Medical Partners of Nevada

4020 E RUSSELL RD
LAS VEGAS NEVADA 89120
(702)780-1313

Consent for Treatment

I, _____, am voluntarily seeking healthcare
(Patient's name)
and hereby consent to medical treatment, procedures, laboratory tests, and other health care services. I understand that I have the right to refuse specific treatments or procedures. I agree in general to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education, and other diagnostic procedures), and emergency procedures as necessary, performed at the request of the attending provider or other providers assisting in my care.

The consent given shall be valid and binding. The provider(s) can rely on this authorization and accept any consent given by the patient until the provider receives written notice that the authorization is revoked.

I understand that I am fully responsible for all fees due to Medical Partners of Nevada or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless the Clinic agrees to accept assignment of my Medicare, Medicaid, or other insurance benefits.

Regrettably, our profession is experiencing a notable increase in people who are exhibiting abusive behaviors toward members of our team. This includes but is not limited to excessive shouting, the use of profanity, threats, belittling, bullying, demanding actions, physical assault, or attempts at intimidation. Such behavior is entirely unacceptable and will NOT be tolerated. You will be asked to leave, and we will not be able to provide care for the patient. Requests to speak with the provider or manager under these circumstances will result in the same outcome. We are committed to safeguarding the mental and physical well-being of our team members.

Requests for medication refills will take up to 72 hours.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient or Legal Representative Relationship

_____
Date

Practice: **Medical Partners of Nevada** **Today's Date:** _____

Name:_____ **DOB:**_____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail:_____

Address:_____

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

Home#: _____ **Cell#:** _____ **Work#:**_____

Pharmacy: _____ **Phone:** _____

Employer: _____ **Phone:** _____

Address: _____

Race: _____ □ **prefer not to answer** □ **do not know**

(White, American Indian, Asian, Black or *African, Native Hawaiian, Hispanic, etc.)*

Preferred Language: _____ □ **prefer not to answer**

Primary Insurance: _____ Are you the insured? ☐Ye s ☐No

Insured Information

Subscriber Name:_____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐other

Phone#:_____ Sex: ☐ Male ☐ Female DOB: __/__/__

Address: _____

Policy ID: _____ Group ID: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name:_____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐other

Phone#:_____ Sex: ☐ Male ☐ Female DOB: __/__/__

Address: _____

Policy ID: _____ Group ID: _____

How did you find out about our practice? ☐ Provider ☐Internet ☐Telephone book ☐Family member ☐ Friend ☐Other: _____

What is the reason for your visit today?_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling ☐ other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the provider and/or medical staff of any and all updates to the information listed above.

_____(Patient Signature)

History and Physical Name: _____ DOB: _____

Medical History: ☐ Alcoholism ☐ Blood disorders ☐ Circulation problems
☐ Liver disease ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Musculoskeletal ☐ Breathing issues
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Heart disease ☐ Asthma
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Mental illness ☐ Kidney disease
☐ Neuropathy (*specify*)_____ ☐Thyroid disease (*specify*)_____ ☐ Diabetes (type I, type 2)
☐ Arthritis (*specify*)_____ ☐ Other (*specify*) _____ ☐ Skin disorders (*specify)*

_____

Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Surgical History

Have you ever had any surgical procedures? ☐ Yes ☐ No
If yes, please describe: _____

Social History

Do you smoke? ☐Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse ☐Yes, I have a current substance abuse problem. Please specify:_____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation?_____Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ Yes, I do the following regular exercise: _____
☐ No, I do not exercise regularly

Family History

Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's _____ ☐ Depression _____
☐ Arthritis _____ ☐ Diabetes _____
☐ Bleeding disorders _____ ☐ Emphysema _____
☐ Blood clot _____ ☐ Heart disease _____
☐ Cancer _____ ☐ High Blood Pressure_____
☐ Cataracts _____ ☐ Neurological _____
☐ Circulation problems _____ ☐ Strokes _____
☐ Other (specify): _____

Review of Systems *(Please check the box if you currently have any of these symptoms)*

Cardiovascular	☐leg pain when walking	☐fever	☐chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐palpitations	☐vascular disease	☐valve problems	
Genitourinary	☐blood in urine	☐hesitancy	☐incontinence	☐increased urgency	
	☐decreased frequency	☐excessive urination	☐kidney disease	☐kidney stones	
Gastrointestinal	☐abdominal pain	☐heart burn	☐blood in stool	☐vomiting	☐ulcers
	☐diarrhea	☐trouble swallowing	☐constipation	☐increase appetite	☐decrease appetite
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the provider and/or medical staff of any and all updates to the information listed above.

