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 _______________________________________

† 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 8-16-17

* 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:** _____

LA PRACTICA POLITICA DE PAGO / INFORMACION SOBRE PUEVA DE INGRESOS

RESPONSABILIDAD DEL PACIENTE - Es responsabilidad del paciente saber lo que cubre y no cubre su seguro médico. Además, es su responsabilidad verificar que la clínica tenga un contrato con su plan de seguro médico. Usted puede recibir más información sobre su seguro médico llamando al número de teléfono en su tarjeta o con su departamento de recursos humanos en su lugar de empleo.

POLITICA DE PAGO –
Para nuestros pacientes con seguro médico, usted es responsable de pagar cualquier Co-Pago o deducible a la hora de recibir los servicios. Aceptamos dinero en efectivo, cheques, Mastercard y VISA.

FACTURACIÓN del SEGURO - como cortesía, si tenemos un contrato con su seguro médico le mandaremos el cobro a ellos. Si en un plazo de 60 días su compañía no ha respondido, el saldo pendiente se convierte su responsabilidad. Por favor tome en cuenta que necesitamos toda la información necesaria del paciente asegurado para procesar el cobro.

FRACTURACION DE MEDICAID
Se requiere una copia de su tarjeta de Medicaid y su identificación a la hora de su registración.
Por este medio autorizo el pago directamente a los proveedores de CCHHS por los beneficios médicos.
Por este medio autorizo a CCHHS a rebelar la información necesaria para procesar el pago.

DIRECTIVE AVANZADA DE SALUD Usted tiene una Directiva de Salud Avanzada, Testamento en Vida, y (o) Poder de Designación de sustituto para decisiones del cuidado médico para manejar su tratamiento médico? ☐ **Sí** ☐ **NO**

Yo verifico que he leído y entiendo la política de pago mencionada anteriormente y estoy de acuerdo con los términos y condiciones.

Firma de Paciente: _____ Fecha: _____

Si el paciente es menor de edad - firma de pariente o guardián

INFORMACION SOBRE PRUEVA DE INGRESOS

Nombre de Paciente: _____
Nombre de Guardián: _____
Nombre de esposo o pareja: _____
Ingresos de empleo (antes de deduccione de impuestos) $_____
☐ **semanal** ☐ **quincenal** ☐ **mensual** ☐ **anual**
Otra fuente de ingresos $_____
Cuanta gente mantiene en su hogar inmediato?_____

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_____ Patient _____
Spouse / Partner Income _____ Spouse/Partner _____
Other Income _____ Children _____
Other/Roomate(s) _____

Total Household Income _____ Total # in Family/Household _____
Note: _____ Patient Tier 1 2 3 4 5

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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:_____

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