PLEASE PRINT

Date:________/________/________ Home Phone: (______)_______-________

PATIENT INFORMATION

Name:____Social Security:_________________________

Address: ____Cell Phone: (______)_______-_________

City:________________________________ State:___________________Zip Code:_____________________

Sex: M [ ] F [ ] Age:________ Birth Date: ________/________/_________ Race: ______________________

Ethnicity:_________________________ Preferred Language:_____________________ Blind: [ ] Deaf: [ ]

[ ] Married [ ] Widowed [ ] Single [ ] Divorced

[ ] Minor [ ] Separated [ ] Partnered for years

Patient Employer/School: __________________________________ Occupation:_______________________

Employer/School Phone: (______)_______-_________ E-mail: _____________________________________

Whom may we thank for referring you?:____

Emergency Contact:____Phone:(______)_______-_________

PRIMARY INSURANCE

Person Responsible for Account:_____________________________Relation to Patient:___________________

Birth Date:________/________/_________ Social Security #:____

Address:____Phone: (______)_______-_________

Person Responsible Employed by:___________________________ Occupation:_________________________

Business Address:_____________________________________Business Phone: (______)_______-_________

Insurance Company:____Phone: (______)_______-_________

Member ID:_______________________Group:___________________Subscriber:________________________

Names of other dependents covered under this plan:____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? Yes [ ] No [ ]

Person Responsible for Account:_____________________________Relation to Patient:___________________

Birth Date:________/________/__________Social Security #:____

Address:____Phone: (______)_______-_________

Person Responsible Employed by:___________________________ Occupation:_________________________

Insurance Company:____Phone: (______)_______-_________

Member ID:_______________________Group:___________________Subscriber:________________________

Names of other dependents covered under this plan:____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _________________________________

Name of Insurance Company(ies)

and assign directly to Dr.__________________________________. All insurance benefits, if any, otherwise will be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative | Date

____ ____________________

Please print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

Confidential Health History

Patient Name:____Today's Date:________/________/________

Age:__________Birth Date:________/________/________Date of last physical:________/________/________

What is your reason for this visit:____

SYMPTOMS

Check conditions you currently have or have had in the past year

General

- [ ] Chills
- [ ] Depression
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Forgetfulness
- [ ] Headache
- [ ] Loss of sleep
- [ ] Loss of weight
- [ ] Nervousness
- [ ] Numbness
- [ ] Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- [ ] Arms
- [ ] Hips
- [ ] Back
- [ ] Legs
- [ ] Feet
- [ ] Neck
- [ ] Hands
- [ ] Shoulders

Genito-Urinary

- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Lack of bladder control
- [ ] Painful urination

Gastrointestinal

- [ ] Poor appetite
- [ ] Bloating
- [ ] Bowel changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive hunger
- [ ] Excessive thirst
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Nausea
- [ ] Rectal bleeding
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Vomiting blood

Cardiovascular

- [ ] Chest pain
- [ ] High blood pressure
- [ ] Irregular heart beat
- [ ] Low blood pressure
- [ ] Poor circulation
- [ ] Rapid heart beat
- [ ] Swelling of ankles
- [ ] Varicose veins

ENT

- [ ] Bleeding gums
- [ ] Blurred vision
- [ ] Crossed eyes
- [ ] Difficulty swallowing
- [ ] Doubled vision
- [ ] Ear ache
- [ ] Ear discharge
- [ ] Hay fever
- [ ] Hoarseness
- [ ] Hearing loss
- [ ] Nose bleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Vision - flashes
- [ ] Vision - halos

Skin

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scars
- [ ] Sores that won't heal

Men Only

- [ ] Breast lump
- [ ] Erectile dysfunction
- [ ] Lump in testes
- [ ] Penis discharge
- [ ] Sore on penis
- [ ] Other

