NEW PATIENT REGISTRATION PACKET

Last Name: _____ First Name: _____
DOB _____ Gender: _____
SSN: _____ Address: _____
Apt/Suite#: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
E-mail: _____ Mobile: _____
Primary Provider: _____ Referring Provider _____
Employer: _____ Work Phone: _____
Marital Status: _____ _____
Spouse Name: _____ Spouse Cell _____

Insurance Information:

Primary: _____ Plan ID: _____
Group#: _____ Phone Number: _____
Policy Holder: _____ Policy Holder DOB: _____
Secondary: _____ Plan ID: _____
Group#: _____ Phone Number: _____
Policy Holder: _____ Policyholder DOB: _____
Guarantor: _____ Guarantor Relationship: _____

Emergency Contact Information:

Name: _____ Phone: _____
Relationship: _____

Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?

☐ Yes ☐ No If yes, please fill out the following:

Facility Name:_____Phone:_____
Address:_____
City:_____ State:_____ Zip:_____

Are you receiving benefits from the Veterans Administration?

☐ Yes ☐ No If yes, please fill out the following:

VA Name:_____Phone:_____
City:_____ State:_____ Zip:_____

Which of the following best describes your race?

☐ Asian	☐ Caucasian	☐ Black / African American		
☐ Subcontinent Asian American	☐ Asian Pacific American	☐ Native American	☐ American Indian/ Alaskan Native	
☐ Hawaiian	☐ Pacific Islander	☐ More than one race	☐ Other	☐ Decline

Please Select one Ethnic Group that Best Describes Your Ancestry:

☐ Hispanic or Latino	☐ Non-Hispanic or Latino
☐ Decline	☐ Do not know

What language do you feel most comfortable using when discussing your healthcare?

☐ English	☐ Spanish	☐ German	☐ French
☐ Italian	☐ Russian	☐ Portuguese	☐ Chinese
☐ Creole	☐ Other	☐ Decline	

How did you hear about us?

☐ Physician Referral	☐ Family or Friend	☐ Insurance Referral	☐ Hospital
☐Integrative Oncology Essentials	☐ Communications Forum (Seminar, etc)	☐ Media (newspaper, magazine, billboard, radio, TV)	
☐ Internet (website, search engine, Facebook, etc.)		☐ No Response	

When conducting your own research, how often do you use the internet for gathering information?

☐ Always	☐ Usually	☐ Sometimes	☐ Never

INTERNAL USE ONLY

HT T R O2 ROOM # _____

WT P BP DIAGNOSIS

ALLERGIES:

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to IV Contrast? ☐ Yes ☐ No If yes, reaction:_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, list all the medications and the reactions:

_____

Other allergies (drug, food, tape etc.)_____

CURRENT MEDICATIONS:

Medication Name	Dose	Frequency (daily/twice day)	What do you take this for?

Pharmacy Name: _____ **Pharmacy Phone:** _____

RADIATION THERAPY, CHEMOTHERAPY, AND HORMONE THERAPY HISTORY:

Have you ever received radiation therapy: ☐ Yes ☐ No If yes, When?_____

What part of the body/area was treated?_____

Have you ever received chemo therapy? ☐ Yes ☐ No If yes, when?_____

Have you ever received hormone therapy? ☐ Yes ☐ No If yes, when?_____

Which Medication?_____

PAST MEDICAL HISTORY Check all that apply.

☐ Cancer diagnosis, if so, what type of cancer? _____

☐ Heart disease / CAD	☐ Emphysema	☐ Diabetes	
☐ Heart attack	☐ COPD	☐ Thyroid disorder	
☐ Congestive heart failure	☐ Pneumonia	☐ Kidney disease	
☐ Atrial fibrillation	☐ Chronic bronchitis	☐ Liver disease	
☐ High cholesterol	☐ Asthma	☐ HIV	
☐ Hypertension	☐ Stroke	☐ Anemia	☐ Other

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? Check all that apply.

CONSTITUTIONAL:

☐ Fever/chills
☐ Increased fatigue
☐ Night sweats
☐ Unexplained weight loss
If so, how much?_____
☐ Weight gain
If so, how much?_____
Current height: _____
Current weight:_____

EYES/EARS/NOSE/THROAT

☐ Cataracts
☐ Glaucoma
☐ Diminished Eyesight
☐ Experienced hearing loss
☐ Sinus problems
☐ Hoarseness
☐ Dentures

CARDIAC:

☐ Angina (chest pain)
☐ Irregular heartbeat

PULMONARY:

☐ Persistent cough
☐ Coughing up blood
☐ Shortness of breath
☐ Inability to lie flat
☐ Positive TB test
Influenza vaccine ☐ Yes ☐ No
Date: _____
Pneumonia vaccine ☐ Yes ☐ No
Date: _____
COVID-19 vaccine ☐ Yes ☐ No
Date: _____

