LIGHTNING MEDICAL

Primary & Exclusive Concierge Convenience Care

New Patient Information

Patient Full Name:_____

SS#_____-___-_____ Date of Birth:_____/_____/_____ Age:_____ Birth Sex: ☐ M ☐ F

Gender Identity: ☐ M ☐ W

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-mail Address _____ May we email you? YES ◯ NO ◉

Marital Status: ☐ Married ☐ Single ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Language: ◯ English ◯ Spanish ◯ Italian ◯ French ◯ Other: _____

Ethnicity/Race: ◯ White ◯ African American ◯ Asian ◯ Hispanic ◯ Other: _____

Responsible Party: (if different from patient)

Relationship to Patient: ◯ Spouse ◯ Parent ◯ Other: _____

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Insurance Information

Primary Insurance Company: _____ Phone: _____

Policy # _____Group # _____

Policy Holder Name: _____ Policy Holder Date of Birth: ____/____/____

Secondary Insurance Company: _____ Phone: _____

Policy # _____ Group # _____

Policy Holder Name: _____ Policy Holder Date of Birth ____/____/____

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Consent to Treat

I authorize the provider (MD/DO/NP) to perform such examinations, treatments, laboratory tests, and to administer such medications as, in their opinion, are necessary or advisable for myself.

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

Release of Information

I authorize the release of any medical information necessary to process any claims and request payment of insurance proceeds including any major medical benefits to the provider (MD/DO/NP) or clinic. This will also serve as authorization for this office to obtain insurance information from Medicare or any other insurance company regarding any claims submitted in my behalf.

Patient Signature: _____ **Date:** _____

Consent to Payment

I understand that I am responsible for payment of all charges incurred on behalf of myself and my families when the insurance denies the claims for those services.

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

2900 N Green Valley Pkwy, Suite 114, Henderson, NV 89014 Office: 702.550.2151 | Fax: 702.977.9033

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CONSENT FOR TREATMENT OF A MINOR

Name of Minor: _____ Date of Birth: _____

Address: _____ City, State: _____

Zip Code: _____ Phone Number: _____

Legal guardian or legal representative name: _____

Work Phone: _____ Cell Phone: _____

I, the undersigned, as the legal guardian or legal representative of_____ (a minor), hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending provider (MD/DO/NP), appropriate staff, and Lightning Medical and it's officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

_____

PRINT NAME LEGAL GUARDIAN OR LEGAL REPRESENTATIVE

_____ _____

SIGNATURE OF LEGAL GUARDIAN OR LEGAL REPRESENTATIVE **DATE**

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Notice of Privacy Policies and Practices

Your protected health information will be used by Lightning Medical to disclose to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. The Notice of Privacy Practices the provider (MD/DO/NP) or clinic is required to provide you is a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. You may place restrictions on the use or disclosure of your health information. However, Lightning Medical may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or the privacy officer if you would like additional information or clarification. It is a violation of the federal privacy standards if Lightning Medical agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request.

Changes to Privacy Practices

The MD,DO,NP or clinic reserve the right to change or modify the privacy practices outlined in the Notice of Privacy Policies. Lightning Medical will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method of request.

I have reviewed this consent form, received the "Notice of Privacy Policies and Practices" and give my permission to Lightning Medical to disclose my health information in accordance with this consent and the notice provided.

Patient Name (Print): _____

Signature of Patient: _____ Date: _____

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Financial Policy

We are committed to timely, successful and cost-efficient treatment of your healthcare needs. In order for us to maintain this high standard of healthcare, it is necessary for us to strictly adhere to financial policies. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of the financial aspect of your medical treatment which must be read and signed prior to any treatment rendered by Lightning Medical. Please note, our practice does not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin, disability, marital status, sexual orientation, or military status, in any of its activities or operations.

Patient Information: All patients must complete our Patient Registration prior to their initial visit with the doctor. It is the patient's (and/or responsible party's) responsibility to keep this office informed of any changes in information (i.e., change of address, phone number, insurance information, etc.). You will be required to update this information on an annual basis.

Initial _____

Payments: All copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, Lightning Medical reserves the right to reschedule your appointment until a time that you are able to make your copayments. Payment for any outstanding balance is due at your appointment.

Initial _____

Procedure Prepayment: Lightning Medical collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy below. We reserve the right to reschedule your procedure until prepayments have been made.

Initial _____

Missed Appointments and Late Arrivals: If you are more than 15 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up for your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $50 charge. Missed procedure, is subject to a $100 charge. These charges are your responsibility and will not be billed to any insurance carrier.

