Carson Medical Group

Patient Registration Form

Patient Information

Please note that the patient's name as provided here must match the name on the insurance card in order for claims to be successfully submitted to insurance.

Last Name: _____ First Name: _____ MI: _____

Previous Name: _____

DOB: _____ Gender: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated

Is the patient a veteran? ☐ Yes ☐ No

Is the patient in foster care? ☐ Yes ☐ No

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different from mailing address): _____

City: _____ State: _____ Zip: _____

		May we leave a detailed message regarding your medical care / treatment at this number?
Home Phone:	( ) -	☐ Yes ☐ No
Cell Phone:	( ) -	☐ Yes ☐ No
Work Phone:	( ) -	☐ Yes ☐ No

I prefer to receive appointment and other reminders as:

☐ Text Phone call, in the: ☐ Morning ☐ Afternoon ☐ Evening

Please provide your email address below to enroll in Carson Medical Group's Patient Portal

E-Mail Address: _____

(to be used for confidential communication)

Patient's Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not employed ☐ Retired

Race (required)	Ethnicity (required)	Primary Language (required)
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other race ☐ Refused to Report	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report	☐ English ☐ Spanish ☐ Other _____

Emergency Contact

Name: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) - _____

Pharmacy Information

Pharmacy of Choice: _____

Address/Location (e.g. N. Carson & Winnie): _____

Miscellaneous Information

Do you have an Advance Directive? (check all that apply)

- ☐ Declined
- ☐ Healthcare proxy (POA)
- ☐ No blood transfusions
- ☐ No advance directive
- ☐ Physician order for life-sustaining treatment
- ☐ Organ donor
- ☐ Do Not Resuscitate
- ☐ Living Will

Is the patient visually impaired? ☐ Yes ☐ No

Is the patient hearing impaired? ☐ Yes ☐ No

Insurance Information

Please be prepared to show your insurance card and identification at every office visit.

Primary Insurance Company: _____

Policy Holder's Name _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____

Policy/ID Number: _____ Group #: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Company: _____

Policy Holder's Name _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____

Policy/ID Number: _____ Group #: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Notice to Patients Regarding the Destruction of Health Care Records

Pursuant to the provisions of subsection 7 of NRS 629.051:

1. The health care records of a person who is less than 23 years of age may not be destroyed; and
2. The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retai for at least 5 years or for any longer period provided by federal law; and
3. Except as otherwise provided in section 7 of NRS 629.051 and unless a longer period of time is provided by federal law, the health ca records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

Consent to Access External Prescription History

_____ By initialling here, I am granting my consent for Carson Medical Group to access my prescription history. I understand that prescription history from multiple, other, unaffiliated medical providers; insurance companies; and pharmacy benefit managers may be availa to providers and staff here and that it may include prescription history dating back several years.

Acknowledgement

All of the above information is true to the best of my knowledge. I authorize Carson Medical Group to release my information to insurance carriers concerning my medical condition/treatment, etc. in order to facilitate claims payment. In addition, I assign benefits to be paid to Cars Medical Group for all services rendered. I understand that I am financially responsible for charges for medical services rendered to the above named patient regardless of insurance coverage/payment. I understand that all co-payments and or deductible amounts are due and payable the time of service.

_____

Patient Name (Please print)

_____ _____

Patient Signature Date

Carson Medical Group

Welcome To
Carson Medical Group

In an effort to serve you better, it is important that you understand that it is your responsibility:

- To know your insurance.
- To know if Carson Medical Group is a contracted provider for your insurance.
- To know if you need prior authorization for procedures.
- To know if procedures (X-rays and labs etc.) have to be done in a specific facility.
- To know if you have a co-payment.
- To know if you have a yearly deductible.
- To know if your deductible has been met?

There are hundreds of insurance companies and it is not possible for our staff to know the specific requirements of each policy.

Please help us to help you.

Signature _____ Date _____

Family Practice
1200 Mountain St
Carson City, NV 89703
Phone 775.882.1324
Fax 775.882.3859

Ear, Nose & Throat
1200 Mountain St
Carson City, NV 89703
Phone 775.884.3687
Fax 775.884.3458

OB/GYN- Carson
1475 Medical Pkwy
Carson City, NV 89703
Phone 775.883.3636
Fax 775.882.2382

Pediatrics – Carson
1475 Medical Pkwy
Carson City, NV 89703
Phone 775.885.2229
Fax 775.882.5045

OB/GYN & Pediatrics-Minden
925 Ironwood Dr, Ste 2111
Phone 775.782.5330
Fax 775.782.5954

Carson Medical Group

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact your physician or our administrator.

Our Obligations *We are required by law to: Maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.*

Immunizations ***In accordance with the Modification to HIPAA Rules dated March 26, 2013 parents and guardians may provide a general permission for health care providers to disclose student immunization records to schools, preschools, and daycare facilities upon the school's request that are mandated by the State of Nevada to ensure attending students are vaccinated. A parent or guardian's signature on this Notice of Privacy Practices shall serve to accomplish this general written permission for release of a child's immunization record upon school requests.***

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose Health Information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Health Care Operations We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Payment We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Your Rights

As Required by Law We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures; however, will be made only to someone who may be able to help prevent the threat.

Business Associates We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Your Rights Continued...

Coroners, Medical Examiners and Funeral Directors We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the persons' agreement; 4) about a death we believe to be result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security and Intelligence Activities We may disclose Health Information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made necessary: 1) for the institution to provide you with health care, 2) to protect your health and the safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

Organ and Tissue Donation If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to your physician.

Right to Amend If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to your physician.

Right to Request Restrictions You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to your physician or our administrator. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to your physician or our administrator. Your request must specify how or where you which to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have to agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice contact your physician or our administrator.

Right to an Accounting of Disclosures You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provide written authorization. To request an accounting of disclosures, you must make your request, in writing to our administrator.

Changes To This Notice We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date in the lower right-hand comer.

Complaints If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our administrator. All complaints must be made in writing. You will not be penalized for filing a complaint.

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Print Patient's Name_____ Patient Date Of Birth_____

Patient Signature_____ Relationship_____

Guarantor/Guardian Signature_____

Print Guarantor/Guardian Name_____

Date Signed _____ ☐ Patient refused to sign

Carson Medical Group

HIPAA- Family Members Information

Patient's Name: _____

Date of Birth: _____ Phone: _____

According to the Health Insurance Portability Accountability Act (HIPAA) regulations, we are required to keep; your health information confidential. You have the right to restrict family members or other persons from accessing your health information. However, we are aware that many of our patients do not wish to restrict their spouse, family member or other person from having access to their health information. In an effort to comply with HIPAA Regulations, and to avoid inconveniences for our patients we are asking that you please complete this form. If at any time you wish to change any of the information on this form, please notify our office in writing, we will honor your request.

Please list the family members or other persons, if any, who we may inform about your general medical condition, diagnosis, appointments, test results, or other health care information (including treatment, payment and procedures.) You are not required to list anyone, but if you do, you are authorizing that person to have complete access to your medical and/or payment information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization has no expiration date. It shall be termed when withdrawn in writing.

Guardian/Patient Signature: _____ Date Signed: _____

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Pediatrics – Carson
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Fax 775.882.5045

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925 Ironwood Dr, Ste 2111
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