GASTROINTESTINAL:

☐ Difficulty swallowing
☐ Decreased appetite
☐ Frequent vomiting
☐ Hiatal hernia
☐ Gastric reflux
☐ Bowel polyps
☐ Dark/black stool
☐ Diverticulosis
☐ Diverticulitis
☐ Blood in stool
☐ Frequent diarrhea
☐ Inflammatory bowel disease (Ulcerative colitis/ Crohn's)
☐ Constipation
☐ Hemorrhoids Colonoscopy/sigmoidoscopy
☐ Yes ☐ No
Date:_____

GENITOURINARY:

☐ Difficulty starting stream
☐ Stopping and starting stream
☐ Blood in urine
☐ Pain or burning on urination
☐ Frequent urination
☐ Getting up at night to urinate
☐ Urinary urgency
☐ Leakage of urine
☐ Kidney stone
☐ Urinary Tract Infections

NEUROLOGICAL:

☐ Frequent headaches
☐ Dizziness/ lightheadedness
☐ Tremors
☐ Paralysis
☐ Numbness
☐ Polio
☐ Weakness in limbs
☐ Seizures

PSYCHIATRIC:

☐ Anxiety
☐ Depression
☐ Psychosis
☐ Bipolar disorder

RHEUMATOLOGICAL:

☐ Systemic lupus erythematosus
☐ Rheumatoid arthritis
☐ Osteoarthritis/arthritis
☐ Scleroderma/CREST syndrome
☐ Gout
☐ Bone pain
☐ Broken bones: _____

PAST SURGICAL HISTORY: Please list when (year)

☐ Eye surgery _____
☐ Tonsillectomy_____
☐ Thyroid surgery_____
☐ Heart surgery_____
☐ Coronary artery by-pass_____
☐ Heart valve replace/repair_____
☐ Coronary artery stent_____
☐ Defibrillator placement_____
☐ Pacemaker placement_____
Type/Model:_____
☐ Breast surgery_____
☐ Appendectomy_____
☐ Cholecystectomy_____
☐ Hernia surgery_____
☐ Colon or rectal surgery_____
☐ Bladder surgery_____
☐ Prostate surgery_____
☐ Hysterectomy or gynecological surgery _____
☐ D & C_____
☐ Other_____

FEMALE HISTORY: Please complete the following information if you are female

Age 1st menstrual period:____
Last menstrual period:_____
Age of menopause:_____
Any change you could be pregnant? ☐ Yes ☐ No
Number of pregnancies: _____
Number of deliveries:_____
Age 1st child was born:_____

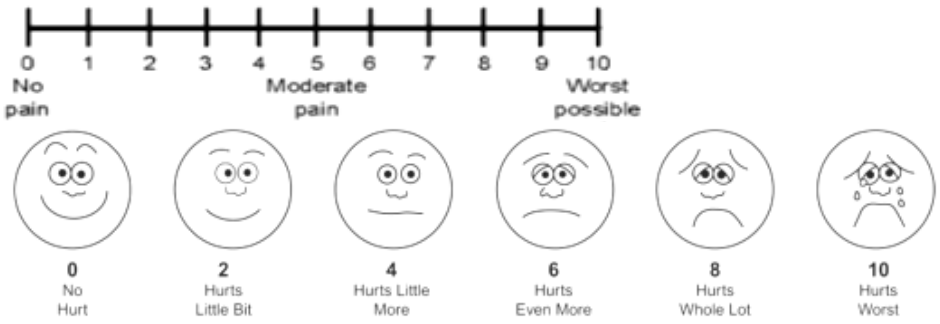
Did you breastfeed? ☐ Yes ☐ No
Did you ever take hormones (estrogen, birth control pills, androgens, etc.)
☐ Yes ☐ No
If yes, What tpe?_____
How long:_____

Vaginal discharge: ☐ Yes ☐ No
Vaginal bleeding: ☐ Yes ☐ No
History of sexually transmitted diseases? ☐ Yes ☐ No
Are you sexually active
☐ Yes ☐ No
Date of last PAP smear?
_____
Date of last mammogram?
_____

MALE HISTORY: Please complete the following information if you are male.

