Sierra Nevada Surgical Associates
Mark DeMar MD, FACS • Kraig A. Knoll MD, FACS
1761 College Parkway, Suite 112 • Carson City • Nevada • 89706
(775) 882-8848 • Fax (775) 882-8859

DIRECTIONS TO OUR CARSON CITY OFFICE

From Reno

Follow I-580 S into Carson City

Take exit 6 onto College Parkway

Keep left at the fork and head east onto College Parkway

We are located on the right hand side of College Parkway, directly past Research Way

We are located in the second building. There is a "B" on the outside of the building

If you reach Goni Road, you have gone too far

From Gardnerville

Follow I-580 N into Carson City

Take exit 6 onto College Parkway

Keep right at the fork and head east onto College Parkway

We are located on the right hand side of College Parkway, directly past Research Way

We are located in the second building. There is a "B" on the outside of the building

If you reach Goni Road, you have gone too far

Medical History- *Sierra Nevada Surgical Associates*

☒ New patient
☒ Existing patient/update

Patient Name:_____ DOB:_____
Reason for your visit: Pharmacy/Street:

List all current Medications: [ ] None **Dosage/freq.:** **Reason:**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List all Surgeries/Dates: [ ] None **Facility/City:**

Abdominal: Y N _____
Rectal: Y N _____
Joint: Y N _____
Thyroid: Y N _____
Breast: Y N _____
Other: _____

Do you have any drugs allergies? [ ] Yes [ ] No
If yes, please list all allergies and reactions:
_____

List other medical specialist involved in your care: _____
_____
Recent Labs or Imaging: _____

SOCIAL HISTORY:

Do you drink Beer/wine/Liquor?
[ ] Yes [ ] No
How often? _____

Do you smoke? [ ] Yes [ ] No
[ ] Daily [ ] Occasionally
[ ] Never Smoker
[ ] Former Smoker - When did you quit?_____

Do you use recreational drugs?[ ] Yes [ ] No
Drug name: _____

Occupation: _____

Marital Status: **# of Children:** **Exercise:**

REVIEW OF SYSTEMS: *Mark if you have or are experiencing any of the following:* [ ] None **Disabilities:** _____

- ☐ Allergy to Latex
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer (Type) _____
- ☐ Diabetes Type: _____
- ☐ Gastrointestinal Problems
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Immune Dysfunction
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease (Hep C)
- ☐ MRSA
- ☐ Night Sweats
- ☐ Pregnant/ Planning a pregnancy/ nursing
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other (specify) _____

CONSTITUTIONAL:
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Malaise (fatigue)
- ☐ Diaphoresis (sweating)
- ☐ Weakness

SKIN:
- ☐ Rash
- ☐ Itching

HENT:
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Tinnitus (Ringing/ Buzzing in ears)
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Stridor
- ☐ Sore Throat

EYES:
- ☐ Blurred Vision
- ☐ Double Vison
- ☐ Photophobia
- ☐ Eye Pain
- ☐ Eye Discharge
- ☐ Eye Redness

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Orthopnea
- ☐ Claudication (leg pain during exercise)
- ☐ Leg Swelling
- ☐ PND (shortness of breath)

RESPIRATORY:
- ☐ Cough
- ☐ Hymoptysis (coughing up blood)
- ☐ Sputum production
- ☐ Shortness of Breath
- ☐ Wheezing

GASTROINTESTINAL:
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Melena

GENITOURINARY:
- ☐ Dysuria (painful/ difficult urination)
- ☐ Urgency
- ☐ Frequency
- ☐ Hematuria (blood in urine)
- ☐ Flank Pain

MUSCULOSKELETAL
- ☐ Myalgia (muscle pain)
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Falls

ENDO/HEME/ALLER:
- ☐ Easy Bruise / Bleed
- ☐ Environmental Allergies
- ☐ Polydipsia (excessive thirst)

NEUROLOGICAL:
- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory Change
- ☐ Speech Change
- ☐ Focal Weakness
- ☐ Seizures
- ☐ Loss of Consciousness

PSYCHIATRIC:
- ☐ Depression
- ☐ Suicidal Thoughts
- ☐ Substance Abuse
- ☐ Hallucinations
- ☐ Nervous / Anxious
- ☐ Insomnia
- ☐ Memory Loss

