HUMANITY HEALTH CENTER

3750 S Jones Blvd, Ste 100/120
Las Vegas, NV 89103

❒ Julie Wu, MD
❒ Ricardo Cruz, DO
❒ Anne Park, FNP
❒ Mark Chen, DO
❒ Anna Salcedo, MD
❒ Kenneth Zeng, DO
❒ Thu Pham, APRN

3221 E Warm Springs Rd
Las Vegas, NV 89120

❒ Anna Salcedo, MD
❒ Kenneth Zeng, DO
❒ Vanessa Mercado, APRN

5597 Spring Mountain Rd
Las Vegas, NV 89146

❒ Julie Wu, MD
❒ Morris Nguyen, PA-C
❒ Thu Pham, APRN

PATIENT REGISTRATION

Name: _____ Social Security #: _____
(Last) (First)

Date of Birth: _____ Sex: ❒ Male ❒ Female

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ Cell Phone (_____) _____

Occupation: _____ Employer: _____

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced
Race: ❒ White ❒ American Indian or Alaska Native ❒ Asian ❒ African American ❒ Pacific Islander
Ethnicity: ❒ Not Hispanic or Latino ❒ Hispanic or Latino
Preferred Language: ❒ English ❒ Spanish ❒ Mandarin ❒ Cantonese ❒ Vietnamese ❒ Filipino ❒ Other: _____

Email: _____

Emergency Contact: _____ Relation: _____

Phone (_____) _____

PRIMARY INSURANCE

Insured Name: _____ S.S.#: _____ DOB: _____
(Last) (First)

Insurance Carrier: _____ Phone (_____) _____

Policy #: _____ Group #: _____

SECONDARY INSURANCE

Insured Name: _____ S.S.#: _____ DOB: _____
(Last) (First)

Insurance Carrier: _____ Phone (_____) _____

Policy #: _____ Group #: _____

PHARMACY

Pharmacy Name: _____ Cross streets: _____

Phone Number: _____

HUMANITY
HEALTH CENTER

FINANCIAL and OFFICE POLICY

You are financially responsible for the medical services you receive. Please review our policies below, then print and sign your name at the end to indicate your agreement to these terms.

APPOINTMENTS

Appointment confirmations will be made at least 24 hours prior to your scheduled appointment but it is your responsibility to keep your scheduled appointment. Please be sure that we have an updated phone number.

Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at that time, HUMANITY HEALTH CENTER reserves the right to reschedule your appointment until such time you are able to make your copayment. Payment for any outstanding balance is due at your appointment unless previous payment arrangements have been made with the billing department.

Missed appointments are subject to a $25.00 No Show Fee. This fee is your responsibility and will not be billed to your insurance company.

INSURANCE PAYMENTS

Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

Coverage Changes and Timely Submissions. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which we must submit a claim on your behalf to your insurer. If we are unable to submit your claim within this period because we have not been supplied with your correct information, you will be responsible for the charges.

Self Pay. If you do not have health insurance, or if your health insurance will not pay for services rendered, you are considered a Self Pay patient. Your charges will be based on our current Self-Pay fee schedule (Available by request and subject to change). Self Pay patients are expected to make payment in full at the time of service.

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BENEFITS and AUTHORIZATIONS

Insurance Plan Participation. We participate in many, but not all insurance plans. It is your responsibility to contact your insurance company to verify that HUMANITY HEALTH CENTER participates in your plan. Out of Network benefits usually have higher deductibles and coinsurance.

Referrals and prior authorization requirements vary widely among insurance carriers and plans. If your carrier requires a referral to be sent to a specialist and/or radiology facility, it is your responsibility to be aware of such requirements. Please allow 3-5 days to process your referral and/or prior authorizations. Depending on your insurance plan, it may take up to 14 business days to process.

Prior Authorization and Non-Covered Services. Some services requested may require an authorization by your insurance company. As a courtesy to our patients, we make a concerted effort to determine if the services we order are covered by your insurance plan and will request this on your behalf.

Out of Network Payments. If we are not part of your insurance carrier's network and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to HUMANITY HEALTH CENTER immediately.

PRESCRIPTIONS

Please provide a list of your current medications. For further medication refills, please allow 2-3 business days for processing except for narcotic and scheduled medications (please ask the nurse for specific policies regarding these types of medications).

