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

Patient Name:____
Address:________________________________City:__________________
Zip Code_____________ Hm #______________________Cell#________________
SS#______________________ Birth Date_________________ Sex: F/M
Marital Status M/S/D/W Email ____

Employer Name:____
Address:____City__________________
Zip:_____________________WK #____________________
Occupation____

Primary Insurance Co Name:____
Policy I.D#___________________________GRP #______________________________
Insured Name______________________________ Birth Date_____________________
Relationship to Patient_______________________SS#___________________________

Secondary Insurance Co. Name:____
Policy I.D#____________________________GRP #_____________________________
Insured Name______________________________ Birth Date_____________________
Relationship to Patient_______________________SS#___________________________

Emergency Contact:
1) Name of person to call in an Emergency?_____________________________________
Address____City___________________
State/Zip_____________________________Phone #______________________________
Cell#__________________Relationship to Patient:_______________________________

2)Name of nearest Relative, not living with you:_________________________________
Address____City___________________
State/Zip_____________________________Phone #______________________________
Cell#__________________Relationship to Patient:______________________________

Responsible Party (if other than Patient)
Responsible Party's Name:______________________________D/O/B________________
Address:___________________________________City/Zip_______________________
Phone #___________________________________SS#___________________________
Employer _________________________________Employer's #_____________________

Pharmacy Name:_______________________________**Phone #**____________________

Referral Source: please circle one or more of the sources listed below:

Nevada Family Care Website	Family Member	Yellow Book
Another Physician	St. Rose Referral Service	Friend
Newspaper	Other__________	Insurance Company
Desert Springs Referral Service	*Desert Springs Hosp. Patient*	*Sprint Phone Book*

Notice of Office Policies

APPOINTMENT TIMELINESS AND CANCELLATION:

Please be prompt for appointments. If you are more than **10 minutes late**, we may reschedule your appointment. Because we try spend adequate time with ALL patients, sometimes we do run behind. We apologize for this inconvenience in advance. We require a **24 hour advanced cancellation notice.** You may be billed a **$25.00** fee for failure to give adequate notice of cancellation. We reserve the right to refuse scheduling to any new patient missing an initial appointment to establish care. Established patients missing 2 appointments within 1 year, will subsequently be allowed same day appointments only.

BILLING:

We bill for doctor's services only. Any fees for lab work, testing, and other outside services are billed separately by the testing facility. 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. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collection and court costs.

FINANCIAL RESPONSIBILITIES:

All Payments, including co-payments, co-insurance, deductibles and deposits are due before services are rendered. Your insurance card must be presented at every visit. If your insurance plan changes or is terminated, you must notify the office immediately. If you fail to do this, you are financially responsible for any and all services that are rendered. We accept checks, cash, MasterCard, Visa, and American Express. All returned checks will incur an additional processing fee of **$25.00** each, and then checks will no longer be accepted from you. If your account is sent to collections, you will be responsible for any fees incurred to collect the outstanding balance.

INSURANCE INFORMATION:

Your insurance policy is a contract between you and your insurance company. 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. Though we will help you to the best of our ability, you are responsible for any communication with your insurance company regarding their coverage.

NARCOTICS AND CONTROLLED SUBSTANCES:

You will not receive prescriptions for any controlled substance on your first visit. Any patient who needs ongoing narcotic prescriptions will be referred to a Pain Specialist for those prescriptions and further pain management. Controlled substances will not be continually refilled.

PAPERWORK FEES:

There is a **$25.00** fee for any form requiring a physician signature - payable in advance - 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 these time constraints, the physicians do not routinely return patient phone calls personally. Any medical questions or messages should be left with the medical assistant who will communicate with your physician and contact you with your 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, prescription 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 prescribed or ordered otherwise. We will always be happy to offer you a prompt in-office appointment to discuss any issues with a physician. **We will NOT fax or call prescriptions in to mail-order companies such as MEDCO, Express Scripts, Caremark, etc.**

HIPAA Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to it. Please review this notice carefully.

