Health First
ADVANCED CARE

NOTICE OF PRIVACY PRACTICE SUMMARY

Patient Name: _____ DOB: _____

This summary discloses how health information about you may be used.

Full notice of your privacy rights is available upon request

DJ Medical Services LLC DBA Health First Advanced Care uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive.

DJ Medical Services LLC DBA Health First Advanced Care will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

DJ Medical Services LLC DBA Health First Advanced Care may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

DJ Medical Services LLC DBA Health First Advanced Care may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request Restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

DJ Medical Services LLC DBA Health First Advanced Care must maintain the privacy of protected health information (PHI), provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above permitted under law.

If you have any questions or concerns, please contact Rosa Macias, Privacy and Security Officer, at

(702) 626-2330.

Patient Signature: _____ Date: _____

Health First
ADVANCED CARE

Name: _____ **Date of Birth:** _____

Social Security: _____ **E-mail:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone #: (____) _____ **Cell Phone #:** (____) _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race/Ethnicity: ☐ African American ☐ Caucasian ☐ Asian ☐ Pacific Islander ☐ American Indian

☐ Alaskan Native ☐ Hispanic ☐ Other _____

Employer: _____ **Phone #:** (____) _____

Employer Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Name of Spouse: _____ **Phone #:** (____) _____

Emergency Contact: _____ **Phone #:** (____) _____

Preferred Pharmacy Name: _____ **Phone #:** (____) _____

Cross Street(s)/Address: _____

INSURANCE COVERAGE

Primary Insurance

Insurance Co. Name:_____

Member ID #: _____

Group ID #: _____

Subscribers' Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Subscribers' Social Security #: _____

Subscribers' Date of Birth: _____

Secondary Insurance

Insurance Co. Name:_____

Member ID #: _____

Group ID #: _____

Subscribers' Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Subscribers' Social Security #: _____

Subscribers' Date of Birth: _____

Health First
ADVANCED CARE

PAST MEDICAL HISTORY

PRE-EXISTING CONDITIONS:

Have you sought care for any health condition in the past 3 years? ☐ Yes ☐ No
If yes, what condition(s)? _____
What treatment was administered? _____
_____

Do you take medication for any condition? ☐ Yes ☐ No
If yes, what medication(s)? _____
_____

Do you take vitamins? ☐ Yes ☐ No
If yes, what vitamin (s)? _____
_____

Do you take supplements? ☐ Yes ☐ No
If yes, what supplement (s)? _____
_____

Do you use eye drops? ☐ Yes ☐ No **Usage:** _____
Do you use ear drops? ☐ Yes ☐ No **Usage:** _____

Have you ever had surgery? ☐ Yes ☐ No
If yes, what type of surgery? _____
_____

HEALTH QUESTIONNAIRE

Social History:

Who do you currently live with? _____
Are you currently sexually active? ☐ Yes ☐ No **If yes, my partner is a:** ☐ Male ☐ Female

Alcohol: ☐ Yes ☐ No **If yes:** ☐ Rare ☐ Social ☐ Daily

Smoke: ☐ Yes ☐ No **If yes: How many packs per day** _____.

Illicit Drugs: ☐ Yes ☐ No **If yes:** _____.

Family History:

Hypertension: ☐ Mother ☐ Father ☐ Sibling

Diabetes: Cancer: ☐ Mother ☐ Father ☐ Sibling ☐ Mother ☐ Father ☐ Sibling

Cardiac Issues: ☐ Mother ☐ Father ☐ Sibling

Stroke: ☐ Mother ☐ Father ☐ Sibling

Mental Illness: ☐ Mother ☐ Father ☐ Sibling

Health First
ADVANCED CARE

SYSTEMATIC REVIEW

GENERAL:
Fever: ☐ Yes ☐ No
Unintentional Weight Loss: ☐ Yes ☐ No
Weakness: ☐ Yes ☐ No

HEENT:
Blurred Vision: ☐ Yes ☐ No
Double Vision: ☐ Yes ☐ No
Glaucoma: ☐ Yes ☐ No
Eye Injury: ☐ Yes ☐ No
Eye Disease: ☐ Yes ☐ No