_____(Patient Signature)

Practice: Medical Partners of Nevada

Name: _____ **Date of birth:** _____

Privacy Information Preferences

Can we leave voicemail on answering machine? ☐Yes ☐No

Will you allow internet-based delivery reminders like email? ☐Yes ☐No

Who can we leave messages with? ☐ Wife ☐Husband ☐Daughter ☐Son

☐ Other: _____

Current Medications ☐ None

☐ I take these prescriptions or over the counter medications:

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Use the back of this form if more room is needed

Allergy	Reaction
☐ No Known Allergies	
☐ Penicillin	_____
☐ Shellfish	_____
☐ Sulfa	_____
☐ Tape	_____
☐ Latex	_____
☐ Betadine *(iodine)*	_____
☐ Aspirin	_____
☐ Tylenol™	_____
☐ Ibuprofen	_____
☐ Codeine	_____
☐ Other *(specify)*	_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the provider and/or medical staff of any and all updates to the information listed above.

_____(Patient Signature)

Medical Release Form

Authorization for the Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle): _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Contact Phone Number(s): _____

I hereby authorize the following entity to release all medical records (including alcohol/drug treatment, mental health information, and/or HIV related information) to:

MEDICAL PARTNERS OF NEVADA
4020 E Russell Rd, LV NV 89120
ATT: ADMINISTRATION
TEL:(702)780-1313 FAX (702)476-9073

Entity Possessing the PHI: _____

Address: _____

Phone Number(s): _____ Fax: _____

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment of eligibility of benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Medical Partners of Nevada.

Signature of Patient or Patient's Representative (if applicable): _____ Date: _____

Relationship to Patient and Description of Authority to Act: _____

Autorización para divulgar Información Protegida de Salud (PHI siglas en inglés)

Por la presente autorizo la siguiente entidad a divulgar todos los registros médicos (incluido el tratamiento de alcohol/drogas, información de salud mental y/o información relacionada con el VIH)

Nombre del paciente: _____ Fecha de nacimiento: _____
(apellido, primer nombre, segundo nombre)

Dirección _____

Teléfono de contacto(s): _____

Entidad que posee la PHI: _____

Dirección: _____

Teléfono: _____ Fax: _____

Entiendo que:

- Puedo negarme a firmar esta autorización y es estrictamente voluntaria.
- La firma de esta autorización no puede condicionar mi tratamiento, el pago, la inscripción o el derecho a los beneficios.
- Puedo revocar esta autorización en cualquier momento por escrito al proveedor autorizado a divulgar la PHI, pero si lo hago, no tendré ningún efecto sobre las acciones realizadas antes de recibir la revocación.
- Si el solicitante o el receptor no es un plan de salud o un proveedor de atención médico, es posible que la información divulgada deje de estar protegida por las normas federales de privacidad y pueda ser divulgada.
- Tengo derecho a recibir una COPIA de este formulario después de firmarlo.
- Recibiré sólo una fotocopia de mi expediente médico y que el original permanecerá en Medical Partners of Nevada.

Firma del paciente o su representante: _____ Fecha: _____

Relación con el paciente y descripción de la autoridad para actuar: _____

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form, you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I,_____Date of Birth_____(print name and date of birth) hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involvingthe use and/or disclosure of health information that pertains to me.

PRINT Name of Personal Representative{s)/Phone number	**PRINT Relationship of each to Patient**

The Authority of this person when serving as my "personal representative" is restricted to the following functions:Description:

☐ This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

☐ This person is restricted to the following information about my health care:

_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this formand returning it to:

MEDICAL PARTNERS OF NEVADA
4020 E RUSSELL RD
LAS VEGAS NEVADA 89120
ATT: ADMINISTRATION

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____

Signature Date

REVOCATION SECTION:

I hereby revoke the designation of_____as my personal representative.

_____ _____

Signature Date

Medical
Partners of
Nevada
4020 E RUSSELL RD
LAS VEGAS NEVADA 89120
(702)780-1313

NO SHOW POLICY AND AGREEMENT

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than a 24-hour notice. Patients who do not show up nor provide more than a 24-hour notice are considered a NO SHOW. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice. A FEE OF $50.00 WILL BE BILLED FOR ALL NO SHOW APPOINTMENTS.

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE TO THE NO SHOW POLICY FEE.

_____
Date

_____ _____
Patient Name Signature