AstranaCare

☐ **New Patient** ☐ **Established Patient**

Date: _____

## Patient Information

**Patient Name**: _____ _____ _____
First Name M Last Name Suffix

**Date of Birth**: _____/_____/_____ **Sex:** ☐ Male ☐ Female ☐ Other: _____

**Social Security Number**: _____- _____-_____ **(needed for care follow-up)**

**Address**: _____ _____
Apt./Ste/Unit

_____ _____ _____
City State Zip Code

**Mobile:** _____ **Home:** _____

**Email*:** _____
****Gives you access to your Patient Chart Portal & Appointment Reminders****
****Appointment Reminders: Automated text/phone calls will be sent to the mobile number provided****
**Can your mobile phone do SMS or Video calls?** ☐ **Yes** ☐ **No**
**How do you prefer to be contacted?** ☐ **Phone** ☐ **Portal**

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

**Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____

**Race:** ☐ White/Caucasian ☐ Black/African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____

**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic or Latino

**Preferred Pharmacy Name/Cross Streets or Phone:** _____

### Emergency Contact

**First & Last Name**:_____ **Phone**: _____

**Relationship to Patient**: _____

## Insurance Information

**Primary Insurance Name**: _____

**Policy #:**_____ **Group #:** _____

Under someone else's policy? ☐ Yes ☐ No **If NO, please skip to next section.**

**If YES, please fill out below:**

Policyholder Name: _____ _____ _____
First M Last

Relationship of Policyholder: _____ Date of Birth: _____/_____/_____

Policyholder SSN: _____ - _____ - _____ Phone Number: _____
**(used to verify insurance)**

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**Patient Name:** _____

**Date of Birth:** _____

**Secondary Insurance Name**: _____

**Policy #:**_____ **Group #:** _____

Under someone else's policy? ☐ Yes ☐ No **If NO, please skip to next section.**

**If YES, please fill out below:**

Policyholder Name: _____ _____ _____
First M Last

Relationship of Policyholder: _____ Date of Birth: _____/_____/_____

Policyholder SSN: _____ - _____ - _____ Phone Number: _____
**(used to verify insurance)**

## Guarantor Contact

**First & Last Name**:_____ **Phone**: _____

**Relationship to Patient**: _____

## Preventive Screenings

| | I Need (Yes/No) | Date Last Received | Result | Next Date Needed |
|---|---|---|---|---|
| Annual Exam | | | | |
| Colorectal Cancer Screenings<br>Check Test Type:<br>☐ FOBT/FIT (annual stool test)<br>☐ Cologuard (DNA stool test)<br>☐ CT Colonography (CT Scan)<br>☐ Colonoscopy (with Gastroenterologist) | | | | |
| Cardiovascular Screening (Blood pressure, cholesterol, lipids) | | | | |
| Diabetes Screening (A1c) | | | | |
| Diabetic Eye Exam Location:_____ | | | | |
| Cervical/Vaginal Screenings (Pap Smear) | | | | |
| Breast Cancer Screening (Mammogram) | | | | |
| Bone Mass Measurement (Bone Density) | | | | |
| Flu Shot | | | | |
| Hepatitis B Shot | | | | |
| Pneumococcal Shot | | | | |
| Shingrix | | | | |
| RSV | | | | |
| COVID Vaccine | | | | |
| Other: | | | | |

| **NEW PATIENT QUESTIONNARE** |
|---|
| **REASON FOR VISIT:** |
| |
| |

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Patient Name: _____

Date of Birth: _____

| PERSONAL HEALTH HISTORY | |
|---|---|
| List any medical problems you currently have: | Date of diagnosis: |
| | |
| | |
| | |
| | |
| | |

| SURGERIES/OTHER HOSPITALIZATIONS | | |
|---|---|---|
| Date | Reason/Surgery Performed: | Hospital |
| | | |
| | | |
| | | |
| | | |

| NAME & SPECIALTY OF OTHER TREATING PHYSICIANS | |
|---|---|
| Physician Name | Specialty |
| | |
| | |
| | |
| | |