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. "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 becomes 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.

Assignment of Benefits:

By signing below I authorize the following:
Payment of insurance benefits to be made directly to Nevada Family Care.
Nevada Family Care to release information needed to secure payment of benefits.
The use of this signature on all Insurance Submissions.
A photocopy of this authorization shall be valid as the original.

____

Signature of Patient or Legal Guardian **Print Name** **Date**

Consent for Treatment:

By signing below, I authorize Robert J. Karl, MD and/or Francesca N. Chamian, 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.

____

Signature of Patient or Legal Guardian **Print Name** **Date**

Financial Agreement:

By signing below, I agree to the following:
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.
In event of default, I agree to pay all costs of collections and attorney’s fees.

____

Signature of Patient or Legal Guardian **Print Name** **Date**

Office Polices Acknowledgment:

By 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.

____

Signature of Patient or Legal Guardian **Print Name** **Date**

Privacy Practices Acknowledgment:

By signing below, I acknowledge that I have **received** the HIPAA Notice of Privacy Practices.

____

Signature of Patient or Legal Guardian ***Print Name*** ***Date***

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____
(Patient Name) (Main Phone Number)

____
(Address) (City) (State) (Zip Code)

____
(Birth Date) (Social Security Number)

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 Ste 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 or Authorized Representative) (Relationship to Patient, if not self) (Date)

____
(Signature of Witness) ***(Date)***

Patient Request for Confidential Communication

In general, the HIPAA privacy rule gives the individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐Home Phone ☐Cell Phone ☐Work Phone ☐Other:_____________

If we are unable to reach you reach by phone, it is ok to (check all that apply):

☐ Leave a message on the Answering Machine

☐ Send U.S. Mail

☐ Send E-mail (This option may be available in the future)

I wish my protected health information be released to the following individuals:

Name: ____________________________ Relationship:_____________________

Name: ____________________________ Relationship:_____________________

Name: ____________________________ Relationship:_____________________

☐ I **do not** wish my protected health information be released to anyone besides myself

____

Signature of Patient or Legal Guardian **Print Name** **Date**

The HIPPAA privacy rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for protected health information (PHI) to the minimum necessary to accomplish the intended purpose. These Provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Insurance Worksheet

Please bring this completed form with you to your appointment

We are pleased you have chosen Nevada Family Care to be your primary care provider and we look forward to providing consistent high quality medical care and related services to you. To avoid confusion about your insurance coverage, we ask that you contact your insurance company prior to your appointment to understand your specific plan benefits and coverage. Please be aware that we will bill you privately for any charges not covered by your plan, so time taken now on your part will eliminate unexpected expenses to you later.

This form to be used as a guide when calling your insurance company regarding your benefits.

To find out if these physicians are participating on your plan, give the insurance representative
Robert J. Karl, MD M. Francesca N. Chamian, MD

Patient Name:_____________________________ **Appt Date:**_____________**Today's Date:**____________

Name of Insurance Co.	Ins. Phone number for benefits	Ins. Rep. spoke with:
Ins. Policy holder's name:	**Policy holder's Social Security #:**	**Policy holder's employer's name:**
Policy Holder's date of birth:	**HMO PPO POS MC Indemnity**	**Policy Effective Date:**

1. If you have an HMO, which physician is listed as my primary care physician?
____

Which laboratory is IN-NETWORK? Quest Labcorp Other: ______________________________
What is my lab benefits? ____

3. What outpatient radiology facility is IN-NETWORK? Insight/Parkway Medical Imaging Steinberg Diagnostic Desert Imaging Nevada Imaging Other: ______________________________
What is my radiology benefit?
____

4. Do I have **Well/Routine Exam Coverage?** Yes ___________ No ___________
If yes, how is it covered? Deductible Amt:______ or 100% with a $ _____Copay, 90%_____, 80% ______

5. Do I have coverage for a **Problem/Sick Visit?** Yes_________ No _________
If yes, how is it covered? Deductible Amt: ______ or 100% with a $_______Copay, 90%_____, 80%______

If at any time, while you are a patient of Nevada Family Care, and your insurance changes, your address changes, or your insurance benefits change, it is your responsibility to immediately notify our business office. **Thank you for your cooperation!**

NEW PATIENT HEALTH QUESTIONAIRE

Thank you for taking your time in completing this patient evaluation form.
This information will help us take better care of you!

