STEPHEN T. VARGO, M.D.
3150 N. TENAYA WAY, SUITE 550
LAS VEGAS, NV 89128

PHONE: (702) 648-9400 Fax: (702) 636-0249

PATIENT INFORMATION: PLEASE PRINT (BLACK INK ONLY)

Name:_____ Date of Birth:_____Male:___Female:___Age:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Employer:_____ Address:_____ Social Security#: _____-_____-_____

Ethnicity:_____Emergency Contact:_____ Phone Number:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company:_____ Member ID:_____Group #:_____

Claims Mailing Address:_____City:_____State:_____ Zip Code:_____

Name of Insured:_____ Relationship to Patient:_____

Insureds Date Of Birth:_____ Social Security #:_____-____-_____Insurance Phone Number:_____

SECONDARY INSURANCE INFORMATION:

Insurance Company:_____Member ID:_____Group #:_____

Claims Mailing Address:_____City:_____State:_____ Zip Code:_____

Name of Insured:_____ Relationship to Patient:_____

Insureds Date Of Birth:_____ Social Security #:_____-____-_____ Insurance Phone Number:_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:
I hereby authorize medical treatment for the above named patient and fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. **I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to STEPHEN T. VARGO, M.D.., for any fees not covered by insurance.**

X_____ I understand that my insurance will be billed as a courtesy to me. I also understand that it is my responsibility to follow up with my insurance company 30 days from the date of service, to make sure they are processing my claims. Any claims not paid within 90 days will be my responsibility. I will be charged $40.00 for an unexcused no-show or cancellation within 24 hours of my appointment.

X_____ If I do not pay my copays or deductibles at the time when they are due or at the time of service, I understand that I will be responsible for an additional $10 (ten) dollar administrative fee for each event, collection fees are additional.

X_____ I also understand that I will be charged for an unexcused no-show or cancellation within 24 hours of my appointment time. In the event of default on any payments due to STEPHEN T. VARGO, M.D.., I agree to pay costs of collection, including attorney fees. I hereby authorize the filing of any insurance in force and the direct payment to STEPHEN T. VARGO, M.D. of any amounts on my claim. I further authorize the office of STEPHEN T. VARGO, M.D. and all pertinent medical records necessary to facilitate insurance billing or medical care and authorize the creditor or higher agent to make any employment or insurance verification and release of all information needed to process claims. I hereby authorize the office of STPHEN T. VARGO, M.D., to Receive, Mail, Fax, or E-mail my records to another physician or medical facility in the course of my diagnosis and treatment.

Signature:_____Date:_____

Acknowledgement of Privacy Practices: I hereby acknowledge that I have received a copy of this Notice Of Privacy Practices.

Signature:_____Date:_____

Stephen Vargo, MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date: _____

Address: _____ SS#: _____

_____ DOB: _____

Please send a copy of my records as indicated for the date(s) of Treatment:
(This portion to be completed by staff)

From _____ to _____

☐ Operative Records ☐ Lab Reports ☐ H&P ☐ X-Ray Reports

☐ Discharge Summary ☐ Other _____

Purpose of releasing medical information: _____

_____

I authorize you to release the records indicated above to:

Stephen Vargo, MD
3150 N. Tenaya Way, Suite 550
Las Vegas, NV 89128

Permission to fax records for medical emergency?: ☒ Yes ☐ No

Signature: _____ Date: _____

Witness: _____ Date: _____

STATEMENT OF UNDERSTANDING

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42.F.R. Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Signature: _____ Date: _____

Witness: _____ Date: _____

This authorization expires ninety (90) days from the date of this signature.

Stephen Vargo, MD

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

In the event that Dr. Stephen Vargo and their staff need to give you results or medical information may we (check all that apply):

- ☒ Leave a message with your spouse, family member, or caregiver as indicated below.
- ☐ Call you on your mobile phone at: ( )____
- ☐ Call you at your work at: (_____)_____
- ☐ Speak directly to you ONLY.

I, _____ _____ (DOB): _____ , _____, give Dr. Vargo and their staff authorization to disclose my protected health information to the following family, friends, and/or caregivers:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

STATEMENTS OF UNDERSTANDING

✧ 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 the office of Dr. Stephen Vargo.

✧ I understand that 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 of healthcare operations as sighted in the Notice of Privacy Practices.

✧ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this 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 (1) year from the date of the signature on this form.

Signature: _____ Date: _____

Name and relationship of person who completed form if not patient: _____

Signature of Staff Member Acknowledging Receipt: _____

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 therefrom 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.

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: Stephen Vargo, MD, PC
Print or Stamp Name of Physician, Medical Group or Association Name

_____
Print Patient's Name

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

_____
Print Name of Translator

By: _____
Patient's Representative's Signature (if applicable) (Date)

_____
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.

STEPHEN VARGO, M.D.

PATIENT RELEASE FORM

PATIENT NAME:_____

ADDRESS:_____

_____

The patient named above ("Patient") hereby acknowledges that STEPHEN VARGO, M.D., is acting independently in providing his medical services, treatments and/or procedures to me at the location and facilities of Nevada Surgery & Cancer Care, LLP ("Nevada Surgery"), and is in no way affiliated with Nevada Surgery.

Patient further acknowledges that STEPHEN VARGO, M.D., is solely responsible for the medical services, treatments, procedures and the results of Patient's care and hereby releases Nevada Surgery & Cancer Care, LLP and holds them harmless from any and all claims, actions, damages, loses, costs and the like regarding and/or resulting directly or indirectly from such medical treatments, services, procedures and care.

Accepted and Approved:

_____ Date:_____

Patient Signature