ANTHEM MEDICAL CENTER

Badar Anwar, M.D.
660 S. Green Valley Pkwy, St 100, Henderson, NV 89052 Office: (702) 731-9711. Fax: (702) 731-0096

Welcome to our office! The information you provide will help us understand your medical conditions and concerns better. Please take a few minutes to answer these questions carefully. All information is strictly confidential and will become part of your electronic medical record. Thank you for your time.

DEMOGRAPHIC DATA: **Today's Date:** _____

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. Sex: ☐ Female ☐ Male Date of Birth: ____/____/____

Patient's Name: (Last) _____ (First) _____ (Middle) _____

Also Known As/Preferred Name: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

E-Mail Address: _____

Phone Numbers: Cell Phone_____ Home _____ Work _____

Best way to contact you? ☐ ***Text*** ☐ Cell Phone ☐ E-mail ☐ Home Phone ☐ Work Phone

Address _____

_____

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer: _____ Occupation _____

Emergency Contact: Name _____ Phone # (____)_____

Relationship to Patient: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Language:
How well do you speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all
Do you speak a language other than English at home? ☐ Yes ☐ No
For persons speaking a language other than English (answering yes to the question above): What is this language? ☐ Spanish OR ☐ Other language (Identify) _____

Primary Insurance	**Secondary Insurance**
Subscriber: _____	Subscriber: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Insured's DOB: _____	Insured's DOB: _____

Retail Pharmacy Name _____ Address _____

_____

Mail Order Pharmacy Name _____ Address _____

_____

When was your last doctor visit to any doctor?_____ **Current Doctor**_____

Patient Name: _____

I have challenges with:

- Hearing difficulty: ☐ deaf or ☐ having serious difficulty hearing
- Vision difficulty: ☐ blind or ☐ having serious difficulty seeing, even when wearing glasses
- Cognitive difficulty: Because of a physical, mental, or emotional problem, ☐ having difficulty remembering, ☐ concentrating, or ☐ making decisions
- Ambulatory difficulty: Having serious difficulty ☐ walking or ☐ climbing stairs
- Self-care difficulty: Having difficulty ☐ bathing or ☐ dressing

Independent living difficulty: Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping.

Describe the reason for today's visit: _____

_____

I. ALLERGIES TO MEDICATIONS: ☐ None, *or* please list Medication and reaction to it:

_____

☐ Skin Rash ☐ Lip &Tongue Swelling ☐ Anaphylactic Shock ☐ Other_____

_____

II. MEDICATIONS: *Please list all your medications – prescription, over the counter, Vitamins and Herbs:*

Medication	**Amount/Mg**	**How many per day**	**When started**

_____

III. PERSONAL MEDICAL HISTORY: ***Have you ever had or currently have any medical problems?*** ☐ No ☐ Yes
If Yes, Mark all that applies:

☐ High Blood Pressure	☐ Cognitive Impairment	☐ Diabetes	☐ Hepatitis- if +, type
☐ High Cholesterol	☐ Dementia/Memory Loss	☐ Hypothyroidism	☐ Irritable Bowel Syndrome
☐ Angina	☐ Depression	☐ Other Thyroid Problem/s	☐ Stomach Ulcers
☐ Heart Attack	☐ Anxiety Disorder	☐ Osteoporosis/Osteopenia	☐ Acid Reflux
☐ Heart Valve Disease	☐ Panic Disorder	☐ Erectile Dysfunction	☐ Diverticulitis/Diverticulosis
Specify _____	☐ Bipolar Disorder	☐ Obesity/Overweight	☐ Cirrhosis of Liver
☐ Congestive Heart Failure	☐ Sleep Apnea	☐ Bleeding Disorder	☐ Kidney Disease
☐ Atrial Fibrillation/Flutter	☐ Restless Leg Syndrome	☐ Clotting Disorder	☐ Kidney Failure/Dialysis
☐ Arrhythmia	☐ Insomnia	☐ Blood Clots, Where?	☐ Kidney Stones
☐ Aortic Aneurysm	☐ Fibromyalgia	☐ Anemia	☐ Enlarged Prostate
☐ PAD/Vascular Disease	☐ Back Problems	☐ Edema/Fluid Retention	☐ Sexually Transmitted Disease
☐ Carotid Disease	☐ Rheumatoid Arthritis	☐ Asthma	Specify _____
☐ TIA/Mini stroke	☐ Osteorthritis/Gout	☐ Chronic Bronchitis	☐ Shingles/Herpes Zoster
☐ Stroke	☐ Chronic Pain	☐ Emphysema/COPD	☐ HIV Disease
☐ Seizures/Epilepsy	☐ Cancer, if yes what type	☐ Environmental Allergies	☐ Tuberculosis
☐ Migraine/Headaches	Specify _____	☐ Anesthesia Complications	☐ Urinary Tract Infections
☐ Neuropathy	☐ Colon Polyps	☐ Organ Transplant	☐ Acne/Skin Disorder
☐ Attention Deficit/ADHD	☐ Gallstones	Specify_____	Specify _____