Name: ____________________________ DOB_______________Today's Date_________________

Medical History: Please circle any medical problems you have (also indicate date of diagnosis):

Asthma	Cancer, Ovaries	Heart Problems:____________
Blood Pressure Problems	Cancer, Prostate	Kidney disease
Blood/Bleeding Disorders	Cancer, Uterus	Liver disease
Cancer, Breast	Cholesterol Problems	Osteoporosis
Cancer, Colon	Depression	Seizures
Cancer, Lung	Diabetes or High Blood Sugar	Strokes
Cancer, Other:____________	Emphysema	Thyroid Problems

Please list any other medical problems you are aware of (including date of diagnosis):

Surgical History: Please list all surgeries (indicate type of surgery and date):

Medications: Please list all medications and suppliments, both prescription and over-the-counter (including name, dose, and when first prescribed):

Allergies: Please list any allergies to medications or otherwise (including reaction):

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

Asthma	Cancer, Ovaries	Heart Problems:____________
Blood Pressure Problems	Cancer, Prostate	Kidney disease
Blood/Bleeding Disorders	Cancer, Uterus	Liver disease
Cancer, Breast	Cholesterol Problems	Osteoporosis
Cancer, Colon	Depression	Seizures
Cancer, Lung	Diabetes or High Blood Sugar	Strokes
Cancer, Other:____________	Emphysema	Thyroid Problems

Social History:
Do you smoke? **Yes** (amount per day ________) **No** - Have you ever? No Yes (quit date ________)

Do you drink alcohol? **Yes** (amount ________) **No** - Have you ever? No Yes (quit date ________)

Marital status: married single divorced separated widowed
Number of children: ____
Occupation: ___________________________ Retired
Have you ever had a blood transfusion? No Yes (date ______)
Have you ever used illicit drugs? No Yes (specify type: _______________________________________)
Any known exposure to HIV or hepatitis? No Yes

Exercise: None Daily Weekly Specify Routine: __________________________________

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

Health Maintenance:
Please check any of the following that you have had in the past, and note date and result:
complete physical
chest X-ray
EKG
eye exam
cholesterol check
thyroid test
cardiac stress test
colonoscopy or flex/sig

For men:
prostate blood test (PSA)
prostate exam

For women:
mammogram
PAP smear
bone density test

Last menstrual period: ________________________
Regarding Birth Control:

Abstinent	Hysterectomy	Tubal Ligation
Barrier(i.e. condoms)	IUD	Vasectomy of Partner
Birth Control Medication	Menopause	

Immunizations:
When was your last flu shot? _____________________
Have you ever had a pneumonia shot? ______________ If yes, list when: __________________
When was your last tetanus booster? ________________
When was your last diphtheria booster? _____________

Review of systems:
Please circle symptoms which you are **currently** experiencing:

Systemic: fever fatigue weight loss night sweats

HEENT: vision changes sinus problems

Cardiac: chest pain shortness of breath with activity irregular heartbeat

Pulmonary: shortness of breath cough

GI: abdominal pain nausea/vomiting heartburn diarrhea constipation rectal bleeding

Endocrine: weight gain increased thirst intolerance of heat intolerance of cold

Hematology: anemia bleeding swollen glands

Rheumatology: joint pain joint swelling

GU: painful urination blood in the urine urine slow to start increased urination

GYN: unusual vaginal bleeding unusual vaginal discharge

Neurology: seizures dizziness severe headaches unusual numbness/tingling weakness of arm/leg

Dermatology: rash changes in moles unusual skin lesions

Psych: depression anxiety chronic insomnia

Please list other symptoms you are concerned about: