MINIMALLY INVASIVE CENTER OF EXCELLENCE
9331 W. Sunset Rd, Las *Vegas, NV.* 89148
Phone (702) 476-2951 Fax (702) 476-0609

PATIENT INFORMATION

Name: Mr. Ms. Mrs. _____
LAST FIRST

Sex: Male Female **Social Security#:**_____ **Driver's License#** _____**State:** _____

Marital Status: Single Married Divorced

ADDRESS: _____

CITY:_____ **STATE:**_____**ZIP:**_____

HOMEPHONE:_____**CELLPHONE:**_____

EMERGENCY CONTACT:_____**RELATIONSHIP:**_____

HOMEPHONE:_____ **CELLPHONE:**_____

Allergies:

_____

PRIMARY INSURANCE COMPANY:_____

INSURANCE COMPANY PHONE#:_____

POLICY#:_____ **GROUP#:**_____

NAME OF INSURED:_____

RELATION TO PATIENT:_____ **BIRTH DATE:**_____**SS#:** _____

_____

SECONDARY INSURANCE CO:_____

INSURANCE COMPANY PHONE#:_____

POLICY#: _____ **GROUP#:**_____

NAME OF INSURED:_____

RELATION TO PATIENT:_____**BIRTH DATE:** _____**SS#:**_____

_____

Companion Driver's form

I have arranged to have a responsible adult companion drive me home. In waiting room._____

_____

Contact by phone (#)

_____ _____ _____

Patient's Signature Date Responsible Adult Companion

MINIMALLY INVASIVE CENTER OF EXCELLENCE

PATIENT RECORD OF DISCLOSURES

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

Information Disclosure Permissions:

I,_____ wish to be contacted in the following manner (check all that apply)

☐ Home telephone:_____

☐ Okay to leave message with detailed information ☐ Leave message with callback number only

☐ Work telephone:_____

☐ Okay to leave message with detailed information ☐ Leave message with callback number only

☐ Written communication:

☐ Okay to mail to my home address_____

☐ Okay to mail to work/office address_____

☐ Okay to fax with detailed information to_____

☐ Other:_____

Persons to whom information may be disclosed:

1. _____/_____
   Name Relationship
2. _____/_____
   Name Relationship
3. _____/_____
   Name Relationship
4. _____/_____
   Name Relationship

Information covered by this authorization includes all medical records, billing information or PHI collected by Minimally Invasive Center of Excellence.

☐ Since the first date of services provided until this authorization is terminated.

☐ To include services provided on (Date):_____only.

☐ To include services provided between the dates of:_____only.

☐ Other:_____

I acknowledge: (i) I may revoke or terminate this authorization by submitting a written revocation to Minimally Invasive Center of Excellence by certified mail (the revocation will be effective only upon receipt), and (ii) that I understand that once the information is disclosed, it may no longer be protected by the federal privacy law.

_____/_____

Patient Signature Date

_____/_____

Witness Signature Date

Patient Name:

Date of Birth:

Surgeon:

Date of Service:

Minimally Invasive Center of Excellence (MICOE)

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Irrevocable Assignment of Benefits

PATIENT AGREEMENT & AUTHORIZATION

I hereby irrevocably assign to MICOE all insurance benefits otherwise payable to me for treatment. I acknowledge that I am financially responsible for paying MICOE for services rendered to the extent the relevant insurer, plan or payer does not pay MICOE for such services in full.

I authorize payment of benefits for services named on claim to:
Minimally Invasive Center of Excellence
9331 W. Sunset Road, Las Vegas, NV 89148

I understand that I am responsible for annual deductible, non-covered services, non-covered pre-existing conditions, co-payments, and all services categorized as "not medically necessary", "cosmetic" or "denied" for any reason by my insurance company.
This assignment of benefits is irrevocable with respect to any services performed by MICOE before I have given written notification of my decision to rescind this agreement. I understand that billing by your office will be done as a courtesy and every effort will be made to collect benefits from my insurance carrier(s). If after 30 days, my carrier has not responded, payment is due in full and I will be liable for uncollected services.

In the event that insurance payment for services rendered to Minimally Invasive Center of Excellence comes directly to me, I agree to pay such payments by endorsing the insurance check to Minimally Invasive Center of Excellence within seven (7) days from the date I received payment.
I further agree to provide MICOE with a copy of the insurer's Explanation of Benefits form along with the payment rendered from the insurer. I understand that all delinquent accounts shall bear interest at the legal interest rate and that I will be responsible for all administrative, legal, and/or collection agency fees involved recouping any and all outstanding payments due.

