NEVADA FAMILY CARE & WELLNESS CENTER

Patient Registration Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed

Name (first) _____(middle)_____ (last) _____ ❑ male ❑ female

Address _____ Apt# _____

City _____ State _____ Zip _____

Birth Date_____ Age _____ Social Security # _____-_____-_____

Home Phone _____ Work Phone _____

Cellular Phone_____

E-Mail _____

***Pharmacy_____ Phone _____**

Confidential Communication

May we leave messages at home with other residents ❑ yes ❑ no

May we leave personal health information on your answering machine/voicemail ❑ yes ❑ no

May we contact you via Home _____Cell_____Email_____ (Please check all that apply)

Who referred you? _____

Who may we contact in case of Emergency? Name _____

Relationship _____ Phone #1 _____ #2 _____

Please list below all individuals with whom we may talk to about your medical concerns:

Please Note: We will not release any personal health information to anyone unless they are listed below

Name_____Relationship_____

Name_____Relationship_____

Name _____ Relationship_____

INSURANCE INFORMATION

Note: We require that your card be presented at every visit ~ OR~ if card is not available you must verify eligibility, and provide ID#, group #, mailing address & provider services #. If not, you will be responsible for the cost of the office visit.

Primary Insurance Company_____

Card Holder Name _____ Birth Date _____

Address _____Social Security # _____-_____-_____

Relationship to card holder: ❑ self ❑ mother ❑ father ❑ other

Secondary Insurance _____

Card Holder Name _____ Birth Date _____

Address _____Social Security # _____-_____-_____

Relationship to Card Holder: ❑ self ❑ mother ❑ father ❑ other

I understand that when I sign this document that I am confirming that all information completed by me is correct, I authorize contact in the means identified above and that any falsification can lead to my dismissal from this practice.

Signature _____ Today's Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name **Birth Date** **Main Phone** **Social Security Number**

Address **City** **State** **Zip Code**

PLEASE DO NOT FILL OUT THIS BOX UNTIL INSTRUCTED BY OFFICE

I hereby authorize: _____

Doctor or Facility

Address **City** **State** **Zip Code**

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your rights with respect to this authorization:

1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "Authorizes" entity above. 3) I understand a photocopy of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. 5) I understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of: Alcohol, Drug Abuse and/or Psychiatric records, Sexually Transmitted Disease and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information, or obtain copies of my health information, by contacting the Privacy Officer.

To release info to:

Nevada Family Care & Wellness Center
861 Coronado Center Dr. #220 Henderson, NV 89052
(P) 702-933-1485 (F) 702-933-1490

Please Specify:

☐ **Complete medical records**

☐ **Records pertaining to:** _____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes

.

Signature of Patient or Legal Representative: _____ **Date:** _____

If signed by other than the patient, select authority and provide documentation:

___ Parent of minor child ___ Power of Attorney ___ Representative of Deceased's Estate ___ Representative of Incapacitated Adult
___Other

Controlled Substances Acknowledgment

The physicians of Nevada Family Care & Wellness Center **DO NOT** prescribe any controlled substances on an initial visit. Examples of such medications are (but not limited to): Oxycodone (Percocet), Hydrocodone (Lortab/Vicodin), Valium, Xanax, Adderall, Ambien, Temazepam, etc. By signing below, I acknowledge that prescriptions for any controlled substance will **NOT** be prescribed on the first visit **nor will they be continually refilled.** Any patient needing ongoing controlled substance prescriptions will be referred to a Specialist for further management.

Unfortunately, there are NO EXCEPTIONS to this policy.

Printed Name Signature Date

Nevada Family Care & Wellness Center 861 Coronado Center Dr. Ste 220 Henderson, NV 89052 (P) 702-933-1485

Health History Questionnaire

Patient Name: _____ DOB: _____

Great healthcare is the result of great communication. At Nevada Family Care & Wellness Center, we want to understand everything we can about your ideas on healthcare, your concerns, and your goals. Keeping you well means knowing you well. Thank you for beginning our conversation before your visit by completing this information.

Allergies

Please list all allergies (medications, food, bee stings, etc) and reactions to each

Allergy	Reaction
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____

Medications

Please list all the medications you are currently taking. Include prescribed drugs and over-the-counter drugs, as well as vitamins and supplements.

