REGISTRATION - PLEASE PRINT ALL INFORMATION IN THIS BOX AND SIGN BELOW

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH

EMPLOYER OR SCHOOL	SS# - -	SEX ( ) M ( ) F ( ) Transgendered	MARITAL STATUS ( ) M ( ) S ( ) D ( ) W

MAILING ADDRESS	UNIT/APT	CITY	STATE	ZIP CODE

PHYSICAL ADDRESS	UNIT/APT	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

Which number is the best way to contact you? □ Home □ Cell □ Work Is it okay to leave a message? □ yes □ no Is it okay to send statements to your address, if needed ? □ yes □ no	E-MAIL ADDRESS *(For patient portal)

EMERGENCY CONTACT (18 or older)	RELATIONSHIP	PHONE

Ethnicity (Select one) □ Hispanic □ Non-Hispanic	Race (Select one) □ White □ Black □ Native American/Alaska Native □ Asian □ Native Hawaiian or other Pacific Islander □ Not Reported What language do you speak at home? _____

I hereby acknowledge that I am aware of CCHHS' Notice of Privacy Practices. Copies are available for review in the waiting room or upon request. All records of minors will be kept for a minimum of 5 years after that individual turns 18 (NRS 629.051)*I understand that by providing my e-mail address I will be enrolled in CCHHS' online patient portal. We do not send statements for balances lower than $18.99, however any unpaid balance remains your responsibility.

PATIENT SIGNATURE_____ **DATE** _____

☐ UNINSURED: ☐ MEDICAID ☐ PRIVATE NSURANCE

INSURANCE NAME	ID #	GROUP NUMBER

CARD HOLDER NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX ( ) M ( ) F

MAILING ADDRESS UNIT/APT	CITY	STATE	ZIP CODE	HOME PHONE

INSURED PATIENTS ONLY

A copy of your insurance card (s) & Driver's license/picture ID are required at the time of registration.

AUTHORIZATION TO PAY BENEFITS TO CCHHS: I hereby authorize payment directly to CCHHS Services Physician for Medical services. I authorize CCHHS to release any information necessary to process this claim.

SIGNED_____ DATE _____

If form not signed by the patient, please indicate relationship:
□ Parent or Guardian of minor patient, please indicate relationship _____
□ Other (specify) _____

cchhs/vg/rev 5-15-17

* Carson City Health & Human Services (CCHHS) 900 E. Long St. Carson City, NV 89706
Tel. 887-2195 Fax 887-2192

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

Your health care here is voluntary and confidential. No information will be given out about you without your written permission except as required by law or to provide services to you in compliance with federal privacy and security standards.

Please Note:

1. **Clinical Staff at *CCHHS are mandatory reporters of Statutory Sexual Seduction (N.R.S. 432B.220).** This means that if you are 15 years of age or younger and are having sex with someone 18 years of age or older and you tell us, we must report it to law enforcement.
2. **Clinical Staff at *CCHHS are also mandatory reporters of Child Abuse and Neglect (N.R.S. 432B.220).** This means that if we have cause to believe that there is any kind of abuse or neglect of a minor occurring, we must report it to law enforcement.
3. **Staff are also mandatory reporters of lewdness (sex) with a child under the age of 14 (NRS 201.230).** This means that if we have a cause to believe that there is any kind of abuse or neglect of a minor occurring, we must report it to law enforcement.
4. **Staff are required to report (NAC 441A.230) certain communicable diseases, such as:** If you have a positive test result for certain communicable diseases we are required to report the results. In some cases, you may be contacted by a clinic investigator who will ask you to provide information about your contacts in order to provide them with testing and treatment.

In this clinic you can choose your method of birth control (as long as it will not cause you health problems). You can also refuse any method of birth control or other services offered by this clinic.

I have the right to know everything about my care and I am encouraged to ask questions.

I understand that in order for us to provide the services I request, I may need to have an examination and/or lab tests, and treatment may be recommended. These may include:

Physical examination	**Lab tests**	**Treatment**
Weight & blood pressure check	Urine	Oral & topical treatment of minor gynecological
Exam of head, neck, lungs, heart,	Vaginal fluids	Health & skin conditions
breasts, abdomen, pelvis, rectum,	Blood tests	Certain communicable diseases,
arms & legs	Pap tests	including STD's

I have read (or have had read to me) the above information, understand this information, and give my permission for examination, treatment, and care by the staff of *CCHHS.

