VIP PRIMARY HEALTH CARE
LAS VEGAS

# REGISTRATION FORM

## CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

## Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ _____

## Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( _____ _____

## Employer information

Employer:
Address:
Phone:

## Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

## Pharmacy Information:

Name:

Crossroads:

Phone:

## Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

## Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

**To the best of my knowledge the above information is complete and accurate.**

**Signed**_____ **Date:**_____

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## Over the Counter (OTC) Drugs/Supplements

| Medication/Supplement Name | Dosage | Frequency Taken |
|---|---|---|
| | | |
| | | |

## Vaccination History

| Vaccine | Date | Vaccine | Date |
|---|---|---|---|
| Flu | | Zostavax (Shingles) | |
| Prevnar (1st series) | | Shingrix (Shingles) | |
| Pneumovax (2nd series, 12 months later) | | Hepatitis A | |
| MMR | | Hepatitis B | |
| Tetanus | | Gardasil (HPV) | |
| Tdap | | | |

## Family History (please mark all that apply)

| Disorder | Mother | Father | Sibling Brother/Sister | Grandparent Paternal/Maternal | Aunt Paternal/Maternal | Uncle Paternal/Maternal |
|---|---|---|---|---|---|---|
| Alcoholism | | | | | | |
| Arthritis | | | | | | |
| Depression | | | | | | |
| Diabetes | | | | | | |
| Drug Abuse | | | | | | |
| Cancer | | | | | | |
| Hypertension | | | | | | |
| Heart Disease | | | | | | |
| Kidney Disease | | | | | | |
| Mental Illness | | | | | | |
| Stroke | | | | | | |
| Thyroid Disease | | | | | | |
| Other: | | | | | | |

Patient Name:_____ DOB: _____

## Social History

**Tobacco Use:** ☐ Never ☐ Former (Date Quit:_____) ☐ Current

Years of Use? _____ No. of Packs? _____ per Day / Month

**Drug Use:** ☐ Never ☐ Former (Date Quit:_____) ☐ Current

What drug(s)? _____ Years of Use? _____

**Alcohol Use:** ☐ Never ☐ Former (Date Quit:_____) ☐ Current

Years of Use? _____ No. of Drinks? _____ per Day / Month

**History of Falls:** (last 3 months) ☐ No falls ☐ 1-2 ☐ 3 or more

**Do you exercise?** (circle one) Yes No

Type of exercise? _____ How often? _____

**Do you feel safe at home?** (circle one) Yes No

**Within the past 12 months, have you worried that your food would run out before you got money to buy more?** ☐ Often true ☐ Sometimes true ☐ Never true

**Within the past 12 months, has lack of reliable transportation kept you from doctor's appointments or getting things needed for daily living?** (circle one) Yes No

**What is the highest level of education you have completed?** (circle one)

High School College Graduate School Post Graduate School

**Do you have an advance directive (i.e. living will, power of attorney, trust)?** _____ (Y/N)

If not, would you like to discuss obtaining one today? _____ (Y/N)

Patient Name:_____ DOB: _____

# Health History Questionnaire

Patient Name:_____ DOB: _____

Main reason for today's visit: _____

Other concerns:_____

_____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

## Allergies (e.g. medication, food, other)

| Item | Reaction (e.g. rash, swelling, etc.) |
|---|---|
| | |
| | |
| | |

## Medications

| Medication Name | Dosage | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Name:_____ DOB: _____

## Surgical History

| Surgery | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Health Maintenance History

| Test | Date | Results |
|---|---|---|
| Blood Tests | | |
| Bone Density Scan | | |
| Colonoscopy | | |
| Eye Exam | | |
| Mammogram | | |
| PAP Smear | | |
| Physical | | |

## Functional Levels (Katz ADL) – Please mark the appropriate box

| | No Assistance | Some Assistance | Full Assistance |
|---|---|---|---|
| Eating | | | |
| Bathing | | | |
| Dressing | | | |
| Toileting | | | |
| Transferring | | | |
| Maintaining Continence | | | |
| Handling Finances | | | |
| Medication Management | | | |

