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

PATIENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	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 or **DCCH 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 626.06). * I understand that by providing my e-mail address I will be enrolled in CCHHS/DCCH's online patient portal.

PATIENT SIGNATURE______________________________ **DATE** ____________

☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ PRIMARY INSURANCE POLICY HOLDER

SPOUSE/PARENT LAST NAME	FIRST NAME	INITIAL	**RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER	WORK PHONE /CELL PHONE	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 PHYSICIAN: I hereby authorize payment directly to *CCHHS or **DCCH Services Physician for Medical Benefits. I hereby authorize *CCHHS or **DCCH 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 7-13-15

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

** Douglas County Community Health (DCCH)
1329 Waterloo Lane, Gardnerville, NV 89410
Tel. 782-9038 Fax 782-9875

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 and **DCCH 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 and **DCCH 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, arms & legs	Blood tests Pap tests	Certain communicable diseases, 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 or **DCCH.

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 or **DCCH. 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 or **DCCH.

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:** ______________

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Acknowledgement of Receipt of Notice

I, ____(print name) hereby acknowledge that I am aware of *CCHHS o **DCCH 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 626.06).

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:____________________

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PRACTICE PAYMENT POLICY / PROOF OF INCOME INFORMATION

Once you have completed these forms, please give them to a receptionist along with your insurance card (s) and your drivers license or ID.

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 or **DCCH, Services Physician for Medical Benefits.

I hereby authorize *CCHHS or **DCCH to release information necessary to process this claim.

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? ________

For Office Use Only

Source of Verification:______________________________ **BY:** _____________________________

Proof of Income provided: **Pay Check Stubs** **Other** ___________________

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

Patient hours worked weekly____________

Spouse / Partner Income ______________

Other Income _____________________

Total Household Income _____________

Patient __________

Spouse/Partner __________

Children ___________

Other/Roommate(s) ___________

Total # in Family/Household _____________

Note:

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

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