RUBY VISTA MEDICAL

DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

## PATIENT INFORMATION

Name _____ Date of Birth _____

Mailing Address _____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Social Security # _____

Email _____

Sex: M F Referred by: _____

Emergency Contact _____ Phone _____

Occupation _____ Employer/Address _____

Work Phone _____

Insurance Coverage: _____ If Not, Payment in Full is Required at Time of Service

**PRIMARY INSURANCE-** We will need to make a copy of your insurance card, front & back

Insurance Company _____ Policy Holder _____

Member ID#_____ Group # _____

Policy Holder Date of Birth _____ Relationship to Patient _____

Policy Holder Social Security # _____ Address _____

Policy Holder Employer/ Address _____

**SECONDARY INSURANCE-**

Insurance Company _____ Policy Holder _____

Member ID#_____ Group # _____

Policy Holder Date of Birth _____ Relationship to Patient _____

Policy Holder Social Security # _____ Address _____

Policy Holder Employer/ Address _____

## AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the medical staff at Ruby Vista Medical to help determine appropriate treatment. If there is any change in medical status, I will inform the Dr. Shane Draper, Dr. Quinn Lindstrom, or Sue Windous FNP-BC. I give permission to Dr. Shane Draper, Dr. Quinn Lindstrom, or Sue Windous FNP-BC to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremities. I authorize my insurance company to pay to Dr. Shane Draper or Dr. Quinn Lindstrom, all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Shane Draper or Dr. Quinn Lindstrom to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Print Name _____

**COPAY OR PAYMENT IS DUE AT TIME OF TREATMENT**

RUBY VISTA MEDICAL

DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

Name: _____ Date of Birth: _____

Primary Care Physician: _____

Preferred Pharmacy: _____

Medications and Dosages: _____

_____

_____

_____

Drug Allergies: _____

_____

Marital Status: M S D W

# of Children: _____

Employed: Full time Part time Retired Student

Nutrition: Excellent Good Average Poor

Exercise: Walking Cardio Weights None

Exercise Frequency: Regular Occasional Never

Smoking: Yes No

Current: Amount per day: _____

Former: Quit Date: _____

Alcohol Use: Yes No Amount: _____

Cannabis Use: Yes No Amount/Type: _____

Illicit Drug Use: Yes No

Signed form of DNR (Do not Resuscitate): Yes No

RUBY VISTA MEDICAL

DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

## PATIENT CHRONIC ILLNESSES:

| | | | |
|---|---|---|---|
| | Anemia | | Gout |
| | Arthritis, Degenerative | | Hepatitis |
| | Arthritis, Rheumatoid | | High Blood Pressure |
| | Asthma | | High Cholesterol |
| | Atrial Fibrillation | | HIV/AIDS |
| | Back Pain | | Hyperthyroidism |
| | Cancer _____ | | Hypothyroidism |
| | Cardiac Murmur | | Kidney Stones |
| | Chronic Kidney Disease | | Obesity |
| | Chronic Pain Syndrome | | Obstructive Sleep Apnea |
| | Congestive Heart Failure | | Osteopenia |
| | Coronary Artery Disease | | Osteoporosis |
| | COPD | | Peripheral Vascular Disease |
| | Deep Vein Thrombosis | | Restless Leg Syndrome |
| | Depression | | Stroke |
| | Diabetes Type I | | Tuberculosis |
| | Diabetes Type II | | Varicose Veins |
| | Eczema | | |

Other: _____

_____

_____

## SURGERIES:

_____

_____

_____

_____

_____

_____

775.738.1100
2078 Idaho Street | Elko, Nevada 89801

RUBY VISTA MEDICAL

DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

## FAMILY HISTORY:

**Mother:** Living / Deceased

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease

Cancer: _____ High Cholesterol Depression Diabetes: Type I / Type II

High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke

Low Thyroid High Thyroid Foot Problems Unknown Other: _____

**Father:** Living / Deceased

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease

Cancer: _____ High Cholesterol Depression Diabetes: Type I / Type II

High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke

Low Thyroid High Thyroid Foot Problems Unknown Other: _____

**Siblings:** (#___ Brothers, #___ Sisters) Living / Deceased

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease

Cancer: _____ High Cholesterol Depression Diabetes: Type I / Type II

High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke

Low Thyroid High Thyroid Foot Problems Unknown Other: _____

**Other Family History:** Unknown Adopted

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease

Cancer: _____ High Cholesterol Depression Diabetes: Type I / Type II

High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke

Low Thyroid High Thyroid Foot Problems Unknown Other: _____

## PRIVACY PRACTICES – CONSENT TO SHARE INFORMATION

The Health Insurance Portability and Accountability Act (HIPPA) require us to give you a notice of our privacy practices and to acknowledge your receipt of the notice. You have been asked to sign that document either electronically or on paper.

The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights with regard to your protected health information. As well as our legal responsibilities.

