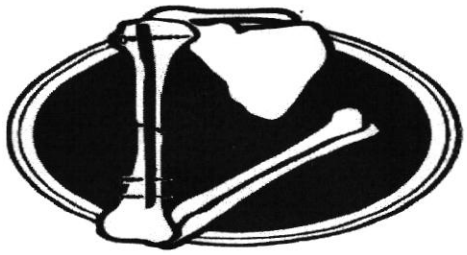

SILVER STATE ORTHOPEDICS

WWW.SILVERSTATESORTHO.COM

3196 S. Maryland Parkway #112 Las Vegas, NV 89109 Phone: (702) 216-2670 Fax: (702) 826-4845

Patient Information

Last: _____ First: _____ MI: ____ Social Security: _____

Street Address: _____ Apt: _____ City: _____ Zip: _____

DOB: _____ Age: _____ Marital Status: S__ M__ D__ W__ Sex: _____

Telephone: (____) _____ Cell: (___) _____ Email: _____

Employer: _____ Employer's Address: _____

Occupation: _____ Work Phone (___) _____

Emergency Contact: _____ Telephone (___) _____

Guarantor Information (Insured Person)

Last: _____ First: _____ MI: ____ Social Security: _____

Street Address: _____ Apt: _____ City: _____ Zip: _____

DOB: _____ Sex: _____ Relationship: _____Telephone: (____) _____

Employer: _____ Work Phone (___) _____

Name(s) of Insurance 1 _____ 2 _____

Additional Information

Accident: Yes____ No: ____ DOI: _____ Work Related: ____ Auto Accident: ____ Atty retained: _____

Describe How Injured: _____

Body Part Injured: _____ Check One: (RIGHT) _____ (LEFT) _____

Do you have insurance: YES __ NO __ Thru Employer: YES __ NO __ Private Insurance: YES ___ NO _

Name(s) of Insurance 1 _____ 2 _____

Were you seen in Emergency Room: YES _____ NO _____ Where: _____ When: _____

Were X-rays taken: YES _____ NO _____ Where: _____ When: _____

I hereby sign to David A. Silverberg, M.D., all benefits for surgical and medical payable under the attached policy and/or policies. I also authorize release of information under the same policy. I understand I am financially responsible for any and all charges not covered/or denied by any insurance.

Signed _____ Date _____

SILVER STATE ORTHOPEDICS

WWW.SILVERSTATEORTHO.COM

3196 S. Maryland Parkway, Suite 112 Las Vegas, NV 89109 Phone (702) 216-2670 Fax (702) 826-4845

Name: _____ Date: _____

Current Medications					
Medication Name	**Strength (mg)**	**Quantity**	**Refills**	**Prescribing Doctor**	**Phone Number**

** If more space is needed please feel free to continue on the back of this page

Drug Allergies	
Drug	Reaction

* _____

Preferred Pharmacy Name

* _____

Address

* _____

City, State, Zip

* _____

Phone

*Please Enter All Information

Signed _____ Date _____

SILVER STATE ORTHOPEDICS

3196 S. Maryland Parkway, Suite 112 Las Vegas, NV 89109
Phone (702) 216-2670 Fax (702) 826-4845

Name: _____ **Date:** _____

Please List All Physicians You Are Currently Consulting

Clinic Name _____

Address _____

Phone number (____) _____

Physician names _____

Specialty_____

Clinic Name _____

Address _____

Phone number (____) _____

Physician names _____

Specialty_____

Clinic Name _____

Address _____

Phone number (____) _____

Physician names _____

Specialty_____

❖ *If additional space is need please continue on back of this page.*

Silver State Orthopedics
Diplomate American Board of Orthopaedic Surgery
3196 S. MARYLAND PARKWAY, SUITE 112
LAS VEGAS, NV 89109
(702) 216-2670 (702) 826-4845 (FAX)

FINANCIAL POLICY

All fees for medical care are based on the usual and customary fees charged in this area by physicians of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGMENTS HAVE BEEN MADE.

Our office does verify eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. The patient "responsible portion" is due at the time of service. This includes co-pays, deductibles and co-insurance(s). We will do all we can to assist you with your health insurance claims, however insurance is a contract between the insurance company and the insured. Not all insurance plans cover all services. In the event your insurance plan determines a service to be 'non-covered', you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Final responsibility for payment of your account rests with you.

If you are scheduled for surgery, we may require a deposit, which must be paid prior to your date of surgery.

Any prior authorizations obtained by this office on your behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim.

If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist in our office. Please be sure to bring your insurance card and photo identification at every appointment.

In the event that my account becomes a delinquent account for forwarded to a collection agency, I agree to pay all incurred charges, collection agency charges, legal fees and court costs. If it is necessary to forward your account to a collection agency, a collection fee mark up of 35% - 50% will be added to the amount owed prior to having the account forwarded to the agency.

A returned check charge of $25 will be charged to my account for each returned check. If a returned check is not made whole (paying the original check amount plus the bounced check fee and the regulatory fee) the returned check will be sent to the Clark County District Attorneys office for additional processing.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medigap, Veterans' Administration or other designated payor of medical benefits to David Silverberg MD LTD for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of this assignment is considered as valid as the original.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Signature) Date

Silver State Orthopedics
Diplomate American Board of Orthopaedic Surgery
3196 S. MARYLAND PARKWAY, SUITE 112
LAS VEGAS, NV 89109
(702) 216-2670 (702) 826-4845 (FAX)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review and/or receive a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: (please circle one or indicate OTHER)

SELF
PARENT
GUARDIAN
POWER OF ATTORNEY (MUST PROVIDE DOCUMENTATION)

OTHER: _____

Silver State Orthopedics
Diplomate American Board of Orthopaedic Surgery
3196 S. MARYLAND PARKWAY, SUITE 112
LAS VEGAS, NV 89109
(702) 216-2670 (702) 826-4845 (FAX)

Privacy Practices Notice

The attached 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. This document is intended to serve as a summary of our privacy practices only.

Uses and Disclosures

Permitted without Authorization:

- Treatment, Payment, Insurance Authorizations and Operations
- Public Health, Abuse or Neglect, and Health Oversight
- Legal Proceedings and Law Enforcement
- Worker's Compensation
- Inmates
- Military, National Security & Intelligence Activities, Protection of the President
- Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
- Certain uses & disclosures including appointment reminders, treatment alternatives, and other health related benefits

Require Authorization:

- Disclosures to Friends or Family
- Any other requested disclosure

Your Rights under Federal Privacy Regulations

- Request restrictions or limit disclosures for treatment, payment or operations
- Receive confidential communications by alternative means
- Inspection and Copies of Protected Health Information
- Request amendment to your medical records
- Accounting of Certain Disclosures
- Right to a Copy of Privacy Notice

Our Duties

- Protect the privacy of your medical information and to abide by the terms of the notice of privacy practices in effect
- Contacts for questions or requests:

U.S. Department of Health and Human Services
HIPPA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

David Silverberg MD, LTD
Attn: Office Manager
P. O. Box 36455
Las Vegas, NV 89133

Effective Date: April 12, 2010

PLEASE KEEP THIS SHEET FOR YOUR RECORDS