Reliant Health
PRIMARY & WELLNESS CARE

COVID QUESTIONNAIRE

Patient Name: _____

Date: _____

Current Body Temperature: _____

Within the past 14 days, have you been in close physical contract with anyone who is known to have laboratory-confirmed COVID-19?

☐ **Yes** ☐ **No**

Within in the past 14 days, have you or members of your household traveled outside of Nevada?

☐ **Yes** ☐ **No**

Within the past 24 hours, have you or anyone in your household recorded a fever of 100.4 degrees Fahrenheit or higher.

☐ **Yes** ☐ **No**

Does anyone in your household currently have COVID-19?

☐ **Yes** ☐ **No**

Reliant Health
PRIMARY & WELLNESS CARE

New Patient Registration Form
*****Please Print*****

Patient Information

Full Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____ Age: _____ Sex: M/F Email: _____

Address: _____

(Street) (City/State/Zip)

Cell Phone: _____ Work Phone:_____

Employer: _____

Insurance Information

Primary insurance: _____ Policy Number: _____

Group Number: _____ Insurance Phone Number: _____

Guarantor Insurance Information: Self Spouse Parent

Guarantor Name(if other than patient): _____ DOB:_____ SSN:_____

Secondary insurance: _____ Policy Number: _____

Group Number: _____ Insurance Phone Number: _____

Guarantor Insurance Information: Self Spouse Parent

Guarantor Name(if other than patient): _____ DOB:_____ SSN:_____

Is your visit due to a job-related injury or automobile accident? ☐ ***Yes*** ☐ ***No***

If yes, please notify our receptionist.

Emergency Contact

Person to notify in case of Emergency: _____

Phone: _____ Relationship to patient: _____

Who do you give the right to release your medical records to?

_____

Reliant Health
PRIMARY & WELLNESS CARE

New Patient Registration Form
*****Please Print*****

Pharmacy Information

Preferred Pharmacy: _____

Major Cross Streets: _____ Phone Number: _____

I authorized the release of any medical information necessary to process this to my insurance company and request payment of benefits to ReliantHealth. I acknowledge that I am financially responsible for payment whether covered by insurance.

Signature: _____ Date: _____

Reliant Health
PRIMARY & WELLNESS CARE

New Patient Registration Form
Please Print

New Patient History

I. Identifying Information:

Name: _____ DOB: _____

List any other physicians or health care providers you see:

_____

_____

II. Medical History: ☐ None

List any medical problems that you have.

_____

_____

_____

Check if you have or have you ever had:

☐ Alcohol abuse	☐ Anesthetic reaction	☐ Bleeding disorder
☐ Asthma	☐ Anemia	☐ Chronic lung condition
☐ Blood cloths	☐ Drug and substance abuse	☐ Depression/anxiety
☐ Diabetes	☐ Heart disease	☐ High blood pressure
☐ High cholesterol	☐ Hepatitis/Jaundice	☐ Cancer(Type)
☐ Irritable bowel syndrome	☐ Kidney stone	☐ Hypothyroidism
☐ Seizure disorder	☐ Stroke	☐ Tuberculosis
☐ Stomach ulcers	☐ Mitral valve prolapse	☐ Rheumatic fever
☐ Transfusion reaction	☐ Eating disorder	☐ Lupus/autoimmune

III. Allergies and Medications:

Are you allergic to any of the following? If yes, what is the effect?

☐ Aspirin	☐ Local Anesthetics	☐ Acrylic	☐ Metal
☐ Penicillin	☐ Latex	☐ Sulfa Drug	☐ Codeine

☐ Other: _____

List all medications that you take with the dose and timing (including all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications.): ☐ None

Reliant Health
PRIMARY & WELLNESS CARE

New Patient Registration Form
*****Please Print*****

Drug	Dose	Frequency	Reason for medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IV. Surgical history:

List all surgeries you have had

Description:	Date:	Description:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

V. Social history:

Do you smoke? ☐Yes ☐No Amount/day: _____ How many years: _____

If you quit smoking, when did you stop? _____

Do you drink? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Quit since: _____

Have you used marijuana or other drugs in the last 5 years? ☐Yes ☐No Type:_____

ReliantHealth
8425 S Eastern Ave
Las Vegas, NV 89123
www.relianthealthnv.com
Phone: 702-202-2060
Fax: 866-536-1461

Release of Information

I, _____, do hereby authorize: ReliantHealth, including all employees, to Release TO and OBTAIN FROM information from the record of:

(Print Patient Name) _____DOB_____

The information that may be released includes:

- Medical Reports
- IEP Program Data Program Graphs
- Progress Notes
- Summary of Treatment to Date
- Discharge Summary
- Medication Record
- Education Record
- Other: _____

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose(s) specified above. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon), by written, dated, communication to the ReliantHealth.

