



Patient Registration Form

Patient Information

Please note that the patient's name as provided here must match the name on the insurance card in order for claims to be successfully submitted to insurance.

Last Name: _____ First Name: _____ MI: _____

Previous Name: _____

Date of birth: _____ Gender: Male Female Transgender

Marital Status: Single Married Divorced Widowed Partner Legally Separated

Is the patient a veteran? Yes No

Is the patient in foster care? Yes No

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different from mailing address): _____

City: _____ State: _____ Zip: _____

May we leave a detailed message regarding your medical care / treatment at this number?

Home Phone: () - _____

Yes No

Cell Phone: () - _____

Yes No

Work Phone: () - _____

Yes No

I prefer to receive appointment and other reminders as:

Text Phone call, in the: Morning Afternoon Evening

Please provide your email address below to enroll in Carson Medical Group's Patient Portal

E-Mail Address: _____

(to be used for confidential communication)

Patient's Employer: _____

Employment Status: Full-Time Part-Time Not employed Retired

Race (required)	Ethnicity (required)	Primary Language (required)
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other race <input type="checkbox"/> Declined to Specify	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Specify	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____

Emergency Contact

Name: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) - _____

Pharmacy Information

Pharmacy of Choice: _____

Address/Location (e.g. N. Carson & Winnie): _____

Miscellaneous Information

Do you have an Advance Directive? (check all that apply)

- | | |
|-------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Declined | <input type="checkbox"/> Physician order for life-sustaining treatment |
| <input type="checkbox"/> Healthcare proxy (POA) | <input type="checkbox"/> Organ donor |
| <input type="checkbox"/> No blood transfusions | <input type="checkbox"/> Do Not Resuscitate |
| <input type="checkbox"/> Living Will | |
| <input type="checkbox"/> Advance | |

Is the patient visually impaired? Yes No

Is the patient hearing impaired? Yes No

Insurance Information

Please be prepared to show your insurance card and identification at every office visit.

Primary Insurance Company: _____

Policy Holder's Name _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of birth: _____

Policy/ID Number: _____ Group #: _____

Patient's Relationship to Policy Holder: Self Spouse Child Other _____

Secondary Insurance Company: _____

Policy Holder's Name _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of birth: _____

Policy/ID Number: _____ Group #: _____

Patient's Relationship to Policy Holder: Self Spouse Child Other _____

Notice to Patients Regarding the Destruction of Health Care Records

Pursuant to the provisions of subsection 7 of NRS 629.051:

1. The health care records of a person who is less than 23 years of age may not be destroyed; and
2. The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and
3. Except as otherwise provided in section 7 of NRS 629.051 and unless a longer period of time is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

Consent to Access External Prescription History

_____ By initialling here, I am granting my consent for Carson Medical Group to access my prescription history. I understand that prescription history from multiple, other, unaffiliated medical providers; insurance companies; and pharmacy benefit managers may be available to providers and staff here and that it may include prescription history dating back several years.

Acknowledgement

All of the above information is true to the best of my knowledge. I authorize Carson Medical Group to release my information to insurance carriers concerning my medical condition/treatment, etc. in order to facilitate claims payment. In addition, I assign benefits to be paid to Carson Medical Group for all services rendered. I understand that I am financially responsible for charges for medical services rendered to the above named patient regardless of insurance coverage/payment. I understand that all co-payments and or deductible amounts are due and payable at the time of service.

Patient Name (Please print)

Patient Signature

Date



Carson Medical Group

PRACTICE POLICY

Thank you for choosing Carson Medical Group. We are truly glad to be part of your care. We strive to promote the health and well-being of our patients and the community. This goal is best achieved when there is a clear understanding of our practice policies and expectations. Please review this document and sign to confirm you understand and agree to follow our policies.

Office Hours Appointment hours vary by provider, but you can contact our office Monday - Friday 8:00 AM - 5:00 PM at 775-283-5050 to reach our staff. On-call physicians are available for emergencies outside of these hours. We observe most major federal holidays (see website for list).

