Shanker Dixit, MD PC
2480 Professional Ct. Las Vegas, NV 89128
Phone: (702)405-7100 Fax: (702)405-3017

Today's Date _____

Patient's Name _____ S.S.# _____
Last First MI

Birth Date _____ Age _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Address _____ **(** _____ **)** _____
Street Apt# City State Zip Code **Cell Phone #**

Occupation _____ Employer _____ Phone # (_____) _____

Email _____ **Home Phone # (** _____ **)** _____

Referred By Dr _____

Primary Insurance Company _____ Ins. Co. Phone # (_____) _____

Insured's Name _____ Date of Birth _____ Gender: ☐ M ☐ F
Last First MI

Insurance Co. Address _____
Street City State Zip Code

SS# or ID# _____ Group # _____ Ins Plan Name _____

Employer _____ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Company _____ Ins. Co. Phone # (_____) _____

Insured's Name _____ Date of Birth _____ Gender: ☐ M ☐ F
Last First MI

Insurance Co. Address _____
Street City State Zip Code

SS# or ID# _____ Group # _____ Ins Plan Name _____

Employer _____ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Alternative Responsible Party (other than yourself)

Name: _____ Tel.No. (_____) _____

Address _____

Alternative Responsible Party (other than yourself)

Name: _____ Tel.No. (_____) _____

Address _____

Signature _____ Date _____

☐ **Patient** ☐ **Parent** ☐ **Guardian**

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NAME: _____ **D.O.B.:** _____

Pharmacy Detail Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

Two major cross streets: _____

Medication Allergies: _____

Please List Current Medications Below: (medicine list brought by patient is acceptable)

Medication	Dosage	Frequency	Reason Taken

Patient History

Past Medical History:

_____

_____

_____

Surgeries or Hospitalizations:

_____

_____

_____

Social History:

Do you smoke or use tobacco products? ☐ YES Packs per day _____ Years _____ ☐ NO ☐ NEVER QUIT _____

Do you drink alcohol? ☐ YES ☐ NO How Much? _____

Do you use recreational Drugs? ☐ YES ☐ NO Which Ones? _____

Do you exercise? ☐ YES ☐ NO How Often? _____

Family History: Please circle appropriate response

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Seizures ☐ Rheumatoid ☐ Arthritis ☐ Lupus

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NAME: _____ **D.O.B.:** _____

REVIEW OF SYSTEMS:

Please circle or underline appropriate response, and add information as necessary. This form must be filled out at every visit. Thank you.

CONSTITUTIONAL SYMPTOMS ☐ Fever ☐ Weight loss ☐ Fatigue ☐ Other _____

MUSCLOSKELETAL

☐ Muscle pain cramps ☐ Joint pain ☐ Joint stiffness ☐ Weakness ☐ Neck pain ☐ Back pain

☐ Other _____

EYES

☐ Eye disease ☐ Eye injury ☐ Blurred vision ☐ Double vision ☐ Glaucoma ☐ Other _____

EARS/NOSE/MOUTH

☐ Hearing Loss ☐ Ringing Sinusitis ☐ Nose bleeds ☐ Mouth sores ☐ Other _____

NEUROLOGICAL

☐ Headaches ☐ Lightheaded ☐ Dizzy ☐ Seizures ☐ Numbness Tingling ☐ Tremor Stroke ☐ Paralysis Seizures

☐ Head injury ☐ Memory loss ☐ Other _____

CARDIOVASCULAR

☐ Chest pain ☐ Palpitations ☐ Swelling of feet, ankles or hands ☐ Other _____

PSYCHIATRIC

☐ Depression ☐ Anxiety ☐ Hallucinations ☐ Other _____

RESPIRATORY

☐ Shortness of Breath ☐ Asthma wheezing ☐ Cough ☐ Other _____

ENDOCRINE

☐ Diabetes ☐ Thyroid disease ☐ Other _____

GASTROINTESTINAL

☐ Loss of appetite ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Other _____

HEMATOLOGIC/LYMPHATIC

☐ Bleeding tendency ☐ Anemia ☐ Enlarged glands ☐ Other _____

GENITOURINARY

☐ Frequent urination ☐ Incontinence ☐ Kidney stone ☐ Sexual ☐ Other _____

ALLERGIC/IMMUNOLOGIC

☐ Drug reaction ☐ RA ☐ Lupus ☐ Immune deficiency ☐ Other _____

SKIN/INTEGUMENTARY

☐ Rash ☐ Itching ☐ Bruising ☐ Change in skin color ☐ Other _____

MISCELLANEOUS

REVIEWED BY: _____ **DATE:** _____

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Office Financial Policy

Patient Name:(please print) _____ Date: _____

The following is our office financial policy. Please read and sign prior to treatment.