Date of last PSA: _____ Score of last PSA:_____ Where:_____
History of sexually transmitted diseases: ☐ Yes ☐ No
☐ Difficulty with Erections ☐ Elevated PSA Are you sexually active? ☐ Yes ☐ No

CANCER RELATED PAIN



Are you in pain now? ☐ Yes ☐ No When did you pain start? _____
On a scale of 1-10 with 10 being the worse pain, how severe is your pain?_____
Location of pain:_____
Pain quality: ☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Cramping ☐Aching ☐Stabbing
How long have you been in pain?_____
How is your pain being managed?_____
Anything making it better?_____ Anything making it worse?_____

WE SCREEN ALL PATIENTS FOR DOMESTIC VIOLENCE OR ABUSE:

Does anyone at home hurt, hit or threaten you? ☐ Yes ☐ No
If yes, explain:_____

MOBILITY-FALL RISK ASSESSMENT:

Do you need assistance walking: ☐ Yes ☐ No

If so, do you use any of the following? ☐Cane ☐Walker ☐Wheelchair

Have you fallen before or been injured because of a fall? ☐ Yes ☐ No

Do you have foot ulcers, bunions, hammertoes, or calluses that are painful or cause you to adjust your steps while walking? ☐ Yes ☐ No

Do you feel unsteady on your feet or shuffle when you walk? ☐ Yes ☐ No

Do you feel dizzy/lightheaded when you stand up? ☐ Yes ☐ No

How many falls have you had in the past 12 months?_____ Any injuries?_____

SOCIAL GEOGRAPHIC HISTORY:

In which state (or country) were you born?_____

In what area did you live most of your life?_____

How long have you lived in your current state of residence?_____

SOCIAL HISTORY:

Have you ever smoked? ☐ Yes ☐ No How long? _____ How many packs a day?_____

Have you quit smoking? ☐ Yes ☐ No If yes, when? _____

Have you ever chewed tobacco? ☐ Yes ☐ No How much?_____

Have you ever quit chewing tobacco? ☐ Yes ☐ No If yes, when?_____

Have you ever attended tobacco cessation classes? ☐ Yes ☐ No When?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often?_____

Have you quit drinking? ☐ Yes ☐ No If yes, when did you quit?_____

Do you use any street drugs? ☐ Yes ☐ No

If so, which street drugs? ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Other:_____

Do you have a medical marijuana card? ☐ Yes ☐ No

Do you need any help with any of the following: coping, financial assistance, nutrition, social work, transportation, home assistance? ☐ Yes ☐ No Please explain:_____

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Do you have a strong social support system ☐ Yes ☐ No If so, who?_____

Do you adhere to any religious beliefs that you would like us to know about?_____

Are you still working? ☐ Yes ☐ No If no, explain:_____

What is/was your primary occupation?_____

Have you served in the military? ☐ Yes ☐ No If so, which branch of military?_____

Did you ever work in an occupation that involved exposure to asbestos or any other cancerous chemicals, fumes, or carcinogens? ☐ Yes ☐ No Please explain:_____

FAMILY HISTORY OF CANCER OR BLOOD DISEASES: Please list ALL (alive & passed)

Father: If living, age _____ If deceased, age of death_____

Any history of cancer?_____ Type:_____

Mother: If living, age_____ If deceased, age of death_____

Any history of cancer?_____Type:_____

Siblings: How many sisters?_____ How many brothers?_____

Any history of cancer?_____Type:_____

Children: How many daughters?_____ How many sons?_____

Any history of cancer?_____Type:_____

Is there any history of cancer of blood diseases in other immediate family members such as aunts, uncles, grandparents, etc.? ☐ Yes ☐ No If yes, Please explain:_____

PLEASE LIST THE NAMES AND PHONE NUMBERS OF OTHER PHYSICIANS YOU SEE

Name	Type of doctor	Phone

Do you have a medical Durable Power of Attorney? ☐ Yes ☐ No

Do you have an Advanced Directive? ☐ Yes ☐ No

Do you have a Living Will? ☐ Yes ☐ No

As the patient, you acknowledge, that with the completion of this form, it constitutes your complete clinical history summary.

Patient signature:_____ **Date:**_____

Nurse signature:_____ **Date:**_____

Physician signature:_____**Date:**_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PLEASE REMEMBER, NO REFERRAL IS EVER NEEDED FOR MENTAL HEALTH SERVICES. IF YOU FEEL LIKE YOU NEED SOMEONE TO SPEAK TO, CALL YOUR INSURANCE OR GO TO THEIR WEBSTIE TO SEE WHO IS IN NETWORK. YOU CAN ALSO FOLLOW UP WITH YOUR PRIMARY CARE PROVIDERP

PATIENT CONSENT FOR DISCLOSURE TO INVOLVED INDIVIDUALS

Patient Name: _____ Date of Birth: _____

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

I give permission to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*:

Family/Friend Name	Relationship to Patient	Phone Number

Patient Signature* _____ **DATE** _____

Printed Name _____ **DOB** _____

Relationship to Patient: _____

**If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.*

Note: Our office expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

Assignment Of Benefits/Right To Payment Authorization, Patient Responsibility, And Release Of Information Form

ONCOLOGY CONSULTANTS, PLLC
52 N PECOS RD – HENDERSON NV 89074 (702-990-4761)
2851 N TENAYA WAY #100 – LAS VEGAS NV 89128 (702-243-3340)

I, the undersigned, assign to the provider/entity referenced above ("Provider"), my rights and benefits in any medical insurance plan, health benefit plan, or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I authorize my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider are owed to Provider and I agree to remit those funds directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment/Authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Patient DOB

_____ _____

Print Name of Patient Date

_____

Relationship to Patient (if signed by Person Legally Responsible)

PAYOR AGREEMENT

We are committed to the success of your medical treatment and care. At our centers, we try to provide excellent medical care and at the same time make sure we can answer all your insurance questions.