CMG+ Walk-In Clinic We are proud to offer walk-in appointments to our established patients for acute care needs at our CMG+ Walk-In Clinic located at 1946 Old Hot Springs Road. Monday-Friday 7:00 AM - 7:00 PM and Saturday & Sunday 8:00 AM - 2:00 PM.

Our Service Your care is guided by your provider's medical expertise. While we encourage shared decision-making, the provider's professional judgment determines what is medically appropriate. We cannot guarantee specific tests, prescriptions, or treatments. By signing, you consent for treatment and agree to follow a reasonable treatment plan outlined by your provider.

Appointments We value your scheduled time. Please arrive on time and notify us at least 24 hours in advance if you need to cancel or reschedule. If you are more than 15 minutes late, we will try to accommodate you, but your visit may need to be rescheduled. Repeated missed, late, or canceled appointments could result in dismissal from our practice.

Standards of Conduct All patients and visitors are expected to treat staff and other patients with respect. Abusive, threatening, discriminatory, or disruptive behavior will not be tolerated and may result in permanent dismissal from our practice.

Patient Portal We strongly encourage use of the Patient Portal and/or corresponding Healow App. It allows secure communication directly with your care team, which is faster and more efficient. The Portal also provides access to appointment details, billing statements and online bill pay, test results, and your medical records.

CURES Act By law, your test results are posted to the portal as soon as we receive them, which may be before your provider reviews them. Please allow time for your care team to review the results. If you haven't heard from us within 72 hours, contact our office.

Medication Refills Patients must request refills in advance, directly through their pharmacy. Allow up to 3 business days for processing, or 14 days for mail-order pharmacies. Refills are only handled during office hours. We do not refill medications prescribed by providers outside Carson Medical Group. New prescriptions and antibiotics require an office visit and are not given over the phone. Keeping your appointments ensures timely refills.

Health Insurance Your health insurance is a contract between you and your plan. We make every effort to help facilitate that relationship, but please note the following responsibilities:

- ~~Card~~(s) - Bring an updated insurance card to every visit. Failure to do so may result in non-payment, leaving you financially responsible.

- Network - It is difficult to tell by reviewing an insurance card whether or not we are in your specific network. It is the patient responsibility to ensure your providers are contracted with your plan.
- PCP Designation - If your plan requires a primary care provider (PCP), ensure it is assigned correctly before your visit to avoid financial responsibility.
- Out Of Network - If it is determined that Carson Medical Group is out-of-network with your plan, you have two options:
 1. We can bill your insurance, but you will not receive a contractual discount and you will be billed the full cost of our charges less any payments made by your insurance.
 2. We can treat you as self-pay, meaning we will not bill your insurance and you will receive our self-pay discount.
- Coordination of Benefits - If you have multiple insurance plans, you are responsible for disclosing all coverage and coordinating with each insurance company to confirm which is primary, secondary, or tertiary. Failure to do so may result in financial responsibility.
- Billing Permissions - By signing this agreement, you allow us to bill your insurance, accept payment, and contact you regarding any outstanding balances.

Third-Party Liability (Non-Work Related) We do not bill motor vehicle or other third-party liability insurance, and we will not bill your health insurance for these injuries. You may be seen on a self-pay basis and can seek reimbursement from the third-party insurance. Reimbursement is not guaranteed.

Worker's Compensation We do not treat Worker's Compensation injuries. Please contact your employer for instructions on where to seek care. If we unknowingly treat a Worker's Compensation injury, you will be financially responsible for the services.

Price Transparency We collect all patient balances fairly and in line with federal rules and insurance contracts. To remain compliant, we do not waive or discount co-pays, co-insurance, deductibles, or other patient responsibilities. Payment is required at the time of service for your estimated portion. Additional services may result in a balance after insurance processes your claim.

- Estimates - Good Faith Estimates for future services are available upon request. Same-day estimates are not provided; we ask that you schedule a separate visit if you would like an advance estimate before receiving additional services.

Failure to Pay We aim to provide care to all patients, but as a private practice, we require payment to continue services. If your account has an unpaid balance or you don't follow through on an agreed upon payment plan, your account may be placed on hold. This will prevent scheduling appointments or portal access, though you can still access your medical records. Please contact our office for assistance.