NECK:
Stiffness: ☐ Yes ☐ No
Pain: ☐ Yes ☐ No
Thyroid Disorder: ☐ Yes ☐ No
Enlarged Glands: ☐ Yes ☐ No

CARDIOVASCULAR:
Chest Pain: ☐ Yes ☐ No
Shortness of Breath: ☐ Yes ☐ No
High Blood Pressure: ☐ Yes ☐ No
Congestive Heart Failure: ☐ Yes ☐ No
Heart Murmur: ☐ Yes ☐ No
A-Fib: ☐ Yes ☐ No
Pacemaker: ☐ Yes ☐ No

GASTROINTESTINAL:
Nausea: ☐ Yes ☐ No
Vomiting: ☐ Yes ☐ No
Diarrhea: ☐ Yes ☐ No
Constipation: ☐ Yes ☐ No
Blood in stool: ☐ Yes ☐ No
Heartburn: ☐ Yes ☐ No
Gallbladder disease: ☐ Yes ☐ No
Liver Disease: ☐ Yes ☐ No
Hepatitis: ☐ Yes ☐ No

SKIN:
Abnormal pigmentation: ☐ Yes ☐ No
Urticaria (Hives): ☐ Yes ☐ No
Eczema: ☐ Yes ☐ No
Rash: ☐ Yes ☐ No
Ecchymosis: ☐ Yes ☐ No

RESPIRATORY:
Chronic Cough: ☐ Yes ☐ No
Asthma: ☐ Yes ☐ No
Wheezing: ☐ Yes ☐ No
Pleurisy: ☐ Yes ☐ No
Pneumonia: ☐ Yes ☐ No
Shortness of breath: ☐ Yes ☐ No

NEUROLOGICAL:
Headaches: ☐ Yes ☐ No
Confusion: ☐ Yes ☐ No
Dysarthria: ☐ Yes ☐ No
Weakness: ☐ Yes ☐ No
Numbness: ☐ Yes ☐ No

PSYCHOLOGICAL:
Anxiety: ☐ Yes ☐ No
Depression: ☐ Yes ☐ No
Mood Changes: ☐ Yes ☐ No

ALLERGIES:
Allergies to Medication: ☐ Yes ☐ No
If yes which Medication _____

HEMATOLOGICAL:
Are you slow to heal after cuts? ☐ Yes ☐ No
Blood disease: ☐ Yes ☐ No
Anemia: ☐ Yes ☐ No
Phlebitis: ☐ Yes ☐ No
Have you had any abnormal bruising of bleeding? ☐ Yes ☐ No