| List of your prescribed drugs and over-the-counter drugs (such as vitamins and inhalers) | | |
|---|---|---|
| Name of Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |

| ALLERGIES TO MEDICATIONS | |
|---|---|
| Name of Drug | Reaction |
| | |
| | |

| SOCIAL HISTORY | | | |
|---|---|---|---|
| Alcohol? | ☐ Yes or No ☐ | How many drinks? | # _____ a day ☐ or ☐ a week |
| Tobacco? | ☐ Yes or No ☐ | How many cigarettes? | # _____ a day ☐ or ☐ a week |
| Recreational Drugs? | ☐ Yes or No ☐ | How many? | # _____ a day ☐ or ☐ a week |

| FAMILY HISTORY | |
|---|---|
| Family Member | Diagnosis |
| Mother | |
| Father | |
| Sibling(s) | |
| Children | |

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**Patient Name:** _____

**Date of Birth:** _____

# Practice Consent Form

***Appointments***

Appointments are scheduled according to the treating provider. New patients must arrive 30 minutes prior to their scheduled appointment to fill out the proper paperwork if not completed beforehand. Existing Patients must arrive 15 minutes prior to their scheduled appointment. Any special appointment times are to be given directly by the provider.

***Referrals***

If referrals are required, we will complete the necessary paperwork and submit it to your health plan for authorization. It has been our experience that each health plan varies in its response timeliness.

***Financial Policy***

Our physicians are providers with traditional insurance health plans. If you have any questions about whether any of our physicians are participants in your health plan, please call or directly speak with our office staff and your insurance company. Co-payments/Deductibles are due at the time of service.

***Emergency/ Non-Emergency Care***

If you believe you have an emergency, please call 911. Your health plan may require that any non-emergency health care received outside of our office also receive prior authorization from your health plan and your physician. If authorization is not obtained, you may be financially responsible for the services rendered.

***Billing***

Insurance is billed as a courtesy to the patient. Please direct all billing inquiries and account questions to (702) 529-2217. Patients without insurance are required to pay for services in full at the time of service. Power of Attorney verification is expected at the first visit if applicable. Any medical records or test results requested by another physician's office may be sent by fax/mail at no charge. Patients requesting medical records/test results will be charged $.60 per page. Payment is expected prior to the release of records.

***ROUTINE PHYSICAL APPOINTMENTS***

I understand a routine physical appointment cannot be accompanied by any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed to the provider the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to doctor. A copy of the signature is as valid as the original.

***ABN (Advance Beneficiary Notice of Non-Coverage)***

Medicare does not pay for everything, even some care that your health care provider has good reason to think you need. You accept that you may have to pay what Medicare does not pay, including any lab work ordered by your provider. 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 (1-800-663-4227/TTY: 1-877-486-2048)

***Consent to Treatment Using Telemedicine***

I consent to treatment involving the use of electronic communications to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical procedure, there are potential risks, and no results can be guaranteed or assured. These risks include but are not limited to: technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

_____ _____

Patient Signature / Legal Guardian Signature Date

AstranaCare

**Patient Name:** _____

**Date of Birth:** _____

***General Consent to Treat/Patient Authorization/Acknowledgment of Benefits Release***

The following are the conditions for services provided by Astrana Care for the patient whose name appears at the top of this page.

**ROUTINE PHYSICAL APPOINTMENTS**

_____ ***Initials*** I understand a routine physical appointment cannot be accompanied with any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed with the physician the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

**LAB DISCLAIMER**

_____ ***Initials*** It may be necessary to perform or request lab work (cultures, pap smears, biopsies, lab work, etc.). Our office WILL send you directly to the Lab of your choice. Our office may send out a specimen to a Lab of the Physician's choice but will consider your insurance carrier. Each test may have more than one fee depending on the complexity. Your insurance carrier may not cover certain tests. It is your responsibility to know your benefits. We cannot change any coding (CPT Procedure Codes or ICD-9 Diagnosis Codes) to conform to your plan's coverage or benefits.

