FRONTIER MEDICAL & BEHAVIORAL CENTER
www.frontiermbc.com

Patient Registration Form

[ ] New Patient [ ] Annual Information Update

Patient Demographics

Patient Name: _____ DOB: _____ Age: _____

Preferred to be addressed as: _____ Gender: ◯ Male ◉ Female

Street Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Patient Portal Sign up? ◯ Y ◉ N

Email: _____

Race: ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Hispanic
◉ Native Hawaiian / Other Pacific ◯ Other: _____

Ethnicity: ◯ Hispanic ◯ Non – Hispanic ◉ Prefer not to disclose

Primary Language: ◯ English ◉ Spanish ◯ Other: _____

Insurance

Primary Insurance: _____ Subscriber ID#: _____

Subscriber name: _____ Relationship to patient: _____

Secondary Insurance: _____ Subscriber ID#: _____

Subscriber name: _____ Relationship to patient: _____

Occupation: _____ Employer: _____

Employer Address:_____

Emergency Contact

Name of local relative (not living in the same household):_____

Relationship to patient: _____ Phone: _____ Work:_____

PHARMACY: _____

____ (initial) It is my responsibility to update all above information in case of changes

_____ _____ _____

Printed Patient / Guardian Name Signature Date

5105 Camino Al Norte Suite 100 N Las Vegas, Nevada 89031
P: 702.750.2438 | F: 702.750.2173 | E: info@frontiermbc.com

FRONTIER MEDICAL & BEHAVIORAL CENTER

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We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information

Acknowledge of Privacy Practice

I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Frontier Medical & Behavioral Center Inc and its providers, for the purposes of treatment, payment, or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

Patient Record of Disclosure

In general HIPPA privacy rule give individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of the PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclose PHI information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to use or disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of PHI disclosure, Information provided below, if completed properly will constitute and adequate record.

Note: Uses of disclosure for TPO (Treatment Records, Payment Information, Healthcare Operations) may be permitted without prior consent in an emergency.

I wish to be contacted in the following manner; (check all that applies)

☐ Home Telephone: _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ O.K to mail to home address
- ☐ O.K to work
- ☐ O.K. to fax to this number _____

☐ Work Telephone: _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ Other Friends and Family

_____

_____

List names of persons that medical records and information may be disclosed to:
(Date, Address, Phone Number, Fax, Description of Discolsure)

_____

_____

_____ _____

Print Name / Signature of Patient / Guardian Date:

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CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Print Name / Signature of Patient / Guardian Date:

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Policies | Waivers | Disclosures

Payment Policy

Payment is due in full at the time of service. We bill most insurance company as a courtesy to you, but you are ultimately responsible for all charges incurred. Deductibles, co-pay and coinsurance are due at the time of service.

Insurance Waiver Statement/Disclosure

I understand that my insurance carrier may not cover some services; or may deny some recommended and performed services. I am financially responsible for all charges whether or not paid by my insurance company. I will be responsible for payment of these charges.

Cancellation Policy

In order to serve you better we ask that if you have an appointment scheduled, please give us a **24 hour notice of cancellation of the appointment.**

Failure to do so will result in a $25 fee to your account. Payment of the fee is due the following visit. Thank you for your cooperation in understanding the terms of the practice. If you have questions regarding the policy, please ask one of our staff members.

Nevada State Law AB 474

In compliance of Nevada State Law AB474 Controlled Substance Act Effective 1/1/2018 (Copy available upon request) Patients who are currently being prescribed a **CONTROLLED SUBSTANCE** will be **REQUIRED** to complete the following prior to being prescribed a controlled substance.

- Please complete a Controlled Substance Packet from the reception.
- A referral and/or a Transfer of Care statement is needed from your current prescriber stating that they will release the responsibility of prescribing the controlled substance to our providers.
- You may be subjected to a Urine Drug Screen or other tests prior to initial prescription of the controlled substance.
- Controlled substances will be re-filled every 30 days with an in-person appointment.

[ ] By signing this form, you acknowledge receipt and understanding of the above polices and statement of Frontier Medical & Behavioral Center Inc. I understand that policies may be subject to change. I agree to the terms of the Payment Policy, Cancellation Policy, and Insurance Disclosure.

_____ _____

Name / Signature of Patient / Guardian Date:

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Informed consent for telemedicine services

Telemedicine 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. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

Patient medical records, Medical images, Live two-way audio and video, Output data from medical devices and sound and video files Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected benefits

Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites. More efficient medical evaluation and management. Obtaining expertise of a distant specialist.

Possible risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:
In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,

I understand that I have the 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 care or treatment,

I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,

I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. FMBC Provider has explained the alternatives to my satisfaction,

I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand that it is my duty to inform FMBC Provider of electronic interactions regarding my care that I may have with other healthcare providers.

I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I attest that I am located in the state of Nevada and will be present in the state of Nevada during all telehealth encounters with FMBC.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, 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 telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize FMBC to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Print Name / Signature of Patient / Guardian Date:

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Medical Records Release Form

I voluntarily consent to authorize my health care provider/s from **Frontier Medical & Behavioral Center**_____ to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:_____ Ph: _____ Fx:_____

Address:_____ Email: _____

Purpose: I authorize the release of my health information for the following specific purpose:
☐ At request of the patient ☐ Collaboration of Care ☐ Other: _____

Information to be disclosed:
I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

☐ Only the following records or types of health information:
_____.

Term: I understand that this Authorization will remain in effect:
☐ From the date of this Authorization until the _____ day of _____, 20___.
☐ Until the Provider fulfills this request.
☐ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____	_____	_____
Patient Printed Name	Guardian Printed Name (If Minor)	Relationship
_____	_____	_____
Patient Signature	Guardian Signature	Date:

_____

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