cfc completefamilycare

PATIENT INFORMATION: (Please Print Clearly-and Complete All Information)

Last Name:_____ First Name:_____ MI:_____

Street Address:_____ Home Phone #: (____)_____-_____

City:_____ State:_____ Zip:_____ Cell Phone #: (____)_____-_____

DOB: ___/___/___ Age:_____ Soc Sec #: _____-_____-_____ Sex: M / F Martial Status: M / S / W / D

Email Address for Patient Portal :_____

Employed: Y / N Employer/School:_____ Dept:_____

Employer's Address:_____

Work Phone #: (___)____-_____

Ethnicity:
_ Hispanic or Latino
_ Not Hispanic or Latino

Race:
_ American Indian
_ African American
_ Pacific Islander
_ Asian
_ White
_ Other

GUARANTOR INFORMATION:

Name:_____ Soc Sec #: _____-_____-_____ DOB:___/___/___ Age:_____

Employer: _____ Emp. Phone #: (____)_____-_____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company:_____

Address:_____ Group #:_____ Policy #:_____

Policy Holder:_____ Soc Sec #: _____-_____-_____ DOB:___/___/___

Secondary Insurance Company:_____

Address:_____ Group #:_____ Policy #:_____

Policy Holder:_____ Soc Sec #: _____-_____-_____ DOB:___/___/___

EMERGENCY CONTACT:

Name:_____ Phone: _____ Relationship: _____

I hereby Authorize Complete Family Care and it's affiliates to furnish to the above insurance company/ies or to a designated attorney, all information which said insurance company/ies or attorney may request. I hereby assign Complete Family Care all money to which I am entitled for medical and/or surgical expense related to the service rendered by Complete Family Care and its employees, but not to exceed my indebtedness to said company. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said company for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection and/or Court costs, and will be responsible for legal fees should this be required.

Guardian Signature Date Patient Signature Date

cfc completefamilycare
800 SOUTH MEADOWS PARKWAY, SUITE 400 RENO, NV 89521
(775) 853-8888 FAX: (775) 853-8288

Informed Consent for Patient Portal

In the event of an Emergency, CALL -911
Do NOT use the Patient Portal

Complete Family Care is offering a secure way to communicate and view patient heath records through our Patient Portal. It is a free and optional service but we reserve the right to change this policy if needed. This form shall provide the facts and risks surrounding the use of the patient portal.

Functionality with Gained Access to the Patient Portal

- Request or change an appointment
- Secure communication with clinic staff
- Request medication refill
- View, print or save health summary information
- Access educational information recommended by your provider

Guidelines and Security

Due to patient privacy laws, we do not accept electronic patient communication through traditional email. The Patient Portal provides a secure method of messaging to ensure your privacy is in compliance with Federal and State regulations. To help keep your health records secure, we need to have your private email address current, should there be any changes, it is your responsibility to inform us immediately.

We strive to keep all of your protected health care information completely confidential, including your email address. Keep your user ID and password secure so only authorized users can gain access to patient information. If you think your account has been compromised, immediately go to the Patient Portal site and change your password.

Do not use the Patient Portal for urgent messages. We will normally respond to non-urgent inquiries within 24 hours but no later than 3 business days after receipt. If you have not heard from us within 3 business days, please call the office at (775) 853-8888 to check the status of your request. Please note that your inquiries may be read and addressed by different CFC clinic staff, similar to how phone calls work.

Please note that each patient with the same email address will be linked together. Upon receiving this consent, we will be sending you an email with a link where you can set-up your Patient Portal.

By signing below, you confirm to have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Complete Family Care or any of their staff liable for network infractions beyond their control.

Confidential email: _____

Patient: _____ **Date of Birth** _____

Patient/Guardian Signature : _____ **Date:** _____

Parent/Guardian Name (in case of minors) _____

Notifier(s):
Patient Name: **Identification Number:**

ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare/Insurance doesn't pay for items checked or listed in the box below, you may have to pay. Medicare/Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

We expect Medicare/Insurance may not pay for the items listed or checked in the box below.

Listed Items Checked Only:	____ Office Visit ____ Office Procedures, including but not limited to EKG, Spirometry, Sleep Test, Injections, Sutures, and etc. _____ Other: _____ _____		
Reason Medicare/ Insurance May Not Pay:	Not covered under plan. Dr. is not your chosen PCP or preferred provider.		
Estimated Cost:	Please see bill at the end of office visit, or ask while you are being seen by the doctor.		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare/Primary Insurance cannot require us to do this.