Please **CHECK MARK** the lab your insurance is contracted with. If unknown, staff will choose your preferred lab, per insurance contract. ☐CPL ☐ Lab Corp ☐ Quest ☐ Unknown ☐ Other: _____

**CONSENT FOR MEDICAL TREATMENT**

I/We voluntarily consent to medical treatment and diagnostic procedures provided by Astrana Care and its associated physicians, clinicians, and other personnel. I/We consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis, and testing for drugs if deemed advisable by my physician. I/We am/are aware that the practice of medicine and surgery is not an exact science, and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

The practice and physicians are authorized to release any medical information required in the processing of application or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/We also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law. I/We fully understand that, as part of a teaching institution, information may be collected from the patient encounter or chart in order to collect data. I/We understand that personal health information may be used or disclosed for the purposes of carrying out treatment, evaluating the quality of services proved and any administrative operations related to treatment or payment. I/We understand that I/we have the right to restrict how the personal health information is used and disclosed for treatment, payment, and administrative operations if I/we submit a written request. I/We understand that each request will be considered for restriction on a case-by-case basis.

**ASSIGNMENT OF INSURANCE BENEFITS**

I/We guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other fundings to the physician and Astrana Care. I/We understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/We understand that Astrana Care can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/We have provided all necessary information for proper assignment of Medicare benefits.

**WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION**

I understand that Nevada Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their

AstranaCare

**Patient Name:** _____

**Date of Birth:** _____

attorneys, or the applicable State Workers' Compensation Commission pursuant to the NV Code NRS616C.050. I/We authorize Astrana Care to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.

**CONTROLLED SUSTANCE PRESCRIPTIONS**

Astrana Care reserves the right not to prescribe narcotic medications. If you take narcotic medications for pain control on a regular basis, you must see a pain management physician. No narcotic prescriptions will be given to a new patient on the initial visit until a complete work up has been performed and old records have been received. Controlled substance medications (narcotics, anti-anxiety, sleeping medications, etc.) are very useful, but have potential for misuse and abuse. These drugs are closely controlled by local, state, and federal government. They are intended to relieve pain, to improve function and/or ability to work, not to simply feel good. If you are prescribed such medications to help manage pain, you are responsible for the controlled substance medication. If the prescription is lost, misplaced, stolen, or used up medication sooner than prescribed, it will not be replaced. You cannot request nor accept substance medication from any other physician or individual while you are receiving this medication from your doctor. Prescription refills of controlled substance cannot be called in to the pharmacy. All controlled substance prescriptions MUST be transmitted to a pharmacy by electronic prescribing ("e-prescribing"), and you must attend your scheduled appointment. You will be informed by your doctor about side effects, including normal psychological effects of tolerance and dependence.

**INFORMATION RELEASE**

Other Person(s) authorized to discuss any medical information (including appointments, billing, and insurance):

| Full Name | Phone Number | Relationship |
|---|---|---|
| | | |

| Full Name | Phone Number | Relationship |
|---|---|---|
| | | |

**CONFIDENTIAL COMMUNICATION**

You may request to receive confidential communications of Protected Health Information (PHI), i.e. Lab results, imaging results, referral/prior authorization, prescription refills, in the method you prefer.

**I authorize Astrana Care to leave PHI messages at the following:** ***(Please select all that apply)***

☐ Mobile Voicemail:_____
☐ Home Voicemail: _____
☐ Work Voicemail:_____
☐ Mobile Patient Portal Web Message (email address required):_____
☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN CALL

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I/We have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

_____ _____

Patient Signature / Legal Guardian Signature | Date

_____

Printed Name

AstranaCare

**Patient Name:** _____

**Date of Birth:** _____

## ***Form Completion Policy***

Astrana Care requires payment for the completion of forms the patient asks providers to complete on their behalf. We receive many requests which require increased administrative time and financial resources in excess of what is normally needed to complete the medical record.

Instructions:

- Submit forms requested in advance. The provider will attempt to complete the forms as quickly as possible; however, in order to properly address each form, providers need adequate time to review the patient's records.
- If applicable, patient must complete their section of the form prior to giving it to the provider.