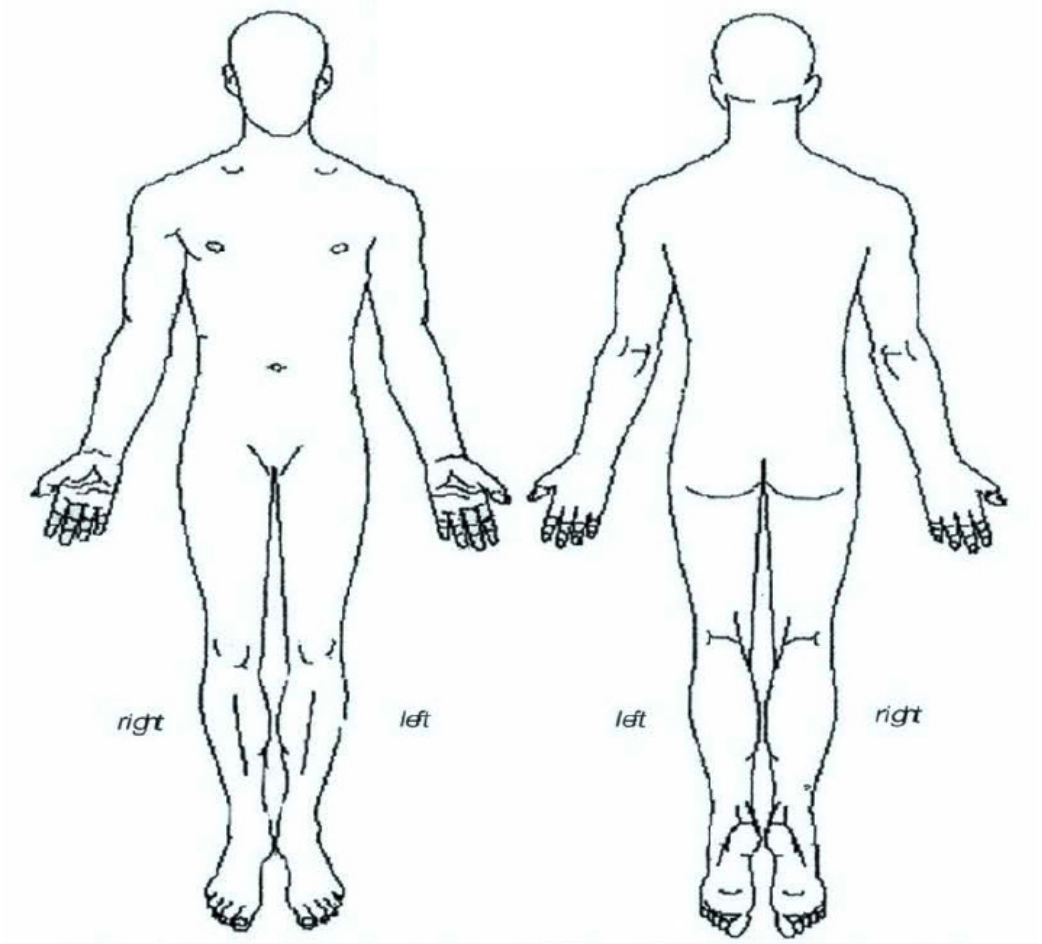
Health First
ADVANCED CARE

PAIN DRAWING

Name: _____ **Date:** _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Using the appropriate symbols, mark areas of pain, including all affected areas, as you feel right now. You may draw in the face as well.

NUMBNESS	PINS & NEEDLES	BURNING PAIN	STABBING PAIN	ACHING PAIN
----------	OOOOOOOOO	XXXXXXXXXX	//////////////	((((((((((((((((



VISUAL ANALOGUE SCALE

Make one mark through the line below to represent your current level of pain, with 0 representing no pain at all and 10 representing the worst possible pain.

_____

0 1 2 3 4 5 6 7 8 9 10

Health First
ADVANCED CARE

REQUEST FOR MEDICAL RECORDS

6655 W Sahara Ave. Suite B200
Las Vegas, NV 89146
Phone: (702) 626-2330
Fax: (702) 760-5349
ATTN: MEDICAL RECORDS

Date: _____

Name: _____ **Date of Birth:** _____

Date(s) Requested: _____ / _____ /_____ **TO PRESENT**

I hereby authorize release of my health information as set forth below. The following individual and/or organization is authorized to make the disclosure:

TO:

_____

Doctor, Hospital, Attorney, Insurance, Self, etc. Phone Number

_____

Address (Street, City, State and Zip) Fax Number

The type and amount of information to be used and disclosed is as follows:

[✓] All medical Records [✓] Discharge Summaries [✓] History & Physicals [✓] Operative Reports

[✓] Discharge Summaries [✓] Radiology Reports/ Images [✓] Consultation Reports

[✓] Lab / Pathology Records [✓] Emergency Room Records

Printed Name: _____

Patient Signature: _____ **Date:** _____

Health First
ADVANCED CARE

HIPPA ACKNOWLEDGEMENT AND CONSENT FOR TREATMENT

Patient Name: _____ **DOB:** _____

I, the undersigned, hereby consent to the following: administration and performance of general treatment, use of prescribed medication, performance of diagnostic procedures/tests and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of my physician/provider or their assigned designees. I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend that this consent continues in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. A photocopy of this consent shall be considered as valid as the original. I understand that I am responsible for all copayments, coinsurance, deductible and other fees not covered by my insurance company and that the clinic files my insurance claims as a courtesy.