Primary Insurance: As a convenience to our patients we will bill most primary insurance carriers for you. If an insurance company has not paid within 60 days of billing payment is due in full from you. All co pays, deductibles and patient responsibilities are due at the time services

Secondary Insurance: We will submit secondary insurance claims on your behalf. If for any reason there may still be a balance after we have submitted your claim to your secondary insurance, we will request for payment

Insurance Eligibility: It is your responsibility to understand your insurance agreement, eligibility, effective date(s) and what benefits you are entitled to. You are responsible for verifying the physicians status with your insurance company (such as in-plan, in-network, preferred, out of network, etc) preventative health checks, labs and injections may or may not be covered under your health insurance policy. If you are unsure of your plan benefits, call your insurance prior to seeing the physician ultimately you are responsible for all fees for service are rended..

Referrals and Authorizations: If you're insurance company requires a referral for any services rendered it is your responsibility to obtain any referral forms, referral numbers and/or authorization numbers prior to your visit. Please note that some providers may offer to assist you in this process, but this does not relieve you of the financial responsibility should any subsequent claims be denied by your insurance for lack of prior authorization. If you did not obtain a referral or any other required authorization from your insurance company, you may be asked to reschedule your appointment, or you will be responsible to pay for the visit in full.

Cash Pay: Unless prior arrangements are made, full payment is due at the time of service for cash patients. If you wish to see the physician where no benefits will be paid by your insurance, you may do so as a cash pay patient. Ask or staff for a schedule of fees.

Past Due Accounts: Upon receipt of an Explanation of Benefits (EOB) from your primary insurance, we will bill you for any remaining balance as indicated by your insurance. You are responsible for paying the amount on the bill in full within 30 days, unless you have contacted our office to make other payment arrangements. Accounts will be considered delinquent if left unpaid by the due date on the statement. All such delinquent accounts may be assigned to a collections agency unless prior arrangements have been made by you or your insurance company. In the event your account is assigned to a collections agency, you will be responsible for all collection fees and/ or court cost up to 100% of the outstanding balance at the time the account is considered delinquent. If the collection agency cannot resolve an outstanding balance, the account may be turned over to an attorney for legal action.

ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all charges made to my account whether or not an insurance company is involved in payment. I am further responsible for all co-payment, co-insurance amounts, no covered supplies and services, and yearly deductibles. I am also responsible for collection fees incurred by Dr. Shanker Dixit efforts to receive payment of my financial obligations for services rendered. Payment for these services is expected at the time services are rendered. If Dr. Shanker Dixit doctors are contracted providers for your insurance carrier, we are required by your insurance company to collect your financial portion at the time services are rendered. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to Dr. Shanker Dixit. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment. I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party _____ **Date** _____

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Our office Policies:

Our office does NOT complete Disability or Workers Compensation Forms

1. Patients are requested to come in 10 minutes prior to the scheduled appointment for any updates that may be required.

2. We will require your picture ID and you insurance card / cards during registration.

3. Co pays are due at the time of service. We accept cash, debit cards and most credit cards. Any returned personal checks returned from the bank will be charged a $50.00 fee.

4. If you miss your appointment without the courtesy of giving us a 24 hour cancellation notice, you will be charged a $25.00 no show fee for an Office Visit and a $50.00 for testing.

5. We charge a $0.60 per page fee for any copies of your medical records that you request.

6. We charge a $50.00 fee for FMLA forms. Payment will be requested prior to the completion of FMLA forms and will be completed in a 1 week period. Our office does **NOT** complete Disability Forms. These forms should be completed by your primary physician.

7. Your prescription refill request will require 24-48 hours for approval upon being received. To better assist you please have your pharmacy request 1-2 weeks prior to your last dose. Our office does **NOT** dispense or prescribe controlled substances.

8. All Prior Authorizations will require a 7-14 day turnaround time subject to the response of your insurance company.

9. I have read and understood the HIPAA NOTICE OF PRIVACY PRACTICES.

Our staff will serve your needs in the best way possible. We highly believe in extending respect to everyone. We ask that you extend to them the same courtesy while at our facility. We will not tolerate abusive patients.

Patients Name: _____ Patients Initials: _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____ **D.O.B.:** _____

☐ I hereby authorize Neurology Center of Las Vegas to disclose and release any medical information, including information related to all my medical records, psychiatric care, drug and alcohol abuse and HIV/Aids confidential information, acquired in the course of my treatment necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities. A photocopy of this authorization is to be considered as valid as the original, until revoked by me in writing.

☐ I do not authorize Neurology Center of Las Vegas to disclose any of my medical information.

I hereby authorize and release any medical information, including information related to all my medical records, psychiatric care, drug and alcohol abuse and HIV/Aids confidential information to the references listed below:

1) _____

2) _____

A photocopy of this authorization is to be considered as valid as the original, until revoked by me in writing. This authorization will remain effect until: _____

Signed by: _____ Date: _____
(Name of Patient or Representative)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to the Federal Law, Federal regulations prohibit you from any further disclosure of the information without specific written authorization of the person to whom it pertains,or is otherwise permitted by such regulations. A general authorization for the release of medical or other information is sufficient for this purpose.