Medical Records You can request your medical records using our release form. Allow up to 10 business days for processing. A reasonable fee may apply for copies or mailing. Records can be provided electronically free of charge.

Lab Services As a convenience to our patients, we allow LabCorp to utilize space in most of our locations. However, it is important to note that we are not affiliated with them. We do not have oversight of their policies or procedures.

Court Orders & Legal Documents We comply with all court orders, powers of attorney, and protective orders. It is your responsibility to provide current documents and notify us when forms expire or change.

Shared Custody Only one guarantor can be linked to an account. If there is a dispute, the parent/guardian who holds the insurance will be assigned as the guarantor. We do not coordinate payment or billing between parents. The parent/guardian bringing the patient to the visit must pay at the time of service, and the guarantor will receive the bill for any additional services.

Forms A fee may apply for completing forms, including disability paperwork, extensive school or work forms, and other medical documentation.

By signing below, I acknowledge that I have received, read, and understand Carson Medical Group's policies. I agree to comply with these policies and understand my responsibilities.

Printed Name _____ **Date of Birth** _____

Signature _____ **Date** _____



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

If you have any questions about this notice, please contact your physician or our administrator.

Our Obligations We are required by law to: Maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

Immunizations In accordance with the Modification to HIPAA Rules dated March 26, 2013 parents and guardians may provide a general permission for health care providers to disclose student immunization records to schools, preschools, and daycare facilities upon the school's request that are mandated by the State of Nevada to ensure attending students are vaccinated. A parent or guardian's signature on this Notice of Privacy Practices shall serve to accomplish this general written permission for release of a child's immunization record upon school requests.

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose Health Information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Health Care Operations We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Your Rights

As Required by Law We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates We may disclose Health Information to our business associates who perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Payment We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may share your health plan information so that another party will pay for your treatment.

Workers' Compensation We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Your Rights Continued...

Coroners, Medical Examiners and Funeral Directors We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the persons' agreement; 4) about a death we believe to be result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security and Intelligence Activities We may disclose Health Information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made necessary: 1) for the institution to provide you with health care, 2) to protect your health and the safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

Organ and Tissue Donation If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records other than psychotherapy notes. To inspect and copy this Health Information, you must make your request in writing to your physician.

Right to Amend If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to your physician.

Right to Request Restrictions You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to your physician or our administrator. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to your physician or our administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice contact your physician or our administrator.

Right to an Accounting of Disclosures You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provide written authorization. To request an accounting of disclosures, you must make your request in writing to our administrator.

Changes To This Notice We reserve the right to make changes to this notice at any time, and such changes would apply to Health Information already on file as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date in the lower right-hand corner.

Complaints If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our administrator. All complaints must be made in writing. You will not be penalized for filing a complaint.

Notice to Patients Regarding the Destruction of Health Care Records

Pursuant to the provisions of subsection 7 of NRS 629.051:

1. The health care records of a person who is less than 23 years of age may not be destroyed; and
2. The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and
3. Except as otherwise provided in section 7 of NRS 629.051 and unless a longer period of time is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

Print Patient's Name _____ Patient Date Of Birth _____

Patient Signature _____

Guarantor/Guardian Signature _____ Relationship _____

Print Guarantor/Guardian Name _____

Date Signed _____

Patient refused to sign



Consent to Disclose Protected Health Information

Patient's Name: _____ Date of Birth: _____

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released to anyone, including spouses, parents, other family members, significant others, or friends, without this authorization. Please include them below if you would like to designate additional individuals to have this access.

A minor patient's parents or legal guardians will have access to the child's medical information, except when prohibited by law.

By signing this authorization, I authorize Carson Medical Group to disclose protected health information about me/my child to the following individual(s).

Please list each individual and mark the type of access you would like each individual to have.

