M. Fariba Rahnema, M.D., F.A.C.E., E.C.N.U
653 N. Town Center Dr. - Suite 504 - Las Vegas, NV 89144
(702) 701-8400 Phone - (702) 701-8401 Fax

PATIENT REGISTRATION

Name: (Last) ______________________ **(First)** ______________________ **(Mi)** ________

Address: ____

City: ______________________ **State:** ______________________ **Zip:** ______________

Home Phone: ______________________ **Cell Phone:** ______________________

Email Address: ____

Primary Care Physician: ______________________ **Referring Physician:** ______________________

Sex: Male Female **Marital Status:** Single Married Divorced Other

SSN: ______________________ **Date of Birth:** ______________________

Employment: Full Time Part Time Student Unemployed

Employer: ______________________ **Employer Phone:** ______________________

Employer Address: ____

Primary Insurance: ______________________ **Insured Party:** Self Spouse Parent

ID #: ______________________ **Group #:** ______________________

Name: (Last) ______________________ **(First)** ______________________ **(Mi)** ________

Address: ____

City: ______________________ **State:** ______________________ **Zip:** ______________

SSN: ______________________ **Date of Birth:** ______________________

Secondary Insurance: ______________________ **Insured Party:** Self Spouse Parent

ID #: ______________________ **Group #:** ______________________

Name: (Last) ______________________ **(First)** ______________________ **(Mi)** ________

Address: ____

City: ______________________ **State:** ______________________ **Zip:** ______________

SSN: ______________________ **Date of Birth:** ______________________

Emergency Contact: Name: ______________________ **Relation:** ______________

Home Phone: ______________________ **Cell Phone:** ______________________

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New healthcare regulations require that we have our patients complete the form below. We are subject to yearly audits by the Centers of Medicare and Medicaid as well as other insurance companies and we need this on file.
Thank you for your cooperation.

Name: ____

Preferred Language:

☐ English ☐Spanish ☐ German ☐ French ☐Italian

☐ Vietnamese ☐ Mandarin ☐ Tagalog ☐ Other: ____________________

Race:

☐ Hispanic: ☐ Asian ☐ Caucasian ☐ African American ☐ Black

☐ Chinese ☐ Filipino ☐ American Indian or Alaska Native ☐ Japanese

☐ Native Hawaiian ☐ Pacific Islander ☐ Other: ____________________

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Other: ____________________

______________________________ ____________________
Signature Date

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Patient Name: ______________________________

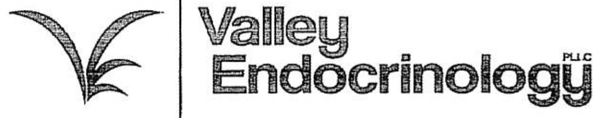
Pharmacy Name: ______________________________

Two Major Cross Streets: ______________________ **Phone:** ______________

CURRENT LIST OF MEDICATIONS

Please list ALL the medications you are currently taking. For each give the name, the strength of each dose, how often taken and when you began taking it. This list MUST be detailed, accurate and complete. Please consult with your family, pharmacist and all physicians. Do not neglect aspirin, pain medications, hormones, contraceptives, water, diet, nerve or sleeping pills and any other prescription or over the counter drugs.

Name of Medication	Strength of Dose	When Taken	Date Started Taking



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OFFICE POLICIES

1. NEW PATIENTS ARE REQUIRED TO ARRIVE 30 MINUTES BEFORE THEIR SCHEDULED TIME TO FILL OUT INTAKE FORMS.

2. A PHOTO I.D. AND INSURANCE CARD(S) ARE REQUIRED AT THE TIME OF SERVICE FOR NEW PATIENT AND ANNUALLY FOR ALL PATIENTS.

3. COPAYS ARE DUE AT THE TIME OF SERVICE. WE ONLY ACCEPT CREDIT/DEBIT CARDS.

4. IN THE EVENT THAT A PATIENT IS UNABLE TO MAKE THEIR SCHEDULED APPOINTMENT, THE PATIENT MUST GIVE US A 24-HOUR ADVANCE NOTICE. A $75 CHARGE FEE WILL APPLY IF CANCELLED OR/AND RESCHEDULE THE SAME DAY, AND $100 FOR ULTRASOUNDS/BIOPSY. IT WILL BE YOUR RESPONSIBILITY AND BILLED DIRECTLY TO YOU. PLEASE HELP US TO SERVE YOU BETTER BY KEEPING YOUR REGULAR APPOINTMENT.

