



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)
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to specify	<input type="checkbox"/> Gay, Lesbian, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Do not know <input type="checkbox"/> Decline to specify	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer <input type="checkbox"/> Female-to-male/Transgender male/Trans man <input type="checkbox"/> Male-female/Transgender female/Trans woman <input type="checkbox"/> Decline to specify	<input type="checkbox"/> Decline to specify <input type="checkbox"/> He / Him / His <input type="checkbox"/> She / Her / hers <input type="checkbox"/> They / Them / Theirs

<u>Ethnicity (Check one box)</u> <input type="checkbox"/> Decline to specify <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Not Hispanic / Latino	<u>Race (Check one box)</u> <input type="checkbox"/> Decline to specify <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian	Preferred Language: _____ Do you need a translator? <input type="checkbox"/> Yes <input type="checkbox"/> No	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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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 disclosure 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 TREATMENT

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

Weight & blood pressure check
Exam of head, neck, lungs, heart,
breasts, abdomen, pelvis, rectum,
arms & legs

Lab tests

Urine
Vaginal fluids
Blood tests
Pap tests

Treatment

Oral & topical treatment of minor
gynecological conditions
Health & skin conditions
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 me 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 examination 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 planning decisions for minors. I acknowledge I can request assistance notifying or involving my parent, legal guardian, or custodian during 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** _____