NEW PATIENT REGISTRATION FORM

P: 702-779-3902 ▪ F: 866-536-1461 ▪ Website: Relianthealthnv.Com

PATIENT INFORMATION:

Name: _____ Social Security: _____

D.O.B.: _____-_____-_____ Age: _____ Sex: Female/ Male _____

Address: _____ Apt/ Suite: _____

City: _____ State: _____ Zip Code: _____

Home: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Email Address: _____@ Gmail/ Yahoo/ Outlook/ Aol/Hotmail.Com

Employer: _____ Contact: ( ) _____-_____ Ext.: _____

Insurance Information:

Is Your Visit Due To A Job-related Injury Or Automobile Accident? ☐ Yes ☐ No, If Yes, **Please Notify Our Receptionist

Primary Insurance: _____ Policy Num.: _____

Group Num.: _____ Insurance Phone Number: ( ) _____-_____

Guarantor Insurance Information: [Self] [Spouse] [Parent Guarantor]

Name (if Other Than Patient): _____ DOB:_____-____-_____ SSN:_____-_____-_____

Secondary Insurance: _____ Policy Num.: _____

Group Num.: _____ Insurance Phone Number: ( ) _____-_____

Guarantor Insurance Information: [Self] [Spouse] [Parent Guarantor]

Name (if Other Than Patient): _____ DOB:_____-_____-_____ SSN:_____-_____-_____

Emergency Contact Information:

Person to notify in case of emergency: _____Phone: ( ) _____-_____

Relationship to patient: _____

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

Pharmacy Information:

Preferred pharmacy name: _____

Major cross streets: _____&_____Phone#: ( ) _____-_____

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

Patient signature: _____Date: _____

Patient History

List all medications that you take with the dose and timing (including all non-prescription medications) if you are not taking ANY type of medications check here: ☐ **none**

MEDICATIONS you may provide list or bring bottle(s) if you have more please write it on the back of the page.

Medication name	Dose	Frequency

ALLERGIES if you **do not** have any check this box: ☐ **none**

Drug allergy	Reaction	Non-drug allergy	Reaction

PAST MEDICAL HISTORY (check ALL that apply)

Condition	You	Mother	Father	Sibling	Condition	You	Mother	Father	Sibling
Anxiety	☐	☐	☐	☐	Hepatitis **A/ B /C**	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐
Cancer _____	☐	☐	☐	☐	Kidney Problems	☐	☐	☐	☐
Copd	☐	☐	☐	☐	Liver Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Migraines	☐	☐	☐	☐
Diabetes – Type 1	☐	☐	☐	☐	Prostate Problems	☐	☐	☐	☐
Diabetes – Type 2	☐	☐	☐	☐	Urinary Problems	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	Thyroid Problem	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	Immune Dis.	☐	☐	☐	☐
HIV	☐	☐	☐	☐	Other:				

SURGICAL HISTORY if you **do not** have any history check this box: ☐ **none**

Procedure type	Approximate date	Procedure type	Approximate date

TESTS (list approximate date)		**VACCINES** (list approximate date)
Mammogram:	Prostate Exam:	Pneumonia:
PAP Smear:	Stress Test:	Shingles:
Bone Density:	Hearing Test:	Tetanus:
Colonoscopy:	Foot Exam:	Flu:
Eye Exam:	EKG:	Covid-19:

List all other doctors/ specialists/ providers who participate in your care

Provider Type	Provider	Provider Type	Provider
Cardiologist (Heart)		Otolaryngologist (ENT)	
Dermatologist (Skin)		Pain Management	
Endocrinologist (Hormone)		Physical Therapy	
Gastroenterologist		Psychiatrist/ Counselor	
Pulmonologist (Lung)		Rheumatologist (Autoimmune)	
Nephrologist (Kidney)		Oncologist/Hematologist	
Neurologist (Nervous Syst)		Urologist (Kidney/ Bladder)	
OB/GYN (Women's Health)		Orthopedic:	

☐ **Tobacco**	Packs/Cig/Chew Per Day:	How Many Years?	Quit Date:	☐ Never Used	
☐ **Vape**	Daily:	How Many Years?	Quit Date:	☐ Never Used	
☐ **Alcohol**	Drinks Per Day /Per Week:	How Many Years?	Quit Date:	☐ Never	
☐ **Drugs**	Type:	How Many Years?	Quit Date:	☐ Never Used	
☐ **Marijuana**	Reason:	Quit Date:	☐ Never Used		
☐ **Exercise Type**:	Minutes Per Day:	Days Per Week:	☐ I Do Not Exercise		
Current Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Domestic Partner
Occupation:	☐ Full Time	☐ Part Time	☐ Retired	☐ Disabled	☐ Unemployed ☐ Homemake