(1) It is important for us to honor the confidentiality between the patient and provider. Please help us do this by checking your preference(s) below:

| Name | Relationship | Phone # |
|---|---|---|
| | | |
| | | |
| | | |

- o You may leave medical information (test results, prescription refill information, etc) on my voicemail at:
  Cell # _____ Home # _____

(2) I do hereby acknowledge that the office of Ruby Vista Medical has explained the notice of their privacy practices, as required by Federal Law (HIPPA) and consent to share my medical information with the above listed.

_____ _____ _____ _____

Print Name of Patient Patient DOB Signature of Patient Date

Note: If the individual listed above is a minor child or legally incapacitated, a parent or legal guardian/representative should sign below on behalf of the individual and list their relationship.

_____ _____ _____

Signature of Legal Guardian Date Relationship

# NOTE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list the notice of each of these categories of uses or disclosures. The listing is below.

**As Required By Law**

We may use or disclose your health information as required by any statue, court order or other mandate enforceable in a court of law.

**Abuse or Neglect**

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonable believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that such a disclosure ahs been made unless the Privacy Official determines that informing you would not be in our best interests.

**Public Health and National Security**

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to the public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

**For Law Enforcement**

As permitted or required by State and Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

**Family, Friends, and Caregivers**

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgement when sharing your health information only when it will be important to those participating in providing your care.

**Workers' Compensation Purposes**

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

**Judicial and Administrative Proceedings**

We may disclose your health information in administrative or judicial proceedings in response to a subpoena or request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

**Incidental Uses and Disclosures**

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this notice.

**Health Oversight Activities**

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

**To Avert a Serious Threat to Health or Safety**

We may disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

**To The U.S. Department of Health and Human Services (HHS)**

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy laws and regulations regulating the privacy and security of health information.

**For Research**

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

**In Connection With Your Death or Organ Donation**

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purpose, or to an organ procurement organization to facilitate transplantation of your of your organs.

**Authorization to use or Disclose Health Information**

Other than stated above or where Federal, State, or Local Law requires, us, we will not disclose your health information other that with your written authorization. You may revoke that authorization in writing at any time.

## Patient Rights

You have the following rights related to your health information.

**Restrictions**

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to requested restriction. Our office will honor your request that we not disclose your health information to health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

**Confidential Communications**

You have the right to read, review, and copy your health information, including your complete, chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If

there will be a charge, we will first contact you to determine whether you would like to modify or withdraw your request.

**Amend Your Health Information**

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, in not part of our records of if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

**Accounting of Disclosures of Your Health Information**

Your have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for which additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you would like to modify or withdraw your request.

**Signature:** _____ **Date:** _____

RUBY VISTA MEDICAL

DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

## Patient Bill of Responsibility

This office is committed to giving our patients the best care possible. As a patient of Ruby Vista Medical, I agree to the following:

- I agree to pay all co-payments and/or deductibles that are due, at the time of service.
- If I do not have insurance, I agree to the "Self Pay Policy"

### Self Pay Policy

30% discount if paid in full at time of service

After 90 days you will be sent to collections and incur a 35% collection fee.

- As a courtesy, we will submit charges to your insurance, but the patient is ultimately responsible for payment.
- I agree to be on time to my appointments, if I am 10 minutes late, I will reschedule.
- I will give 24-hour notice if I need to reschedule my appointment.

Signature: _____ Date: _____

775.738.1100
2078 Idaho Street | Elko, Nevada 89801

DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

RUBY VISTA MEDICAL

# PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referral needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier. Payment for office services are due at the time of service. We will accept VISA, Mastercard, Cash, or Check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have to your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan in which we do not have prior agreement, we will prepare and send the claim for you on unassigned bases. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office in not informed, you will be responsible for an charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due on week prior to surgery.
- Past due accounts are subject to collection proceedings. All, costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.
- There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee.

Signature: _____ Date: _____

RUBY VISTA MEDICAL

DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
Foot & Ankle Specialists
SUE WINDOUS,
FNP-BC

## Authorization to Use or Disclose Health Information

Patient Name: _____ Health Record #_____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. Dr. Shane Draper is authorized to make the disclosure
3. The type of information to be used or disclosed is as follows (indicate your choice below and include other infor where indicated.)
    a. _____ entire medical record
    b. _____ laboratory results (please describe the dates or types of laboratory tests you would like to disclose) _____
    c. _____ x-ray and imaging reports (please describe the dates or types of x-ray or images you would like to disclose)_____
    d. _____ other (please describe) _____
4. I understand that the information in my health record may include information relating to to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. The information identified above may be used by or disclosed to the following individuals or organizations:
   Name: Ruby Vista Medical Dr. Shane Draper, Dr. Quinn Lindstrom, Sue Windous FNP-BC
   Address: 2078 Idaho Street Elko, Nevada 89801
   Phone #: (775) 738-1100 Fax #: 775-738-1101
6. This information for which I'm authorizing disclosure will be used for the following purpose:
    a. _____ my personal records
    b. _____ sharing with other health care providers as needed
    c. _____ other (please describe) _____
7. I understand that I have a 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 Ruby Vista Medical. 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 my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. This authorization will NEVER EXPIRE. If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.
9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information by not be protected by federal privacy laws or regulations.
10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative: _____ Date: _____

If signed by level representative, relative to patient: _____

Signature of witness: _____ Date:_____