I recognize that the physicians, furnishing services, including surgeons, pathologists, anesthesiologist, and the like, are independent contractors and are not employees or agents of MICOE and that as a result, the services provided will be billed by each of them independently of the surgery center. In addition, ancillary services, such as laboratory procedures and medications will also be billed by each such service independently.

RELEASE OF MEDICAL RECORDS

I hereby authorize Minimally Invasive Center of Excellence to release to my insurance carrier(s) any information required to process my claims.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have been made aware of and have reviewed a copy of the Notice of Privacy Practices for MICOE

Patient Signature:_____Date:_____

Printed Name:_____

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ASSIGNMENT OF BENEFITS AND RIGHTS

I hereby authorize the _____Insurance Company to pay by check made payment and mailed directly to:

MINIMALLY INVASIVE CENTER OF EXCELLENCE
9331 W SUNSET ROAD, LAS VEGAS, NV 89148

For the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as a payment toward the total charges for the services rendered. I understand that as a courtesy to me, MICOE will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby agree to pay, in a current manner, any charges not covered by my insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs incurred by the outpatient medical center in the collection of outstanding fees.

I hereby further empower said health care provider as my attorney in fact for my use and benefits to present, collect, appeal, and/or benefit(s) for the medical services rendered me on said date.

Patient Name:_____Date:_____

Signature:_____

Minimally Invasive Center of Excellence

9331 W Sunset Rd

Las Vegas NV 89148

702- 476-2951 Fax 702-476-0609

scheduler@misilasvegas.com

Attorney: _____ Telephone: _____

Fax: _____

SSN: _____

Date of Injury: _____

I do hereby authorized Dr. Marjorie Belsky and/or Dr. Mario Tarquino to furnish you, my attorney with a full report of her/his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums.as may be due and owing her/him for medical services rendered to me by reason of this accident, and by reason of any other bills that is due to her/his office. I also authorize you to withhold such sums from the settlement, judgment, or verdict as may be necessary to adequately protect said doctor.

I hereby give lien on my case to said doctor against any and all proceeds of any settlements, judgments, or verdict which may be paid to you, my attorney; or myself, as a result of the injuries for which I have been treated, or injuries in connection therewith.

I agree to never rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter; the new attorney honor this lien as inherent to the settlement, and enforceable upon the case as if it were executed by her/him.

I fully understand that I am directly and fully responsible to said doctors for all medical bills submitted by their group for services rendered, by that and me this agreement is made solely for said doctor's additional protection and in consideration of them awaiting payment. I further understand that such a payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover a fee.

Interest on this lien is eighteen percent per annum commencing 30 days from the date of payment of settlement, judgment, or award relating to services rendered to me by the 'clinic above.

I waive the Statue of Limitation regarding the doctor's above right to recover. This lien is governed by the laws of the State of Nevada,

Minimally Invasive Center of Excellence

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Las Vegas NV 89148

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scheduler@misilasvegas.com

Attorney: _____ Patient: _____

Telephone: _____ SSN: _____

Attorney Fax: _____

Date of Injury: _____

I do hereby authorize and direct you, my attorney to pay directly to the said surgery center, the Minimally Invasive Center of Excellence such sums as may be due and owing for the medical services rendered to me by reason of this accident, and by reason any other bills including separate implant costs that is due to this surgery center.

I also authorize you to withhold such sums from the settlement, judgment or verdict as may be necessary to adequacy protect the surgery center. I hereby give lien on my case to the said Minimally Invasive Center of Excellence against any and all proceeds of any settlements, judgments, or verdicts which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated, or injuries in connection therewith.

I agree to never rescind this document and that a rescission will not be honoured by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by her/him.

I fully understand that I am directly and fully responsible to said Minimally Invasive Center of Excellence for all medical bills submitted by their services rendered, by that and this agreement is made solely for said Minimally Invasive Center of Excellence protection and in consideration of them awaiting payment. I further understand that such a payment is not contingent on any settlement, judgment or verdict by which I may eventually recover a fee.

