PATIENT INFORMATION			
Last Name:		Social Security #:	
First Name:	Mid. Initial:	Date of Birth:	
Home Address1:		Age:	Sex:
Apt/Suite #:		Home Phone#:	
City, State, Zip:		Work Phone#:	
Email: none		Cell Phone#:	
** You do not have to supply your email address, however, we are collecting information as Las Vegas Radiology is working on ways to use the Internet to better communicate with our patients. We do not sell or provide our patients phone numbers, addresses or email addresses to any other organization. All information is held in the strictest confidence.			
Race: African American ☐ Caucasian ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Other ☐			
Ethnicity: Hispanic ☐ Non-Hispanic ☐	Primary Language:		
EMPLOYER INFORMATION			
Employer Name:			
Employer Address: ,		Emp. City/St/Zip:	
Employer Suite #:		Employer Phone#:	
EMERGENCY CONTACT INFORMATION: In case of emergency who should be notified?			
Name:		Tel#	
PRIMARY INSURANCE			
Plan/Policy Name:		Group #:	
Plan Tel#:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy #:	
Relationship to Patient: ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other			
SECONDARY INSURANCE			
Plan/Policy Name:		Group #:	
Plan Tel#:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy #:	
Relationship to Patient: ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other			
For Office Use Only			
Pt#	Additional Notes:		
ASSIGNMENT OF INSURANCE BENEFITS			
The above information is complete and correct. I authorize treatment of the above patient. I hereby authorize the release of information necessary to file a claim with my insurance company and/or any other contracted payment source and I assign benefits otherwise payable to me to provider listed on claim. All services rendered are charged to the patient. I am responsible for all collection fees that are associated with recovering my outstanding balance.			

Patient or authorized person's signature: _____ Date:

TOMORROW'S RADIOLOGY IMAGING… TODAY
7500 Smoke Ranch Road, Suite 100, Las Vegas, Nevada 89128
3201 S. Maryland Pkwy, Suite 102, Las Vegas, Nevada 89109
7660 W. Cheyenne Ave. #112, Las Vegas, Nevada 89129

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of: _____ (mm/dd/yyyy) and that I understand that if I have any questions regarding this notice, I may contact the Privacy Officer.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until revoked in writing.

NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	

PATIENT:	DOB:
SIGNATURE (REQUIRED):	DATE:

SIGNATURE OF: ☐ PARENT ☐ LEGAL GUARDIAN	
SIGNATURE (REQUIRED):	DATE:
PRINT NAME:	

(FOR OFFICE USE ONLY)

NOTICE OF PRIVACY PRACTICES SENT/DELIVERED ON:	INITIALS:
SIGNED ACKWOLEDGMENT OF RECEIPT RECEIVED ON:	INITIALS:
PATIENT REFUSED OR FAILED TO ACKNOWLEDGE RECEIPT ON:	INITIALS:

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name	Birth Date	Social Security No.
Address	Telephone No.	Patient Number

I hereby authorize_____
Facility Name

To release information from the medical records of_____
Patient Name

To: Las Vegas Radiology

Examination date(s):_____
Specify dates – this line MUST BE completed

Records to be released

Lab Records_____

Imaging/Radiology exams _____

Entire Record _____

Other _____

This authorization expires 60 days from the date signed below and covers only treatment for dates specified above.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn, by written request from me, at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. A photocopy of this authorization shall constitute a valid authorization.

_____
Date Signature of Patient/Parent/Conservator/Guardian Relationship to

Patient/Authority to act for patient _____
ID Present

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED **"A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."**

By: _____ (Date)
Physician or Duly Authorized Representative Signature

By: _____ (Date)
Patient's Signature

By: _____ (Date)
Print or Stamp Name of Physician, Medical Group or Association Name

_____
Print Patient's Name

By: _____ (Date)
Signature of Translator (if applicable)

By: _____ (Date)
Patient's Representative Signature (if applicable)

_____
Print Name of Translator

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

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TODAY

PATIENT MEDICATION LOG SHEET

Today's Date:			
Patient Name:			**Patient Number:**
ALLERGIES			
VITAMINS			
MEDICATION			

NOTES:	