GASTROENTEROLOGY
ASSOCIATES

Frank J Nemec, MD
Donald Kwok, MD
Travis Vickers DO

Gregory Kwok, MD
Brent Burnette, MD
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PATIENT INFORMATION

Patient Name (Last, First MI)_____DOB:_____Age:_____

Social Security No:_____ Marital Status:_____ Gender:_____

Address (Street-City-State-Zip)_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Employer Name:_____ Employer Phone:_____ Occupation:_____

Employer address:_____

Spouse's Name: (Last, First MI)_____DOB_____

Spouse's Social Security No.:_____ Spouse's Cell/Work Phone_____

Spouse's occupation:_____

Emergency Contact:_____ Relationship:_____ Phone No:_____

Referring Physician:_____ Primary Physician:_____

Have you executed an Advanced Directive, Living Will, or Durable Power of Attorney? _____
If yes, please provide us with a copy for your chart.

_____ _____
Signature Date

6950 S. Cimarron Rd, Suite 200 Las Vegas, NV 89113 Ph 702-796-0231 Fax 702-796-5211
www.lasvegasgastro.com

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Patient's Name_____

Insurance Information

If insured you must fill out the section in its entirety

Primary Insurance:_____ Phone number:_____

Address (Street-City-State-Zip):_____

Name of Insured:_____ Soc Sec No._____ DOB_____

Policy No._____ Group No_____ Relationship to Patient_____

Secondary Insurance:_____ Phone number:_____

Address (Street-City-State-Zip):_____

Name of Insured:_____ Soc Sec No._____ DOB_____

Policy No._____ Group No_____ Relationship to Patient_____

FINANCIAL POLICY

COPAYMENT/ COINSURANCE/ DEDUCTIBLE

Patients with insurance all Co-payment, Coinsurance and/or Deductible are due at time of service. There are no exceptions.

Patients without insurance, all Payment is due at time services are rendered. There are no exceptions.

Initials_____

I authorize the release of any medical records or other information necessary to process my medical insurance claims for the purpose of TPO (Treatment, Payment, Operations). I also authorize payment of medical and/or governmental benefits to Frank J Nemec, MD, Ltd/ dba Gastroenterology Associates for any and all services rendered. I further agree and understand that I have received the financial policy and will be responsible for all non-covered charges, Co-Payments, Deductibles and/or Co-insurances as designated by my insurance carrier(s). **Initials_____**

There is a $25.00 charge for all No Shows appointments. **Initials_____**

All returned checks are subject to a $25.00 return check fee**. Initials_____**

Delinquent accounts can be subject to further collections by an outside agency or attorney. Accounts will be considered delinquent if unpaid after 90 days. In the event your account is turned over to an outside collection agency, you will be responsible for any and all reasonable collection and court costs.

Initials_____

_____ _____

Signature of Responsible party **Date**

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Privacy Practice Acknowledgement and Authorization to Release Healthcare Information

I have received the notice of Privacy Practices, and I have been provided an opportunity to review it. I authorize Gastroenterology Associates to release my medical records information to the following Person(s).

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Gastroenterology Associates to release healthcare information of the patient named above to:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

I Further authorize the physicians and staff of Gastroenterology Associates to communicate and leave messages by
☐ Mail ☐ Cell phone ☐ Answering Machine ☐ Fax_____ any information concerning my care.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

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Medical Records Release form to obtain records from another Doctor or Hospital

TO:_____

_____

(DOCTOR OR HOSPITAL)

I HEREBY AUTHORIZE YOU TO RELEASE ANY/ALL MEDICAL RECORDS TO:

GASTROENTEROLOGY ASSOCIATES
6950 S Cimarron Rd #200
LAS VEGAS, NV 89113
(702) 796-0231 PHONE
(702) 796-5211 FAX

PLEASE SEND THE COMPLETE MEDICAL RECORDS CONCERNING MY ILLNESS AND TREATMENT DURING THE PERIOD OF

FROM:_____ TO:_____

PRINT PATIENTS NAME:_____

SIGNED:_____

(PATIENT OR LEGAL GUARDIAN)

ADDRESS:_____

DOB:_____ SS#:_____

WITNESS:_____

DATE:_____

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Patient:_____

Office Policies

Medication and Medication Refills: Please allow 48 hours for prescription refills. Medication refills will only be done during regular business hours. No refills will be given after hours, during weekends or holidays. It is the responsibility of the patient to know when their prescription needs to be refilled. In addition prescriptions called in on Friday's after 12pm will not be processed until the following business day (which is Monday, unless it is a holiday then Tuesday). **Initials_____**

Medication History: I Authorize Gastroenterology Associates to Import my Past and Present Medication History**. Initial_____**

Pharmacy Information_____

Portal: Gastroenterology Associates uses our patient portal to communicate with patients in various ways (results, medication refills, general questions). Please note any emergency should not be communicated via the portal as it can take up to 24 hours to respond. **Initials_____**

Results: All results will be published onto your patient portal within 7-10 days after your procedure, please note results will not be given over the phone. If you wish to discuss your results with the physician an appointment must be made. **Initials_____**

Treatment of Staff: Any patient who acts in any way disruptive or abusive towards the staff can be discharged from the practice**. Initials_____**

Late appointments: Any patient that arrives 15 minutes late to their appointment, is subject to their appointment being cancelled and rescheduled. **Initials_____**

No Shows: There is a $25.00 charge for all no show appointments. **Initials_____**

Switching Physicians: It is the policy of the physicians that patients cannot switch physicians within the group once they have seen another physician in the practice**. Initials_____**

I understand the office policies and agree to the terms.

_____ _____

Signature Date

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