I understand that all confidentiality and notice of privacy practices in accordance with HIPAA Privacy and Confidentiality laws, ReliantHealth shall maintain a Notice of Privacy Practices at all times. This notice and policy must comply with all legal and regulatory requirements, such as HIPAA and Nevada Health Information Privacy Laws.

This notice and policy must be reviewed with all Patient/families at the time the Provider begins rendering Services and annually thereafter.

_____ _____

Signature of Patient/Guardian Date

☐ I have chosen to receive a copy of this Release

☐ I have chosen not to receive a copy of this Release.

Health Insurance Portability and Accountability Act

(HIPAA)

This notice describes how protected health information about a patient may be used and disclosed and how the patient can gain access to this information. Please review it carefully.

ReliantHealth understands that we collect private and/or potentially sensitive medical information about each patient and/or the patient's family. We call this information 'protected health information'. This notice explains the patient's privacy rights and addresses how ReliantHealth may use and disclose protected health information.

ReliantHealth does not use or disclose protected health information unless permitted or required to do so by law. ReliantHealth must adhere to laws aimed at securing the privacy of the patient's protected health information. These laws are known as Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or the level of disclosure to the minimum we deem necessary to accomplish the intended purpose. Please note that privacy provisions articulated in this notice do not apply to health information that does not identify the patient or anyone else. For more information on Reliant Health's privacy practices, or to receive another copy of this notice, please contact:

ReliantHealth

C/o Administrative Department

1180 N Town Center Dr Ste 100

Las Vegas, NV 89144

Email: info@relaintphysicians.com

Phone: 702-202-2060

Fax: 866-536-1461

ReliantHealth is required by law to follow the terms set forth in this notice. We reserve the right to change this notice. If make a change in our privacy policies or procedures, we will provide the patient with a new privacy notice either by mail or in person.

Protected Health Information

Protected health information is about the patient that relates to past, present, or future their health condition, or treatment or payment for treatment that can be used to identify the patient. This includes any information,

whether oral or recorded in any form, that is created or received by ReliantHealth. This also includes electronic information and information in any other form or medium that could identify the patient. Examples of information that can identify a patient include, but are not limited to the following:

- Patient's name
- Telephone number
- Address
- Date of birth
- Social security number
- Service start/end date
- Diagnosis

Uses and Disclosures of Health Information for Treatment, Payment, and Health Care Operation

1. Treatment, Payment, and Health Care Operations

The following section describes different ways that we use and disclose protected health information for treatment, payment, and health care operations. Not every possible use or disclosure will be noted, and there may be incidental disclosures that are byproduct of one of the listed uses and disclosures. The ways we use and disclose protected health information will fall within one of these categories:

a. Treatment
We may use a patient's protected health information to provide the patient with services, and we may disclose this information to any and all ReliantHealth staff involved with the patient's treatment. Treatment includes (a) activities performed by ReliantHealth personnel in the course of providing service to the patient or in coordinating or managing the patient's service with other service providers and (b) consultations with and between ReliantHealth staff and other professionals involved in the patient's treatment.

b. Payment
We may use and disclose the patient's protected health information so that we may bill and collect payment from the patient, an insurance company, or another party for services that ReliantHealth provides to the patient.

c. Health Care Operations
ReliantHealth may use and disclose the patient's protected health information in order to maintain necessary administrative, education, quality assurance, and business functions. For example, we may use a patient's protected health information to evaluate the performance of our staff in providing treatment for the patient. We may also use information about patient to help us evaluation what additional services to offer, how we may improve efficiency, or the effectiveness of certain treatments. Additionally, we may

use protected health information for review, analysis, and other teaching and learning purposes.

2. Special Circumstances

Treatment, payment, and health care operations further include the circumstances listed below.

a. Appointment reminders
We may use and disclose the patient's protected health information to contact the patient as a reminder that he/she may have an appointment for treatment or services.

b. Treatment information
We may use and disclose the patient's protected health information to contact him/her about treatment information.

c. Satisfaction Surveys
We may use and disclose the patient's protected health information to contact him/her about treatment information.

3. Uses and Disclosures You Can Limit

a. ReliantHealth Patient Directory
Unless the patient notifies us, he/she objects, we may include certain information about him/her in ReliantHealth Patient's Directory in order to respond to inquiries and disseminate information more efficiently. This directory is accessed by ReliantHealth staff who may or may not be involved in the patient treatment.

b. General Notification
Unless the client notifies us that he/she objects, we may provider his/her protected health information to individual's such as the patient's family member's, caregiver's, and friends, who are involved in the patient's treatment or who help pay for the patient's treatment.

