Family Doctors of Boulder City

New Patient Information

PLEASE MAKE SURE THE FRONT DESK HAS A CURRENT COPY OF YOUR INSURANCE CARD(S) AND ID

Patient's Name		SS#	
Address	City	State	Zip
Cell Phone	Home Phone	Marital Status S M D W	
Date of Birth	Sex M F	E-mail Address	

Primary Insured's Name	SS#	Date of Birth	
Primary Insured's Address	City	State	Zip
Primary Insured's Cell Phone	Home Phone		

Emergency Contact	Phone

Name and location of Pharmacy(ies) most frequently used?

Consent To Treat

By requesting care in Family Doctors of Boulder City, I am giving the health provider and staff permission to examine, diagnose and treat me. I also give authorization for my medication history to be retrieved prior to my appointment. I understand that all the health professionals at Family Doctors of Boulder City are appropriately licensed and will observe accepted professional standard of care.

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

Acknowledgement of Financial Responsibility

As a courtesy, insurance claims will be submitted on your behalf to the insurance company you specify during the registration process. We expect all known co-payments and deductibles, except for those due under MedicarelMedicaid or other federal healthcare programs, to be paid at the time of service. We reserve the right to collect copays, deductibles and coinsurance upon notification by the insurer. If you are having financial difficulty or have any questions, please contact our Billing Office to discuss your account. Non-payment of accounts will result in referral to an outside collection agency that could impact the patient's/guarantor's credit record. Legal Fees and collection costs incurred to collect outstanding accounts will be the patient's/guarantor's responsibility.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility. I understand that regardless of any insurance coverage I may have, lam ultimately responsible for payment of my account with Family Doctors of Boulder City.

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

Acknolwdgement of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct, plan and direct my treatment and follow-up among the multiple providers, agencies and individuals who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payors. 3) Conduct normal healthcare operations. I understand that this Practice has the right to change its Notice of Privacy Policy from time to time and that I may contact this facility at any time to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

Patient's/Guarantor's Signature:_____ Date:_____

Family Doctors of Boulder City

Patient Disclosure Preferences

Patient Name: _____

Date of Birth: _____

Social Security: _____

Telephone: _____

Authorization for the release of protected Health Information

You are identifying the following individual(s) as the recipients of your protected health information.

NAME

1. _____
2. _____
3. _____

I understand that I may revoke this authorization at any time by giving written notice. Revocation will not affect any action taken in reliance on this authorization before I submitted written notice of revocation.

I, _____, attest that the above information is correct and have had full opportunity to read and consider the contents of this authorization. I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature_____**Date**_____

If this authorization is signed by a personal representative on the behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

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.