Reno Primary Care

Patient Demographics

Full Name	
Address	
City, State, Zip	
Date of Birth	
Cell Phone Number	
Email	
Referred By	

Emergency Contact Information

Name:	Ph #:	Relationship:
Name:	Ph #:	Relationship:

Primary Insurance

Insurance:	ID Number:
Group Number:	Phone Number:
Address:	
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

Secondary Insurance

Insurance:	ID Number:
Group Number:	Phone Number:
Address:	
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**

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FINANCIAL POLICY

Thank you for choosing RENO PRIMARY CARE to participate in your medical care. In an effort to provide you with a full understanding of your financial obligations, an important aspect of your medical care, we have developed the following policies:

All patients are financially responsible for services provided

- Our office requires that you provide a copy of your current insurance card and photo ID at every visit.
- As a requirement of both our office and your insurance company, co-payments are due at the time of service.
- Payment of co-insurance or any charges not covered by your plan is required at the time of service.
- Medicare recipients are expected to update the National File with any changes by calling 1-800-MEDICARE.
- Payment is required in full at the time of service from uninsured patients unless arrangements have been made in advance.
- If previous arrangements have not been made, any account balance over 90 days will be turned over to a collection agency.
- A fee of $25 will be charged to you for returned checks, plus any bank fees incurred.

Appointments

- A $50 fee will be assessed for canceled appointments without 24 hours' notice or 3 no shows.
- Patients who accumulate a total of three "NO SHOWS" in a calendar year may be terminated from the practice.
- If you are more than 10 minutes late, your appointment will be rescheduled.

Referrals/Authorizations

It is the patient's responsibility to ensure that any referrals or authorizations for treatment are provided to the office prior to your appointment. If the authorization or referral is not obtained prior to your visit, you will be expected to pay for all charges at the time of your visit.

Our practice firmly believes that a good provider patient relationship is based upon understanding and good communication. Questions about our Financial Policy should be directed to the front desk personnel.

I have read and understand the Financial Policy and agree to comply and accept responsibility for services provided by RENO PRIMARY CARE.

_____ _____

Signature of financially responsible party Date

_____

Printed Name

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Consent for Treatment

General Consent to Care:
I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, through Reno Primary Care on an outpatient basis.

I agree and acknowledge that Reno Primary Care is not liable for the actions or omissions of, or the instructions given by the providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at the Reno Primary Care facility.

Telemedicine
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

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

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. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent for Minor Child/Children and/or Patient.

I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Reno Primary Care. Any care deemed medically necessary may be provided with or without my presence:

Child: _____ Date of birth _____

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

_____[ ] *Patient under 18 years of age* _____.
Signature of Patient or Legal Guardian **Date**

_____ _____
Printed Name of Patient or Legal Guardian **Relationship to Patient**

This consent to medical treatment expires 12 months from the date signed or until revoked in writing.

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CONSENT TO RECEIVE CONTROLLED SUBSTANCE (SCHEDULE II, III OR IV)

By signing this form, you are acknowledging that your provider has explained to you that the types of medications that may be prescribed for your condition may include opioids and/or other drugs known as "controlled substances" (also known as Schedule II, III or IV drugs) and that these medications have known risks and side effects and can be harmful if taken without medical supervision. You further understand that this medication may lead to tolerance, physical dependence and/or addiction.

In order to allow you to make an informed decision, it is important that you and your provider discuss the following things, and that you have an opportunity to have your questions answered:

1. The nature of your symptoms and your underlying medical condition.
2. The proper use of the medication that is being prescribed.
3. Alternative means of treating your symptoms and the cause of your symptoms.
4. The important provisions of your treatment plan.
5. The potential risks and anticipated benefits of long-term opioid use or other medications.
6. The side effects, both short- and long-term of the medication that is being prescribed or provided, such as nausea, constipation, decreased libido, sexual dysfunction, osteoporosis, and cognitive impairment, as well as other conditions that are not listed here.
7. The fact some medications are known to have a risk of tolerance, physical dependency, and addiction over time.
8. The risk of drug interactions, over-sedation, respiratory depression, overdose, and death especially if the medication is not taken as prescribed or combined with alcohol use or other drugs.
9. The risk of impaired motor skills affecting driving and other tasks which can lead to accidents and injury or death.
10. If the medication is an opioid, the risk of opioid misuse, tolerance, dependence, addiction and overdose, the signs and symptoms of overdose including respiratory depression, and the availability of an opioid antagonist such as naloxone that may be prescribed that can reverse opioid overdose; you will be told that you should share information about naloxone with your family and friends and teach them how to recognize and respond to an overdose.
11. The serious risk of harm to an unborn child including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome, if a woman takes these medications while pregnant.
12. The methods to safely store and legally dispose of unused medication.
13. The ways that requests for refills of the prescription will be handled by your provider, including refills that will exceed 30 days, 90 days, or longer and how long-term use will be addressed by your provider; and,
14. If the patient is an unemancipated minor, the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse, or diversion.