When Written Authorization is Required

Other than the range of purposes previously identified in this notice, we will not use or disclose the patient's protected health information for any purpose unless the patient provides us with specific written authorization to do so. If the patient's grant us authorization, the patient can still with draw this authorization at any time, though the authorization must be revoked in writing. In order to withdraw the authorization, the patient must deliver, mail, email, or fax the revocation to:

ReliantHealth

1180 N Town Center Dr Ste 100

Las Vegas, NV 89144

Email: info@reliantphysicians.ocm

Fax: 866-536-1461

If the patient revokes the authorization, we will discontinue the use or disclosure of the patient's protected health information to be extent that we relied on his/her authorization for the use/disclosure. However, we cannot take back or undo any use/disclosure made under the patient's grant of authorization prior to our receipt of the patient's written revocation of that authorization, and we must continue any use/disclosure that is necessary in keeping records of the patient's treatment.

The Patient's Rights Regarding the Patient's Health Information

The patient has certain rights regarding his/her health information, which are listed below. In each of these cases, if the patient wants to exercise his/her rights, the patient must do so in writing by completing a form that the patient can obtain from ReliantHealth. In some cases we may charge the patient for the costs of providing materials to the patient. The patient can get information on how to exercise his/her rights and any costs for materials by contacting:

ReliantHealth

1180 N Town Center Dr Ste 100

Las Vegas, NV 89144

Email: info@reliantphysicians.com

Fax: 866-536-1461

1. **Right to Inspect and Copy**
   With some exceptions, the patient has the right to inspect and get a copy of the patient's protected health information that may be used to make decisions about the patient's care. We may deny the patient's request to inspect and/or copy information in certain limited circumstances, and if we do this, the patient may ask that the denial decision be reviewed.

2. **Right to Amend**
   The patient has the right to amend his/her health information maintained by ReliantHealth or used by us to make decision about the patient. We will require that the patient provide a reason for the request, and we may deny the request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment), (b) is not part of the health information that we keep, (c) is of a type that the patient would not be permitted to inspect and copy, or (d) is already accurate and complete.

3. **Right to Accounting of Disclosures**
   The patient has the right to request an accounting of disclosures. An accounting is a list of certain disclosures we made regarding the patient's protected health information. The list does not include all disclosures. For example, it does not include disclosures to the patient, disclosure of treatment, payment, and healthcare operations purposes described above, or disclosure made with the patient's authorization as describe above.

4. **Right to Request Restrictions**
   The patient has the right to request a restriction or limitation on the health information we use or disclose about the patient (a) treatment, payment, or health care operations, or (b) to someone who is involved in the patient's care or payment for it, such as a family member or friend. We are not required to agree to the patient's request. Anytime ReliantHealth agrees to a restriction, it must be in writing and signed by the Executive Director or his/her designee.

5. **Right to Request Confidential Communications**
   The patient has the right to a paper copy of this notice, whether or not the patient may have previously agreed to receive the notice electronically.

Patient Name: _____

Birthdate: _____

Patient Signature: _____

Date: _____

Reliant Health
PRIMARY & WELLNESS CARE

Financial Policy

Thank you for choosing ReliantHealth as your healthcare provider. We are committed to providing you the best quality medical care. We look forward to establishing a lasting relationship and partnership with you. As part of this relationship, we wish to establish our expectation of your financial responsibility.

Self-Pay: Patients without insurance coverage will be required to pay for all services at the time they are rendered. We do offer a discounted rate to self-pay patients.

Insurance Collection: Your medical insurance policy is a contract between you and your insurance carrier and differs from individual to individual, even if from the same insurance carrier. Our providers should not be expected to know your individual insurance benefits or coverage amounts or terms, and you should not take any opinion they may offer as fact. As a courtesy, we will bill your medical insurance carrier for services we provide. We will be diligent in making sure your insurance is filed accurately and promptly. It is your responsibility to ensure we have the most current copy of your insurance card, demographic, and contact information. If your insurance cannot be verified at the time of service, you will be responsible for payment at time of service. You are responsible for any balance remaining after your insurance carrier has processed your claim (60-90 days). Should your insurance company reimburse us at a later date, we will gladly refund/reimburse you.

Co-payments, Outstanding Balances and Fees: All co-payments, outstanding balances and fees for services not covered by your insurance policy are due at the time services are rendered. For any questions regarding coverage for any services/treatments, we encourage you to contact your insurance carrier to review costs. As a convenience, we accept all major credit cards, debit cards, and cash.

