____

Date last Menstrual period: _____ Menopause? ☐ Yes ☐ No

Number of Pregnancies: _____ Number of Births: _____

Miscarriages/Abortions: Tubal Ligation? ☐ Yes ☐ No

Other concerns you would like to discuss: _____

OFFICE STAFF USE ONLY

Date: _____ Staff: _____

Height: Weight: BP: HR: Temp:

Signature: **Date:**

7375 Prairie Falcon RD, Suite 150 ● Las Vegas, NV 89128 ● 702.648.9400 ● 702.636.0249 (fax)

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

In the event NexusCare needs to provide your results may we:

☐ Leave a message with your spouse, family member or designated caregiver as indicated below.

☐ Leave a message on your voicemail: _____

☐ Call your work number: _____

☐ Speak directly to you ONLY.

I, _____ , give NexusCare authorization to disclose my protected health information to the following people/entities:

Name:	_____	Mobile:	_____	Relationship:	_____
Name:	_____	Mobile:	_____	Relationship:	_____
Name:	_____	Mobile:	_____	Relationship:	_____

STATEMENTS OF UNDERSTANDING

- 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 Nexus Care.
- I understand that 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 of healthcare operations as sighted in the Notice of Privacy Practices.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. 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 refer to my Notice of Privacy, which I obtained from my doctor's office.
- Unless otherwise revoked, this authorization will expire three (3) years from the date of signature.

Signature:_____ **Date:**_____

Name of person who completed this form if not patient:_____

Relationship of person who completed form for patient:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date: _____

Address: _____ DOB: _____

_____ SSN: _____

I authorize you to release the requested medical records pertinent to my care:

NexusCare
7375 Prairie Falcon RD, Suite 150
Las Vegas, NV 89128

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42.F.R. Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked, but not retroactive, to the release of information made in good faith.

Signature:_____ **Date:**_____

- This authorization expires ninety (90) days from the date of this signature.

OFFICE STAFF USE ONLY

Please send a copy of the request records:

Purpose for releasing medical information: _____

From: _____ To: _____

☐ Operative Reports ☐ H&P/Consults ☐ Discharge Reports

☐ Laboratory Reports ☐ Radiology Reports ☐ Pathology Reports

☐ Other: _____