SUNSET CLINIC
FAMILY MEDICINE • URGENT CARE

CLINICAL POLICIES

1. New patients are accepted based on their insurance coverage; the only exception is for self-pay/uninsured patients whom pay a flat fee per visit.
2. Results for any type of diagnostic testing: labs, imaging, or other results **will only** be discussed in a follow-up appointment. It is the patient's responsibility to schedule a follow-up appointment for these results. There may be exceptions to this policy based on urgency, upon which time you will be notified via phone.
3. It is patient's responsibility to notify Sunset Clinic if you are obtaining controlled meds from other specialist(s) (i.e. pain management, psychiatrist).
4. Quantity of controlled meds are limited and under the discretion of the prescriber.
5. Medication refills for on-going medical conditions can be accommodated by having your pharmacy request a refill authorization. Please allow **at least** 72 hours for a refill request to be completed. Denial of medication refills may require scheduling an office visit.
6. All patients requesting a controlled medication **will** undergo a DEA history investigation as well as a urine drug screening at random. Prescribing decisions will be at the discretion of the medical provider.
7. Certain controlled substances **cannot** be refilled, **by law,** without an appointment.
8. **Under no circumstances** are patients allowed to photograph, video or audio record their visit.
9. Pre-operative visits must be done **at least** 2 weeks before intended elective surgery to allow for proper risk assessment.
10. FMLA/disability/work excuse paperwork is filled at the discretion of the provider that has established rapport with the patient. It cannot be filled out at the initial new patient visit and will take a **minimum of 1 week** to complete. Fees may apply.
11. Sunset Clinic participates in the Health Information Exchange (HIE): allowing us access to your records in the event that you are seen in the ED or hospital. By signing below, you give us your consent.
12. Sunset Clinic reserves the right to refuse service to any individual.
13. Sunset Clinic reserves the right to discharge a patient from care.
14. Sunset Clinic abides by a **zero tolerance** policy and is a gun/drug free campus.

Disclaimer: Sunset Clinic reserves the right to change this policy as it deems necessary without notice.

By signing below I acknowledge that I have read and received a copy of the Sunset Clinic policies.

_____ _____

Patient's Name Date

_____ _____

Patient/ Guarantor's Signature Relationship

SUNSET CLINIC
FAMILY MEDICINE • URGENT CARE

Authorize to Disclose Protected Health Information (PHI)

This request is to OBTAIN medical records. Please return if not completed in its entirety.

Patient Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____

I HEREBY AUTHORIZE:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax#: _____

TO DISCLOSE THE ABOVE NAME INDIVIDUALS PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

The type and amount of information to be used or disclosed is as follows:

Include Dates where appropriate: **FROM** (Date) _____**THROUGH** (Date) _____

☐ **Entire Record, or** ☐ **Medication List** ☐ **Immunization Records** ☐ **Providers Notes**
☐ **Laboratory Results** ☐ **X-ray / Radiology Reports** ☐ **Other** _____

IF PRESENT, I GIVE PERMISSION TO RELEASE ANY SENSITIVE INFORMATION REGARDING: (Initial on Applicable Lines Below)

_____ Substance Abuse **_____ Psychiatric / Mental Health** **_____ HIV Information**
_____ Genetic Test Results **_____Child & Domestic Abuse History** **_____Addictive Behavior**
_____ Communicable Disease / STI

REASON FOR REQUEST: Continuing Medical Care

I understand that authorizing this disclosure of this health information in voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department and obtain a copy of the Privacy Notice.

THIS INFORMATION IS TO BE DISCLOSED TO:

☐ **3551 E. Bonanza Rd., Ste 107**	**Las Vegas, NV 89110**	**P: (702)589-5135**	**F: (702)589-5138**
☐ **4830 W Lone Mountain Rd.**	**Las Vegas, NV 89130**	**P: (702)645-8555**	**F: (702)645-8585**
☐ **6525 N Buffalo Dr., Ste 130**	**Las Vegas, NV 89131**	**P: (702)851-0911**	**F: (702)784-0065**
☐ **3175 St. Rose Parkway, Ste 121**	**Henderson, NV 89052**	**P: (702)802-5100**	**F: (702)202-1066**
☐ **8530 W. Sunset Rd., Ste 110**	**Las Vegas, NV 89113**	**P: (702)754-1900**	**F: (702)750-1535**

Signature of Patient: _____Date: _____

Signature of Parent, Guardian or
Personal Representative (if necessary): _____Date: _____

I understand I have the right to revoke this authorization at any time. I understand that if I revoke I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT OR CONDITION, THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE OF THIS AUTHORIZATION

This company does not discriminate in health programs and activities. For communication assistance, please call (866)831-0911

Property of Sunset Clinic – Do not distribute or Reproduce Without Expressed Permission

SUNSET CLINIC

FINANCIAL POLICY

1. Sunset Clinic accepts cash, Visa, Mastercard, and Discover cards. This includes debit cards with a Visa or Mastercard logo.
2. Accounts with returned checks will be charged a $50 fee.
3. Copays, co-insurance and deductibles are calculated and due at check-in for your appointment.
4. Uninsured patients must pay for visit upon check-in.
5. It is the policy of Sunset Clinic to accept and bill certain insurances for payment of charges incurred by patients; however, your insurance policy is between the patient, the insured and the insurance company. Should a problem arise during the processing of the patient's claim(s) it will be the patient's sole responsibility to address this problem with the insurance company.
6. Patient balances are due upon receipt of the statement.
7. Patients with an unpaid balance who arrive for an appointment will be asked to satisfy this balance.
8. There will be a total of three (3) Statements mailed to patients prior to the account being referred to an outside collection agency. Accounts being sent to an outside collections agency will accrue a $100.00 collection fee, in addition to any interest allowed by law.
9. Patients who arrive for an appointment whose account is delinquent or in a collection status will not receive any services until the account is brought current or satisfactory payment arrangement have been made with the billing department, collection agency and/or office manager.
10. Parents are responsible for accounts of their minor children.
11. Adult patients, unless mentally disabled, are responsible for their own accounts.
12. It will be the patient's sole responsibility, or in case of a minor, the parent's responsibility, to maintain accurate demographic and insurance information on file with the office.
13. Administrative charges of $25.00 per signature is payable by the patient (not insurance) for any documents that require the doctor's review and signature.
14. FMLA forms cost $50.00 to complete and may require an appointment/exam.
15. The schedule for the office is run very efficiently to be fair to all patients and allow for proper scheduling with a minimum amount of wait time. We ask that you call and cancel your appointment by speaking to a member of the staff. Failure to do so will result in the following (payable by the patient, not insurance):
    Testing $50/appointment **Doctor visit $25/appointment**

Disclaimer: Sunset Clinic reserves the right to change this policy as it deems necessary without notification.

By signing below, I acknowledge that I have read and received a copy of the Sunset Clinic financial policy.

_____ _____

Patient's Name Date

_____ _____

Patient/ Guarantor's Signature Relationship