Pre-employment drug screen. I consent to all paperwork/lab results being shared with CC Human Resources.

HIV rapid testing may be part of your exam . Please let your provider know if you wish **NOT** to have this test done

Family Planning : I have voluntarily chosen to receive health care at *CCHHS. I am aware that I will not be coerced into receiving services or to use any particular method of birth control. I understand that acceptance of family planning services is not necessary in order for me to participate in other programs or to receive other services offered by *CCHHS

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Family Planning - 18 years of age or younger: (please mark the appropriate boxes)

- ☐ I would like my parents to be involved in my Family Planning Decision.
- ☐ Do not contact my parents. ☐ It is NOT okay if insurance statements are sent to my home.
- ☐ I need help in telling my parents.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

PRACTICE PAYMENT POLICY / PROOF OF INCOME INFORMATION

PATIENT RESPONSIBILITY

It is the patient's responsibility to know what their insurance does and does not cover. In addition, it is the patient's responsibility to verify whether the facility is contracted with your plan. You can find out more about your insurance by calling the phone number on your card or through your human resources department at your place of employment.

PAYMENT POLICY

For insured patients - The patient is responsible for paying for any co-payment or deductible at the time of service at the sign in desk. We accept cash, checks, Mastercard and VISA.

INSURANCE BILLING

As a courtesy, we will bill selected contracted insurance companies. If we have not heard from the insurance carrier within 60 days, the balance becomes the patient's responsibility according to the tier assigned at the time of registration . Please note in order to bill insurance, we require all the necessary information on the insured patient.

MEDICAID BILLING

A copy of your Medicaid card & Driver's license/picture ID is necessary at the time of registration. I hereby authorize payment directly to *CCHHS for Medical Benefits. I hereby authorize *CCHHS to release information necessary to process this claim.

HEALTHCARE DIRECTIVE Do you have an advanced healthcare directive, living will, and/or durable power of attorney to manage your medical treatment? ☐ **YES** ☐ **NO**

I verify that I have read and understood the above Practice Payment Policy and I agree to the terms and conditions.

Patient Signature:_____ **Date:** _____

If patient is a Minor - Parent or Guardian signature

PROOF OF INCOME INFORMATION

Name of Patient :_____

Name of Guardian:_____

Name of Spouse / Partner:_____

Employment Source of Gross Income $_____ □ **Weekly** □ **Bi-weekly** □ **Monthly** □ **Yearly**

Other Source of Income $_____ _____

How many people do you support in your immediate household? _____

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Source of Verification:_____ **BY:** _____

Proof of Income provided: □ **Pay Check Stubs** □ **Other** _____

Patient Income: Weekly _____ **Bi-weekly** _____ **Monthly** _____ **Annual** _____

Patient hours worked weekly_____ **Patient** _____

Spouse / Partner Income _____ **Spouse/Partner** _____

Other Income _____ **Children** _____

Other/Roommate(s) _____

Total Household Income _____ **Total # in Family/Household** _____

Note: **Patient Qualified for** **1 2 3 4 5**

cchhs/vg/rev 5-22-17

* Carson City Health & Human Services (CCHHS) 900 E. Long St. Carson City, NV 89706
Tel. 887-2195 Fax 887-2192

Acknowledgement of Receipt of Notice

I, _____(print name) hereby acknowledge that I am aware of *CCHHS Notice of Privacy practices. Copies are available for review in the waiting room or upon request. All records of minors will be kept for a minimum of 5 years after that individual turns 23 (NRS 629.051)

Signed:_____ **Date:**_____

Phone: (___)_____

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient, please indicate relationship_____

( ) Beneficiary or representative of deceased patient

( ) Guardian or conservator of an incompetent patient

( ) Other (specify)

Name of Patient: _____

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For Official Use Only

( ) Acknowledgement refused:
Describe effort to obtain signature:

_____

_____

State patient's reason for refusal:

_____

_____

Staff Signature _____ Date:_____

cchhs/vg/rev 2-1-17

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