Women only

- [ ] Abnormal pap smear
- [ ] Bleeding between periods
- [ ] Breast lump
- [ ] Menstrual pain
- [ ] Hot flashes
- [ ] Nipples discharge
- [ ] Painful intercourse
- [ ] Vaginal discharge
- [ ] Other

Date of last period:

________/________/________

Date of last pap smear:

________/________/________

Date of last mammogram

/ /

Are you pregnant? Y N

Number of children:

CONDITIONS

Check the conditions you currently have or have had in the past year

- [ ] AIDS
- [ ] Alcoholism
- [ ] Anemia
- [ ] Anorexia
- [ ] Appendicitis
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding disorders
- [ ] Breast lump
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Cataracts
- [ ] Chemical Dependency
- [ ] Chick pox
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Goiter
- [ ] Gonorrhea
- [ ] Gout
- [ ] Heart disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herpes
- [ ] High cholesterol
- [ ] HIV positive
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Measles
- [ ] Migraine headaches
- [ ] Miscarriage
- [ ] Mononucleosis
- [ ] Multiple sclerosis
- [ ] Mumps
- [ ] Pacemaker
- [ ] Pneumonia
- [ ] Polio
- [ ] Prostate problems
- [ ] Psychiatric Care
- [ ] Rheumatic
- [ ] Scarlet fever
- [ ] Stroke
- [ ] Suicide attempt
- [ ] Thyroid problems
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Typhoid fever
- [ ] Ulcers
- [ ] Vaginal infections
- [ ] Venereal disease

Medications: list medications you are currently taking:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? [ ] Yes [ ] No
If yes, please give approximate dates:________________________

Serious Illnesses/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex	Complications if any

Health Habits

Check which you use and how often

- [ ] Caffeine ____________________
- [ ] Tobacco ____________________
- [ ] Street Drugs__________________
- [ ] Other ____________________

Occupational

Check if your work exposes you to:

- [ ] Stress
- [ ] Hazardous Substances
- [ ] Heavy Lifting
- [ ] Other:______________

Occupation_______________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ ____________________
Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ____________________
Please print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

Forte Family Practice Health Questionnaire-9 (PHQ-9)

Today's Date:________/________/________

Patient Name:____Date of Birth:________/________/________

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answer:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or or hurting yourself in some way	0	1	2	3

For Office Coding: _______+_______+_______+_______

= Total Score: _______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

Forte Family Practice HIPAA Release Form

Patient Name:____Date of Birth________/________/_________

Social Security #:____________________________________Phone: (_________)_________-____________

I authorize the following name(s) of person(s) to have access to my protected health information (PHI). For example, spouse, child, other family members, another physician office, etc.

Authorized parties:

____ Relation: _________________________________

____ Relation: _________________________________

____ Relation: _________________________________

____ Relation: _________________________________

I do not wish to allow any other party to access my records____________________
Initial

I GIVE MY PERMISSION TO RELEASE ANY INFORMATION REGARDING:
(Initial applicable lines below)

__________ Substance Abuse __________Psychiatric/Mental Health __________HIV Info

Forte Family Practice Notice of Privacy Policy is detailed on how my information may be used and disclosed under state and federal law. I may obtain a hard copy of the privacy policy at any time. A copy of this authorization may be used in the place of the original. I understand that I may request restrictions to the Notice of Privacy Policy at any time. I am also aware the Forte Family Practice done not have to agree with restrictions I have requested.

____ _______________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ _______________________
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Forte Family Practice Patient Financial Responsibility Disclosure Statement

All charges for services rendered are due and payable at the time of service.

Medical Insurance: We are contracted with most insurance companies, billing the insurance is a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. The person signing on behalf of the patient or the patient's responsible party must:

- Inform Forte Family Practice of the current address and phone number for the patient's responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay, co-insurance, and/or deductible at the time of visit.
- Pay an additional amount owed within 30(thirty) days of receiving a statement from our office. (When Forte Family Practice receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or patient's responsible party will be responsible for the original check amount in addition to a $35.00 service charge. Once the notice of the returned check is received, Forte Family Practice will send out a letter to notify the responsible party of the returned check. If a response is not received within 15 days from the letter date by the patient or the responsible party, the account may be turned over to our collection agency and collection fee of 50% will be added to the outstanding balance in addition to the $35.00 check service charge.