5. A PATIENT WHO FAILS TO KEEP 3 OR MORE APPOINTMENTS IN A TWELVE-MONTH PERIOD (INCLUDING SAME DAY CANCELLATIONS), WITHOUT PRIOR NOTICE OR CANCELLATION, YOU MAY BE DISCHARGED FROM THE PRACTICE AT THE DISCRETION OF THE PATIENT'S PHYSICIAN.

6. FOR PAPER MEDICAL RECORDS REQUESTS, THERE WILL BE A CHARGE OF $0.60 PER PAGE. PLEASE ALLOW 10-15 BUSINESS DAYS FOR COMPLETION.

7. OUR OFFICE CHARGES $50 FOR FMLA. WE WILL NOT DO DISABILITY PAPERWORK. THIS CHARGE APPLIES TO EACH FORM THAT IS BEING REQUESTED TO BE FILLED OUT BY OUR OFFICE. PLEASE ALLOW 5-7 BUSINESS DAYS FOR OUR OFFICE TO COMPLETE THEM, THANK YOU.

SIGNING BELOW ACKNOWLEDGES THAT YOU HAVE RECEIVED OFFICE POLICY AND AGREE TO ABIDE BY THE GUIDELINES.

______________________	______________________	______________________
PRINT NAME	SIGNATURE	DATE

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A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the Nevada Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After the arbitration hearing, which is usually less formal than a court preceding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award.

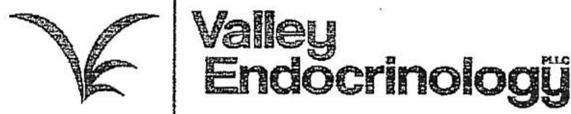
The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of the doctor is bound.



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What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and have an attorney of your choice, at your expense. This agreement generally helps to lower litigation time and costs for both patients and physicians. Further, both parties are spared the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

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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 there from 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

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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: ______________________________
Physician or Duly Authorized Representative Signature (Date)

By: ______________________________
Patient's Signature (Date)

By: Valley Endocrinology
Print or Stamp Name of Physician, Medical Group or Association Name

____
Print Patient's Name

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

____
Patient's Representative's Signature (If applicable) (Date)

____
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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HEALTH HISTORY QUESTIONAIRE

Name: ______________________________ **DOB:** ________________ **Date:** ____________

*Please answer all questions. If you do not know an answer, or do not understand the question, insert a question mark in the space. Please do not leave any blanks.

Chief Complaint

List the problems which have brought you here to seek medical help and approximately when each began.

	Problem	Date Began
1		
2		
3		
4		
5		

GENERAL HEALTH AND HABITS

Characterize your present health status: Excellent Very Good Average Poor

Exercise:

Do you exercise regularly: YES NO
How long have you exercised on a regular basis: ________
Type of exercise(s): ______________________________

____

How often: ____________________ days/week
____________________ mins/day

Nutrition:

Your weight: 10 yrs ago: ________ 5 yrs ago: ________
Now: ________
Your appetite: Excellent Good
Fair Poor
Are there foods you avoid or limit for health reasons?

____

Smoking:

Do you smoke: YES NO
How many per day: ________ How many years: ________
What do you smoke: Cigarettes Pipe Cigars
When did you quit: ________ years ________ months
How long have you smoked: _______ years ______ months

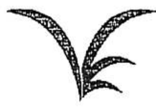
Alcohol/Beverages:

How much alcohol do you drink:
____________ per day ______________ per week
When did you stop: __________ years __________ months
Caffeinated beverages (coffee, tea, cola)
Cans/bottles: ___________ per day ___________ per week

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgeries you have, including the nature of each operation and where and when it was done.

Surgery	Nature	Where/When



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HEALTH INFORMATION AND PRIVACY ACT
RELEASE OF PATIENT INFORMATION
PATIENT AUTHORIZATION FORM

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I ____ give my authorization for Valley Endocrinology to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, personal identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use or disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical or hospital services.