Options: **Check only one box. We cannot choose a box for you.**
❑ **OPTION 1.** I want the all of the above. You may ask to be paid now, but I also want Medicare/Insurance billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN) or I Insurance Summary Notice. understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare/Insurance** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
❑ **OPTION 2.** I want the all of the above, but do not bill Medicare/Insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare/Insurance is not billed**.
❑ **OPTION 3.** I don't want the procedures listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare/Insurance would pay.
Additional Information:

This notice gives our opinion, not an official Medicare/Insurance decision. If you have other questions on this notice or Medicare billing, call 1-800-633-4227/**TTY**: 1-877-486-2048, all other insurances, call the number on the back of your insurance card. Signing below means that you have received and understand this notice.

Signature:	**Date:**

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PRIVACY PRACTICES NOTICE

Complete Family Care strictly adheres to the regulations mandated by the
Health Insurance Portability and Accountability Act (HIPAA, Title II)

Copies of the INFORMATION PRACTICES NOTICE,
describing the Privacy Practices and Guidelines
set forth as a result of the legislation,
are available for review or receipt upon request.

_____ I hereby acknowledge that I have read the above and choose not to receive a copy of the Privacy Practices and Guidelines at this time. I have been made aware that I can request, at any time, to review or to obtain a copy of the INFORMATION PRACTICES NOTICE for Complete Family Care.

_____ I requested and have received a copy of the INFORMATION PRACTICES NOTICE for Complete Family Care.

PATIENT CONTACT INSTRUCTIONS

I, _____ give permission to leave messages as follows:

____ You may leave message on my home telephone voice mailbox in regard to ANY lab results, Radiology or future appointments.
____ You may leave messages with anyone at my home in regard to ANY lab results, Radiology or future appointments.
____ You may NOT leave messages with any other person except myself, but may leave it on my cell phone voicemail.
____ You may NOT leave any messages of any kind on my voicemail or any person. If you cannot contact me, you may mail any information if you wish.

APPOINTMENT CANCELLATION POLICY

Due to an increase in missed (No Call/No Show) and cancelled appointments, our office has chosen to take the following actions.

Missed (No Call/No show) and cancelled appointments in an untimely manner are a serious problem, costing us money and decreasing our ability to service other patients in need. There will be a $25.00 charge for any missed (No Call/No show) appointments and any appointments not cancelled within 24 hours. By signing below you will be responsible to pay this amount to our office upon receipt of a bill.

Upon signing this document, patient agrees to have read and accept the terms as written above:

_____ _____
Patient Signature Date

_____
Patient Name (Print)

cfc completefamilycare
800 SOUTH MEADOWS PARKWAY, SUITE 400 RENO, NV 89521
(775) 853-8888 FAX: (775) 853-8288

BENEFITS ASSIGNMENT AGREEMENT

I hereby authorize Dr.Yco (Complete Family Care to furnish my designated insurance company(ies) or to a designated attorney, all information which said insurance company(ies) or attorney(ies) may request. I hereby assign to Dr. all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him/her, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from my designated insurance company; over and above my indebtedness will be refunded to me when my bill is paid in full. I understood I am financially responsible to said doctors(s) for charges and covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and responsible legal fees should this be required.

Consent to the Use and Disclosure of Health Information for the Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke the consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Parent/Guardian (if patient is a minor)

_____

Signature Date

CONSENT OF RELEASE OF INFORMATION

Date:_____

- ❑ General Authorization
- ❑ Specific Request of Drug and Alcohol Abuse Patient
- ❑ Specific Request of HIV Diagnostic Testing Patient
- ❑ Specific Request of Psychiatric Patient

I hereby request and authorize_____
Health care Facility

to release information from the medical record of:

_____
Patient's Name Date of Birth

THE INFORMATION IS TO BE RELEASED IS:

_____All Medical Information
_____Laboratory
_____Office Notes
_____Hospital Notes
_____X-rays
_____Specific Information:
_____

THE INFORMATION TO BE RELEASED TO:

COMPLETE FAMILY CARE
800 SOUTH MEADOWS PARKWAY, #400
RENO, NV 89521
(775) 853-8888
FAX: (775) 853-8288

- I have read and understand the above consent and hereby release the above named Health Care Facility and its employees from any and all legal responsibility in connection with this act.
- I understand this consent is subject to written revocation only, at any time except to the extent the person who is to make the disclosure has already acted in reliance on it.
- This consent will expire in 60 days from the date if signature if not revoked earlier.

_____
Patient's Signature Date

_____
Signature of Witness Date

_____
Signature of Responsible Party Date