FMLA FORMS

Family and Medical Leave Act provides up to 12 unpaid weeks of job-protected leave per year for medical condition(s) that have been addressed and/or treated by the physician. Please allow 5-7 business days to process. HUMANITY HEALTH CENTER reserves the right to charge a reasonable fee of $40.00 for the completion of the requested forms. This fee is subject to change, please verify with the staff for the updated amount due.

MEDICAL RECORDS

HUMANITY HEALTH CENTER reserves the right to charge for the reasonable cost of $0.10 cents per page for copying and/or mailing the records at your request. If you are requesting your medical records to be transferred from HUMANITY HEALTH CENTER to another provider, we will satisfy your request once we have received the request from your authorized provider at no cost to you.

HUMANITY
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ADVANCED DIRECTIVE (LIVING WILL)

Do you have an advanced directive? ❒ Yes ❒ No

Would you like to keep a copy on the chart? ❒ Yes ❒ No

PAYMENT AUTHORIZATION

I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits either to myself or to the party who accepts the assignment. I authorize payment of medical benefits to the physician. I further authorize the release of any and all medical or other information to such services to my insurance carrier in order to determine benefits due to me. I agree to be personally and fully responsible for payment for medical services rendered. I understand that if I cancel a scheduled appointment, it must be within regular clinic hours at least one day prior to my appointment, or a $25.00 surcharge will be required prior to attending any future appointments. I consent to receive calls from HUMANITY HEALTH CENTER for my protected healthcare and other services at the phone number listed in my patient registration form.

AGREEMENT and ASSIGNMENT OF BENEFITS

I have read and understand the financial policy of HUMANITY HEALTH CENTER and I agree to abide by its terms. I hereby assign all medical benefits and authorize my insurance carrier(s) to issue payment directly to HUMANITY HEALTH CENTER. I understand that I am financially responsible and binding for all services I receive from HUMANITY HEALTH CENTER.

Print Name: _____

Signature: _____ Date: _____

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I,_____, by signing this authorization am authorizing confidential communication of my health information to the following recipients:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The type and amount of information to be disclosed is as follows:

❒ Complete Health Records
❒ Physical Exams
❒ Lab Results
❒ Consultation Reports
❒ Appointments
❒ Billing Information
❒ Procedure Reports

I understand I have the right to revoke this authorization at any time by submitting the request in writing to HUMANITY HEALTH CENTER.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Effective Date: _____

HUMANITY HEALTH CENTER

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.

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associated (e.g. a billing service) sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category or uses or disclosures. Not every possible use or disclosure in a category is listed.

FOR TREATMENT. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTHCARE OPERATIONS. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services to evaluate the performance of our staff in caring for you.

OTHER USES OF DISCLOSURES THAT CAN BE MADE WITH CONSENT OR AUTHORIZATION

1) As required during an investigation by law enforcement agencies
2) To avert a serious threat to public health or safety
3) As required by military command authorities for their medical records
4) To worker's compensation or similar programs for processing of claims
5) In response to a legal proceeding
6) To a coroner or medical examiner for identification of a body
7) If an inmate, to te correctional institute or law
8) As required by the US Food and Drug Administration (FDA)
9) Other healthcare providers and providers' payment activities
10) Other covered entities' and provider's payment activities
11) Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)

12) Uses and disclosures required by law
13) Health oversight activities
14) Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives of other health related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to inspect and copy in certain very limited circumstances. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect the copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND. If you feel that medical information we have about you 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. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any

corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

RIGHT TO AN ACCOUNTING OF NON-STANDARD DISCLOSURES. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 12, 2003. Your request should indicate in what form you want the list (example; on paper) The first list you request within the 12 month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or change Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice with effective date in the upper right corner of the page.

HUMANITY HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Patient Name: _____ Date: _____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, may individual rights and the practices legal duties with respect to my protected health information. The Notice includes:

❒ A statement that this practice is required by law to maintain the privacy of protected Health Information.
❒ A statement that this practice is required to abide by the terms of the notice currently in effect.
❒ Types of uses and disclosures that this practice is permitted to make each of the following purposes: treatment, payment and health care operations.
❒ A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
❒ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

1) The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
2) The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
3) The right to receive confidential communications of protected health information.
4) The right to inspect and copy protected health information.
5) The right to amend protected health information.
6) The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practices' current Notice of Privacy Practices on request.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Relationship to patient *(if signed by a personal representative of the patient)*_____

Effective Date: _____

HUMANITY HEALTH CENTER

Patient Name _____ DOB _____ Date of Appointment _____

Reason for Visit

What brings you to the office today?

_____

_____

_____

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns?

_____

Current Medications

What medications are you currently taking?