Other problems_____

Patient Name: _____

IV. SURGICAL HISTORY: *Please list all of your previous surgeries with dates:* ☐ **None**

☐ Angioplasty and ☐Stent
☐ Bypass Surgery (CABG)
☐ Heart Valve Replacement
Specify: ☐ Aortic ☐ Mitral
☐ Metallic Or ☐ Tissue Valve
☐ Carotid Surgery - ☐ Rt ☐ Lt
☐ Leg Arterial Bypass ☐ Rt ☐ Lt
☐ Pacemaker ☐ Defibrillator
☐ Carpal Tunnel Surgery
☐ Joint Surgery ☐ Replacement

☐ Cataract surgery - ☐ Rt ☐ Lt
☐ Tonsillectomy
☐ Appendectomy
☐ Gallbladder surgery☐ Open ☐ Laparoscopic_
☐ Colon Resection
☐ Colostomy
☐ Hernia Repair ☐ Groin/Inguinal ☐ Rt ☐ Lt
☐ Umbilical ☐ Ventral
☐ Back Surgery - ☐ Lower ☐ Neck
☐ Arthroscopic ☐ Hip ☐ Knee ☐ Shoulder ☐ Rt ☐ Lt

☐ Breast Biopsy - ☐ Rt ☐ Lt
☐ Breast Lumpectomy - ☐ Rt ☐ Lt
☐ Mastectomy - ☐ Rt ☐ Lt
☐ Breast Augmentation/☐ Reduction
☐ Hysterectomy - ☐ Total ☐ Partial
☐ Tubal Ligation
☐ Vasectomy
☐ Prostate Surgery
☐ Cancer Surgery
Other Surgeries: _____

Previous Injuries: _____

V. SOCIAL HISTORY:

***Tobacco Use*:** Have you **ever smoked**? ☐ Never ☐ **Yes**

If yes, do you **currently smoke** - ☐ No ☐ **Yes** and I might quit ☐ **Yes**, but I am not ready to quit yet
If yes, do you smoke ☐ **every day or** ☐ **some days** only
What form of tobacco do you use? ☐ Cigarettes ☐ Pipe ☐ E-Cig/Vape ☐ Cigar? ☐ Snuff ☐ Chew.
How much do you smoke? ____ /day.
If **Former smoker**, Quit Date/Year _____. For how many years did you smoke? ____ years.
How many cigarettes did you use to smoke in the past? ☐ 1 pack per day (PPD) ☐ 1/2 PPD ☐ 1/4 PPD or less

***Alcohol Use*:** Do you sometimes drink beer, wine, or other alcoholic beverages? ☐ No ☐ **Yes**

If yes, *how often* do you have a drink containing alcohol?
☐ Once a month or less often ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do your have on a typical day:
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have *six or more* drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Intravenous/Addictive/Street Drug Use: ☐ No ☐ Yes - which drug? _____Current user ☐Yes ☐No
Last used? _____. Mode of Use? ☐ By Mouth☐ By Injection ☐ Through Nose ☐ Other_____

Exercise: Do you exercise regularly? ☐ No ☐ Yes - What type? ☐ Aerobic ☐ Stretching ☐ Weight Lifting
How Long?_____ Minutes/Day ☐ Hours/Day. How Often? ☐ 1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 Days/Week