By signing this form you consent to out using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at Valley Endocrinology.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as requested by Law, Public Health issues requested by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you choose not to sign this consent, it may be difficult for Valley Endocrinology to provide treatment. You will be provided with a copy of this signed authorization upon your request.

Signature: ____________________________________

Printed Name: ________________________________

Date: ____

Witness: ______________________________________

Health Insurance Portability and Accountability act of 1996 (42 U.S. Section 1320d et seq.) (45 CFR Subtitle A, Subchapter c.)

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND/OR CAREGIVERS

In the event Valley Endocrinology may need to give your medical information, may we…(check all that apply).

_____ Leave a detailed message on an answering machine.
_____ Leave a message with my spouse or family member.
_____ Call you on your cell phone, the number is: ______________________________
_____ Call you at work, the number is: ______________________________
_____ **ONLY** speak to you directly.

I, ______________________________ DOB ________________, give Valley Endocrinology and staff, authorization to disclose my protected health information to the following family, friends and/or caregiver.

Name: ______________________________ **Relation:** ____________________
Name: ______________________________ **Relation:** ____________________
Name: ______________________________ **Relation:** ____________________
Name: ______________________________ **Relation:** ____________________
Name: ______________________________ **Relation:** ____________________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Valley Endocrinology.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment and healthcare operations in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization and I need not sign the form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtained from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: ______________________________. If I fail to specify a date this authorization will expire one year from the signature date on this form.

______________________________ ____________________
Signature of Patient/ Guardian/ Personal Representative **Date**

______________________________ ____________________
Signature of Employee **Date**

M. Fariba Rahnema, M.D., F.A.C.E., E.C.N.U
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MEDICAL RECORDS RELEASE

I authorize the release of my medical information:

☐ **ALL MEDICAL RECORDS** (*Including but not limited to progress notes, history, physicians orders, lab results and diagnostic tests*)
☐ **LAB REPORT(s)** ☐ **XRAY REPORT(s)** ☐ **DC SUMMARY**

I authorize the above records to be ***RELEASED FROM:***

Facility Name: ____________________
Address: ____________________
City: ____________________ State: ____________ Zip: ____________
Phone: ____________________ Fax: ____________________

I authorize the above records to be ***RELEASED TO:***

Valley Endocrinology
653 N. Town Center Dr.
Suite 504
Las Vegas, NV 89144
Phone: (702) 701-8400 ~ Fax: (702-701-8401

The expiration of this authorization will be:

☐ 90 days from signature ☐ On this date: ____________
☐ When this event happens: ____________________

Reason for disclosure of this health information:

☐ Transfer of records to another provider
☐ Transfer of records to complete health records at another entity
☐ Insurance Claims Information ☐ Attorney
☐ Person Use ☐ Other: ____________

Additional Patient Information

- I understand that I have the right to revoke this authorization. I understand that to revoke this authorization I must do so in writing to Valley Endocrinology. I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- I understand that I do not have to sign this authorization to receive treatment.
- I understand that my health information may be subject to re-disclosure and not protected by the federal privacy rule.
- I understand that if I do not specify an expiration date, this authorization will expire 6 months from signature date.

PATIENT NAME: ____________________ **DATE OF BIRTH:** ____________

PATIENT SSN: ____________________ **PHONE:** ____________________

SIGNATURE: ____________________ **DATE:** ____________

Financial Policy

______ *Initials* 1. Patients are required to pay their co-pay at the time of service. If you cannot pay, you must speak with billing department before your office visit, to set up payment arrangements except for new patients.

______ *Initials* 2. I understand I am financially responsible for all charges whether or not paid by my insurance company also that it is my responsibility to know my benefits. I hereby authorize Valley Endocrinology to release all information necessary to secure payment. I authorize payment of my medical benefits directly to Valley Endocrinology.

______ *Initials* 3. Should you issue a check that is returned to us "UNPAID", the following will occur: You will receive a telephone call from a Valley Endocrinology representative, asking you to come in and make the check good within 48 hours. We will, collect the original check amount, bank fees determined by our bank and a $25 re-processing fee. Should this happen again, the bank fees increase and our second processing fee increases to $50. No checks will then be accepted here in the future. This repayment and any future payments will be accepted in cash, credit or debit card.