Name of prescription	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates ☐ Aspirin ☐ Iodine
☐ Local Anesthetics ☐ Sulfa ☐ Codeine

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism	☐ Back Problems	☐ Ear Problems	☐ Hepatitis A, B, C	☐ Measles	☐ Skin Disorders
☐ Allergies	☐ Bleeding Disorder	☐ Eating Disorder	☐ High Blood Pressure	☐ Migraines	☐ Stomach Ulcer
☐ Anemia	☐ Blood Disorder	☐ Epilepsy	☐ High Cholesterol	☐ Osteoporosis	☐ Substance Abuse
☐ Anxiety	☐ Blood Transfusion	☐ Glaucoma	☐ Joint Disorder	☐ Pneumonia	☐ Thyroid
☐ Asthma	☐ Cancer	☐ Gout	☐ Kidney Disorder	☐ Polio	☐ Tuberculosis
☐ AIDS/HIV	☐ Diabetes	☐ Heart Disease	☐ Liver Disorder	☐ Rheumatic Fever	☐ Venereal Disease
☐ Arthritis	☐ Depression	☐ Heart Problems	☐ Lung Disease	☐ Stroke	

Hospitalizations & Surgeries

Reason	Where	Date

Last Colonoscopy _____

Women Only

#Pregnancies	#Miscarriages	#Abortions	#Living

Last Pap	Last Mammogram	Birth Control Method

PREVIOUS PCP (Primary Care Physician)

_____

Last Dexa Bone Density _____

Family History

☐ Alcoholism	☐ Cancer	☐ Joint Disorder
☐ Allergies	☐ Depression	☐ Kidney Disease
☐ Alzheimer's Disease	☐ Diabetes	☐ Liver Disorder
☐ Anemia	☐ Epilepsy	☐ Lung Disease
☐ Anxiety	☐ Genetic Disorder	☐ Migraines
☐ Arthritis	☐ Glaucoma	☐ Psychiatric Disorders
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ AIDS/HIV	☐ Hepatitis	☐ Stroke
☐ Bleeding Disorder	☐ High Cholesterol	☐ Substance Abuse
☐ Blood Disorder	☐ Hypertension	☐ Thyroid Disorder

Details _____

_____

LifestyleFactors

Are you sexually active?

☐ Yes ☐ No # of partners in the past year? _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Do you smoke? If yes, How many packs per day?

☐ Yes ☐ No #packs/day ____ ☐ Former Smoker

Do you use recreational drugs?

☐ Yes ☐ No Types:_____

How much alcohol do you drink? _____ ☐ Week ☐ Month

How much caffeine do you drink? _____

How often do you exercise? _____

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I authorize _____

Name of person or facility, which has your medical information.

To release health information to:

- ☐ Julie Wu, MD
- ☐ Ricardo Cruz, DO
- ☐ Anne Park, FNP
- ☐ Anna Salcedo, MD
- ☐ Kenneth Zeng, DO
- ☐ Vanessa Mercado, APRN
- ☐ Morris Nguyen, PA-C
- ☐ Thu Pham, APRN
- ☐ Mark Chen, DO

Location:

☐ 3750 S Jones Blvd, Ste 120
Las Vegas, NV 89103
PHONE (702) 434-8880
FAX (888) 815-1754

☐ 3221 E Warm Springs Rd
Las Vegas, NV 89120
PHONE (702) 434-8880
FAX (888) 815-1754

☐ 5597 Spring Mountain Rd
Las Vegas, NV 89146
PHONE (702) 434-8880
FAX (888) 815-1754

Patient Name _____ **DOB** _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The purpose of this release is (check one or more)

- ☐ At the request of the patient/patient representative(s)
- ☐ Other (state reason) _____

Information for Informed Consent

This authorization for release of medical information waives any and all rights that the patient now has in the future may have to bring legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the client will be given a copy of the completed "Consent for Release of Medical Information."

This authorization will remain in effect for one year, unless otherwise stated.

INFORMATION TO BE RELEASED

- ☐ Emergency Medicine Reports
- ☐ History & Physical Exams
- ☐ Psychological/Vocational
- ☐ Colonoscopy Results
- ☐ Other:
- ☐ Outpatient Records
- ☐ Progress Notes
- ☐ Laboratory Results
- ☐ All
- ☐ Consultations/Evaluation
- ☐ Discharge Summary
- ☐ Radiology Reports

_____ _____

Patient Signature Signature of Witness

Date _____ Time _____ am / pm