COMPLETE FAMILY CARE

Patient Demographics

Last Name	First	Middle Initial	Birth Date: / /	Age:

Street Address	Apt #	City	State	Zip

Mailing Address/ P.O Box	Apt #	City	State	Zip

E-mail Address: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Cell Phone Number ( )	Home Phone Number ( )	Alternate Phone Number ( )

Preferred Language:
☐ English ☐ Spanish

Which of the following groups do you feel you belong to? ☐American Indian/Alaska Native
☐ Pacific Islander ☐ Native Hawaiian ☐Black/African American ☐Caucasian ☐ Asian
☐ Hispanic/Latino ☐Refused to report

SSN:

Birth Sex:
☐ Male
☐ Female

Gender Identity:
☐Male ☐Female
☐Transgender Male/ Female to Male
☐Transgender Female/ Male to Female
☐Other
☐Chose not to disclose

Sexual Orientation:
☐ Straight
☐ Lesbian or Gay
☐ Bisexual
☐ Something else
☐ Chose not to disclose

Emergency Contact info (REQUIRED)

Name: Relation: Phone Number: ( )

Pharmacy Information *(REQUIRED)*

Pharmacy Name:

Address

Phone Number

For Minor Patients- Parent or Guardian Information

Parent/ Guardian Full Name: | SSN:

Relation to Patient: Father Mother
Other _____ | Date of Birth: | Birth Sex:

Address *(If different from above)* Apt # City State Zip

Phone Number *(If different from above)* ( )

Medical Insurance

1-Primary Insurance Company ID # Group # Address

Name of Insured DOB Insured's Employer | Relationship to patient ☐ Self ☐Spouse ☐ Parent ☐ Other

2-Secondary Insurance Company ID # Group # Address

Name of Insured DOB Insured's Employer | Relationship to patient ☐ Self ☐Spouse ☐Parent ☐Other

I _____CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE TO MY KNOWLEDGE.

(Print Name)

Signature *(Patient or Parent/ Guardian)*_____Date:_____

2828 E. Lake Mead Blvd, North Las Vegas, NV 89030 Phone: (702)551-2222 Fax: (702)448-4755

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Medications (IF NONE WRITE "NO")

Please list any medications (prescription & over the counter), supplements, or vitamins you take: *(If you brought your medication list with you today, then please provide list to front office staff to copy)*		
Medication name	Strength/Dose	How often do you take it?

Allergies (IF NONE WRITE "NO")

Allergy	Reaction

Medical History (IF NONE WRITE "NO")

Please check (x) any medical conditions you currently have or have had in the past:				
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ COPD	☐ Depression
☐ Diabetes	☐ High Cholesterol	☐ Heart Disease	☐ Hepatitis/Liver disease	☐ HIV
☐ High Blood Pressure	☐ Heart Attack	☐ Kidney Disease	☐ Stroke	☐ Thyroid Problems
☐ Cancer:				
☐ Other:				

Surgical History (IF NONE WRITE "NO")

Please list any surgeries you have had in the past:	
Surgery	Approximate Year Performed

Family History (IF NONE WRITE "NO")

Family Member	Are They Living?	Medical Conditions
Mother	☐ YES ☐ NO	
Father	☐ YES ☐ NO	
Sister(s)	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
Brother(s)	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	

COMPLETE FAMILY CARE

PLEASE READ AND SIGN ALL OF THE CONSENTS

PATIENT ACKNOWLEDGMENT FORM (HIPAA)

Our Notice of Privacy Practices provides informatiion about the privacy rights of our patients; and how we may use and disclose protected health information (PHI) about our patients. Federal regulation requires that we give our patients or their authorized representative opportunity to review our Notice before signing this acknowledgment. A one-page summary of our notice is displayed in our office. A copy of our notice will be made available to you at your request.

By signing this form you acknowledge only that we have provided you with immediate Access to our Notice of Privacy Practices.

Authorized Signature: **Date:**

MEDICAL CONSENT TO TREAT PATIENT OR CONSENT TO TREAT A MINOR

By signing below, I state that I am the natural patient or parent, legal guardian having legal custody of the minor child. I give permission for Complete Family Care, to perform or administer x-ray, examination, anesthetic, medical or surgical diagnosis and/ or treatment when the need for such treatment is clear, and when efforts to contact me are unsuccessful.

Authorized Signature: **Date:**

RELEASE AUTHORIZATION:

I authorize Complete Family Care to disclose all or any part of the patient's medical record and/ or clinic charges (including information regarding alcohol or drug abuse, psychiatric illness or comunicable disease related information including HIV) to any person or corporation (i) which is or may be liable or under contract to Complete Family Care for reimbursement, subrogation and/ or direct recovery and coordination of benefits for this and all futre claims including but notlimited to hospital/ medical service companies, workers' compensation carriers, welfare funds, governmental agencies and (ii) any health care provider for continued patient care. Complete Family Care may also disclose on an anonymous basis any information concerning the patient's case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal Law, statute or regulation. Except, as above, Complete Family Care will require the patient's, or in the case of a minor child, a natural parent or legal guardian's written consent to reléase information about the patient. I also agree that in al instances, the original medical records (including x-rays and laboratory specimens) remain the property of Complete Family Care.

Authorized Signature: **Date:**

ASSIGNMENT OF BENEFITS

In the eent the patient, his/her authorised representative or guarantor signing below, is entitled to benefits of any type arising out of any pollicy of insurance insuring the patient or any other party liable to the patient, those benefits are hereby assigned to Complete Family Care for application against the patient's bill. Such payment shall discharge that insurance company of any obligation under the policy to the extent that payment has been made correctly according to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/ or not covered by this assignment. For any Medicare eligible coverage, I request that payment of any authorized Medicare benefits be made on my behalf; I assign the benefits payable for physicians' services to the physician or organization furnishing the services or authorize such physician or organization to submit a cliam for payment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to this patient, is herby assigned to Complete Family Care or to the provider group rendering service for application to patient's bill. A photocopy of this assignment is to be considered as valid as an original

Authorized Signature: **Date:**

Financial Responsibility

I agree that in return for the services provided to the patient by Complete Family Care, or other health care providers, I will pay the account of the patient prior to discharge or make financial arrangements satisfactory to Complete Family Care or any other providers for payment. I fan account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate. IT IS UNDERSTOOD THAT THERE MAY BE ADDITIONAL CHARGES FOR X-RAY, LABORATORY TESTS OR OTHER SERVICES AND SUPPLIES PERFORMED OR PROVIDED BY PROVIDERS OR ORGANIZATIONS OTHER THAN Complete Family Care THAT WILL BE BILLED SEPARATELY.

Guarantor Signature: **Date:**

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Patient Name:	Date of Birth:

What is Telehealth and How does it work?

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. One of our Medical Assistants will be with you during your visit, and you will be connected to a provider through video conferencing technology. The Medical Assistant will manage the equipment and the diagnostic tools, like a stethoscope to hear your heart and an otoscope to see in your ears. He or she will also assist the provider with your physical examination. The provider will make recommendations for your care, order prescriptions if necessary, and make referrals for specialty care if needed.

By signing this form, I understand the following:

1. I hereby authorize Complete Family Care to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
3. I accept that the professionals can contact interactive sessions with video call, however I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
4. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these my information will be kept private.

Patient Consent To The Use of Telehealth

I have read and fully understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

Signature of Patient *(or person*

authorized to sign for patient): _____ Date: _____

If authorized signer,

Relationship to patient:_____Date:_____