Drug Name	Strength	Frequency Taken
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Immunization History

Immunizations and most recent date of administration:

Chickenpox	Date: _____	Flu	Date: _____
HPV	Date: _____	Hepatitis A	Date: _____
Hepatitis B	Date: _____	Meningitis	Date: _____
Pneumonia	Date: _____	MMR	Date: _____
Shingles	Date: _____	Tetanus	Date: _____

Past Surgical History

Surgery	Reason	Year

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Social History

Marital Status: Married Divorced Separated Domestic Partner Single

Number of Children: Biologic- _____ Step- _____ Adopted-_____ Living in your home- _____

Occupation: Employed Self-Employed Unemployed Retired Student
Homemaker

Name of Employer: _____

What is your Race/Ethnicity? _____

Personal History

Please circle all that apply:

Common	Blood	Cancer		GI	Heart
Diabetes	Anemia	Bladder	Lung	Heartburn	Attack (MI)
Blood Pressure	Bleeding Disorder	Brain	Ovaries	Crohns	Arrhythmia
Cholesterol	Clot (DVT/PE)	Breast	Prostate	Colitis	Disease
Kidney Disease	Clotting Disorder	Colon	Uterus	IBS	Failure
Liver Disease					

Mood	Neurology	Thyroid	Lung	Bone/Joint	
Anxiety	Paralysis	Hypo (low)	Asthma	Gout	Rheumatoid
Depression	Seizures	Hyper (high)	COPD	Osteoarthritis	Lupus
OCD	Stroke		Emphysema	Osteoporosis	Lupus-Like
Bipolar					

Family History

Please circle all that apply:

Common	Blood	Cancer		GI	Heart
Diabetes	Anemia	Bladder	Lung	Heartburn	Attack (MI)
Blood Pressure	Bleeding Disorder	Brain	Ovaries	Crohns	Arrhythmia
Cholesterol	Clot (DVT/PE)	Breast	Prostate	Colitis	Disease
Kidney Disease	Clotting Disorder	Colon	Uterus	IBS	Failure
Liver Disease					

Mood	Neurology	Thyroid	Lung	Bone/Joint	
Anxiety	Paralysis	Hypo (low)	Asthma	Gout	Rheumatoid
Depression	Seizures	Hyper (high)	COPD	Osteoarthritis	Lupus
	Stroke		Emphysema	Osteoporosis	Lupus-Like

Health Maintenance

Last Done:

Date of last pap smear	_____	Normal _____	Abnormal _____
Date of last mammogram	_____	Normal _____	Abnormal _____
Date of last menstrual period	_____		
Blood/Lab Work	_____	Normal _____	Abnormal _____
Bone Density	_____	Normal _____	Abnormal _____
Colonoscopy	_____	Normal _____	Abnormal _____
EKG	_____	Normal _____	Abnormal _____
Heart Stress Test	_____	Normal _____	Abnormal _____
Prostate Check	_____	Normal _____	Abnormal _____

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Sexual History

Sexual Preference:	Men	Women	Both	
Last Sexual Activity:	Never	Within 1 Year	>1 Years Ago	
Pregnancy:	Number times pregnant- _____		Number live births- _____	
Birth Control:	Abstinent Tubal Litigation	Condoms Medication	Hysterectomy Menopause	Vasectomy Other- _____

Exercise: None Daily Weekly Specific Routine

Diet: No Special Diabetic High Fiber Low Fat Low Carb Vegetarian
Vegan Other: _____

Do you have a living will of advanced directive? Yes (*Please provide copy*) No

Review of Systems

General:	Chills	Fatigue	Fever	Weight change	
Eyes:	Blurry Vision	Eye pain	Light sensitivity		
Ear/Nose/Throat:	Hearing Problem	Pain	Congestion	Runny Nose	Bloody Nose
	Dental Probems	Hoarseness			
Heart:	Chest Pain	Skipped beats	Flip Flop beats	Racing Heart	
	Shortness of breath while lying down at night			Foot/Ankle Swelling	
Lungs:	Cough	Shortness of Breath		Coughing up blood	
Stomach/Intestinal: Changes	Abdominal Pain	Heartburn	Constipation	Diarrhea	Stool
Genital/Urinary:	Pain w/Urination	Genital Lesion	Blood in Urine	ED	Increased Urinary Freq
	Changes in Urine Stream				
Bone/Joint/Muscle:	Joint Pain	Back Pain	Muscle Pain		
Skin:	Atypical Moles	Dry Skin	Itching Skin	Rash	
Brain/Nerves:	Dizziness	Headaches	Tingling/Numbness	Weakness	
Blood:	Easy Bruising	Bleeding	Lymph Node Swelling		
Mood:	Anxiety	Depression	Trouble Sleeping		

Substance History:

Smoking Tobacco:	Never	Past Smoker (Quit Date: _____)	Current Smoker
Chewing Tobacco:	Never	Past User (Quit Date: _____)	Current User
Alcohol:	Never	Past Drinker (Quit Date: _____)	Current Drinker
Drug Use (Illicit)	Never	Past User (Quit Date: _____)	Current User What Drug? _____

Infectious Disease History:

Have you ever had a blood transfusion?	No	Yes	Date:_____
Have you ever been exposed to Hepatitis?	No	Yes	Date:_____
Have you ever been exposed to HIV?	No	Yes	Date: _____

Acknowledgement and Signature Form

Assignment of Benefits: By initialing to the right and signing below I authorize the following-

1. Payment of insurance benefits to be made directly to Nevada Family Care & Wellness Center
2. Nevada Family Care & Wellness Center to release information needed to secure payment of benefits
3. The use of this signature on all Insurance submissions.
4. A photocopy of this authorization shall be valid as the original.

Initials_____

Consent for Treatment: By initialing to the right and signing below, I authorize Abraham T. Fakhouri, MD, F. Richard Tan, MD, Gary Manley, PA-C, and Kelly Rowe, FNP to render medical care to me whether on an impatient or outpatient basis. I further authorize their employees to render routine nursing care and to carry out the orders of my physician, or other healthcare provider, including consultants, associates and assistants of their choosing.

Initials_____

Financial Agreement: By initialing to the right and signing below, I agree to the following:

1. I understand that the filing of insurance claims is a courtesy and that I am financially responsible for all charges whether or not they are covered by my insurance.
2. In event of default, I agree to pay all costs of collections and attorney's fees.

Initials_____

Office Policies Acknowledgment: By Initialing to the right and signing below, I acknowledge that I have **received** the Notice of Office Policies for Nevada Family Care & Wellness Center and that I **agree to abide** by these policies.

Initials_____

Controlled Substances Acknowledgement: By initialing to the right and signing below, I acknowledge that prescriptions for any controlled substance will **not** be prescribed on the first visit now will they be continually refilled. Any patient needing ongoing controlled substance prescriptions will be referred to a Specialist for further management.

Initials_____

Privacy Practices Acknowledgement: By initialing to the right and signing below, I acknowledge that I have **received** the HIPAA Notice of Privacy Practices.

Initials_____

By initialing above and signing below, I agree and acknowledge the Assignment of Benefits, Consent for Treatment, Financial Agreement, Office Policies Acknowledgement and Privacy Practices Acknowledgement.

_____

Signature of Patient or Legal Guardian **Print Name** **Date**

Notice of Office Policies

APPOINTMENT CANCELLATION MISSED APPOINTMENTS AND TIMELINESS:

We require a **24 hour advances cancellation notice.** You may be billed a **$25.00** fee for failure to give adequate notice of cancellation. We reserve the right to refuse scheduling to any new patient missing an initial appointment to establish care. If you miss more than one appointment, you may be allowed same day appointments only. Please be prompt for appointments. If you are **more than 10 minutes late**, we may have to reschedule your appointment. Since we spend the time needed with each patient visit, we do run behind on occasion. In those situations, we would be happy to reschedule you upon request with no penalty. We apologize for this inconvenience in advance.

FINANCIAL AND BILLING RESPONSIBILITIES:

All payments, including co-payments, co-insurance, deductibles and deposits are due during check-in at the time services are rendered. We accept checks, cash, MasterCard, Visa, and American Express. All returned checks will incur an additional processing of **$25.00** each, and then checks will no longer be accepted from you. We bill for doctor's services only. **Any fees for lab work, testing, and other outside services are billed separately by the testing facility. This included the laboratory service located in our facility.** You insurance card must be presented at every visit. If you insurance plan changes or is terminated, you must notify the office immediately or you will be financially responsible for any and all services that are rendered.

If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly. All accounts will be considered delinquent after 90 days. Delinquent accounts will placed with a private collection agency and will be subject to all reasonable collection and court costs necessary to collect the outstanding balance.

INSURANCE INFORMATION:

Your insurance policy is a contract between you and your insurance company. Our relationship is with you, and you are ultimately responsible for services provided, regardless of your insurance. Not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time that the services are rendered. Though we will help you to the best of our ability, you are responsible for any communication with you insurance company regarding their coverage.

CONTROLLED SUBSTANCES:

You will **NOT** receive prescriptions for any controlled substance on your first visit nor will they be continually refilled. Any patient needing ongoing controlled substance prescriptions will be referred to a Specialist for further management. If you have questions about this policy, please ask.

