Kubal Family Medicine, LLC
3950 South Eastern Avenue, Suite 120
Las Vegas, NV 89119

Patient Information Sheet

First Name _____ M.I _____ Last Name _____

Social Security #_____ Date of Birth _____ Sex _____

Race/Ethnicity _____ Preferred Language _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Street Address _____

City _____ State _____ Zip Code _____

Emergency Contact Name _____Relationship to you _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number(s) _____

Employer Name_____

Street Address_____

City _____ State _____ Zip Code _____

Phone Number(s) _____

Insurance Information (please present insurance card and ID at the front desk)

Primary Insurance _____**Secondary Insurance** _____

ID# _____**ID#** _____

Group# _____**Group#** _____

Ins Tel# _____**Ins Tel#**_____

Medications

Please list any medications you are currently taking (over-the-counter and prescription)

_____

_____

_____

_____

_____

Allergies

Please list any allergies (this includes any medication allergies)

_____

_____

Pharmacies

Please list your primary pharmacy (with address and/or cross streets), or a mail order company

_____

_____

Personal Medical History

In the space provided below, please list any/all personal medical conditions

_____

_____

_____

Personal Surgical History

Please list any personal surgeries

_____

_____

Social History

Do you smoke (this includes any tobacco products and marijuana)? _____

If yes, number or packs per day? _____ For how long? _____

If quit, for how long? _____

Do you drink alcohol? _____If yes, average number of drinks per day _____

Family History

In the space provided below, please list any family medical conditions
(be as specific as possible)

_____

_____

_____

_____

_____

Kubal Family Medicine (KFM)- Privacy Policies

KFM values the confidentiality of your medical records. We will not release (or obtain) any medical information without your consent.

Do we have permission to release your protected health information to anyone involved in your care other than healthcare providers? If so, please list below.

_____

_____

_____

_____

_____

Patient or responsible party signature _____ Date _____

Kubal Family Medicine - General Guidelines

Kubal Family Medicine (KFM) values the confidentiality of your medical records KFM will not release (or obtain) any information without your signed consent.

Please allow up to three (3) business days to fulfill any medication refill requests.

Most office evaluations require a face-to-face visit. Unless you are specifically instructed by Dr. Kubal, please assume that you require an appointment.

As a courtesy to other patients at KFM, please try to limit the office visits to 15 minutes or less. It is Dr. Kubal's goal to address as many issues as possible during each office visit by making each visit as efficient/productive as possible. This strategy not only leads to better medical care, but also limits the wait-time for all patients.

KFM does not discriminate against its patients, in regards to sexual orientation, religion, race, skin color, etc. However, KFM reserves the right to dismiss any patient if he/she is consistently disruptive to the daily medical office operations, if he/she is generally non-compliant with the treatment plan, or if any patient is perceived to be a physical threat to any other patients and/or medical office staff. *KFM understands that each person has different life situations, and we will be as accommodating as possible.*

In the waiting room and examining rooms, fees for various items are posted. Please make sure you are aware of these fees, if they ever apply to you.

****** Please sign below, acknowledging that you have read this page ******

Patient or responsible party signature_____Date_____

Kubal Family Medicine

Financial Policy

Kubal Family Medicine (KFM) is dedicated in providing excellent medical care to you, and an explanation of your financial responsibilities is an essential element of your care. *Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service.* KFM accepts debit cards, Visa, Mastercard, American Express, and Discover. Apple Pay is also accepted.

Your Insurance

KFM has made prior arrangements with many insurers and health plans to accept an assignment of benefits, and to bill out as a courtesy to you. This means KFM will bill those plans for which it has an agreement with, and will only require you to pay the authorized co-payment and any additional charges due at the time of service (this includes in-house services such as ultrasound co-payments, injections, and paperwork). This office's policy is to collect this co-payment when you arrive for your appointment.

If you have no health insurance, or if you have insurance with a plan which we do not have a prior agreement (aka "self-pay"), the charges are due at the time of service.

In the rare event that your health plan determines a service to be "not covered", you will be responsible for the negotiated rate for the services performed. Payment is due upon receipt of a statement from our office.

Request for Medical Records

In accordance with Nevada law, KFM requires written consent for the release of medical records. The charge is $0.60 per page if a copy is given directly to the patient, or forwarded to a law firm. If records are forwarded to another physician or healthcare facility, this will be done as a courtesy to the patient at no charge. Due to the potential volume of paperwork involved, please allow up to 7 business days to complete these tasks.

Missed Appointments and Rescheduling

Fees are assessed, based on the specific circumstance. Refer to the front desk for more information.

Medical Forms and In-house Services

Fees are assessed. Refer to the front desk for more information.

Assignment of Benefits

I hereby assign all medical/surgical benefits to which I'm entitled to. I hereby authorize my insurance carrier to issue payment directly to KFM, for medical services rendered. As previously stated, I'm responsible for any amount not covered by my insurance.

General Rules Regarding Collections

I authorize KFM to (1) release any information necessary to insurance carriers regarding my care, (2) process insurance claims generated in the course of examination and treatment, and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

In the event that I do not fulfill my obligation to pay what I owe, the billing office will make every effort to collect, with the option of consulting with a collection agency. I agree to pay all collection/legal fees that may be added to my account.

Unless specifically denied, I give KFM the permission to contact me via home phone, cell phone, text, fax, email, or any other form of communication whenever needed.

Patient or responsible party signature_____Date_____