

NEVADA FAMILY CARE

100 North Green Valley Parkway, suite 239
Henderson Nevada 89074
www.NevadaFamilyCare.com

Dear New Patient:

Welcome to Nevada Family Care.

Enclosed are your intake forms which need to be **completed in full** prior your visit. On your initial visit, you will be seen by a physician for a comprehensive history and a basic examination. Services, procedures and the purpose of your subsequent visits will be discussed at that time. Depending on the complexity of the case, this process may take upwards of 30 minutes. For this reason, we have a 24 hour cancellation policy for all patient visits.

We make every attempt to keep our schedule timely, but please understand that, occasionally, unforeseen medical problems will arise and can disrupt our schedule. Therefore we ask that you keep your available time very flexible, especially for your first visit.

Please bring the following, if applicable to your visit:

- All medications that you are taking (bring the bottles if possible)
- Any recent test results or medical reports that you may have, including –
 - Lab Studies
 - EKG, Stress Test
 - Xray, MRI, Cat Scan
 - Prostate, Pap Smear, Mammogram, Bone Density
 - Colonoscopy
- A close friend or family member who aids in your personal health.

Please give these results/reports to the receptionist when you arrive so that they can be copied for your chart.

We are looking forward seeing to you, and hope to be of assistance in your journey to get healthy and stay healthy.

Sincerely,

Nevada Family Care

HIPAA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Please review this notice carefully. "Protected Health Information" or PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This applies to all records containing your PHI that are created or retained by Nevada Family Care.

Uses and Disclosures of PHI: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other uses required by law.

1. Treatment: Your PHI will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be disclosed to a laboratory, home health agency, or pharmacy that provides care to you. Additionally, your PHI may also be disclosed to other health care providers for purposes related to your treatment, such as a specialist referral.

2. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your health insurer may be contacted to certify that you are eligible for benefits, and the details regarding your treatment may need to be disclosed to determine if your insurer will pay for your treatment. Your PHI may also be disclosed to obtain payment from you or third parties if they are responsible for your costs. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations: Your PHI may be used or disclosed in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, your PHI may be disclosed to medical school students that see patients at our offices. Your PHI may be used to contact you as a reminder of your appointment. In addition, a sign-in sheet may be used at the registration desk where you will be asked to sign your name and indicate your physician. You may also be called by name in the waiting room when your physician is ready to see you.

4. Other Situations: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors, and Organ Donors; Research ; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

5. Other Permitted and Required Uses and Disclosures: Any other uses or disclosures of your PHI will be made only with your consent, authorization or opportunity to object unless required by law.

Your Rights: You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications: You have the right to request receipt of confidential communications from our office by alternative means or to an alternative location.

2. Requesting restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health-care Professional.

3. Inspection and copies: You have the right to inspect and obtain a copy of your PHI. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information. Our office may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

4. Amendment: You have the right to ask your physician to amend your health information if you believe it is incorrect or incomplete. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. Accounting of Disclosures: You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations.

6. A Paper Copy of this Notice: You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact us at (702) 933-1485.

7. Complaints: You have the right to complain if you believe your privacy rights have been violated. You may file a complaint, in writing, with our office or with the Secretary of the Department of Health and Human Services. **You will not be penalized by us for the complaint.**

8. Revoke this Authorization: You have the right to revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

All requests as noted in this Notice of Privacy Practices must be submitted in writing.

This notice was published and became effective on/or before **August 1st, 2008.**

We are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have and questions or objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone, at 702.933.1485.

Notice of Office Policies

CANCELED OR MISSED APPOINTMENTS AND TIMELINESS

We require a **24 hour advanced cancellation notice**. If this notice is not given, you may be billed a **\$25.00** fee. We reserve the right to refuse scheduling to any new patient missing an initial "establish care" appointment. If you routinely miss appointments, you may be limited same-day appointments only. Please be prompt for appointments. If you are more than **10 minutes late**, your appointment may be rescheduled. Because we spend the time needed with each patient visit, we do run behind on occasion. In those situations, we would be happy to reschedule you upon request with no penalty.