Interest on this lien is eighteen percent per annum commencing 30 days from the date of payment of settlement, judgment or award relating to services rendered to me by the surgery center above.

I waive the Statute of Limitations regarding the surgery center above right to recover. This lien is governed by the laws of the State of Nevada.

It is understood and agreed that a copy of this lien shall have the same force and effect as the original.

Patient represents and warrants that he/she has not taken out any loan (such as an "Injury Loan" or "Litigation Loan") the repayment of which is contingent on recovery in or which would give rise to a lien

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Attorney:_____ Patient:_____

Telephone:_____ SSN:_____

Fax:_____ Date of Injury:_____

I do hereby authorize Dr._____ and/or Dr. _____ to furnish you, my attorney with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical services rendered to me by reason of this accident, and by reason of any other bills that is due to his/her office. I also authorize you to withhold such sums from the settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby give lien on my case to said doctor against any and all proceeds of any settlement, judgments, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated, or injuries in connection therewith.

I agree to never rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement, and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctors for all medical bills submitted by their group for services rendered, by that and me this agreement is made solely for said doctor's additional protection and in consideration of them awaiting payment. I further understand that such a payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover a fee.

Interest on this lien is eighteen percent per annum commencing 30 days from the date of payment of settlement, judgment, or award relating to services rendered to me by the clinic above.

I waive the Statue of Limitation regarding the doctor's above right to recover. This lien is governed by the laws of the State of Nevada.

It is understood and agreed that a copy of this lien shall have the same force and effect as the original.

Patient Signature:_____Date:_____

The undersigned being attorneys of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor named above.

Attorney Signature:_____Date:_____

Attorney's Officer, please sign lien and fax to doctor's office. Retain a copy for your records

MINIMALLY INVASIVE CENTER OF EXCELLENCE (MICOE)
PATIENT RIGHTS

1. Exercise these rights without regard to sex, cultural, economic, educational, religious background, or the source of payment for care.

2. Patients of MICOE are treated with respect, consideration, and dignity.

3. Patients are provided the appropriate privacy. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly, including the right of the patient to have auditory privacy for any discussion of his/her medical treatment at MICOE.

4. The patient has the right to be advised as to the reason for the presence of any individual involved with his/her patient care.

5. Knowledge of the name of the physician who has primary responsibility for coordination of the care at MICOE, as well as the names and professional relationships of other physicians and non-physicians who will be involved with the patient care.

6. Except when required by law, patient disclosures and records are treated confidentially, and written permission shall be obtained from the patient before the medical records can be made available to anyone not directly concerned with the care.

7. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, prognosis and prospect for recovery in terms that the patient can understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

8. Patients are given the opportunity to participate in decisions involving their healthcare at MICOE, except when such participation is contraindicated for medical reasons.

9. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. This information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person(s) who will carry out the procedure or treatment.

10. Information is available to patients and staff concerning:
    a. Patient rights, including those specified above
    b. Patient conduct and responsibilities
    c. Services available at the organization
    d. Provisions for after-hours and emergency care
    e. Fees for services
    r Payment policies
    g. Patient's right to refuse to participate in experimental research
    h Methods for expressing grievances and suggestions to MICOE
    i. Advance directives, if so requested by the patient
    j. Credentialing of healthcare professionals.

11. Patients are informed of their right to change primary or specialty physicians if other qualified physicians are available.

12. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

13. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.

14. Patients will receive information in a format that they can readily understand. When necessary, an interpreter will be used.

15. Reasonable responses to any reasonable requests made for services.

16. Patients may leave MICOE, even against the advice of Physicians, with a release.

17 Reasonable continuity of care and to know in advance the time and location of appointment, as well as the identity of persons providing the care.

18 Be informed of continuing healthcare requirements following discharge from MICOE.

MINIMALLY INVASIVE CENTER OF EXCELLENCE
PATIENT RESPONSIBILITIES

POLICY:

1. Patients have the responsibility to provide accurate and complete information about current and past illnesses, medications, supplements, over the counter products, allergies or sensitivities and other matters pertaining to their health.

2. Patients have the responsibility to follow the treatment plan recommended by their practitioner or express concerns regarding their ability to comply.

3. Patients are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions. The patient must be respectful of all health care professionals, staff, and other patients in the facility. Patients have the responsibility to arrive as scheduled for appointments and to cancel in advance appointments they cannot keep.