Family history/Parents & siblings only of any of the following/? [ ] unknown [ ] Hay fever _____ [ ] Asthma_____ [ ]
Diabetes_____ [ ] Heart disease_____ [ ] Tuberculosis _____ [ ] Hypertension_____ [ ] Hepatitis_____ [ ]
Thyroid disease_____ [ ] Arthritis___ [ ] Cancer Type: _____ Other: _____
Father: Alive / deceased Mother: Alive / deceased Number of siblings: Sisters: Brothers:

Do you have a medical power of attorney? If yes, name of person and relationship to you: _____
POA Contact #: _____

Do you have a Living will/Advance Directive? [ ] Yes [ ] No

- **Signature:**_____ **Date:** _____

SIERRA NEVADA SURGICAL ASSOCIATES

MARK DEMAR, MD,FACS KRAIG KNOLL, MD, FACS

PATIENT REGISTRATION:

NAME:_____ DOB:_____ SS#:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

HOME#:_____ CELL#:_____ WORK#:_____

EMPLOYER NAME/ADDRESS:_____ RETIRED / NOT EMPLOYED

EMAIL:_____ MARITAL STATUS: (Circle One Below)

GENDER: (Circle One) Male Female Married Single Widowed Divorced

PRIMARY PHYSICIAN:_____ REFERRING DOCTOR:_____

PERMISSION TO LEAVE MESSAGE ON PHONE NUMBER LISTED ABOVE: (Circle One) YES NO

SPOUSE / PARENT INFORMATION (Circle One)

NAME:_____ DOB:_____ SS#:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

PHONE#:_____ WORK#:_____ EMPLOYER:_____

INSURANCE INFORMATION:

PRIMARY:_____ INS. ID:_____

POLICY HOLDER:_____ DOB:_____ RELATIONSHIP TO PT:_____

SECONDARY:_____ INS. ID:_____

POLICY HOLDER:_____ DOB:_____ RELATIONSHIP TO PT:_____

REQUESTED PHARMACY/NUMBER/ADDRESS:_____

EMERGENCY CONTACTS ***(NOT LIVING WITH YOU)***

NAME:_____ RELATIONSHIP:_____ PHONE#:_____

NAME:_____ RELATIONSHIP:_____ PHONE#:_____

I hereby authorize use or disclosure of protected health information about me as described below. Please note that we are not able to release ANY information, including appointment times and date, to anyone who has not been authorized below. PLEASE CHECK ONE:

I **DO NOT** want anyone to receive disclosure of protected health information about me.

The following person/people may receive disclosure of protected health information about me.

NAME:_____ RELATIONSHIP_____ PHONE#:_____

NAME:_____ RELATIONSHIP_____ PHONE#:_____

NAME:_____ RELATIONSHIP_____ PHONE#:_____

I hereby consent for treatment and give authorization for payment of insurance benefits to be made directly to Sierra Nevada Surgical Associates and any assisting physicians for services rendered. The above information I have provided is current and accurate. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this heal care provider to release any information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

SIGNATURE:_____ **DATE:**_____

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1761 E. College Parkway Suite 112 Carson City NV 89706
775-882-8848 Fax 775-882-8859

Patient Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization reserves the right to change their notice and practices and that I may contact this organization at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I have the right to request restrictions in writing as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that this organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code and Federal Regulations. Revocations will only be accepted in person or via certified U.S. mail.

I understand that as part of this organization's treatment, payment, or health care operation, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

By signing below, I agree that I fully understand and accept the terms of this consent.

_____ _____

Patient Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by:_____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] I attempted to obtain patient's signature on this consent, but was unable to do so as documented below:

Date:_____Initials:_____Reason:_____

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Financial Policy

Due to the complexity and variety of health insurance plans offered, it is the responsibility of every patient to ensure that they fully understand the terms of their health plan, including: contracted providers, limits of coverage, covered services, co-payments/coinsurance amounts, deductibles, out-of-pocket maximum responsibilities for medical services, procedures, and medications. Sierra Nevada Surgical Associates is not responsible for understanding your particular insurance coverage.

Please review the following carefully and sign below to indicate your understanding and agreement.