You have been warned about the serious dangers of overdose and/or combining the prescribed medication(s) with other drugs or alcohol, including the risk of death. You have also been advised that there is limited evidence as to the benefit of long-term opioid therapy.

You have been informed, and understand, that your provider may ask you to undergo medical tests and examinations before and during your treatment. Those tests may include random unannounced

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requests for lab work during your treatment to check for drugs, and psychological evaluations if your provider deems them necessary to assess how the medication is affecting you.

If you refuse to have those tests done, it may not be possible to assess whether the medication is causing any side effects or harming you, and it may then no longer be safe to continue prescribing the medication.

For female patients only:

I understand that there may be possible unknown side effects of the prescribed medication(s) that could harm an unborn child. If I am not pregnant, I will use appropriate contraception/birth control during the course of my treatment. If I become pregnant or am uncertain, ***I WILL NOTIFY MY PROVIDER IMMEDIATELY***.

For ALL patients:

I realize that this treatment may include prolonged or continuous use of this medication, and that an appropriate treatment goal may also include the eventual withdrawal from the use of this medication.

My treatment plan will be tailored specifically for me. I understand that I am expected to participate in any other treatment that my provider may recommend or prescribe to treat or ease my symptoms or condition, including physical/occupational therapy and/or psychological counseling.

I understand that I may withdraw from this treatment plan and discontinue medication use at any time. I further understand that I need to inform my health care provider if I intend to discontinue use of the prescribed medication since there may be a medical risk associated with abrupt termination of the treatment; I understand that I will be provided with withdrawal management and medical supervision if needed when discontinuing medication use.

_____

Signature of Patient/Patient Representative

If you are not the patient, explain relationship:_____

(e.g., parent/guardian, conservator)

_____

Date

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Family & Friends Release of Information

List family and friends, *if any,* whom we may inform about your <u>medical conditions, treatments and your diagnosis.</u>

Name	**Relationship**	**Date of Birth**
_____	_____	_____
_____	_____	_____

This Authorization will remain in effect until I provide a written notice of revocation to Reno Primary Care Medical Record Department.

_____
Date

_____
Signature of patient

_____
Printed Name

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Privacy Practice and Non-Discrimination Notice

I understand that: I was provided with an option to receive a copy of the Privacy Practices and Non-Discrimination notice for Reno Primary Care and have waived that option. These documents can be found posted in the practice waiting area.

Patient/Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

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Acknowledgment of Possible Lab/Pathology Charges

Please be advised that if you have a preventative office visit or an in-office procedure (i.e. pap smears, cultures etc.) you may receive a bill from an outside source such as a PathLogic lab, Quest Diagnosis, Lap Corp or Renown Lab. Our charges for services rendered do not include any cost or fee's associated with lab/specimen testing. These services may or may not be a covered benefit by your insurance even if the lab is contracted. It is the patient's responsibility to know their lab benefits and inform the practice of any preferred or in-network labs.

I have read and understand the above statement that I may receive a bill from an outside company for results from procedures that are done at Reno Primary Care.

My in-network lab or preferred lab/pathology company is:

_____

Patient Signature: _____

Printed Name: _____

Date: _____

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Consent to Pay for Non-Covered Services

I, _____ (Patient or Guardian Name), understand that some the services and/or supplies may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by my Health Insurance. I understand that my health insurance coverage has certain restrictions and limitations, such as prior-authorization requirements and non-covered service and/or supply guidelines.

By signing this form, I understand that I am agreeing to pay for the services and or supplies that are not covered if my insurer denies payment.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
Witness Signature Date