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 Check Test Type: ☐ FOBT/FIT (annual stool test) ☐ Cologuard (DNA stool test) ☐ CT Colonography (CT Scan) ☐ 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:

AstranaCare

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

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