~ I understand that full payment of any fees, co-payments, coinsurance, deductible amounts or other charges for services performed in the office, is due at the time of service.

~ I understand that if I have medical insurance, **it is my responsibility to understand my financial responsibility according to my health plan, including co-payments, coinsurance payments, deductibles, out-of-pocket limits, payment limits, limits of coverage, and other issues related to my plan.** Sierra Nevada Surgical Associates will bill my insurance. I understand that all charges are my responsibility.

~ I understand that if I require surgery, I may be responsible for a deposit prior to being scheduled. Under special circumstances, limited payment arrangements may be accepted. Any payment arrangement must be prior approved by our business office. I understand that it is my responsibility to set up these payment arrangements with the office.

~ I understand that a $30.00 fee will be added to my account for any returned checks.

~ A finance charge of 1.5% per month (18%APR) will be added to my account on the unpaid balance. If any delinquent balance is placed for collections, the responsible party agrees to pay an additional 30% collection fee and all legal fees with or without suit including attorney fees and court costs.

~ I understand that I am responsible for all services that have been provided to me by Dr. Knoll or Dr. DeMar. This includes any services provided in the hospital, or before my initial visit with their office.

Thank you for choosing Sierra Nevada Surgical Associates for your medical care. Our main concern is that you receive the care required to restore your health.

If you have any questions or concerns about our payment policies, do not hesitate to discuss with our office staff.

I have read and agree to the above terms:

_____
Patient/Responsible Party Signature

_____
Print Name

_____
Date

For your convenience, we accept all credit cards, cash and checks.

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NOTICE OF PRIVACY PRACTICES

What is this notice? This notice is required by law to inform you of how your health information will be protected. This notice explains how our office may use or disclose your health information, and about your rights regarding health information.

Understanding your health information: Each time you visit a physician, healthcare provider or hospital, a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnosis, treatment and a plan for future care.

This information, often referred to as your medical record, serves as a basis for planning your care and treatment, for updating other healthcare professionals who treat you, for verifying accurate billing, and as a legal document of the care you received.

Your Rights: You have the following rights with respect to your medical and billing records kept by us:

- **Obtain a copy of this notice.** You will receive a copy of this notice at your first visit. Thereafter, you may request a copy of this notice from our receptionist.
- **Authorization to use your health information.** Before we use or disclose your health information, other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- **Access to your health information:** You may request a copy of your health information from the receptionist.
- **Amend your health information.** If you believe the information we have about you is incorrect or incomplete, you may request that we correct the existing information or add the missing information. We reserve the right to accept or reject your request and will notify you of our decision.
- **Request confidential communications.** You may request your information by phone or by writing to our address provided at the top of this notice. We will make every reasonable effort to comply with your request.
- **Limit our use or disclosure of your health information.** You may request in writing that we restrict the use or disclosure of your health information for treatment, payment, health care operation, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or to collect payment for our services.

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- **Accounting disclosure:** You may request a list of disclosures of your health information that we have made for reasons other than treatment, payment or healthcare operations. Disclosure that we make with your authorization will not be listed. The first list you request within a 12-month period is free. We may charge you for additional lists.

Examples: The following examples will help you understand the ways in which we may use or disclose your health information:

- To facilitate your medical treatment
- To collect payment for health care services that we provide
- To facilitate routine healthcare operations
- To notify your family and friends about your condition
- To inform persons about your death
- To remind you about appointments
- To inform you about alternative treatment
- To inform you about our healthcare services
- To solicit your participation in research studies
- To comply with workers' compensation law
- To comply with other laws, such as: public health, abuse and crime reporting, or health registry reporting
- To permit our business associates to perform their contracted services

Our responsibilities: We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our workforce and business associates, and to provide this notice about our privacy practice. We reserve the right to change our policies and procedures for protecting health information. When we do so, we will also change this notice. The new notice will be posted in our waiting room, and copies will be available from the receptionist.

For more information or to report a problem: Please let us know if you have any questions about this notice. If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, let us know. You may contact our office with complaints.

You may also send a written complaint to :
US Department of Health and Human Services, Office of Civil Rights, Hubert H.
Humphrey Bldg., 200 Independence Ave., SW, Room 509F HIM Building, Washington DC, 20201

This notice was published and becomes effective on/or before May 1, 2014