Please circle the symptoms that you may be CURRENTLY experiencing if ANY

Constitutional:	Fever	Chills	Night sweats	Fatigue
Eyes:	Loss of vision	Blurred vision	Visual changes	Other: _____
E, N, T and mouth:	Sore throat	Hearing loss	Mouth sores	Nasal congestion
Respiratory:	Cough	Wheezing	Difficulty breathing	Shortness of breath
Cardiovascular:	Chest pain	Palpitations	Cramping thighs	Leg swelling
Gi:	Abdominal pain	Nausea	Vomit	Diarrhea
Musculoskeletal:	Muscle pain	Back pain	Joint pain	Restricted motion
Skin:	Rash	Sores/wound	Blisters	Other: _____
Psychiatric	Depression	Anxiety	Sleep disturbances	Suicidal thoughts
Endocrine:	Heat intolerance	Cold intolerance	Excessive thirst	Other: _____
Neuro:	Headache	Dizziness	Memory loss	Other: _____
Immunologic:	Allergic reaction	Recurrent infection	Other: _____	
Genitourinary	Painful urination	Incontinence	Dysfunction	Other: _____

QUESTIONNAIRE FOR SLEEP APNEA

Stop

Snoring? Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	**Yes**	**No**
Tired? Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep? While driving or talking to someone)?	**Yes**	**No**
Observed? Has anyone observed you stop breathing or choking/gasping during your sleep?	**Yes**	**No**
Pressure? Do you have or are being treated for high blood pressure?	**Yes**	**No**

Bang

Body mass index more than 35 kg/M2?	**Yes**	**No**
Age older than 50-year-old?	**Yes**	**No**
Neck size large? *(Measured around adams apple)* For male, is your shirt collar 17 inches/43 cm or larger? For female, is your shirt collar 16 inches/41 cm or larger?	**Yes**	**No**
Gender = male?	**Yes**	**No**

Total score		

Scoring criteria: for general population

Low risk of OSA: yes to 0-2 questions

Intermediate risk of OSA: yes to 3-4 questions

High risk of OSA: yes to 5-8 questions

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Name:_____DOB:_____Date:_____

Over the last two weeks how often have you been bothered by any of the following? Please circle your answer.

PHQ-9	NOT at all	Several days	More than half of the days	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, 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, have left yourself or family down.	0	1	2	3
7. Trouble concentrating on things like reading or watching television.	0	1	2	3
8. Moving or speaking slower, that people have noticed. Or the opposite- being so fidgety 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
ADD THE SCORE FOR EACH COLUMN				
TOTAL				

How difficult have these problems (if any) made it for you to do your work, take care of things at home, or get along with other people? Circle one of the following that best describes it.

NOT difficult at all Somewhat difficult Very difficult Extremely difficult

Over the last two weeks how often have you been bothered by any of the following? Please circle your answer.

GAD- 7	Not sure at all	Some days	Over half days	Nearly every day
1. Feeling nervous, anxious or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
ADD THE SCORE FOR EACH COLUMN				
TOTAL				

How difficult have these problems (if any) made it for you to do your work, take care of things at home, or get along with other people? Circle one of the following that best describes it.

NOT difficult at all Somewhat difficult Very difficult Extremely difficult

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Release of medical information

The information that may be released includes: • Medical Reports • IEPS• Graphs • Progress Notes • Summary Of Treatment

I, _____, D.O.B.: _____-_____-_____ Do hereby authorize: **Reliant Health** staff to obtain my records from the following on my behalf.
Doctor office/ facility name:
_____
Address:
_____
Phone number / Fax number:

To Date • Discharge Summary • Medication Records • Testing • Education Records • 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 reliant health.

_____ I understand that all confidentiality and notice of privacy practices in accordance with HIPAA privacy and confidentiality laws, reliant health shall always maintain A notice of privacy practices. 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

By signing below, I have read and initialed the information above, I agree and consent to medical information being released or requested on my behalf.

Signature of patient/guardian _____ date: ____-_____-_____

Signature of parent/ guardian: _____ date: ____-_____-_____
(If patient is A minor 17 and younger)

☐ I have chosen to receive A copy of this release

☐ I have chosen not to receive A copy of this release.

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Financial policy

Thank you for choosing reliant health as your healthcare provider. We are committed to providing 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 the 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 later, 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 canceled at least 24 hours before the appointment time will result in A $50.00 fee. Appointments can only be canceled 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.

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 reliant health 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.

Reliant health 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.

Patient name: _____ D.O.B.: _____

Signature: _____ date: _____

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NEW PATIENT REGISTRATION FORMS

HIPAA information and consent form

Please be sure to read through each section of this form completely and sign at the end when done, if any questions feel free to ask front desk staff for clarification.

