The Sleep Center of Nevada

PATIENT INFORMATION					
Last Name:			Social Security #:		PT#
First Name:		Mid. Initial:	Date of Birth:		
Home Address:			Age:	Sex:	
Apt/Suite #:			Home Phone#:		
City, State, Zip:			Work Phone#:		
Email:			Cell Phone#:		

** You do not have to supply your email address; however, we are collecting information, as The Sleep Center of Nevada is working on ways to use the Internet to better communicate with our patients. We do not sell or provide our patients' phone numbers, addresses or email addresses to any other organization. All information is held in the strictest confidence.

Race:		Gender Identity:	Sexual Orientation:
Ethnicity:		Primary Language:	

HOW DO YOU PREFER YOUR APPOINTMENT REMINDER

Preferred Phone: (check box) ☐ Home ☐ Work ☐ Cell / Communicate by: (check box) ☐ Phone ☐ E-mail ☐ Text

EMPLOYER INFORMATION

Employer Name:	
Employer Address:	Emp. City/St/Zip:
Employer Suite #:	Employer Phone#:

EMGERGENCY CONTACT INFORMATION: In case of emergency who should be notified?

(PRINT) Name:	Tel#	Relationship:

PRIMARY INSURANCE

Plan/Policy Name:	Group #:
Plan Tel#:	Subscriber DOB:
Subscriber Name:	Subscriber ID/Policy #:

Relationship to Patient: (check box) ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other

SECONDARY INSURANCE

Plan/Policy Name:	Group #:
Plan Tel#:	Subscriber DOB:
Subscriber Name:	Subscriber ID/Policy #:

Relationship to Patient: (check box) ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical/surgical benefits to The Sleep Center of Nevada for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Medicare - Medicaid

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original

Patient Name (please print): _____

Patient or authorized person's signature: _____ Date: _____

General Consent for Care and Treatment Consent

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.

_____	_____
Signature of Patient or Personal Representative	**Date**
_____	_____
Printed Name of Patient or Personal Representative	**Relationship to Patient**
_____	_____
Printed Name of Witness	Employee Job Title
_____	_____
Signature of Witness	**Date**

The Sleep Center of Nevada

Patient HIPAA Acknowledgement and Consent Form

Patient Name: Chester Lester Tester61097

Date of Birth: 01/01/1981

_____ (Patient/Representative initials) **Notice of Privacy Practices**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations 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. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. 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.

_____ (Patient/Representative initials) **Release of Information**

I hereby permit 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.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If yes, whom?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ (Patient/Representative Initials) **I consent** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

_____ (Patient/Representative Initials) **I do not consent** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

We want to stay connected with our patients.
Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

- **The cell phone number that I authorize** to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.
- **The email that I authorize** to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

OR

_____ (Patient/ Representative Initials) I decline to receive communication via text.

_____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent

Opt Out/Revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text.**

_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email.**

Patient Name: _____

Patient/Patient Representative Signature: _____
Date: _____ Time: _____

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at The Sleep Center of Nevada as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information*.**

Consent

By signing this consent form you are agreeing that your provider at The Sleep Center of Nevada may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to The Sleep Center of Nevada to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name _____ Patient D.O.B. _____

Signature of Patient or Guardian _____ Today's Date _____

Relationship to Patient _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient/Representative Initials) ***I wish*** to designate the following individual to pick up a prescription order on my behalf:

- Name: _____ Date: _____
- Name: _____ Date: _____

_____ (Patient/ Representative Initials) ***I do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____