Patient Name:_____ DOB: _____

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## Past Medical History (please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Anemia | | Diverticulosis | | Kidney Disease | |
| Anxiety | | Diverticulitis | | Kidney Stones | |
| Arthritis | | Emphysema | | Liver Disease/Hepatitis | |
| Asthma | | Gout | | Migraines/Headache | |
| Bleeding Disorder | | Heart Attack | | Osteoporosis | |
| Blood Clots – Legs | | Heart Failure | | Pulmonary Embolism | |
| Cancer/Type: | | Pacemaker | | Seizures | |
| Colon Polyps | | Heart Murmur | | Stroke | |
| COPD | | Hiatal Hernia/Acid Reflux | | Thyroid Disorder | |
| Coronary Artery Disease | | HIV/AIDS | | Tuberculosis | |
| Dementia | | High Cholesterol | | | |
| Depression | | High Blood Pressure | | Other: | |
| Diabetes | | Irregular Heart rate (AFib) | | | |

_____ _____

Patient Signature Date

_____ _____

Legal Guardian/Caregiver Signature Date

Patient Name:_____ DOB: _____

# Consent to Contact

Patient Name: _____ DOB: _____

I agree to allow to contact me by email, mobile phone and/or text message regarding my healthcare. I may withdraw my consent at any time by contacting VIP Primary Healthcare at 702-342-1384.

I would also like to receive updates and information via email from VIP Primary Healthcare regarding events, happenings and new services. If you would like to receive updates and information from VIP Primary Healthcare

This personal information is being collected under the authority of VIP Primary Healthcare. It will not be used or disclosed for other purposes.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to allow VIP Primary Healthcare to contact me.

Patient Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

Staff Signature: _____ Date: _____

# General Consent for Care and Treatment

Patient Name: _____ DOB: _____

*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 potential risks 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).*

The purpose of this consent is to obtain your permission to perform reasonable and necessary medical examinations, testing and treatment. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at VIP Primary Healthcare This consent will remain fully effective until it is revoked in writing.

I agree to provide accurate and complete information about my health history, condition(s) and presenting complaint, to agree upon a treatment plan and follow that plan.

I understand that I have the right to discuss all treatment plans with my provider, including the purpose, potential risks and benefits of any test(s) ordered, recommended procedures and treatment plan(s). I also have the right to ask questions if I do not understand.

I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed at or by VIP Primary Healthcare.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to care and treatment provided by VIP Primary Healthcare.

Patient Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

Staff Signature: _____ Date: _____

# HIPAA Notice of Privacy Practices

**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.**

VIP Primary Healthcare and its employees are dedicated to maintaining the privacy of your Protected Health Information ("PHI") and Personally Identifiable Information ("PII"), which is information that identifies you and relates to your physical or mental health condition. Applicable federal and state laws require us to provide you with this Notice of Privacy Practices, and to inform you of your rights and our obligations concerning PHI/PII. We are required to follow the privacy practices described below while this Notice is in effect.

A. **Permitted Uses and Disclosures of PHI/PII**. We may use or disclose your PHI/PII for the following reasons:

1. **Treatment**. We may disclose your PHI/PII to a physician or other health care provider providing treatment to you. For example, we may disclose medical information about you to physicians, nurses, technicians or personnel who are involved with the administration of your care.

2. **Payment**. We may disclose your PHI/PII to bill and collect payment for the services we provide to you. For example, we may send a bill to you or to a third-party payor for the rendering of services by us. The bill may contain information that identifies you, your diagnos(es), procedure(s) and suppl(ies) used. We may also disclose PHI/PII to insurance companies to establish insurance eligibility benefits for you. We may also provide your PHI/PII to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. **Health Care Operations**. We may disclose your PHI/PII in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, training health care and non-health care professionals, and other business operations. For example, we may use your PHI/PII to evaluate the performance of the health care services you received. We may also provide your PHI/PII to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us.

4. **Emergency Treatment**. We may disclose your PHI/PII if you require emergency treatment or are unable to communicate with us.

5. **Personal Representatives**. We may disclose your PHI/PII to a person legally authorized to act on your behalf, such as a parent, legal guardian, administrator or executor of your estate, or other individual authorized under applicable law.

6. **Family and Friends**. We may disclose your PHI/PII to a family member, friend or any other person as directed by you or who you identify as being involved with your care or payment for care, unless you object.