Sexual Activity: Sexually Active? ☐ No ☐ Yes ☐ Not Currently active. Birth Control Method: _____ ☐ None
Sex partner/s is/are: ☐ Male ☐ Female ☐ Both Male and Female. Number of Sexual Partners: ☐ Single ☐ Multiple

Females: Are your Pregnant? ☐ Yes ☐ No. Planning Pregnancy? ☐ Yes ☐ No. 1st day of Last Period_____
Number of Pregnancies _____. Number of deliveries _____. Age of Menopause _____

Abusive Relationship: Are you in a relationship in which you have been hurt or threatened? ☐ Yes ☐ No

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VI. Health Maintenance: ***When was your most recent test? Leave blank if you never had these tests.***

For Women:
If over 20 Last Pap test: _____
If over 40 Last Mammogram: _____
If over 65 Last Bone Density test: _____

For Men:
If over 55 Last PSA blood test: _____
If over 70 Last Bone Density test: _____

For Both Men and Women: *If over 45* Last Colonoscopy or Screening for colon cancer screening: _____

Patient Name: _____

VII. FAMILY HISTORY: *Please write the ages of your family and mark any medical conditions present:*

	Mother	Father	Brother	Brother	Brother	Sister	Sister	Sister	Daughter	Daughter	Daughter	Son	Son	Son	Grandmother	Grandfather	Grandmother	Grandfather	Mother's Sister	Cousin	Cousin	Other
Alive (Y) or dead (N)?																						
Age now or Age at death:																						
Medical Condition:																						
Alcoholism																						
Alzheimer's Dementia																						
Diabetes																						
Stroke																						
Heart Attack																						
High Blood Pressure																						
High Cholesterol																						
Thyroid Disease																						
Depression																						
Attention Deficit Disorder																						
Bipolar Disorder																						
Colon Cancer																						
Breast, Ovarian, tubal,																						
or peritoneal Cancer																						
Early Prostate Cancer																						
Other Cancer, Type																						
Tuberculosis																						
Hepatitis, Type A, B or C:																						
AIDS/HIV Disease																						
Hemochromatosis																						
Thalassemia																						
Sickle Cell Anemia																						
Polycystic Kidney disease																						
Other:																						

VIII. LIFE STYLE CHANGES?

Lifestyle, including sleeping pattern, diet, activity level and stress relieving techniques impact a great deal on long term health. How interested would you be in changing your lifestyle to improve your health?

Change in diet: ☐ Very Interested ☐ Somewhat Interested ☐ Not interested
Change in Exercise/Activity Habits: ☐ Very Interested ☐ Somewhat Interested ☐ Not interested
Focusing on better sleep at night: ☐ Very Interested ☐ Somewhat Interested ☐ Not interested
Incorporating Meditation in your daily life: ☐ Very Interested ☐ Somewhat Interested ☐ Not interested

Patient Name: _____

IX. IMMUNIZATIONS: When were your most recent vaccinations:

Seasonal Flu Shot? ☐ Yes: When and where _____
If ☐ No - ☐ Allergic to vaccine or ☐ Do not want to take it ☐ Forgot or did not know about it.

Pneumonia Shot after age 65?: ☐ Yes: ☐ Prevnar13, Date: _____ ☐ Pneumovax23, Date: _____
☐ Vaxneuvance, Date _____ ☐ Prevnar 20, Date _____ ☐ Capvaxive, Date _____
If ☐ No: Are you: ☐ Allergic to vaccine or ☐ Don't want to take it. ☐ Forgot or did not know about it

Did you take your COVID 19 Vaccine: ☐ Yes ☐ No
☐ Pfizer-BioNTech: 1st Dose _____ 2nd Dose _____ 3rd Dose _____
☐ Moderna: 1st Dose _____ 2nd Dose _____ 3rd Dose _____
☐ J&J Jansenn: 1st Dose _____ 2nd Dose _____

Shingles Vaccination: ☐ No ☐Yes: ☐ Shingrix, Date: #1_____#2 _____ ☐ Zostavax, Date: _____

Tetanus/Diphtheria: ☐ No ☐Yes : : ☐ Td, Date: _____ ☐ Tdap, Date: _____

Chickenpox: _____ ***HPV:*** _____ ***MMR:*** _____ ***Meningitis:*** ____ ***Hepatitis A:*** _____ ***Hepatitis B:*** _____