FINANCIAL AND BILLING RESPONSIBILITIES

All Payments, including co-payments, co-insurance, deductibles and deposits are due during check-in at the time services are rendered. We accept checks, cash, MasterCard, Visa, and American Express. Returned checks will incur an additional processing fee of **\$25.00** each, and then checks will no longer be accepted from you. We bill for physician services only. **Any fees for labwork, testing, and any other outside services are billed separately by the provider of those services.** You should present your insurance card at each visit. If your insurance status changes, you must notify the office immediately or be financially responsible for all services that are rendered. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly. All accounts will be considered delinquent after 90 days. These accounts will be placed with a collection agency and will be subject to all reasonable collection and court costs necessary collect the outstanding balance.

INSURANCE INFORMATION

Your insurance policy is a contract between you and your insurance company. Though we will help you to the best of our ability, our relationship is with you, and you are ultimately responsible for services provided, regardless of your insurance. Not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time that the services are rendered.

CONTROLLED SUBSTANCES

You will **not** receive prescriptions for any controlled substance on your first visit nor will they be continually refilled. Any patient needing ongoing controlled substance prescriptions will be referred to a Specialist for further management. If you have questions about this, please ask.

PAPERWORK FEES

There is a **\$25.00** fee for any form requiring a physician signature with no exceptions. This fee includes any copying service as well as the time needed to fill out forms. The forms must be submitted to the office a minimum of **one week** prior to the due date.

PATIENT COMMUNICATION

Our physicians believe in spending quality time with patients at their office visits. Because of time constraints, the physicians do not routinely return patient phone calls personally. Any medical questions or messages should be left with our staff and will be promptly communicated with a physician. We will contact you with the physician's directions. We will always be happy to offer you a prompt in-office appointment to discuss any issues with a physician directly.

PRESCRIPTIONS/REFILLS/REFERRALS/LAB ORDERS/TESTING ORDERS

All new prescriptions, refills, referrals, lab orders, or test orders will be **issued at your appointment time only**. Please request any needed services at your visit as they will not be given at any other time. We will always be happy to offer you a prompt in-office appointment to discuss any issues with a physician.

Acknowledgement and Signature Form

Assignment of Benefits: By initialing to the right and signing below I authorize the following -

1. Payment of insurance benefits to be made directly to Nevada Family Care.
2. Nevada Family Care to release information needed to secure payment of benefits.
3. The use of this signature on all Insurance Submissions.
4. A photocopy of this authorization shall be valid as the original.

Initials_____

Consent for Treatment: By initialing to the right and signing below, I authorize Robert J. Karl, MD, Francesca N. Chamian, MD, Angela Ortega-Bermudez, DO, Clarissa BarrettoKo, DO and/or Abraham T. Fakhouri, MD to render medical care to me whether on an inpatient or outpatient basis. I further authorize their employees to render routine nursing care and to carry out the orders of my physician, or other healthcare provider, including consultants, associates and assistants of their choosing.

Initials_____

Financial Agreement: By initialing to the right and signing below, I agree to the following:

1. I understand that the filing of insurance claims is a courtesy and that I am financially responsible for all charges whether or not they are covered by insurance.
2. In event of default, I agree to pay all costs of collections and attorney’s fees.

Initials_____

Office Policies Acknowledgment: By initialing to the right and signing below, I acknowledge that I have **received** the Notice of Office Policies for Nevada Family Care and that I **agree to abide** by these policies.

Initials_____

Privacy Practices Acknowledgment: By initialing to the right and signing below, I acknowledge that I have **received** the HIPAA Notice of Privacy Practices.

Initials_____

By initialing above and signing below, I agree and acknowledge the Assignment of Benefits, Consent for Treatment, Financial Agreement, Office Policies Acknowledgement and Privacy Practices Acknowledgement.

Signature of Patient or Legal Guardian

Print Name

Date

Patient Registration Information - PRINT AND complete ALL sections!