The health insurance portability and accountability act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is A "friendly" version. A more complete text is posted in the office. What this is all about: specifically, there are rules and restrictions on who may see or be notified of your protected health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of health and human services. www.hhs.gov we have adopted the following policies:

A. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies A patient's condition or information which is not already A matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information

B. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

C. The practice utilizes A number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

D. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

E. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

F. Your confidential information will not be used for the purposes of marketing or advertising products, goods or services.

G. We agree to provide patients with access to their records in accordance with state and federal laws.

H. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

I. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
J. Uses and disclosures not requiring consent or authorization by law, protected health information may be released without your consent or authorization under the following conditions:

- Suspected or known child abuse or neglect
- Suspected or known sexual abuse of A child
- Adult and domestic abuse
- Judicial or administrative proceedings (I.E., You are ordered here by the court)
- Serious threat to health or safety (I.E. "Duty to warn" and threat to national security)

By signing below, I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient name printed: _____ D.O.B.: _____ Date: _____

Patient signature: _____

Minor name printed: _____ D.O.B.: _____ Date: _____

Parent/ guardian name: _____

Parent/ guardian signature: _____ Date: _____

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Controlled substance agreement form

If you have been prescribed A controlled substance, we need you to complete this form before receiving medication. This form is only valid if completed before seeing your provider of choice.

In Nevada, per assembly bill 474, prescribers must inform their patients of information regarding the treatment of pain with the use of a controlled substance. It is important that you review the following information carefully and request additional information you may need to make an informed choice about the medication(s) prescribed. Please review the information listed here and initial each item.

_____ I understand that I am being prescribed medications, including controlled substances for the treatment of pain.
_____ I understand that all pain medications, including controlled substances, have different benefits and risks in the treatment of my symptoms. I have been advised of the potential risks and benefits of treatment using controlled substances.
_____ I understand that prescription-controlled substances can carry serious risks of addiction and overdose, especially with prolonged use.
_____ I understand that I am not to use the controlled substance prescribed to me in conjunction with drugs or alcohol, or other medications (unless otherwise directed by my prescriber).
_____ Before I was prescribed this pain medication, I was advised regarding non-opioid alternative means of treatment for my symptoms, including but not limited to anti-inflammatories (I.E., Aleve, tylenol, ibuprofen, etc.).
_____ I understand that when I take controlled substance(s), I may experience certain reactions or side effects that could be dangerous, including, but not limited to, sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.
_____ I understand that when I take controlled substance(s), it may not be safe for me to drive A car, operate machinery or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I understand that I should not do things that would put myself or other people at risk for being injured.
_____ I understand that when I take controlled substances, I may become physically dependent on them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.
_____ I understand that I may become addicted to controlled substances and require addiction treatment if I cannot control how I am using them, or if I continue to use them for A prolonged period. I have discussed with my prescriber the proper use of the controlled substance.
_____ I understand that anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past or who have A parent or sibling who has had drug or alcohol abuse problems are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.
_____ I understand that I must store prescriptions in A secure place and out of the reach of children, and other family members and/or use A locked medicine cabinet. To safely dispose of unused medications, I can return the unused medications in the bottle to A local pharmacy, A local drug-take-back day, or A local police or sheriff substation in my community, or I may safely

dispose of them by dissolving them in A dettera pouch. I understand that I am not to dispose of unused medications in the toilet or sink.

___ I understand that my doctor may not be permitted to refill my medication via telephone and, therefore, any requests for refills may require A consultation appointment. I understand that my doctor may decline to refill my prescription if S/he believes it to be medically unnecessary and/or harmful to my well-being. I understand that I am being prescribed A controlled substance for A short duration and that prescriptions for additional periods of time may require additional consultation, assessment and agreements.

_____ I understand that due to the risk of possible overdose resulting from of controlled substances, the opioid overdose antidote naloxone (narcan®) is now available without A prescription. I may obtain naloxone (narcan®) from A pharmacist.

_____ For women: it is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to A fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance, neonatal abstinence syndrome, neurologic and heart problems in the baby, prematurity, and fetal or neonatal death.

Informed consent:

Provider name: _____

Provider signature: _____ date: _____

I declare that I fully understand each of the statements written above and by signing I give my consent for treatment of my condition with medications, including controlled substances. I have had the opportunity to ask any questions regarding this agreement between myself and my provider.

Patient name printed: _____ D.O.B.: _____

Patient signature: _____ date: _____

As the parent/guardian, I have discussed with the prescriber the risks of the controlled substance being prescribed to my minor. It has been made clear that if there is any indication of abuse or misuse of the controlled substance the patient will be expelled from receiving this prescription from reliant health entirely.

Minor name: _____ D.O.B.: _____

Parent/guardian name: _____

Parent/guardian signature: _____ date: _____