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operation and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint to the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of Information. I hereby permit the practice, and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Patient Name: _____ **DOB:** _____

Patient/Legal Guardian Signature: _____ **Date:** _____

Health First
ADVANCED CARE

CONTRACT FOR CONTROLLED SUBSTANCES

The purpose of this agreement is to maintain a safe, controlled treatment plan. I am asking for narcotic pain medication because other treatment and medication I have received have not given enough pain relief. It is unlikely that any medication will completely take away my pain, but for humane reasons, narcotic pain medication will be given to me if pain continues, if I follow the terms and conditions of this agreement. I understand that the possible complications of chronic narcotic therapy include:

- Chemical dependency (addiction)
- Constipation, which could be serve enough to require medical treatment
- Difficulty with urination
- Drowsiness
- Nausea
- Itching
- Slowed respiration
- Reduced sexual function

If I take more medication than what I was prescribed, a dangerous situation could result such as coma, organ damage or even death. I understand that if I run out of medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms, which can be extremely uncomfortable or dangerous. If I become pregnant there are known or unknown risks to unborn child which include narcotic addition and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctor know if I am pregnant and they will help me find ways of controlling my pain without narcotics.

The terms of this contract include the following:

1. Only one pharmacy will be used for filling narcotic prescription.
2. If it is found that I received a prescription for narcotic medications from a source other than Beautiful Minds Psychiatric Services, I will be discharged from Beautiful Minds Psychiatric Services and any prescription for narcotic medication will be discontinued.
3. It is necessary to call Beautiful Minds Psychiatric Services Monday through Friday (9:00 am- 5:00pm) to refill medications. It is important to make sure that I have enough medication to get through the weekend or after hours.
4. The physician/provider on-call or after hours on weekends will NOT REFILL my medication. They do not have charts available for reviews to make decisions regarding medication.
5. I agree and will sign a release to allow Beautiful Minds Psychiatric Services providers to communicate with my referring physician, primary care physician and pharmacists regarding my use of medication.
6. I will contact and communicate with Beautiful Minds Psychiatric Services about narcotic and pain-related side effects. I would NOT contact a physician/provider who does not work for Beautiful Minds Psychiatric Services regarding the above concerns. If I have significant side effects that occur after hours or during the weekend, it is appropriate to go to the emergency room at the nearest hospital.

Health First
ADVANCED CARE

Patient Name: _____ **DOB:** _____

CONTRACT FOR CONTROLLED SUBSTANCES (continued)

7. I agree to take the narcotic medication, exactly as instructed by DJ Medical Services LLC DBA Health First Advanced Care Providers. I am NOT allowed to change the dosage amount or alter the time schedule of taking the medication without talking to DJ Medical Services LLC DBA Health First Advanced Care Provider.
8. I agree that DJ Medical Services LLC DBA Health First Advanced Care will not replace any lost, stolen, or inaccessible narcotic medication or narcotic prescription for any reason.
9. I must keep all regular follow-up appointments as recommended by DJ Medical Services LLC DBA Health First Advanced Care Providers. Failure to comply may cause discontinuation of narcotic prescription and discharge from DJ Medical Services LLC DBA Health First Advanced Care Services.
10. DJ Medical Services LLC DBA Health First Advanced Care Services will not accept telephone requests for narcotic prescriptions or refills from anyone other than me.
11. All narcotic prescriptions will be picked up by me. If I am too disabled or sick, an exception may be allowed at the discretion of DJ Medical Services LLC DBA Health First Advanced Care provider.
12. I understand that the benefits of narcotic medication will be evaluated extensively using the criteria of pain relief:
    1. Increase in general function
    2. Increase in life activities
    3. Improvement in pain intensity levels
    4. Absence of unacceptable side effects
    5. If appropriate, return to work and maintenance of job.
13. I agree to periodic urine and lab screenings for the medication and drugs if DJ Medical Services LLC DBA Health First Advanced Care Services deems appropriate.
14. I have given information about the use of narcotic medication and risk of side effects including development of tolerance, dependence, addiction, and withdrawal problems due to medications, and I agree to undergo narcotic administration.
15. I agree to NOT hoard medication or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescription and discharge from DJ Medical Services LLC DBA Health First Advanced Care

    I agree to the following:
    1. That I am NOT currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance abuse.
    2. That I have never been involved in the sale, illegal possession, or transport of any drugs.
    3. Women only: That I am not pregnant and will inform physician/provider if I become pregnant.
    4. This form has been fully explained to me, I have read it, or I had it read to me, and I understand and agree to the terms of this contract. If any part of this contract, as outlined above, is broken, I understand that it will result in immediate discharge from DJ Medical Services LLC DBA Health First Advanced Care and discontinuation of narcotic prescriptions.