Patient Name

Address: _____ City: _____

Zip: _____ Home#: _____ Cell# _____

SS# _____ Birth Date _____ Sex: F/M

Marital Status: M/S/D/W Email _____

Employer Name

Address: _____ City: _____

Zip: _____ Work#: _____ Occupation: _____

Primary Insurance Name

Policy#: _____ Group#: _____

Insured Name: _____ Birth Date: _____

Relationship to Patient: _____ SS#: _____

Secondary Insurance Name

Policy#: _____ Group#: _____

Insured Name: _____ Birth Date: _____

Relationship to Patient: _____ SS#: _____

Emergency Contact Name

Address: _____ City: _____

Zip: _____ Home#: _____ Cell#: _____

Relationship to Patient: _____

Responsible Party Name (if other than Patient):

Address: _____ City: _____

Zip: _____ Home#: _____ Cell#: _____

SS#: _____ Birth Date: _____ Employer: _____

Referral Source

How did you hear about us (indicate all that apply):

- Web
- Family
- Friend
- Phone Book
- Another Physician _____
- Hospital Referral
- Insurance Company
- Other: _____

Confidential Communication

I wish to be contacted by phone as follows (check all that apply): Home Cell Work

It is ok to (check all that apply): Leave Answering Machine Message Send U.S. Mail

My protected health information may be released to the following individuals:

Do not release information to anyone besides myself

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____	____/____/____	(____)____-____	____-____-____
Patient Name	Birth Date	Main Phone Number	Social Security Number

_____	_____	_____	_____
Address	City	State	Zip Code

PLEASE DO NOT FILL OUT BELOW UNTIL INSTRUCTED BY OFFICE

I hereby authorize: _____
Doctor or Facility

_____	_____	_____	_____
Address	City	State	Zip Code

its designee, medical records department, or equivalent, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any; behavioral medicine services records, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below.

Release Information to:

Nevada Family Care
(phone) 702-933-1485 (fax) 702-933-1490
100 N Green Valley Parkway Suite 239, Henderson NV 89074

Please Specify: Complete Medical Records

Records Pertaining to: _____

This authorization can be revoked, in writing, at any time except to the extent that information has already been releases or disclosed. Any authorization for release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved.

This authorization will expire automatically 1 year from the date signed.

_____	_____
Patient Signature/Legal Guardian	Date

NEW PATIENT HEALTH INFORMATION - Please Fill Out Completely

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Pharmacy: Local - _____ **CrossStreets:** _____ **Phone:** _____
MailOrder - _____ **ID:** _____

Race/Ethnicity (please circle): American Indian Asian Black/African American White
 Native Hawaiian/Pacific Islander Other Decline to Answer

Ethnicity (please circle): Hispanic/Latino Non-Hispanic/Latino Decline to Answer

Personal Medical History (please circle and list):

Common	Blood	Cancer	GI	Heart	Bone/Joint
Diabetes	Anemia	Bladder	Heartburn (GERD)	Attack (MI)	Gout
Blood Pressure	Bleeding Disorder	Brain	Crohns	Arrhythmia	Osteoarthritis
Cholesterol	Clot (DVT/PE)	Breast	Colitis	Disease	Osteoporosis
Kidney Disease	Clotting Disorder	Colon	IBS	Failure	Rheumatoid
Liver Disease	Neurology	Lung	Thyroid	Lung	Lupus
Mood	Paralysis	Ovaries	Hypo (low)	Asthma	Lupus-Like
Anxiety	Seizures	Prostate	Hyper (High)	COPD	
Depression	Stroke	Uterus		Emphysema	

Other: _____

Allergies (please list with reaction): None

Medications (please list): None

Suppliments (please list): None

Health Maintenance (Please Indicate):		Last Done	Normal	Abnormal
Testing:	Blood/Labwork			
	Bone Density			
	Colonoscopy			
	EKG			
	Heart Stress Test			
	Heart Cath			
	Mammogram			
	Pap			
	Prostate Check			
Immunizations:	Flu			
	HPV			
	Hepatitis A			
	Hepatitis B			
	Meningitis			
	Pneumonia			
	Shingles			
	Tetanus			

