NEW HORIZONS PRIMARY CARE

Dr. Ricardo Velazquez
Internal Medicine
Board Certified

2010 Goldring Ave., Las Vegas, NV. 89106
Phone: **702-399-8808** Fax: **702-384-8807**

PATIENT INTAKE

Patient's Name: _____ Date of Birth: _____

Is your visit today related to any of the following:

Please check off all that apply

☐ Car Accident

☐ Slip and Fall

☐ Workers Compensation:

☐ Other:_____

☐ No No my visit is not related to any of the above

☐ Yes Yes my visit is related to one (1) or more of the above

Patient Signature: _____ Date Signed: _____

THIS INFORMATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

PATIENT INFORMATION

Date: _____ ☐NEW PATIENT ☐UPDATE

Patient: _____
LAST FIRST MI

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

E-Mail: _____

Referral? ☐Yes ☐ No Referred by: _____

Work Related Injury: □ Yes □No **Automobile Accident:□ Yes □No** **Date of Injury/Accident:_____**

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

WORK: X
DIRECT: _____
OTHER: _____
PAGER: _____
FAX: _____

E-Mail: _____

INSURANCE INFORMATION

Subscriber: _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

_____

_____
CITY ST ZIP CODE

TEL: _____
TOLL-FREE: _____
FAX: _____

SECONDARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

_____

_____
CITY ST ZIP CODE

TEL: _____
TOLL-FREE: _____
FAX: _____

ATUHORIZATION TO RELEASE INFORMATION & ASSIGNEMNT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Ricardo Velazquez M.D. PLLC dba New Horizons Primary Care. We will gladly file your insurance claim, however payment for co pays and deductibles are required at the time services are rendered, We cannot guarantee payment to Ricardo Velazquez MD PLLC dba New Horizons Primary Care. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies claim, you will become responsible for all amounts not covered payable to Ricardo Velazquez MD PLLC dba New Horizons Primary Care. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency and interest rates.

I authorize release of all medical records to referring primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records if necessary. FAILUIRE TO CANCELL YOUR APPOIUNTMENT WITH 24HRS WIILL RESULT IN A $50.00 FEE.($100.00FOR PROCEDURES)

SIGNATURE:_____DATE:_____

BY SIGNING YOU AGREE TO ALL THE TERMS AND CONDITIONS EXPLAINED

PATIENT REGISTRATION & HISTORY 1/7

New Horizons Primary Care
2010 Goldring Ave #308
Las Vegas, NV. 89106
(702) 399-8808 OFFICE
(702) 384-8807 FAX

PATIENT MEDICAL QUESTIONNAIRE

General Information

Patient Name:_____ Date:_____

Reason for Appointment:_____ Referring Dr._____

Current Medications (Please Include Over-the-Counter Medications)

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Are you allergic to any medications?_____

Have You Experienced Any of the Following? (Circle all that Apply)

Poor Appetite	Seizures	Skin Rash	Extremenity Weakness	Difficulty Urinating
Itching	Jaundice	Heart Murmur	Nausea/Vomiting	Blood in Urine
Fatigue	Headache	Vision Problems	Nose Bleeds	Rapid/ Irregular Heartbeat
Fevers	Hearing Loss	Passing Out	Vomiting Blood	Weight Gain/Loss
Chills	Ringing in Ear	Night Sweats	Mouth Sores	Difficulty in Swallowing
Infection	Dizziness	Indigestion	Blood in Stool	Nail Discoloration
Constipation	Stress Problems	Cough up Blood	Shortness of Breath	Chest Pain/Angina
Muscle Aches	Diarrhea	Hair Loss	Unusual Swelling	Yellow/White Mucus
Coughing	Gall Stone	Stomach Pain	Kidney/Bladder Infections	Backache/Disc Problem

Other:_____

_____

New Horizons Primary Care

Ricardo J. Velazquez M.D.

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my health care, Ricardo Velazquez MD PLLC dba New Horizons Primary Care originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Ricardo Velazquez MD PLLC dba New Horizons Primary Care is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Ricardo Velazquez MD PLLC dba New Horizons Primary Care to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

X_____ _____
Patient/Legal Guardian Signature Date

New Horizons Primary Care

Ricardo J. Velazquez M.D

Date:

Request Of Medical Information

Patient Name:

DOB:

I hereby request the release of:
ALL MY MEDICAL RECORDS INCLUDING ANY LABS AND RADIOLOGY REPORTS.