7. **Required by Law**. We may disclose your PHI/PII for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI/PII to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you and/or your representative if we disclose your PHI/PII because we believe you are a victim of abuse, neglect or domestic violence, unless we determine that informing you and/or your representative would place you at risk. In addition, we must provide PHI/PII to comply with an order in a legal or administrative proceeding. Finally, we may be required to provide PHI/PII in response to a lawsuit or dispute, court order, administrative order, subpoena or other lawful process, but only if efforts have been made, by us or the requesting party, to contact you about the request (which may include written notice) or to obtain an order to protect the requested PHI/PII.

8. **Serious Threat to Health or Safety**. We may disclose your PHI/PII if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.

9. **Public Health**. We may disclose your PHI/PII to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.

10. **Health Oversight Activities**. We may disclose your PHI/PII to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative or criminal investigations or proceedings; inspections; licensure or disciplinary actions; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.

11. **Research**. We may disclose your PHI/PII for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI/PII.

12. **Workers' Compensation**. We may disclose your PHI/PII to comply with laws relating to workers' compensation or other similar programs.

13. **Specialized Government Activities**. If you are active military or a veteran, we may disclose your PHI/PII as required by military command authorities. We may also be required to disclose PHI/PII to authorized federal officials for the conduct of intelligence or other national security activities.

14. **Organ Donation**. If you are an organ donor or have not indicated that you do not wish to be a donor, we may disclose your PHI/PII to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

15. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your PHI/PII to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.

16. **Disaster Relief**. Unless you object, we may disclose your PHI/PII to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts.

17. **Direct Contact with You.** We may use your PHI/PII to contact you to remind you that you have an appointment, or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

B. **Disclosures Requiring Written Authorization**.

1. **Not Otherwise Permitted**. In any other situation not described in Section A above, we may not disclose your PHI/PII without your written authorization.

2. **Psychotherapy Notes**. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.

3. **Marketing and Sale of PHI**. We must receive your written authorization for any disclosure of PHI/PII for marketing purposes or for any disclosure which is a sale of PHI/PII.

**Disclaimer:** VIP has attempted to explain with this notice the circumstances where state law may be more protective that the federal privacy rule and provides greater privacy protection. Except for situations listed above and treatment, payment or health care operation purposes, the use or disclosure of your health information requires VIP to obtain your written authorization. You may withdraw your authorization in writing by submitting your written withdrawal to P3's Compliance Director at the address listed at the end of this Notice.

C. **Your Rights**.

1. **Right to Receive Paper Copy of This Notice**. You have the right to receive a paper copy of this Notice upon request.

2. **Right to Access PHI/PII**. You have the right to inspect and copy your PHI/PII for as long as we maintain your medical record. You must make a written request for access to the Compliance Officer at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of your medical record pursuant to state law. In certain circumstances, we may deny your request to access your PHI/PII, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial.

3. **Right to Request Restrictions**. You have the right to request a restriction on the use or disclosure of your PHI/PII for the purpose of treatment, payment or health care operations, except for in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. However, we are not legally required to agree to such a restriction.

4. **Right to Restrict Disclosure for Services Paid by You in Full**. You have the right to restrict the disclosure of your PHI/PII to a health plan if the PHI/PII pertains to health care services for which you paid in full directly to us.

5. **Right to Request Amendment**. You have the right to request that we amend your PHI/PII if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI/PII, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI/PII is accurate and complete.

6. **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures of PHI/PII made by us (other than those made for treatment, payment or health care operations purposes) during the six (6) years prior to the date of your request. You must make a written request for an accounting, specifying the time period for the accounting, to the Compliance Officer at the address listed at the end of this Notice.

7. **Right to Confidential Communications**. You have the right to request that we communicate with you about your PHI/PII by certain means or at certain locations. For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Compliance Officer at the address listed at the end of this Notice.

8. **Right to Notice of Breach**. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI/PII.

D. **Changes to this Notice**. We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of your PHI/PII, your rights or our duties, we will revise and distribute this Notice.