Initial _____

Financial Responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment in full for all medical services provided to you. Any charge not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

Coverage Changes and Timely Submission: It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a timeline within Lightning Medical must submit a claim on your behalf to your insurer. If Lightning Medical is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges. Initial _____

Self-Pay: If you do not have health insurance, or if your health insurance will not pay for services rendered by Lighting Medical you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Self-pay patients are expected to make payment in full at the time of service. Initial _____

Insurance Plan Participation: We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned provider (MD/DO/NP) or clinic participates in your plan. Out of network charges may have higher deductibles and copayments. Initial _____

Referrals: Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Lightning Medical it is your responsibility to be aware of this fact, and to obtain this referral. Initial _____

Prior Authorization and Non-Covered Services: Lightning Medical may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Lightning Medical as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and if so, whether prior authorization for treatment is required. If we determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Initial _____

Out of Network Payments: If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Lightning Medical, immediately. Initial _____

Reassignment of Balances: If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement. Initial _____

Collection of Unpaid Accounts: If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and /or an attorney, which may result in reporting to credit bureaus and /or legal action. Lightning Medical reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Lightning Medical for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection cost.

Returned Checks: Returned checks will be subject to a $100 returned check fee. Initial _____

Refunds: Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow for four to six weeks or your request to be processed. **Initial** _____

Statements: Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates. **Initial** _____

FMLA/Disability Forms: A charge of $50.00 is due before the forms will be completed. (Disability, FMLA, Physician Statements, etc.) **Initial** _____

Workers Compensation/Auto Liability: Our office requires authorization prior to the initial visit. We will do our best to obtain the authorization prior to the visit. You are also required to provide us with Health Insurance coverage in case your workers' comp or auto denies the service. If you do not have health insurance, you may be asked to pay for the service advance. Any claims paid after we have received your payment will be refunded promptly. **Initial** _____

I have read and understand the financial policy of Lightning Medical and I agree to abide by its terms. I hereby assign all medical benefits and authorize my insurance carrier (s) to issue payment directly to Lightning Medical. I understand that I am financially responsible for all services I received from Lightning Medical. This financial policy is binding upon you and your estate, executor and /or administrators, if applicable.

I understand that if I do not sign this Financial Policy, Lightning Medical may decline to provide treatment to me.

Print Patient Name: _____

Signature of Patient: _____
(*if patient is a minor, DO NOT SIGN - Parent/Guardian to sign next line)

(*if patient is a minor)
*Signature of Responsible Party: _____

Relation to patient: _____

Date: _____

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First)* ☐ M ☐ F	**DOB:**
☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Check vaccines all that apply	☐ Tetanus	☐ Pneumonia	☐
	☐ Hepatitis	☐ Chickenpox	☐
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	☐

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					

	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Please list ANY other providers you currently see or have seen in the last 5 years and the reason

Provider Name	Reason for Care

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HIPAA RELEASE

Patient Name: _____ **Date of Birth:** _____/_____/_____

I hereby authorize the following person(s) to be able to obtain my protected health information (PHI) from Lightning Medical. By listing someone below (such as a spouse or other family member, legal guardian, etc.), I am giving Lightning Medical staff permission to communicate to another person about scheduling, treatment, care, and billing as it pertains to me, the patient, If I do not provide the information below, then the staff CANNOT speak to anyone other than me, the patient, about any PHI.

NOTE: If the patient is a minor, the staff at Lightning Medical are allowed to speak to the parent who consented to treatment.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

OR, initial below:

_____ I wish for no one to have access to my protected health information.

I understand that I have the right to revoke this authorization at any time. However, in the event that I do so, It will not apply to information that has already been released. I understand that any disclosure of information carries with it the potential for authorized re-disclosure which Lightning Medical is not responsible for.

Signature of Patient: _____ Date: _____

*** If patient is a minor:**
Signature of Responsible Party: _____ Relationship to patient: _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____Date of Birth: _____

I hereby authorize : LIGHTNING MEDICAL_____ Phone: _____

Health information to be disclosed (Check Appropriate Box)

❑ 2 years prior from last date seen by the healthcare provider

❑The following health information (be specific): _____

The health information is being disclosed for the following purpose: (check appropriate line):

❑ Change of Insurance or provider

❑ Continuation of Care

❑ I understand I may revoke this Authorization at any time by sending written notice of my revocation to The Center for Wellness and Pain Care. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event or condition:

_____

❑ I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV related diseases and communicable disease-related information.

❑ I understand that Light Medical may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal Privacy Regulations.

I have read the authorization and acknowledge that I fully understand the terms and conditions.

Signature of patient: _____

Printed name: _____ Date: _____