Providers will make every effort to complete these forms within 5-7 business days; however, we cannot make any assurance of completion with the patient's time frame(s). Payment is required prior to completion of all forms.

**$50 fee for completion of the following forms:**

- FMLA/Disability
- Letter of Condition
- Misc. patient request

**$20 fee for the completion of the following forms:**

- DMV Disability Placard
- Physical Forms

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## ***Cancellation and Late Policy***

It is the policy of Astrana Care that patients arrive on time for their scheduled appointments. In the event that a patient is unable to make their scheduled appointment, the patient must give 24 hours advanced notice by calling the office.

If an existing patient is late for their appointment time, the patient may not be treated that day and may have to reschedule. If the patient is treated, they will be working in between other patients in accordance with their appointment time.

A patient who fails to keep 3 or more appointments in a twelve-month period without prior notice of cancellation may be discharged from the practice at the discretion of the patient's provider. Additionally, if a patient no-shows 3 times in a twelve-month period, the patient will be required to be a walk-in appointment to be seen by their provider. Furthermore, a patient that is consistently late to their appointment, may also be required to be a walk-in with the potential to be discharged from the practice at the discretion of the patient's provider.

By signing below, I attest that I have read and understood the above mentioned. If you would like a paper copy of this form, you may request a copy from an office staff member.

_____ _____

Patient Signature / Legal Guardian Signature Date

_____

Printed Name

# Patient Consent Form

## For Electronic Exchange of Individual Health Information

HealtHIE Nevada is a nonprofit organization that connects the health care community and enables the sharing of information electronically and securely to improve the quality of health care services. To learn more about the health information exchange (HIE), read the **Patient Information Brochure**. You can ask the doctor that gave you this form for it, or you can visit the website at www.HealtHIENevada.org.

### Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services
   - Evaluate and improve the quality of medical care provided to all patients

2. **Types of information included and where it comes from:** The information about you comes from participating organizations that have provided you with medical care. These may include hospitals, physicians, pharmacies, clinical laboratories and other health care organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this **Consent Form**. This information may relate to sensitive health conditions, including, but not limited to:

   | | | |
   |---|---|---|
   | • Alcohol or drug use problems | • HIV/AIDS | • Birth control / abortion (family planning) |
   | • Genetic (inherited) diseases or tests | • Mental health conditions | • Sexually transmitted diseases |

3. **Improper access or disclosure of your information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada state law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.

4. **Effective period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.

5. **Revoking your consent:** You may revoke your consent at any time by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

   *Note:* Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and state laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada state law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

You are entitled to receive a copy of this **Consent Form** after you sign it.

For Internal Use Only: MRN _____

# Patient Consent Form for Electronic Exchange of Individual Health Information

*Please read through the consent form and provide the following information: (Please print)*

**PATIENT NAME**_____
*Last* *First* *Middle*

**PREVIOUS NAME(S)**_____ **GENDER:** M ☐ F ☐

**STREET ADDRESS/P.O. BOX**_____

**CITY**_____ **STATE** _____ **ZIP CODE** _____

**PHONE NUMBER** _____ **EMAIL**_____

**DATE OF BIRTH** _____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients: PLEASE READ.** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is her/his responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

***Consent Choices: (CHECK A, B, or C) Nevada Medicaid Patients are exempt from making a selection.***

*Your choice to give or to deny consent may not be the basis for denial of health services.*

☐ **A. I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **B. I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information).

☐ **C. I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____ _____
Signature of patient, parent (for children under 18) or authorized representative Date Time

*If I sign this form as the patient's authorized representative, I understand that all references in this form to "I," "me" or "my" refer to the patient.*

_____ _____ _____ _____
Name of authorized representative (printed) Relationship Date Time

_____ _____
Address of authorized representative Phone number

**FOR INTERNAL USE ONLY**
Name of Organization:_____ Name of Witness:_____
*As a witness to this consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card or other evidence of identity customarily relied upon in health care.*