Name: _____ Relationship: _____ Phone Number: _____

- Appointment Information
- Billing Information
- Detailed Medical Information
- Pick Up Medical Records
- Accompany to Visits and Consent for Treatment (Minors only)

Name: _____ Relationship: _____ Phone Number: _____

- Appointment Information
- Billing Information
- Detailed Medical Information
- Pick Up Medical Records
- Accompany to Visits and Consent for Treatment (Minors only)

Name: _____ Relationship: _____ Phone Number: _____

- Appointment Information
- Billing Information
- Detailed Medical Information
- Pick Up Medical Records
- Accompany to Visits and Consent for Treatment (Minors only)

This authorization has no expiration date. It shall be terminated when withdrawn in writing or when an updated form has been completed.

Patient/Parent/Legal Guardian Signature: _____ Date Signed: _____

Parent/Legal Guardian Name: _____ (Minors Only) (Please Print)

Gynecology Health History Form

Patient Name _____ Date of Birth _____

Gender Identification/Preferred Pronoun _____

Social History

Marital Status Single Married Long-term relationship Divorced Widowed

Reason for Visit _____

Primary Care Provider _____

Occupation _____

Menstrual History

Age at first menstrual period _____ Age of menopause _____ First day of last menstrual period _____

If your menstrual periods are regular; periods start every _____ days

If your menstrual periods are irregular; periods start every _____ to _____ days (e.g., 12 to 60)

Duration of bleeding _____ days Flow is Heavy Regular Light

Is pain associated with periods? Yes No Occasionally

If yes, is it? Before menses During menses Both

Pregnancy History (all pregnancies) Including abortions & ectopic (tubal) pregnancies.

Have never been pregnant

Year	Location	Pregnancy Duration	Delivery Type (Cesarean/ Vaginal)	Complications (Mother/Infant)	Sex (Male/Female)	Birth Weight

Birth Control History

What birth control method(s) do you currently use (including vasectomy)? _____

Sexual/GYN History

Do you have a sexual partner? Yes No

If yes: Male Female Both

Please check any that apply or None

Herpes-genital Syphilis Pelvic inflammatory disease Vaginal infections Endometriosis

Chlamydia Gonorrhea Sexual abuse HPV Other _____

Past Obstetrical/Gynecological Surgeries

Check all that apply or: None

Surgery	Year	Surgery	Year
<input type="checkbox"/> Dilation & Curettage (D&C)	_____	<input type="checkbox"/> Myomectomy (Fibroid Removal)	_____
<input type="checkbox"/> Hysteroscopy	_____	<input type="checkbox"/> Ovarian Surgery	_____
<input type="checkbox"/> Infertility Surgery	_____	<input type="checkbox"/> Left Ovary Removed	_____
<input type="checkbox"/> Tubal Ligation	_____	<input type="checkbox"/> Right Ovary Removed	_____
<input type="checkbox"/> Laparoscopy	_____	<input type="checkbox"/> Vaginal or Bladder Repair for Prolapse or incontinence	_____
<input type="checkbox"/> Hysterectomy (Vaginal)	_____	<input type="checkbox"/> Cesarean Section	_____
<input type="checkbox"/> Hysterectomy (Abdominal)	_____	<input type="checkbox"/> Other _____	_____

Past Surgical History (non-Obstetrical/Gynecological)

Please list all surgeries and year or: None **Year**

_____	_____
_____	_____
_____	_____
_____	_____

PAP Smear/Mammogram History

Date of last PAP smear _____ Have you had an abnormal PAP smear? Yes No

Have you had treatment for an abnormal pap smear? Yes No

If yes, what type of treatment? Cryotherapy Cone Biopsy Loop Excision (LEEP)

Year of treatment _____

Date of last mammogram (month & year) _____ Have you had an abnormal mammogram Yes No

Past Medical History

Check all that apply or: None

- | | | |
|----------------------------------------------|--------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease (Including Hepatitis) | <input type="checkbox"/> HIV+ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy or Seizure Disorder | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Anxiety or Depression |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer Type: _____ |

Medication Allergies

Do you have allergies to medication? Yes No

If yes, please list medications and reaction _____

Current Medications (Include dose/amount per day)

Medication	Dose/Amount	Frequency

Do you currently?