Patient/Legal Guardian Signature: _____ **Date:** _____

Health First
ADVANCED CARE

CONSENT FOR TELEHEALTH CONSULTATION

HOW IT WORKS Your clinician uses a digital Note Taker and/or Commure to create an accurate and timely record of your care. Instead of writing notes by hand, the session will be recorded which allows clinicians to give you their undivided attention during your time together. This means better care and more meaningful conversations between you and your clinician.

AUDIO RECORDING

Some states have two-party consent for audio recordings, so it's important for you to know that your voice and conversation with your clinician are recorded to document the appointment.

DATA STORAGE

As soon as the audio is transcribed (usually a few seconds after the appointment ends), the audio recording is permanently deleted.

PRIVACY AND SECURITY

The recording process complies with the Health Insurance Portability and Accountability Act (HIPAA)

VOLUNTARY PARTICIPATION

If you still have any questions or concerns, your clinician would be happy to discuss this with you. You have the right to withdraw your consent at any time (even temporarily).

Consent for Use of Artificial Intelligence (Al) Tools in Your Therapy Services

Introduction At Daryl J Yann/ DJ Medical Services LLC DBA Health First Advanced Care, we are committed to providing you with the best possible treatment. To help us manage our practice efficiently and enhance our services, we use technology, including certain artificial intelligence (Al) tools. This document explains how we use these tools and asks for your consent to use them as part of your treatment. Your privacy, confidentiality, and the quality of your treatment remain our highest priorities.

How We Use Al Tools Al tools are used strictly for administrative and supplementary support tasks under the direct supervision of your therapist. These tools do not provide therapy, make independent clinical decisions, or interact with you directly. The specific purposes for which we may use Al now and in the future include: • Assisting your therapist in drafting and organizing session notes; • Managing appointment scheduling and/or sending reminders; • Processing billing and insurance claims; • Analyzing data to identify therapy trends and track progress, which is always reviewed by your therapist; • Analyzing business information and generating reports or trends to help me manage my business; or • Helping to identify and organize external resources or referrals for your use.

How We DO NOT Use Al Tools To be clear, we do not use Al to: • Make independent therapeutic decisions or diagnoses; • Communicate with you directly to provide therapeutic advice; • Generate treatment recommendations without the direct review, approval, and input of your licensed therapist; or • Detect or interpret your emotions or mental state.

Consent for Session Transcription (If Applicable) To help create accurate and detailed session notes, your therapist uses an Al tool called CommureScribe that transcribes our sessions and then prepares a draft progress note. CommureScribe is a feature that works with the Electronic Health Record and practice management platform that I use with SimplePractice.

I consent to the use of an Al transcription tool to record and transcribe my therapy sessions for the purpose of assisting my therapist with note-taking.

Patient/Legal Guardian Signature: _____ **Date:** _____



Your Rights and Confidentiality Confidentiality: All information, including any data processed by an Al tool, is treated as part of your confidential health record and is protected by the same privacy and security standards as all other aspects of your care, including HIPAA.

• SimplePractice and its Note Taker tool are HIPAA-compliant and HITRUST certified.

• All audio-recordings of therapy sessions through Not Taker are immediately deleted as soon as a transcript is created, generally within minutes of a session ending.

• Transcripts that are created through CommureScribe are only retained for the shorter of 7 days or when the progress note is signed and locked by your therapist. After that, they are permanently deleted.

• During the time that transcripts are available in CommureScribe, they always remain confidential and secure, and are only available for your therapist's use to verify the accuracy of the progress note. They are not used for any other purpose.

Right to Revoke Consent: Your consent is voluntary. You have the right to withdraw this consent at any time by notifying your therapist in writing. Revoking your consent will not affect your ability to receive therapy services.

Client Acknowledgment and Consent By signing below, I confirm that:

1. I have read and understood this form.
2. I have had the opportunity to ask questions about the use of Al tools in my treatment.
3. I voluntarily agree to the use of Al tools for the purposes described above.

Patient/Legal Guardian Signature: _____ **Date:** _____