X. REVIEW OF SYMPTOMS: *Check/Circle any problems you are* **EXPERIENCING NOW***:*

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Unexplained weight loss ☐weight gain ☐Fatigue

Eyes: ☐Blurred Vision ☐Double Vision ☐Sensitivity to light ☐eye pain ☐itchy eyes

Ears/Nose/Throat/Mouth: ☐Hearing Loss ☐Ringing in ears ☐Sore throat ☐Nose Bleeds

Respiratory: ☐Cough ☐Blood with cough ☐Wheezing ☐Difficulty Breathing ☐Snoring

Cardiovascular: ☐Chest pain/ Discomfort/Heart Burn ☐Palpitations ☐Irregular Heart Beat

GI: ☐Stomach Pain ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Blood in stools ☐Jaundice

GU: ☐Loss of Bladder control ☐Nighttime urination ☐Blood in urine ☐Lump in testicle ☐Weak urine stream

Musculoskeletal: ☐Muscle pain or ☐Weakness ☐Back Pain ☐Joint Pain or ☐Swelling: Where?_____

Endocrine: ☐Excessive ☐Thirst or ☐Urination ☐Intolerance to ☐Heat or ☐Cold ☐Unusual Hair growth

Blood/Lymphatic: ☐Unusual Lumps ☐Easy Bruising ☐Excessive Bleeding

Skin/Breast:☐Breast Lump ☐Mole change☐Rash ☐Hives ☐Ulcers or Sores - Where? _____

Allergy: ☐Sneezing☐Frequent infections ☐Anaphylactic reaction - to what? _____

Neurological: ☐Unusual Headache ☐Memory Loss ☐Wake up unrefreshed ☐Daytime Sleepiness

Psychiatric: ☐Nervousness ☐Thoughts of Suicide ☐Sleep difficulty☐Low Mood ☐Difficulty with concentration

XI. OTHER MATTERS OR CONCERNS: *Please list any other concerns that you would like to address:*

Notice of Privacy Practices

July 8, 2026

ANTHEM MEDICAL CENTER

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

• **Treatment means** providing, coordinating, and managing health care and / or related services by one or more health care providers. Examples of treatment would include office visits, x-rays, wart removal, office surgery etc.
• **Payment means** such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your medical services.
• **Health Care Operations include** the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information (i.e the Centers for Disease Control) or to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose

your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

• The right to request a copy of your PROTECTED HEALTH INFORMATION (charges for the copying are subject to state requirements).

• The right to request an amendment to your PROTECTED HEALTH INFORMATION.

• The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices or to file a complaint, please contact:

Krystal Montgomery-Showers
Administrative Director/HIPAA Compliance Officer
Anthem Medical Center
660 S. Green Valley Pkwy, Ste 100
Henderson, NV 89052
Phone: 702.731.9711

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877-696-6775 (toll-free)

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No-Show/No-Call Appointment Fee Acknowledgment Form

To ensure that we can provide the best service possible and accommodate all our patients effectively, we have established a policy regarding missed appointments. Please review the following:

If you miss your scheduled appointment without providing at least 24 hours' notice, you will be charged a $25 fee. This fee is not covered by insurance (if applicable) and must be paid before rescheduling or attending any future appointments.

We understand that emergencies and unexpected situations can arise, and we ask that you contact us as soon as possible if you are unable to attend your appointment.

By signing below, you acknowledge that you have read, understood, and agree to the above policy.

Patient's Name (Printed): _____

Patient's Signature: _____ **Date:** _____

Authorization for Use of Photograph and e-Mail

I authorize ANTHEM MEDICAL CENTER to take and use my photograph for the purpose of Identification in my medical record. This photograph will become part of my confidential medical record and will be stored securely in accordance with HIPAA privacy regulations.

- ☐ I authorize **BADAR ANWAR, M.D. PC** to **email** me my medical records. I understand that my email address is not HIPPA compliant (Privacy Act).
- ☐ I **DO NOT** authorize **BADAR ANWAR, M.D. PC** to use my **email** to transmit medical records or a form of communication regarding my health.