______ *Initials* 4. I understand that Valley Endocrinology is a participation physician in the Medicare Program. I understand that Medicare patients are responsible for the annual deductible of $183 and the amount equal to 20% of the Medicare allowable.

______ *Initials* 5. I hereby authorize Valley Endocrinology to furnish information to my insurance company concerning my examinations, findings and treatment.

______ *Initials* 6. If you are not able to keep your appointment, you must call 24 hours prior and cancel. If you no show or do not cancel, we will charge you $50 for that missed doctor appointment, if an ultrasound appointment is missed we will charge you $100. In fairness to other patients you must follow these guidelines. I also understand that if I do not show for my appointments three times that I may be dismissed from the practice.

______ *Initials* 7. I understand that in the event my account is referred to a collection agency due to lack of payment on my part, I agree to pay all collection fees that will be added to my balance which is charged by the collection agency.

______ *Initials* 8. All forms requiring the provider's time to complete, bears a $25 fee that must be paid at the time of completion. Insurance companies will not pay for this service.

______ *Initials* 9. Medical records requests bear a .60 per page fee NRS 629.061. We are authorized by the Federal Government to charge for these requests. If you are moving and wait until you select your new provider, we will honor the request from another provider's office and fax at no charge. Should you want a copy of all your records, we will collect .60 per page, plus postage if applicable. You must allow Valley Endocrinology one week to process your request. If you have an outstanding balance we will not release records until your account is paid.

By signing below, I acknowledge all of the above and agree to provisions in Valley Endocrinology's policy. If I do not sign this acknowledgment I am aware I will be subject to Valley Endocrinology not accepting my insurance, I will pay cash for my visits at the time of service. I also acknowledge Valley Endocrinology will not issue any medical records unless I have given Valley Endocrinology the names of whom, I authorize the release of my medical records. I have read and agreed to all the provisions of the financial policy. I understand that I am ultimately responsible for all the profession fees incurred for professional services by the physician.

______________________________ ______________________

Signature of Responsible Party Date

Valley Endocrinology PLLC

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PLEASE READ AND RETURN TO FRONT DESK

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

- **Treatment:** Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professional who may provide treatment or who may be consulted by staff members.
- **Payment:** Your health information may be used to seek payment from your health plan, from other source of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
- **Health Care Operations:** Your health information may be used as necessary to support the day-to-day activities and management of Valley Endocrinology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
- **Law Enforcement:** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
- **Public Health Reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health.
- **Other uses and disclosures require your authorization:** disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorizations. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

- **Appointment Reminders:** Your health information will be used by our staff to send you appointment reminders.
- **Information about Treatment:** Your health information may be used to send information that you may find interesting on the treatment and management of your medical condition. W may also send you information describing other health related products and services that we believe may interest you.
- **Fund Raising:** Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

☐

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Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive and accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Valley Endocrinology Duties

We are required by law to maintain the privacy of your health information and to provide with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outline in this notice.

Right to Revise Privacy Practices

As permitted by the law, we reserve the right to amend our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect of copy protected health information be submitted in writing.

You may obtain a form to request access to your records by contacting the Medical Records Clerk or Office Supervisor. Your request will be reviewed and will generally be approved unless there are legal of medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Valley Endocrinology
653 N. Town Center Dr Ste # 504
Las Vegas, NV 89144

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing that cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Valley Endocrinology
653 N. Town Center Dr Ste # 504
Las Vegas, NV 89144

Effective Date This Notice is effective on or after April 14, 2003.

M. Fariba Rahnema, M.D., F.A.C.E., E.C.N.U
653 N. Town Center Dr. - Suite 504 - Las Vegas, NV 89144
(702) 701-8400 Phone - (702) 701-8401 Fax

Acknowledgement of Receipt of Notice of Privacy Practices

Valley Endocrinology reserves the right to modify the privacy practices outlined in the notice.

Signature:
I have received a copy of the Notice of Privacy Practices for Valley Endocrinology.

____

Name of Patient (Print or Type)

____

Signature of Patient **Date**

____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

******************************For Office Use Only***********************************

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices Attempt to obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on ____________________. This acknowledgment was not obtained because:

☐ The patient was undergoing emergency treatment

☐ The patient declined to sign the acknowledgment

☐ Other

Signature:

____

Name of Patient (Print or Type)

____

Name of Staff Member

____

Date