CLINIC PATIENT REGISTRATION FORM

PATIENT INFORMATION

LEGAL NAME _____ Birthdate ____/____/____
LAST FIRST MI MM DD YYYY

Preferred Name: _____ SS#: _____ Preferred Pharmacy: _____

Phone Number: _____ E-Mail Address: _____

Preferred ☐ Call □ Text □ Leave Message ☐ Do NOT enroll me in the Patient Portal

Physical Address _____
STREET UNIT/APT CITY STATE ZIP

☐ SAME AS PHYSICAL

Mailing Address _____
STREET UNIT/APT CITY STATE ZIP

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
First and Last Name

Birth Sex (Check one box)	**Sexual Orientation (Check one box)**	**Gender Identity (Check one box)**	**Preferred Pronouns (Check one box)**
□ Male □ Female □ Decline to specify	□ Gay, Lesbian, or homosexual □ Straight or heterosexual □ Bisexual □ Do not know □ Decline to specify	□ Male □ Female □ Genderqueer □ Female-to-male/Transgender male/Trans man □ Male-female/Transgender female/Trans woman □ Decline to specify	□ Decline to specify □ He / Him / His □ She / Her / hers □ They / Them / Theirs

Ethnicity (Check one box)	**Race (Check one box)**	**Preferred Language:**	**Advanced Directive:** Do you have an advanced healthcare directive or any legal document in which you specify what actions should be taken for your health if you are no longer able to make decisions because of illness or incapacity?
□ Decline to specify □ Hispanic / Latino □ Not Hispanic / Latino	□ Decline to specify □ White □ Black/African American □ Pacific Islander □ American Indian / Alaskan Native □ Asian	_____ **Do you need a translator?** □ Yes □ No	□ Yes □ No

INSURANCE INFORMATION – ***OFFICE USE ONLY***

☐ Medicaid

☐ NV Check-up

☐ No Insurance

☐ Do NOT send statements to my address on file

☐ Private Insurance: _____

Carrier: _____

Payer ID#: _____

Policy #: _____

Group #: _____

Policy Holder Name: _____

DOB: _____

Relationship: _____

Sex: ☐ M ☐ F ☐ X

I hereby authorize Carson City Health and Human Services (CCHHS) to apply on my behalf for covered services rendered. I understand that if the policyholder is someone other than myself, a potential for discloser of confidential health information may be related to the claim to the policyholder. I authorize payment be made directly to CCHHS for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize CCHHS to release any information necessary, including medical information, to process this claim or any related claim. I may revoke this authorization at any time in writing.

Signature: _____ **Date:** _____

18 YEARS OF AGE OR YOUNGER

☐ I would like my parents to be involved in my Family Planning Decision.

☐ Do not contact my parents.

☐ I need help in telling my parents. ☐ It is NOT okay for insurance statements to be sent to my home.

Signature: _____ **Date:** _____

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.

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. CCHHS can accept cash, checks, Mastercard and VISA. Please note, CCHHS will not send statements for balances lower than $18.99, however any unpaid balance remains the patient's responsibility.

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.

PROOF OF INCOME INFORMATION

PLEASE NOTE: Patients with insurance and without must fill out the proof of income information. Even with insurance, you may be responsible for a portion of your visit. By completing income information, you may be eligible to receive a discount on the services you receive today during your visit. This includes any balances not covered by insurance where applicable.

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:

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

Signature: _____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I _____(print patient name) hereby acknowledge that I am aware of Carson City Health and Human Services Privacy Practices. I am aware that copies are available for review in the waiting room or upon request.

OR

☐ I would like to receive a copy of CCHHS Notice of Privacy Practices.

☐ I decline to receive a copy of CCHHS Notice of Privacy Practices.

Signature: _____ Date_____

FOR OFFICE USE ONLY

If Acknowledgement refused Describe effort to obtain signature:_____

State reason for refusal: _____

Staff Signature _____ Date _____

INFORMED CONSENT FOR EXAMINATION AND TREATEMENT

GENERAL

_____ Initials Due to the nature and sensitivity of certain visits and information discussed with the healthcare providers at CCHHS, I acknowledge CCHHS will not disclose any Patient Health Information (PHI) without my written consent unless related to continuity of care or billing specific information. I will complete a Release of Information should I request specific information to be released to myself or designated party.

_____ Initials Staff at CCHHS are mandatory reporters in accordance with Nevada State Statues for incidents including but not limited to Statutory Sexual Seduction, Child Abuse and Neglect, lewdness or sex with a child under the age of 14 and other reportable incidents as defined by applicable Nevada Revised Statues. Staff are also required to report certain communicable diseases when applicable.

_____ Initials I have the right to know everything about my care and am encouraged to ask questions. I hereby voluntarily request and authorize medical examination and treatment by the clinical staff at Carson City Health and Human Services Clinic. These may include:

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

FAMILY PLANNING

_____ Initials 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 m to participate in other programs or to receive other services offered at CCHHS.

_____ Initials I have the right to choose my own method of birth control with provider input related to potential health problems or side effects that may affect my health. I may also refuse any method of birth control or any other services offered by this clinic.

MINOR

_____ Initials I am aware that all records of minors will be kept for a minimum of 5 years after that individual turns 18 years old (NRS 629.051

_____ Initials In accordance with NRS 129.030 (3), I understand the nature and proposed examination or services and the probable outcome, and voluntarily request the proposed examination or services.

_____ Initials By receiving an examination or services, parents, legal guardian or custodian are not liable for the payment for that examinatio or services unless they have granted consent for the proposed examination or services (NRS 129.030 (7)). I understand by requesting the proposed examination or services, I am liable for the sliding scale payment for the requested examination or services received during my visit.

_____ Initials While not necessary for treatment, CCHHS encourages parents, legal guardians, or custodians to be involved in family plannin decisions for minors. I acknowledge I can request assistance notifying or involving my parent, legal guardian, or custodian duri my visit if needed.

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

Signature: _____ **Date**_____

Carson City Health and Human Services, Clinical Services (CCHHS)

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