Patient Acknowledgment and Signature

By signing below, I acknowledge and agree to the use of my photograph as described:

- **Patient or Legal Representative Signature:** _____
- **Printed Name:** _____
- **Relationship with Patient (if applicable):** _____
- **Date:** _____

Anthem Medical Center
Badar Anwar, M.D.
660 S. Green Valley Pkwy, Suite 100
Henderson, NV 89052
T. 702-731-9711 . F.702-731-0096

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____ Fax # of Physician: _____

Reason for Records Release: _____

These records are to be sent to Anthem Medical Center at the address above.

Patient's Name: _____ DOB: _____

Address: _____

Phone #: _____

The type and amount of information to be disclosed is initialed as follows:(specify dates where appropriate)

____ X-Ray films (Specify type/date)
____Immunizations
____Most recent 3 years of Records
____Entire Medical Record
____ Substance and Drug Abuse, if any
____ AIDS/HIV, if any
____ Genetic testing, from date
_____Psychological or psychiatric conditions, if any

Other: _____

_____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this Authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for any copying fees. Shipping and applicable sales tax may also be charged.

Patient name (Print): _____Date: _____

Patient's (or Representative) Signature:_____

Patient's Representative (Print): _____Relationship to Patient:_____

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Assignment of Benefits

I hereby assign to Badar Anwar, M.D., Professional Corporation any insurance or other third-party benefits available for health care services provided to me. I understand that Badar Anwar, M.D., Professional Corporation has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Badar Anwar, M.D., Professional Corporation I agree to forward to Badar Anwar, M.D., Professional Corporation all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.
Further, I authorize Badar Anwar, M.D., Professional Corporation to release any medical information acquired in the course of my treatment, needed for this medical insurance claim payment. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing.

Name: _____ Date:_____

Signature of Patient/Legal Guardian:_____

Insurance Coverage Waiver

I understand that my eligibility for coverage by *(name of insurance company)* _____ cannot be confirmed at this time. I wish to receive medical service from Badar Anwar, M.D., Professional Corporation. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Name: _____ Date:_____

Signature of Patient/Legal Guardian:_____

Acknowledgement of Privacy Practices

I, *(your name)*_____ , acknowledge the receipt of the notice of Privacy Practices of Anthem Medical center.

Signature _____
Date _____

Your PROTECTED HEALTH INFORMATION will *only* be shared with other persons/entities as set forth in our Notice of Privacy Practices and a receipt of which you acknowledged above. This is your opportunity to list the names of family members or friends that you would want to have access to your medical records and you would want us to discuss your medical conditions with. If you do not wish to list any name/s please write "None".

_____

_____

_____

Name of Patient: _____
Signature of Patient
Or Parent/Guardian if Minor:_____Date: _____

Signature of Employee Witness: _____Date: _____

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Welcome to Our Medical Practice

Dear Patient:

We are very happy to welcome you to our medical practice at Anthem Medical Center and want you to know that we appreciate the chance to take care of you and your family. Our office is focused on providing you with high quality medical care. We would like to outline some of our practice policies to acquaint you with the way we operate our practice. In this letter you will find answers to some of the commonly asked questions about our practice. I hope this is useful information for you.

Disease Prevention:

Our practice is geared toward preventive medicine – Prevention is better and cheaper than cure. Of course, we will treat your disease condition when you develop it but that also allows us an opportunity to take appropriate steps to screen for other preventable conditions. I recommend periodic Wellness Visits along with lab tests and other screening evaluations for prevention of commonly encountered medical conditions. I will make those recommendations to you depending on your age group based on national guidelines.

Monitoring Your Medical Condition:

Majority of the conditions that we treat in our practice involve using medications for extended periods of time along with periodic monitoring for the safety and efficacy of prescribed medications. A lot of the time we run periodic blood tests for this purpose. All this necessitates the need for you to follow up in the office for a doctor's visit so that we can reevaluate your problems. The interval between the follow up is determined by your specific needs and is based on national guidelines. We do not generally review results of blood tests, x-rays, etc. over the phone – this should appropriately be done with a face-to-face encounter so we can address all the issues and answer all the questions that you may have and start a treatment plan as necessary.
If you have tests ordered or blood work done at our office, we will give you a follow-up appointment with us to review those results. If you have any tests done and for any reason, I have not reviewed those with you please give our office a call to set up an appointment to review these with me. No news is NOT necessarily good news – please double check and confirm. This way as a patient-physician team we can minimize and eliminate any errors that could arise in your medical care.
Referrals to other doctors are made at the time of your visit to our office and not over the phone.

