Las Vegas Neuroscience and Pain medicine Institute

PH: 702.220.5557; FAX: 702.220.5565

Mouchir Harb M.D.

Where Health And Care Come Together

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IMPORTANT INFORMATION FOR OUR PATIENTS

AFTER HOURS INFORMATION:

If you have an emergency dial 911.

If you need to talk to the office staff, please call during business hours 10:00 am to 4:30 pm, Monday through Friday. The answering service ***will not*** take messages. If you need to talk to the doctor please call during business hours and a message will be taken by the staff, the doctor will return you call after hours within three business days. If you feel that you need to talk to the doctor before he calls you back, please feel free to schedule an appointment to address your concerns.

PRESCRIPTION REFILLS:

If you need a refill on your medication please call your pharmacy and have them fax a refill request. It is not necessary to call the office first. Please allow up to 3 business days to respond. **DO NOT ALLOW YOUR MEDICINE TO RUN OUT.** Calling the office will not get it there any faster; Dr. Harb must review your chart before it can be sent back to your pharmacy. Also, if you have not been seen when the doctor has asked for you to return, your prescriptions will not be filled until you have been seen.

Medicine is not an exact science. Time spent with a patient could last longer than expected. A delay of up to one hour or more could be expected. We appreciate your patience and cooperation.

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PLEASE KEEP THIS DOCUMENT FOR FUTURE REFERENCE.

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Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑	❑	❑	❑	❑

❑	❑	❑	❑ Welfare	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the Las Vegas Neuroscience and Pain Medicine Institute or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Office Policies

We ask that you read the following regarding our office policies. If you have any questions please ask the front desk MA for clarification.

OFFICE HOURS:

Our office is open from 10:00 am to 4:30 pm, Monday through Friday with the last patient being scheduled at 4:00 pm. We are closed on weekends and major holidays.

PRESCRIPTION REFILLS:

If you need a refill on your medication please call your pharmacy and have them fax a refill request. It is not necessary to call the office first. Please allow up to 3 business days to respond. **DO NOT ALLOW YOUR MEDICINE TO RUN OUT.** Calling the office will not get it there any faster; Dr. Harb must review your chart before it can be sent back to your pharmacy. Narcotics cannot be called in or faxed; you ***must*** be seen every month for refills. Also, if you have not been seen when the doctor has asked for you to return, your prescriptions will not be filled until you have been seen.

SCHEDULED APPOINTMENTS:

If you cannot keep your appointment with our office you must give us at least a **24** hour notice. Failure to do so will result in a **$25** fee being assessed to your account. Calling on the same day as your appointment constitutes a no show.

If you cannot keep your appointment for any procedure you must give a **72** hour notice or the fee is **$75** and you will not be rescheduled until the fee is paid.

PHONE POLICIES:

All phones must be turned off in the office. There are no cameras, camera phones, photography, videotaping, or audiotaping of any kind permitted without written consent of the office staff.

________________________________ PATIENT'S SIGNATURE

____________________ DATE

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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Patient Name:____

Name of parent/guardian (if applicable):____

In the event that Las Vegas Neuroscience and Pain Medicine Institute may need to give your test results, or medical information, may we. . .

Check all that apply:

__Leave detailed message on an answering machine

__Leave message with spouse or family member

__Call you or your cell phone, the phone number is:____________________

__Call you at work, the phone number is:_____________________________

I,_______________________(Dob)__________________, give Las Vegas Neuroscience and Pain Medicine Institute the authorization to disclose my protected health information to the following family, friends, and/or caregiver:

Name: __________________________________ Relation to Patient: _____________________
Name: __________________________________ Relation to Patient: _____________________
Name: __________________________________ Relation to Patient: _____________________
Name: __________________________________ Relation to Patient: _____________________

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 it to the front office at Las Vegas Neuroscience and Pain Medicine Institute.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that any disclosure of the information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. I also understand that I do not need to sign this document to assure treatment. If I have any questions about the disclosure of my health information, I can receive further information by the doctor or his staff.

____ ________________________

Signature of Patient/Guardian (If applicable) Date

HIPAA Notice of Privacy Practices

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information:

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information:

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please as to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

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CONSENT FOR CARE AND TREATMENT

I, _______________________, do herby agree and consent for Dr. Mouchir Harb, M.D. to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my physical and/or mental condition. By signing below you have given Dr. Mouchir Harb M.D. permission to care and treat you.

HIPAA NOTICE OF PRIVACY PRACTICE

(This page will be retained in your medical records at Las Vegas Neuroscience and pain medicine Institute.)

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to the protected health information. If you have any questions about this form, please ask the front desk MA.

ACKNOLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I hereby acknowledge that I have received or been given the opportunity to relieved a copy of Las Vegas Neuroscience and Pain Medicine's Notice of Privacy Practices.

Print Name:______________________________________ Date:_____________________

Signature:____ Date: _____________________

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FINANCIAL POLOCIES

COPAYMENTS/COINSURANCE:
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ALL COPAYMENT/COINSURANCE AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.
****

We expect payment unless arrangements have been made in advance. Patients are responsible for knowing their own insurance. If your insurance has changed it is your responsibility to inform our office.