Out of Network/Non-Participating Insurance Carriers: If your insurance carrier considers us 'out of network' or does not participate with us, you are responsible for payment in full at the time of service. We will gladly provide any proof visit/receipts, etc.

No Show/Cancellation Policy: Missed appointments represent a cost to us, to you and to other patients who could have been accommodated. Appointments missed or not cancelled at least 24 hours before the appointment time will result in a $50.00 fee. **Appointments can only be cancelled by calling during regular business hours (8 A.M. – 5 P.M.).** Please help us serve you better by keeping your scheduled appointment.

Forms: There is a flat rate fee of $30.00 of several types of forms.

Examples include:

☐ DMV forms

☐ FMLA form

Charges for these services will range from $25 for a basic form, and is per episode visit. *In an effort to provide you with financially viable quality of care, we thank you in advance for understanding the necessity of adding these charges.*

Past Due Payments: Just as we make every effort to accommodate you when you are in need of medical care, we expect you to make every effort to pay your bill promptly. If you have financial hardship or you are unable to pay your bill in its entirety, please contact our billing manager to discuss payment options. If your account becomes delinquent (past 30 days) your account will be subject to interest and collection costs.

Returned Checks: A $50.00 fee will be charged on all returned checks. Additionally, we will no longer be able to accept checks from you for yourself or any members of your family.

Transfer of Care: When transferring care to another provider, we will request and require you to close out any balances due. Payment is due at the time the records request is made.

I authorize ReliantHealth to release all requested information concerning my medical treatment to my insurance carrier. I further authorize my insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the provider(s) of this office, for their professional services rendered.

ReliantHealth reserves the right to dismiss any patient from the practice who consistently fails to meet this policy or who refuses to sign this agreement. By signing below, I understand and agree to the terms of this office's Financial Policy.

Signature: _____ Date: _____

Reliant Health
PRIMARY & WELLNESS CARE

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidget or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Total Score _____+_____+_____=_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ **Not difficult at all**
- ☐ **Somewhat difficult**
- ☐ **Very difficult**
- ☐ **Extremely difficult**

Major depressive disorder (MDD) is suggested if:

- Of the 9 items, 5 or more are checked at least more than half of the days.
- Either item 1 or 2 is checked at least more than half the days.

Other depressive syndrome is suggested if:

- Of the 9 items, between 2 to 4 are checked at least more than half the days.
- Either items 1 or 2 are checked at least more than half the days.

PHQ-9 score can be used to plan and monitor treatment. To score the instrument, tally the numbers of all the checked responses under each heading (not at all = 0, several days = 1, more than half the days = 2, and nearly every day = 3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for interpreting PHQ-9 score

Score	Depression severity	Action
0-4	None – minimal	Patient may not need depression treatment
5-9	Mild	Use clinical judgement about treatment, based on patient's duration of symptoms and functional impairment.
10-14	Moderate	Use clinical judgement about treatment, based on patient's duration of symptoms and functional impairment.
15-19	Moderately severe	Treat using antidepressant, psychotherapy, or a combination of treatment.
20-27	Severe	Treat using antidepressant with or without psychotherapy.

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, life at home, or relationships with other people. Patient response of “very difficult” or “extremely difficult” suggests that the patient’s functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

Note: Depression should not be diagnosed or excluded solely based on the PHQ-9 score $\geq$ 10 has a sensitivity of 88% and a specificity of 88% for major depression. Since the questionnaire relies on patient self-report, the practitioner should verify all responses. A definitive diagnosis is made taking into account how well the patient understood the questionnaire, as well as the relevant information from the patient.

Reference: Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.

Reliant Health
PRIMARY & WELLNESS CARE

STOP-BANG Sleep Apnea Questionnaire

Patient Name: _____

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	☐ Yes	☐ No
Do you often feel **T**IRED, fatigued, or sleepy during the daytime?	☐ Yes	☐ No
Has anyone **O**BSERVED you stop breathing during your sleep?	☐ Yes	☐ No
Do you have or are you being treated for high blood **P**RESSURE?	☐ Yes	☐ No

BANG		
BMI more than 35kg/m2?	☐ Yes	☐ No
AGE over 50 years old?	☐ Yes	☐ No
NECK circumference > 16 inches (40cm)?	☐ Yes	☐ No
GENDER: Male?	☐ Yes	☐ No

TOTAL SCORE		

High Risk of OSA: Yes 5 – 8

Intermediate risk of OSA: Yes 3 – 4

Low risk of OSA: Yes 0 – 2