4. Patients have the responsibility to become informed of the scope of basic services offered, change of provider if other qualified provider is available, the costs, and the necessity for medical insurance and to actively seek clarification of any aspect of participation in MINIMALLY INVASIVE CENTER OF EXCELLENCE services and programs (including cost) that is not understood.

5. The patient must accept personal responsibility for any charges not covered by insurance.

6. Patients have the responsibility to provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by his/her provider.

7. Patients have the responsibility to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PATIENT SIGNATURE:_____ DATE:_____

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ADVANCE DIRECTIVE

How does this person know what I would want?
After you choose someone, talk to that person about what you want. You can also write down in the Advance Health Care Directive when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent. Take a copy with you when you go into a healthcare/medical facility.

Sometimes treatment decisions are hard to make, and it truly helps your family and your doctors if they know what you want. The Advance Health Care Directive also gives them legal protection when they follow your wishes.

What if I change my mind?
You can change or revoke your Advance Health Care Directive at any time as long as you can communicate your wishes.

Do I have to fill out the form?
No, you don't have to fill out the form if you don't want to. You can just talk with your doctors and ask them to write down what you've said in your medical chart. And you can talk with your family. But your treatment wishes will be clearer if you write them down, and your wishes are more likely to be followed.

Will I still be treated if I don't fill out an Advance Directive?
Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you.

Remember that an Advance Health Care Directive lets you name someone to make treatment decisions for you. That person can make most medical decisions—not just those about life-sustaining treatment—when you can't speak for yourself. Besides naming an agent, you can also use the form to say when you would and wouldn't want particular kinds of treatment.

How can I get more information about an Advance Directive?
You can ask your doctor or nurse, or more information can be made available to you by the center.

Patient's Int: _____

Date: _____

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How can I get more information about an Advance Directive?
You can ask your doctor or nurse, or more information can be made available to you by the center.

Patient's Int: _____

Date: _____

MICOE Surgery Center

Medication Reconciliation Pre-op Form

Patient label

ALLERGIES: ☐ NKDA ☐verified ☐ see attached list for extensive allergies

Medication:_____Reaction_____

_____

_____

_____

Medication Information Obtained From:

☐ Patient ☐ family member☐written list by patient

CURRENT HOME MEDICATIONS LIST PATIENT PLEASE COMPLETE SHADED AREA PRIOR TO SURGERY

Include prescriptions, over the counter drugs,herbal remedies,vitamins, dietary supplements

Medication	Taken For	How Often Is It Taken	Date/Time Last Taken	Date/Time Last Taken	Date/Time Last Taken	Date/Time Last Taken
* incomplete –patient did not have complete information			_____RN ☐incomplete	_____RN ☐incomplete	_____RN ☐incomplete	_____RN ☐incomplete

Patient Acknowledgement: I have provided as accurate a list as I can of my home medications. I will continue to follow the medication orders of the prescribing physician unless instructed to change. I understand that my medication list may be shared with other physicians.

Patient Signature:_____Date/Time:_____

***Current home medication list has been reviewed with the patient pre-operatively**

Staff Signature:_____Date/Time: _____

See back for post-op medication reconciliation

MICOE Surgery Center

Medication Reconciliation Post-op Form

Patient Label

MEDICATIONS RECEIVED AT MISI SURGERY CENTER

WHICH MAY HAVE AN EFFECT ON THE PATIENT AFTER DISCHARGE

NEW MEDICATIONS TO BEGIN TAKING

Medication	Dose	How Often Is It Taken	RX Given at	Med Info Given
			☐ Pre-op ☐DOS	☐ yes
			☐ Pre-op ☐DOS	☐ yes
			☐ Pre-op ☐DOS	☐ yes
			☐ Pre-op ☐DOS	☐ yes
			☐ Pre-op ☐DOS	☐ yes
			☐Pre-op ☐DOS	☐ yes
			☐ Pre-op ☐DOS	☐ yes

Please contact your prescribing physician concerning questions about continuing prescriptions after discharge.

I have received a copy of my reconciled medication at discharge MICOE Surgery Center and understand that a copy of the medication list will be a confidential part of my medical records.

Patient signature:_____ Date/Time:_____

1) Staff reviewing discharge post-op medications:_____

Date/Time:_____

2) Staff reviewing discharge post-op medications:_____

Date/Time:_____