In the event that your insurance carrier request a refund for payment made to us, you will be responsible for all services rendered.

In the event that your insurance company establishes an internal "usual and customary fee schedule" you will be responsible for the difference between charges and "usual and customary payment"

IF ANY PAYMENT IS MADE DIRECTLY TO YOU FOR SERVICES RENDERED BY OUR OFFICE YOU HAVE AN OBLIGATION TO PROMPTLY REMIT THAT PAYMENT TO OUR OFFICE.

OUR OFFICE DOES NOT ACCEPT CHECKS!!

We accept: Visa®, MasterCard®, Debit Card, and Cash only!!

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance and third party payors to Las Vegas Neuroscience and Pain Medicine Institute. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payments. In the event that we have to turn your account to collections this practice will add up to 50% on to the balance. As a courtesy we will bill your insurance company for their portion of the bill. However, any of the amounts that your insurance assesses as patient responsibility, will be billed to you.

I have read the above information and understand my responsibilities for payment of my account.

_____________________________________ _________________________

Print Patient Name Date

_____________________________________ _________________________

Signature Date

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Patient Name:_______________________________ DOB:________________________

Symptoms: Circle any symptoms you currently have or have had in the last year.

General

Depression
Dizziness
Fainting
Fever
Headache
Forgetfulness
Loss of sleep
Unexplained weight loss
Nervousness
Numbness
Night Sweats
Chronic Cough
Bloody sputum

Gastrointestinal

Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea
Excessive Hunger
Excessive Thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal Bleeding
Stomach Pain
Vomiting
Vomiting blood

Eye, Ear, Nose, Throat

Bleeding gums
Blurred vision
Cross eyed
Difficulty swallowing Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Nose bleeds
Loss of hearing
Presistent cough
Ringing in the ears
Sinus problems
Vision flashes or halos

Men Only

Breast lumps
Erection difficulties
Lump in testicles
Penis discharge
Sore penis
Other:_______________

Women Only

Abnormal discharge
Abnormal bleeding
Breast lumps
Severe menstrual pain
Hot flashes
Painful intercourse
Vaginal discharge
Are you pregnant? _____

Muscle, Joint, Bone

Pain, weakness, or numbness in:

Arms Hips
Back Legs
Feet Neck
Hands Shoulders

Cardiovascular

Chest Pain
Irregular heart beat
Low blood pressure
High blood pressure
Poor Circulation
Rapid heart beat
Swelling of ankles

Skin

Bruise easily
Hives
Itching
Change in mole
Rash
Scares
Sores that won't heal

Gento-Urinary

Blood in urine
Frequent Urination
Lack of bladder control
Painful urination

Have you recently traveled outside of the united states? ______
Do you live in concentrated housing with or without another tuberculosis patient?__________

Conditions: Circle conditions you currently have or have had in the past year.

Alcoholism	Bulimia	Goiter	HIV positive	MS	Scarlet fever	AIDS
Arthritis	Cancer	Gonorrhea	Kidney disease	Mumps	Stroke	
Anemia	Cataracts	Gout	Liver disease	Pace maker	Suicide Attempt	
Anorexia	Chicken pox	Heart Disease	Measles	Pneumonia	Thyroid problems	
Appendicitis	Diabetes	Hepatitis	Migraine	Polio	Tonsillitis	
Asthma	Emphysema	Hernia	Headache	Prostate Issues	Typhoid fever	
Bleeding disorder	Epilepsy	Herpes	Miscarriage	Psychiatric care	Ulcer	
Bronchitis	Glaucoma	High Cholest.	Mononucleosis	Rheumatic fever	Venereal Disease	
					Chemical dependency	

Medications: List all medications currently taking

____
____

Allergies:

____
____

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FAMILY HISTORY FILL IN HEALTH INFORMATION ABOUT YOUR IMMEDIATE FAMILY

Does any immediate blood relative have any of the following?

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	DISEASE	RELATION
FATHER				ARTHRITIS, GOUT	
MOTHER				ASTHMA, HAY FEVER	
BROTHER				CANCER	
BROTHER				CHEMICAL DEPENDENCEY	
BROTHER				DIABETES	
BROTHER				HEART DISEASE, STROKE	
SISTER				HIGH BLOOD PRESSURE	
SISTER				KIDNEY DISEASE	
SISTER				TUBERCULOSIS	
SISTER				OTHER	

HOSPITALIZATIONS ***PREGNANCIES***

YEAR	HOSPITAL	REASON	YEAR	SEX	COMPLICATIONS

Have you ever had a blood transfusion? Yes/ No If yes, please give dates:_______________________________________

HEALTH HABBITS ***OCCUPATIONAL***

Please indicate how much you use below:	Please indicate if your job exposes you to the following:
Caffeine	Stress
Tobacco	Hazardous Substance
Street Drugs	Heavy Lifting
Other	Other

What is your occupation?____

Have you had any serious illnesses or injuries? Yes/ No If yes, please list.

____

____

____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I or my minor child ever has a change in health.

____

Print Patient Name Date

____

Signature of Patient/ Guardian (If applicable) Date