To:

New Horizons Primary Care
Ricardo Velazquez M.D.
2010 Goldring Ave. Ste 308
Las Vegas NV 89106
Phone:(702) 399-8808 Fax:(702)384-8807

X_____ Date: _____
Patient/Legal Guardian Signature

NOTICE TO ALL PATIENTS

Charge for "No Shows and Late Cancellations": This policy states that if patient does not show for a scheduled appointment, they be assessed a $50.00 No Show Fee that must be paid prior to their next appointment. This Policy also states that if a patient cancels a procedure less than 24 hours prior to the schedule time, they be assessed a $100.00 Cancellation Fee that must be paid prior to rescheduling procedure.

By Signing below you acknowledge that you are aware of the above policy.

_____ _____

Patient/Guardor Signature Date

NOTICIA PARA TODOS LOS PACIENTES

Se cobrará a cada paciente "Faltar y cancelar su cita tarde": Esta nueva política trata de los pacientes que no asistan ni llamen previamente para cancelar su cita médica y ya estén confirmados previamente, se les cargará el monto de $50.00. Esta suma deberá ser pagada antes de su próxima cita con él doctor. Se cargara el monto de $100.00 a cualquier procedimientos que no sean cancelados antes de 24 horas de su cita.

Firmando este papel usted afirma estar informado de esta nueva política.

_____ _____

Patient/Guardor Signature Date

CONTROLLED MEDICATIONS

THIS MEMO SERVES AS AKNOWLEDGEMENT BY THE PATIENT THAT IF HE/SHE IS PRESCRIBED OR CURRENTLY TAKING ANY PAIN MEDICATION (XANAX, LORTAB, ETC) IT'S THE PATIENT'S RESPONSABILITY TO MAKE SURE THAT THEY LEAVE THE OFFICE WITH THE PRESCRIPTION IN HAND. THESE MEDICATIONS CANNOT BE CALLED IN TO ANY PHARMACY DUE TO REGULATIONS OF DEA. IF YOU FORGET YOUR PRESCRIPTION OR CALL 3 DAYS AFTER YOUR APPOINTMENT NEEDING ANY PAIN OR CONTROLLED MEDICATION THE DEA ADMINISTRATION REQUIRES THAT THE PATIENT IS SEEN IN ORDER TO BE PRESCRIBED THESE MEDICATIONS.

PLEASE KEEP IN MIND THAT ITS YOUR RESPONSIBILITY TO MAKE SURE THAT WHEN YOU CHECK OUT, IF YOU ARE TAKING ANY THAT IS CONTROLLED YOU ALERT THE CHECK OUT ASSISTANT THAT YOU NEED YOUR HAND WRITTEN PRESCRIPTION FROM THE DR.

PT NAME _____ PT SIGNATURE _____ DATE _____

MEDICINAS CONTROLADAS

SI UD ES RECETADA O ESTA TOMANDO ACTUALMENTE ALGUNA MEDICINA CONTROLADA COMO (XANAX,LORTAB,ETC) ES SU RESPONSABILIDAD ASEGURAR DE QUE LE ESCRIBAN LA RECETA AL TERMINAR SU CONSULTA. ALERTE A LA SECRETARIA DESPUES DE TERMINAR CON EL MEDICO QUE NECESITA SU RECETA ESCRITA. LAS REGULACIONES DE DEA (DRUG ENFORCEMENT AGENCY) REQUIERE QUE ESTAS MEDICNIAS CONTROLADAS SEAN POR RECETA ESCRITA. SI SE LE OLVIDA Y UD LLAMA AL OTRO DIA POR ESTA RECETA NO SE PUEDE MANDAR POR FAXES NI LLAMAR A LA FARMACIA. TENDRIA QUE VER A CONSULTAR AL MEDICO OTRA VEZ PARA OBTENER LA RECETA.

POR FAVOR RECUERDE SI UD TOMA O SE LE RECETA ALGUNA MEDICINA CONTROLADA ALERTE A LA SECRETARIA CUANDO TERMINE SU CONSULTA.

NOMBRE DEL PACIENTE _____ FIRMA DE PACIENTE _____ FECHA _____