Family Doctors
OF GREEN VALLEY
Where your family comes first.

Patient Information (Personal Injury)

Last Name: ____________________ First Name: ____________________ MI:______
Social Security #: ____________________ Date of Birth: ____________________
Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address: ____ Apt #: ______________
City: ________________________ State: ____________ Zip Code: ______________
Home Phone: ______________________ Cell Phone: ________________________
Emergency Contact Name: ____________________ Phone Number: ________________
E-mail Address: __________________________________

Pharmacy Name:_________________________ Pharmacy Phone Number: ____________

Employer Information of Patient

Employer:____________________________ Phone Number:__________________
Address:____
City: ________________________ State: ____________ Zip Code: ______________
Occupation: ____

Responsible Party (if other than patient): Relationship to Patient: ______________________
Last Name: __________________ First Name: __________________ Date of Birth: ________
Address: ____
Street Address *Apt No.* *City* *State* *Zip Code*

Who we can thank for referring you to Family Doctors of Green Valley
☐Doctor:___________ ☐Patient:______________ ☐Friend:________ ☐Attorney:_________
☐Hospital___________ ☐Search Engine___________ ☐ Internet/Online _____________
☐Social Media_________ ☐Website:______________ ☐Insurance Co: ___________
☐Henderson Phone Book ☐Sun City/Anthem Phone Book ☐Driving By

By signing below, I certify the above information is correct.

________________________________ ________________________
Signature of Patient or Responsible Party Date

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Due to HIPAA (Health Information Portability & Accountability Act) we have had difficulties contacting patients. By filling out and signing below, you are authorizing the release of medical information.

Date: ________________
Patient Name: ______________________
Date of Birth: ______________________
Social Security #: ____________________

Check all that apply:

☐ I authorize my medical information to be released to the following person (s):

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

☐ When calling to release test results, what is the **BEST** number to contact you?

______________________ Daytime Phone Number

______________________ Evening Phone Number

And in the event you are unable to be reached, may we leave a message?

☐ Yes ☐ No

☐ Authorizing medical information and/or newsletters pertaining to the practice to be released by e-mail.

______________________________ E-Mail Address

______________________ Patient Name (Please Print)

______________________ Patient Signature

NOTE: In the event that we are unable to contact you by either phone or e-mail, after several attempts your results will be mailed to you. If you have any questions, please contact the Nursing Department at (702) 616-9471.

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291 N Pecos. Henderson, NV 89074
Phone: (702) 616-9471 Fax: (702) 616-9681

Release of Information

Date: ________________________

Patient Name: ____________________________

Social Security: ____________________________

Date of Birth: __________________

For Office Use Only:

Authorizing Release from:

____
Name of Doctor or Facility

____
Address

______________________________ ______________________________
Phone Number Fax Number

Authorizing Release to:
Family Doctors Of Green Valley
Name of Doctor or Facility
291 N Pecos Henderson, NV 89074
Address
702-616-9471 **702-616-9681**
Phone Number Fax Number

Records Requested:

☐ All Medical Records

☐ Radiology ☐ Cardiology ☐ Labs ☐ Doctor Notes ☐ Other:_________

____ ______________________
Patient Signature Date

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Acknowledgement of Policies

I have read, understand and agree with all of the listed policies below:

- **Family Doctors of Green Valley's Financial Policy**
- **Patient Consent for use and disclosure of Protected Health Information (PHI) form**
- **Family Doctors of Green Valley's Office Policy Acknowledgement Form**

____________________________________ ____________________________
Patient or Legal Guardian Signature Date

____
Printed Name of Patient

Optional:
If you would like to receive a copy of our Privacy Practices forms, please sign below

Acknowledgement of Receipt of Privacy Practices

I ____________________________ have received a copy of Family Doctors of Green Valley’s notice of Privacy Practices which became effective on April 14, 2003.

______________________________ __________________________
Patient or Legal Guardian Date

DOCTOR'S LIEN
AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Doctor/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/ injury/ illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/ injury/ illness and agree to irrevocably instruct my attorney to pay you in full from and proceeds of settlement, claim or judgment related to this accident/ injury/ illness.

I also understand that if the settlement does not cover my entire bill at this clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment, which I may eventually recover.

Furthermore, in consideration for the below named Doctor/ Clinic refraining from attempting to collect immediate payment for service rendered for my accident/ injury/ illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/ Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

Ravi Ramanathan
P.O. Box 30102 Dept 316
Salt Lake City, UT 84130-0102
Tel: (702)616-9471
Fax: (702)616-9681
E-mail: Drram@fdogv.com

____
Patient Name (Please Print)

____
Patient Signature

____
Date

INSTRUCTIONS TO COUNCEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctors/Clinic prior to distributing any proceeds to me, for the services that have been provided to me for the accident/injury/illness that I have agreed to pay.

____________________	____________________
Firm Name	**Patient Signature**
____________________	____________________
Attorney Name	Date

ATTORNEY ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my Client's instructions to Counsel and Lien and agreed to honor the same.

____________________	____________________
Attorney Signature	Date

DOCTOR'S LIEN

TO: ATTORNEY

____

____

____

DOCTOR

___Ravi S. Ramanathan_____

_291 N. Pecos Road_________

_Henderson, NV 89074_______

PATIENT: ____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her case history, examination, diagnosis, treatment, pharmaceutically dispensed medications, and prognosis in regard to my accident/injury/illness which occurred/began on:

____
Date of Injury

I hereby give a lien to said doctor on my claim, judgment, settlement, or verdict as a result of said accident/injury/illness, and authorize and direct you, attorney, to pay directly to said doctor such sums as may be due and owing him/her for services rendered to me, and to withhold such sums from such claim, judgment, settlement, or verdict as may be necessary to protect said doctor adequately.

I fully understand I am directly and fully responsible to said doctor for all medical bills submitted by him/her for service rendered to me, and that this agreement is made solely for said doctor's additional protection, and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any claim, judgment, settlement, or verdict by which I may eventually recover said fee.

____
Signature of patient, Legal Guardian, or Personal Representative

____
Date

____
Name of patient, Legal Guardian, or Personal Representative (PLEASE PRINT)

____
Relationship to Patient

The understanding, being attorney or authorized representative of attorney for the above patient, does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named doctor.

____
Attorney's Signature/Authorized Representative for Attorney

____
Date