- Smoke or Vape Yes No If yes, number of packs per day? _____
- Use Marijuana Yes No If yes, how much and how often? _____
- Use Alcohol Yes No If yes, how much and how often? _____
- Use Illicit Drugs Yes No If yes, how much and how often? _____

Preventative Care

When was your last?

	Date		Date		Date
Colonoscopy	_____	Flu Vaccine	_____	Gardasil Vaccine	_____
DEXA (bone density) Scan	_____	Tdap Vaccine	_____	Shingles Vaccine	_____
Labs	_____	Pneumonia Vaccine	_____	COVID Vaccine	_____

Family History

Do you have family history of the following? *If yes, please indicate which family member.*

- | | Family Member | | Family Member |
|------------------------------------------------|---------------|-----------------------------------------|---------------|
| <input type="checkbox"/> Blood Clots | _____ | <input type="checkbox"/> Uterine Cancer | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Breast Cancer | _____ |
| <input type="checkbox"/> Heart Disease | _____ | <input type="checkbox"/> Colon Cancer | _____ |
| <input type="checkbox"/> Ovarian Cancer | _____ | | |
| <input type="checkbox"/> Other Family History: | _____ | | |

STOP here if you are not pregnant

If you are currently pregnant, or planning pregnancy in the near future, please continue.

Genetic History

- Have you/the father ever had genetic carrier screening? Yes No
- Are you/the father Italian, Greek, Mediterranean, Asian, African American or Ashkenazi Jewish? Yes No
- Are you and the father blood related? Yes No
- Do you/the father have family history of any genetic or chromosome disorders? Yes No
- If yes, what disorders and what are the relationships to you/the father? _____

Patient Consent Form

For Electronic Exchange of Individual Health Information



HealthIE Nevada is a nonprofit organization that connects the health care community and enables the sharing of information electronically and securely to improve the quality of health care services. To learn more about the health information exchange (HIE), read the **Patient Information Brochure**. You can ask the doctor that gave you this form for it, or you can visit the website at www.healthIENevada.org.

Details about patient information in HealthIE Nevada and the consent process:

- 1. How your information will be used and who can access it:** When you provide consent, only HealthIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers and pharmacies), will have access to your health information. It can only be used to:
 - Provide you with medical treatment and related services
 - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information
- 2. Types of information included and where it comes from:** The information about you comes from participating organizations that have provided you with medical care. These may include hospitals, physicians, pharmacies, clinical laboratories and other health care organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this **Consent Form**. This information may relate to sensitive health conditions, including, but not limited to:
 - Alcohol or drug use problems
 - HIV/AIDS
 - Birth control and abortion (family planning)
 - Genetic (inherited) diseases or tests
 - Mental health conditions
 - Sexually transmitted diseases
- 3. Improper access or disclosure of your information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada state law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
- 4. Effective period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealthIE Nevada ceases to conduct business.
- 5. Revoking your consent:** You may revoke your consent at any time by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealthIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

- 6. How your information is protected:** Federal and state laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada state law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

You are entitled to receive a copy of this **Consent Form** after you sign it.



Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please print)

PATIENT NAME

Last

First

Middle

PREVIOUS NAME(S) _____ **GENDER:** M ___ F ___

STREET ADDRESS/P.O. BOX _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE NUMBER _____ **EMAIL** _____

DATE OF BIRTH _____ (MM) _____ (DD) _____ (YYYY)

Nevada Medicaid Patients: PLEASE READ. Nevada law mandates that “a person who is a recipient of Medicaid or insurance pursuant to the Children’s Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically” (NRS 439.538). When a patient is no longer a Medicaid recipient, it is her/his responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.

Your choice to give or to deny consent may not be the basis for denial of health services.

I CONSENT for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

I DO NOT CONSENT for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

Signature of patient, parent/legal guardian, or authorized representative

Date

**If I sign this form as the patient’s authorized representative, I understand that all references in this form to “I,” “me” or “my” refer to the patient.*

Name of parent/legal guardian or authorized representative (printed)

Relationship to patient

Address of authorized representative

Phone number