Exercise:	None	Daily	Weekly	Specify Routine	Exercise:
Diet:	No Special	Diabetic	High Fiber	Low Fat	Low Carb
	Vegetarian	Vegan	Other - _____		

Do you have a living will or advanced directive? Yes (*Please provide a copy if you do*) No

Surgical History (please list): None

Family History (Please circle and list any of the following conditions that are present in your family):

Common	Blood	Cancer	GI	Heart	Bone/Joint
Diabetes	Anemia	Bladder	Heartburn (GERD)	Attack (MI)	Gout
Blood Pressure	Bleeding Disorder	Brain	Crohns	Arrhythmia	Osteoarthritis
Cholesterol	Clot (DVT/PE)	Breast	Colitis	Disease	Osteoporosis
Kidney Disease	Clotting Disorder	Colon	IBS	Failure	Rheumatoid
Liver Disease	Neurology	Lung	Thyroid	Lung	Lupus
Mood	Paralysis	Ovaries	Hypo (low)	Asthma	Lupus-Like
Anxiety	Seizures	Prostate	Hyper (High)	COPD	
Depression	Stroke	Uterus		Emphysema	

Other: _____

Social History (please circle and fill in):

Marital status:	Married	Divorced	Separated	Domestic Partner	Single
Number of Children:	Biologic - _____	Step - _____	Adopted - _____	Living in your home - _____	
Occupation:	Employed	Self-employed	Unemployed	Retired	

Sexual History (please circle and fill in):

Sexual Preference:	Men	Women	Both		
Last Sexual Activity:	Never		Within 1 year	>1 years ago	
Menstrual Period	Last Date	Regular	Irregular	Heavy	
Pregnancy	Number Times Pregnant - _____			Number Live Births - _____	
Birth Control	Abstinent	Condoms	Hysterectomy	Vasectomy	Tubal Ligation
	Medication	Menopause	Other - _____		

Substance History (please circle):

Smoking Tobacco:	Never	Past Smoker	(Quit Date - _____)	Current Smoker	How Many? (pack/day)
					<1/2 1/2 - 1 1-1 1/2 1 1/2-2 >2
Chewing Tobacco:	Never	Past User	(Quit Date - _____)	Current User	How Many? (package-tins/day)
					<1/2 1/2 - 1 1-1 1/2 1 1/2-2 >2
Alcohol:	Never	Past Drinker	(Quit Date - _____)	Current Drinker	How Many? - _____ Drinks per
					Day Week Month Year
Drug Use(Illicit):	Never	Past User	(Quit Date - _____)	Current User	What Drug? - _____
					How Often? - _____

Infectious Disease History (please circle):

Have you ever had a Blood Transfusion?	No	Yes	Date - _____	
Have you ever been exposed to Hepatitis:	No	Yes	Date - _____	How - _____
Have you ever been exposed to HIV:	No	Yes	Date - _____	How - _____

Review of systems:

General:	Chills	Fatigue	Fever	Weight Change	
Eyes:	Blurry Vision	Eye Pain	Light Sensitivity		
Ear/Nose/Throat:	Hearing Problem	Pain	Congestion	Runny Nose	Bloody Nose
	Hoarseness	Dental Problems			
Heart:	Chest Pain	Skipped Beats	Flip Flop Beats	Racing Heart	
	Shortness of breath when lying down at night			Foot/Ankle Swelling	
Lungs:	Cough	Shortness of breath		Coughing up blood	
Stomach/Intestinal:	Abdominal Pain	Heartburn	Constipation	Diarrhea	Stool Changes
Genital/Urinary:	Pain with Urination	Genital Lesion	Blood in Urine	ED	Increased Urinary Frequency
	Changes in Urine Stream				
Bone/Joint/Muscle:	Joint Pain	Back Pain	Muscle Pain		
Skin:	Atypical Moles	Dry Skin	Itching Skin	Rash	
Brain/Nerves:	Dizziness	Headaches	Tingling/Numbness	Weakness	
Blood:	Easy Bruising	Bleeding	Lymph Node Swelling		
Mood:	Anxiety	Depression	Trouble Sleeping		