E. **Acknowledgment of Receipt of Notice**. We will ask you to sign an acknowledgment that you received this Notice.

F. **Questions and Complaints.** If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to you PHI/PII, you may complain to us and to the U.S. Department of Health and Human Services Office for Civil Rights ("OCR") if you believe your privacy rights have been violated by our office. We will not retaliate in any way if you choose to file a complaint with us or with the OCR. Please direct any of your questions or complaints to the VIP Compliance Department

Compliance Department
VIP Primary Healthcare
3195 Saint Rose Pkwy, Suite 212
Henderson, NV 89052
702-342-1384

Complaints to the OCR may be made electronically via the OCR Complaint Portal; using the OCR Complaint Form by mail, fax, or e-mail; or by phone, using the following contact information:

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Avenue, S.W.
Room 515F HHH Bldg.
Washington, D.C. 20201

**Portal**: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
**Complaint Form**:
https://www.hhs.gov/sites/default/files/hip-complaint-form-0945-0002exp-04302019.pdf
**Email**: OCRComplaint@hhs.gov
**Voice Phone** (800) 368-1019
**FAX** (202) 619-3818
**TDD** (800) 537-7697

This notice is effective September 1, 2020.

P3 Medical Group

Built by Doctors. Loved by Patients.

# PATIENT RIGHTS AND RESPONSIBILITIES

P3 Medical Group is committed to delivering a safe, respectful, and effective healthcare environment. In order to establish trust and maintain collaboration with our Providers, and help maximize the quality and efficiency of your care, we have established the following Patient Rights and Responsibilities:

***Patient Rights***

As a P3 Medical Group Patient, you have the **right** to:

- Information
  - Know the name and qualifications of all individuals involved in your Care Team;
  - Have access to your medical information in a form you understand;
  - Be provided copies of your medical records upon request;
  - Be informed of estimated costs prior to treatment;
  - Know what resources are available to help manage your health care; and
  - Receive a copy of these Rights and Responsibilities.
- Access to Care
  - Have your new, acute, and chronic healthcare needs addressed through preventive screenings, vaccinations, comprehensive examinations, care management for disease specific conditions, and/or follow-up evaluations;
  - Have access to services, providers, specialists and hospitals within the VIP Network;
  - Exercise choice in obtaining Medicare services; and
  - Appeal a health plan coverage determination.
- Respect
  - Be treated with dignity and respect at all times;
  - Be protected against unethical practices or discriminatory treatment;
  - Obtain an advance directive to enable you to communicate your health care wishes should you become incapacitated;
  - File a complaint and receive a response according to our grievance process;
  - Be free from any form of restraint or seclusion, unless medically necessary, authorized by a provider, and professionally implemented;
  - Have a family member or friend present during any office examination; and
  - Have your privacy and confidentiality respected and maintained by all P3 Medical Group team members.

***Patient Responsibilities***

As a P3 Medical Group Patient, you have the **responsibility** to:

- Actively participate your care management
  - Provide accurate and complete information regarding your health;
  - Inform your Provider(s) of any medication allergies and/or side effects;
  - Follow the directions and treatment plans given by your Provider(s);
  - Communicate any barriers which may prevent the directions and/or treatment plan from being followed;
  - Make healthy lifestyle choices;
  - Educate yourself about your own healthcare and your health plan;
  - Be knowledgeable regarding prescribed and over-the-counter medications, vitamins and supplements; and
  - Call the office at least three (3) days prior to when refills are needed.
- Be considerate and courteous
  - Communicate in a constructive manner; and
  - Be respectful and cooperative with Providers and other patients.
- Ensure accurate records and timely payment for services:
  - Inform your Provider if your contact or personal information changes;
  - Pay all copayments, deductibles, and/or past due balance at the time of service; and
  - Bring your insurance card and photo identification to every office visit for verification.

*These Rights and Responsibilities may be subject to limitation or modification under applicable state or federal law.*

## Acknowledgement of Receipt

Patient Name:_____ DOB: _____

- I have read and understand the HIPAA Notice of Privacy Practices for VIP Primary Healthcare. I also received a copy of the HIPAA Notice of Privacy Practices (attached).

- I have read and understand the Patient Rights and Responsibilities for VIP Primary Healthcare. I also received a copy of the Patient Rights and Responsibilities (attached).

Patient Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

Staff Signature: _____ Date: _____