7325 S. Pecos Rd Ste. #102 Las Vegas, NV 89120 Phone: (702)982-6402 Fax: (702)202-0674 www.chamianmedicalgroup.com

CHAMIAN MEDICAL GROUP(CMG) PATIENT INFORMATION SHEET

NAME_____SEX_____DOB_____SSN_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

HOME PHONE#_____CELL#_____WORK#_____

PHARMACY_____PHONE _____

ADDRESS_____ ZIP CODE_____

EMPLOYER_____PHONE_____

HOW DID YOU KNOW ABOUT US? _____

INSURANCE INFORMATION

☐ ***CHECK THIS BOX IF YOU ARE SELF PAY***

PRIMARY INSURANCE COMPANY_____

NAME OF POLICY HOLDER_____DOB_____SSN_____

PHONE_____POLICY #_____GROUP #_____

SECONDARY INSURANCE COMPANY_____

NAME OF POLICY HOLDER_____DOB_____SSN_____

PHONE_____POLICY #_____GROUP #_____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

☐ ***CHECK THIS BOX IF THE SAME AS ABOVE***

NAME_____SEX_____DOB_____SSN_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

HOME PHONE# _____CELL#_____WORK#_____

EMPLOYER_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

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Name of patient: _____ DOB: _____

CHAMIAN MEDICAL GROUP(CMG) TERMS AND CONDITIONS

As a patient of CMG, I attest that I am agreeing to the terms listed below:

i. I will not ask for a controlled substance prescription at all times even if it is an emergency and I will not hold CMG accountable for any consequence of not obtaining such prescription
ii. I will conduct myself in a polite manner at all times and I will not harass CMG staff and its affiliates
iii. I will pay the balance due to my account including my co-pay or co-insurance
iv. I will be charged a processing fee of $35 If I am requesting for paper work to be filled up by the provider or staff and an additional fee will be charged based on the paper burden
v. I am aware of the $40 fee which will be posted to my account if I do not show up for my appointment or cancel less than 24 hours prior to the scheduled visit
vi. CMG is not responsible for radiology, laboratory or specialist bills that I will receive for whatever reason it may be
vii. A $25 fee will be charged to my account in addition to any bank fee that CMG may incur as a result of a bounced check
viii. CMG terms and conditions may change without prior notice
ix. I am fully aware that failure to comply with these terms would result in immediate termination of my doctor/patient relationship with CMG. Furthermore, I waive all my rights to take legal action for whatever negative impact that would result from imposing these terms.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I ALSO UNDERSTAND THE CMG TERMS AND CONDITIONS AND ABIDE BY THEM. I HEREBY AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND I ASSIGN BENEFITS OTHEREWISE PAYABLE TO ME TO THE HEALTH CARE PROVIDER INDICATED IN THE CLAIM. I UNDERSTAND THAT ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT/GUARANTOR AND THAT THE PATIENT/GUARANTOR IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IN THE EVENT OF COLLECTION PROCEEDINGS DUE TO LACK OF PAYMENT ON MY PART, I AGREE TO PAY ANY AND ALL COLLECTION FEES THAT MAY BE ADDED TO MY ACCOUNT IN ORDER TO RECOVER MONIES DUE TO THE HEALTHCARE PROVIDER.

_____ _____

Signature of Patient or Legal Guardian **Date**

CONSENT FOR TREATMENT

By signing below, I authorize CMG to render medical care to me whether on an in-patient or out-patient basis. I further authorize their employees to render medical care and to carry out the orders of my healthcare provider, including consultants, associates and assistants of their choosing.

_____ _____

Signature of Patient or Legal Guardian **Date**

PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read and understood the HIPAA Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian **Date**

******A COPY OF THE SIGNATURE IS AS VALID AS THE ORIGINAL******