Medication Refills and Monitoring:

We ask that you bring all the medications that you are currently taking including the ones prescribed by other doctors along with you every time you come in and give these to our medical assistant working with you that day so that these are updated in your electronic medical record. It is also best for us to prescribe or renew the medications that you need while you are present in the office with all your information available to us. Obviously, we lose that opportunity when it is done via phone or through the pharmacist's request.

Normally I send your prescriptions electronically directly to your pharmacy at the time of your visit after making any necessary changes as necessary based on your response to the treatment. In special circumstances we will print prescriptions for you so that you can hand carry them to the pharmacy. Controlled medications can only be prescribed electronically.

Our practice is to set up a follow up appointment every time you leave the office so that you will return before your prescription runs out. We generally discourage getting prescriptions or refills for long durations and recommend periodic follow-up visits with the doctor to monitor your condition on an ongoing basis to detect any problems at the earliest and ward off a disaster later on.

Please make a complete list of all medications that you are currently taking and bring it with you for doctor's visits or bring all of your medication bottles with you. Our front office staff will review your demographic and insurance information with you at each visit to ensure that we maintain your correct information in the file. This allows us to be able to submit your claim to insurance in a timely manner.

ANTHEM MEDICAL CENTER
Badar Anwar, M.D.
660 S. Green Valley Pkwy, St 100, Henderson, NV 89052. Tele: (702)731-9711. Fax (702)731-0096

Refills without a doctor visit: Please evaluate your medication supply prior to your office visits and try to obtain all refills with your scheduled appointments. Should refills be requested after a visit they will be authorized in case of extenuating circumstance warranting the refill outside of the timeframe of a scheduled office visit. In those situations, the refill will only be performed during normal office hours and may require up to 48-hour turn around time. We do not fill antibiotics, pain medications or other scheduled narcotics over the phone.
When you call, please have the following information ready: patient name and date of birth; prescription name; pharmacy name, street address of pharmacy and telephone number.

Forms, Letters and FMLA Paperwork:

Please allow 5-7 working days for the completion of any forms, prior authorizations, or letters. Please be aware that some forms may require an office visit.
There is a standard fee for any form completion including FMLA. This amount is due at the time the forms are submitted to our office.

Evaluation for Urgent Needs:

We will see you for your other urgent problems that may arise between the scheduled visits if needed. Generally, we will squeeze you in between scheduled patients for this type of visit. So, we request your patience as we see previously scheduled patients before seeing same day appointments or walk in patients.

Need for Hospital Admission:

If for any reason you develop a condition and get admitted to Dignity Health Saint Rose Siena Hospital, I would like to take care of you while you are hospitalized instead of assigning this duty to another physician or hospitalist. However, your insurance may dictate that you be treated by a particular contracted hospitalist group and in that case, I will be unable to take care of you while you are in the hospital.

Medical Records:

In our office we maintain electronic medical records. If you are twenty-three years or older we will be keeping your records for 5 years as required by state law. Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission. Same is true about discussing your medical condition with anyone except by your expressed permission. If you desire that a certain member of your family or friend be allowed to discuss your medical condition with our office, please specify those names on the form provided to you with the initial intake package.

Insurance Company Contracts and Co-pays:

For the benefit of my patients, I am contracted with several insurance carriers as a Provider. You will want to check your benefits booklet or with the benefits department of your employer to verify if I am listed as a provider within your network.

As part of our contract with the insurance companies, we are legally required by the terms of the contract to collect any co-pays or deductibles from you at the time of service. We do ask that you be prepared to pay your co-pay at the time of check-in before seeing the doctor. Failure on our part to collect these monies can result in cancellation of our provider's contract with the insurance company. Patients who do not have insurance coverage will be expected to pay at the time of service, and the payment will be collected before the doctor visit. For your convenience we accept Cash, Check, MasterCard and Visa.

If you have any questions or need further clarification of our practice philosophy or our policies, please do not hesitate to contact our office for assistance. Please let us know if we can do anything to make your care and visits to our office better.

Wishing you and your family Good Health!

Sincerely,

Badar Anwar MD