PATIENT INFORMATION FOR MEDICAL RECORDS

(Please Print Clearly-Complete All Information)

PATIENT INFORMATION

Last Name:___________________________ First Name:____________________________ MI:________

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

City:__________________________ State:______ Zip:__________ Cell Phone #: (____)______-______

DOB: ___/___/___ Age:________ Soc Sec #: _____-_____-_____ Sex: M / F Martial Status:____________

Email Address for Patient Portal :____

Employed: Y / N Employer/School:___________________________ Dept:_________

Employer's Address:____

City:______________ State:______ Zip:_______ Work Phone #: (___)____-_______

Ethnicity:
_ Hispanic or Latino
_ Not Hispanic or Latino

Race:
_ American Indian or Alaska Native
_ Black or African American
_ Native Hawaiian or Other Pacific Island
_ White
_ Other Race

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

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 _____Hospital Notes
_____Laboratory _____X-rays
_____Office Notes _____Specific Information:
____

THE INFORMATION TO BE RELEASED TO:

COMPLETE FAMILY CARE
255 W. PECKHAM LANE, #2
RENO, NV 89509
(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

COMPLETE FAMILY CARE
255 W. PECKHAM, SUITE 2
RENO, NV 89509
(775) 853-8888
FAX: (775) 853-8288

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.

ACKNOWLEDGEMENT

_____ 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 INFORMATIN PRECTICES NOTICE for Complete Family Care.

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

Signed by:_________________________________ _________________________
Signature of Patient or Legal Guardian | Relationship to Patient

_________________________________ _________________________
Print Patient's Name | Date

____
Print Name of Patient or Legal Guardian, if applicable

COMPLETE FAMILY CARE
255 W. PECKHAM, SUITE 2
RENO, NV 89509

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 message s 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.

____ ________________________
Patient Signature Date

____
Witness

APPOINTMENT CANCELLATION POLICY

Due to an increase in misses (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 misses (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.

__________________________________ ___________________________
Patient Signature Date

____
Patient Name (Print)

COMPLETE FAMILY CARE
255 W. PECKHAM, SUITE 2
RENO, NV 89509

BENEFITS ASSIGNMENT AGREEMENT

I hereby authorize Dr.____________________ 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.

____
Patient's Signature

____
Date

Your Health is Our Passion…

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 or 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 take 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)

_____ Accepted ______ Denied

____

Signature

____

Date

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare/Insurance doesn't pay for items checked in 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 a good reason to think you need. We expect Medicare/Insurance may not pay for the items listed or checked in box below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
___ Office Visit ___ Office Procedures, including but not limited to EKG, Spirometry, Sleep Test, Injections, Sutures, and ect. ___ Other: ______________________	Not covered under plan Dr is not your chosen PCP or preferred vendor	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 items listed in first box listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** __________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** 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 **D.** __________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** __________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.