Please understand that the payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly asked financial and office policy questions.

How may I pay?

We accept payment by cash, check, money order, Visa, Discover, Mastercard, and American Express.

What is my financial responsibility for radiation therapy?

You are responsible for paying for your office visit copay for all office visits with your radiation oncologist at time of visit.

Radiation treatment copay or coinsurance are due no later date of service unless otherwise coordinated with the financial counselor. You are responsible for making your payment at the front desk of your treatment office. You will be given a receipt for your payment.

How do I know what my insurance will pay?

We are participating providers with most insurance plans. The amount of your coverage depends on your insurance plan. Plan coverage most often assigns a portion of financial responsibility to the patient, often referred to as “cost share”, “coinsurance”, or “copayment”.

It is strongly advised that you contact your insurance company for explanation of benefits for ‘outpatient radiation therapy’. You can contact the member services department by calling the number on the back of your insurance card.

How do I know what I will owe weekly for my treatment?

Prior to starting treatment, you need to contact our office financial counselor to discuss your treatment *estimated* cost. You will be provided with information on your insurance plan benefits and payment options available to you. Feel free to contact the financial counselor if you have any questions regarding your billing statement during your course of treatment, or after treatment has been completed. For questions regarding payment of claims you will need to contact your insurance company directly.

I have read and understand the above patient financial question and answer notice/payor agreement.

Printed Name _____ **DOB** _____

Signature _____ **Date** _____

Patient Authorization for Disclosure of Health Information
All sections of this authorization form MUST be completed to be considered valid

Patient Name: _____ Date of Birth: _____.
Address: _____ City: _____ State: _____ Zip: _____.
E-mail Address: _____ Phone: _____.

I request that my protected health information (PHI) from Oncology Las Vegas disclosed to:
Recipient Name: _____.
Address: _____ City: _____ State: _____ Zip: _____.
E-mail Address: _____ Phone: _____.
Fax (healthcare provider only): _____.

I request the following PHI to be released from my medical record(s):
Name of Physician: _____.
Specific Treatment Dates: _____ to _____.
☐Consultation Reports ☐ Diagnostic Films ☐ Dosimetry Records ☐ Laboratory Results
☐ Physician Dictation ☐ Portal Films/Simulation Films ☐ Progress Notes
☐ Radiology or Imaging Reports ☐ Surgery/Pathology ☐ Complete Medical Record
☐ Billing Records ☐ Genetic Records ☐ Other (please specify):

Purpose for requesting information: ☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal
☐ Other: _____.

Disclosure Format: ☐ US Mail – paper format ☐ Fax (healthcare provider only) ☐ Secure E-mail
☐ Other (please specify): _____.

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 2851 N. Tenaya Way, suite 100 Las Vegas, NV 89128. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature:* _____.
Date: _____ Time: _____.
Printed Name of Authorized Representative: _____.
Relationship to Patient: _____.
*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID (*required when records are picked up*)
Driver's License State: _____ Number: _____.
Witness Signature: _____.
Date: _____ Time: _____.

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.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment:

We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment:

We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:

- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care:

We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research:

We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications:

We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement/Legal Proceedings:
We may disclose health information for law enforcement purposes as required by law or in respons

Other Uses of Your Protected Health Information That Require Your Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any lime. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternate means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
- Changes to This Notice

We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge:

A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgement was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below)

_____

_____

_____

_____

_____ _____

Signature of Employee Date

Patient Consent Form for Electronic Exchange of Individual Health Information

HealtHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healtHIEnevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services.
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.
2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealtHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases
3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.
5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

HealtHIE NEVADA

For Internal Use Only: MRN_____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME_____
Last *First* *Middle*

PREVIOUS NAME(S)_____ GENDER: M____ F____

STREET ADDRESS / P.O. BOX_____

CITY_____ STATE_____ ZIP CODE_____

PHONE NUMBER _____ EMAIL_____

DATE OF BIRTH _____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____ _____
Signature of patient or authorized representative Date Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Name of Authorized Representative (Printed) Relationship Date Time

_____
Address of authorized representative signing this form (please print):

_____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:_____ Name of Witness:_____
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.