PAPERWORK FEES:

There is a **$25.00** fee for any form requiring a physician signature with no exceptions. This fee includes any copying service as well as the time needed to fill out the forms. The forms must be submitted to the office a minimum of **one week** prior to the due date.

PATIENT COMMUNICATION:

Our physicians believe in spending quality time with patients at their office visits. Because of these time constraints, the physicians do not routinely return patient phone calls personally. Any medical questions or messages should be left with the medical assistant who will communicate with your physician and contact you with your physician's directions. We will always be happy to offer you a prompt in-office appointment to discuss any issues with a physician directly.

PRESCRIPTIONS/REFILLS/REFERRALS/LAB ORDERS/TESTING ORDERS:

All new prescriptions, prescription refills, referrals, lab orders, or test orders will be **issued at your appointment time only.** Please request any needed services at your visit as they will not be prescribed or ordered otherwise. We will always be happy to offer you a prompt in-office appointment to discuss any issues with a physician.

Nevada Family Care & Wellness Center 861 Coronado Center Dr. #220 Henderson, NV 89052 (P) 702-933-1485

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" or PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services. This applies to all records containing your PHI that are created or retained by Nevada Family Care & Wellness Center.

Uses and Disclosure of PHI: Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services too you, to pay your health care bills, to support the operation of the physician's practice, and any other uses require by law.

1. **Treatment**: Your PHI will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, you PHI may be disclosed to a laboratory, home health agency, or pharmacy that provides care to you, additionally, your PHI may also be disclosed to other health care providers for purposes related to your treatment, such as a specialist referral.
2. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your health insurer may be contacted to certify that you are eligible for benefits, and the details regarding your treatment may need to be disclosed to determine if your insurer will pay for your treatment. Your PHI may also be disclosed to obtain payment from you or third parties if they are responsible for your costs. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health care operations:** Your PHI may be used or disclosed in order to support the business activities of your physician's practice, These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities, For example, your PHI may be disclosed to medical school students that see patients at our offices. Your PHI may be used to contact you as a reminder of your appointment. In addition, a sign-in sheet may be used at the registration desk where you will be asked to sign your name and indicate your physician; you may also be called by name in the waiting room when your physician is ready to see you.
4. **Other situations:** We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donors; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements if Section 164.500.
5. **Other permitted and required uses and disclosures:** Any other uses or disclosures of your PHI will be made only with your consent, authorization or opportunity to object unless required by law.

Your rights: You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications:** You have the right to request receipt of confidential communications from our office by alternative means or to an alternative location.
2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment of healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

3. **Inspection and copies:** You have the right to inspect and obtain a copy of your PHI. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information. Our office may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.
4. **Amendment:** You have the right to ask your physician to amend your health information if you believe it is incorrect or incomplete. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
5. **Accounting of disclosures:** You have the right to request an "accounting of disclosures." An "accounting of disclosure" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations.
6. **A paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact us at (702) 933-1485.
7. **Complaints:** You have the right to complain if you believe your privacy rights have been violated. You may file a complaint, in writing, with our office or with the Secretary of the Department of Health and Human Services. **You will not be penalized by us for the complaint**.
8. **Revoke this authorization:** You have the right to revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

All requests as noted in this Notice of Privacy Practices must be submitted in writing.

This notice was published and became effective on/or before January 1st, 2018

We are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions or objections to this form, Please ask to speak with our HIPAA Compliance Officer in person or by phone, at 702-933-1485

NEVADA FAMILY CARE & WELLNESS CENTER

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www.NFCWC.com

Effective January 1st, 2018

Regarding all testing: Lab and Radiology results

Since some of our patients have has questions regarding how they receive their results, we have developed this summary regarding our for giving patient results.

All results, including lab work, radiology (X-rays, CTs, MRIs, Etc.) and all other testing are given to the patient in person at a **follow-up visit**. We believe that it is imperative for every patient to understand the results of their test and the recommended treatments or follow-up. Many times it is also necessary to prescribe and educate regarding medications and orders for further treatment. We believe that this happens most efficiently and most accuracy in person.

We do not give results or physician interpretation of results over the phone, by fax, or by mail. The patient is always welcome to receive a copy of the test results, without interpretation, if requested and in person. Physician interpretation, future orders, or guidance will **only be given** at an appointment with your physician.

The only exceptions to this are STAT tests, done the same day. It is the patient's responsibility to call us by the end of the day or the next morning for results of stat testing.

Please understand that this policy applies to all patients.

Thank you,

Nevada Family Care & Wellness Center

Abraham Fakhouri, MD
F.Richard Tan, MD
Gary Manley, PA-C
Kelly Rowe, FNP