Non-Payment on Account: Should collection proceedings or other legal actions become necessary to collect on an overdue account, the patient or the patient's responsible party, understands that Forte Family Practice has the right to disclose information to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient or patient's responsible party understands that they are responsible for all costs of collection including, but not limited to, interest due at 8.75% APR, all legal costs, and a collection fee of 10% will be added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients.

No Show and Same Day Cancellation Policy: There is a $25.00 no show and same day cancellation fee. Please be aware that insurance will not cover this charge. As a courtesy, it will be your responsibility to cancel or reschedule your appointment with a *24 hour advanced notice.*

Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Signature of Patient, Parent, Guardian or Personal Representative ______________________ Date ______________________

Please print name of Patient, Parent, Guardian, or Personal Representative ______________________ Relationship to Patient ______________________

Forte Family Practice Medical Record Request Form

Patient Information:

Patient Name:____Date of Birth:________/________/________

Address:____Social Security #:_______________________

City:_____________________State:________Zip Code:____________Phone: (______)______-_________

Obtain Records From:

Provider/Clinic Name:____

Address:____City:_____________________State:________

Phone: (__________)___________-_____________ Fax: (__________)___________-_____________

Send Records To (circle one):

9010 West Cheyenne Ave **Las Vegas, Nevada 89129** **Phone (702) 240-8646** **Fax (702) 240-0206**	**4845 South Rainbow Blvd** **Las Vegas, Nevada 89103** **Phone (702) 362-9800** **Fax (702) 871-9805**

Information To Be Sent:

________ All Records ________ Other:__________________________________

Reason for Release:

Expiration: This authorization will expire on ________/________/________

Revocation: I understand that I may revoke this consent at any time. I do not authorize further release to any third party. I understand that once information is released under this authorization, the clinic, the employees, and my physician cannot prevent the disclosure of that information.

Authorization: I authorization for the above provider to release the information marked above to the recipient.

____ ______________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________________

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Forte Family Practice Information Request and Agreement

We will be transferring to electronic medical records in the near future. At your request we will be forwarding your prescriptions to you pharmacy via E-Scripts. Please provide your pharmacy information below:

Patient Name:____Date of Birth:________/________/________

Pharmacy Name:____

Pharmacy Address/Cross Streets:____

Pharmacy Phone: (________)_________-___________ Pharmacy Fax: (_________)________-___________

After transferring to electronic medical records (EMR) we will also have the option of sending appointment reminders via phone calls, text, or e-mail. Please check below which method you prefer and provide your current contact information.

I prefer receiving my reminder calls via:

________ Text Message: (________)_________-___________

________ Phone Call: (________)_________-___________

________ E-mail: ____________________________________

Patient Consent Form for Electronic Exchange of Individual Health Information

HealtHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healtHIEnevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:

   - Provide you with medical treatment and related services.
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.

2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealtHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental Health conditions
   - Sexually transmitted diseases

3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.

4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.

5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

   Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

For Internal Use Only: MRN________________

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME____
Last *First* *Middle*

PREVIOUS NAME(S)______________________________ **GENDER:** M______F______

STREET ADDRESS / P.O. BOX______________________________________

CITY______________________**STATE**__________**ZIP CODE**__________

PHONE NUMBER____________________ **EMAIL**____________________________

DATE OF BIRTH__________(MM)__________(DD)____________(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgment.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

______________________________________ ______________________
Signature of patient or authorized representative **Date** **Time**

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

__________________________ ______________ ______________________
Name of Authorized Representive (Printed) Relationship Date Time

____
Address of authorized representative signing this form (please print):

____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:________Forte Family Practice__________ Name of Witness:______________________
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily replied upon in health care.