FOR OFFICE USE ONLY: PLEASE CHECK ONE

| | |
|---|---|
| ADULT PRIMARY CARE | |
| PEDIATRIC PRIMARY CARE | |
| ADULT BEHAVIORAL HEALTH | |
| PEDIATRIC BEHAVIORAL HEALTH | |
| RELEASE OF INFORMATION SIGNED | |

NORTHERN NEVADA HOPES *your partner in health.*

# **PATIENT** | Registration

_____ _____/_____/_____

DATE SOCIAL SECURITY NUMBER

_____

FIRST NAME MIDDLE NAME LAST NAME

_____

OTHER PREFFERED NAME (IF APPLICABLE)

_____

HOME ADDRESS CITY STATE ZIP CODE

_____ _____ _____

PHONE NUMBER WORK PHONE NUMBER EMAIL ADDRESS

_____

AGE DATE OF BIRTH PLACE OF BIRTH SEX AT BIRTH

_____

CURRENT GENDER IDENTITY PREFFERED PRONOUN SEXUAL ORIENTATION

**Do you give us permission to:**

| | | | | | |
|---|---|---|---|---|---|
| Call you at home? | ☐ Yes | ☐ No | Call you at work? | ☐ Yes | ☐ No |
| Leave message(s) at home? | ☐ Yes | ☐ No | Leave message(s) at work? | ☐ Yes | ☐ No |
| Email you? | ☐ Yes | ☐ No | Send HOPES information? | ☐ Yes | ☐ No |
| Ask for survey participation? | ☐ Yes | ☐ No | | | |

**Have you tested positive for any of the following?** (please check all that apply)

☐ HIV ☐ Hepatitis C ☐ Other _____

**Gender:**

☐ Male ☐ Female ☐ Other

**Race:**

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other

**Ethnicity:**

☐ Hispanic ☐ Non-Hispanic

**Preferred Language:**

☐ English ☐ Spanish ☐ Other _____

**Marital Status:**

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widow/Widower

**Have you been in the military?** ☐ Yes ☐ No

**How did you hear about us?**

☐ By a current HOPES patient ☐ Public ad ☐ Online ☐ Other_____

**Have you ever encountered or been encouraged by Change Point or our outreach team to seek services at HOPES?**

☐ Yes ☐ No

_____

EMPLOYER (IF APPLICABLE) POSITION

_____

PARTNER/SPOUSE (IF APPLICABLE) PHONE NUMBER

_____

EMERGENCY CONTACT PHONE NUMBER

_____

RELATIONSHIP TO PATIENT

_____

PRIMARY CARE PHYSICIAN (IF APPLICABLE) PHONE NUMBER

**To the best of my knowledge, all information on this registration form is true and correct. I understand that it is my responsibility to notify HOPES staff immediately if there are any changes in my name, address, telephone number, work status, and/or location, insurance coverage, SSI, SSD, or any other benefits received through outside agencies or community based organizations.**

_____

PATIENT SIGNATURE DATE

_____

PARENT/ LEGAL GUARDIAN NAME DATE

_____

PARENT/ LEGAL GUARDIAN SIGNATURE DATE

FOR OFFICE USE ONLY: PLEASE CHECK ONE

| | |
|---|---|
| ADULT PRIMARY CARE | |
| PEDIATRIC PRIMARY CARE | |
| ADULT BEHAVIORAL HEALTH | |
| PEDIATRIC BEHAVIORAL HEALTH | |

NORTHERN NEVADA HOPES *your partner in health.*

# **PATIENT** | Consent to Treatment

I hereby consent to and authorize such treatment as prescribed and fully explained to me by HOPES. I further consent to and authorize such laboratory tests and procedures, x-ray examinations and other routine medical services that are deemed necessary by the HOPES providers. It is not possible to make guarantees concerning the results of the examination for treatment. I acknowledge no such guarantee has been made to me. I understand I will have the opportunity to discuss any and all care and/or treatment proposed to me with the HOPES providers and I may refuse to consent for care and/or treatment if I do not want to proceed with such course of treatment. I will provide HOPES with accurate information regarding my medical, sexual, drug, and/or alcohol history and personal or social concerns which may impact my health or medical care to ensure proper treatment, care, and referral for needed services. I am responsible for having all lab tests, x-rays, and other diagnostic procedures done in a timely manner, prior to my next scheduled clinic appointment, and I will report for all scheduled clinic appointment on time.

_____ I will be able to choose a HOPES provider based on availability. I understand that I may be seen by another HOPES provider if my regular provider is unavailable. I understand that if I am late for my appointment, I may not be seen by my scheduled provider. I understand that I must request medication refills by contacting the pharmacy at least three business days prior to my medication supply being exhausted.

_____ I acknowledge that the HOPES Clinic **does not operate an emergency care service**. Staff members are available to me during regular business hours to answer any questions or concerns regarding my need for urgent care. If my situation is an emergency, I will call 911 for assistance or go to the nearest emergency room. If I wish to speak to a provider after hours, I can call the HOPES clinic at (775) 786-4673. I will be directed to the answering service and a provider will return my call.

_____ I understand that HOPES has an integrated team approach to patient management and that medical information may be shared among physicians, Physician Assistants, pharmacists, behavioral health providers, RNs, case managers, medical assistants, trainees, medical students, or interns without consent. This information is used solely for the purpose of coordination of clinical care and social service's needs.

## PAYMENT FEES FOR SERVICES

Northern Nevada HOPES provides services to clients who have no third party insurance coverage using a sliding fee scale, adhering to the Health and Human Services Poverty Guidelines. I understand that charges for services are contingent upon my income and can change as my income increases or decreases. In the event that I am entitled to benefits arising out of any policy of private or commercial insurance, said benefits will be applied for and assigned to Northern Nevada HOPES. If I am covered by Medicare, or Medicaid a claim will be sent to the appropriate agency. However, I understand that I am responsible for any copays, deductibles, or other charges required by any insurance policy or government agency and that such copays are payable at the time of rendered services unless other prior arrangements have been made.

I have carefully read and fully understand this consent and agreement. I have received a copy of this consent/agreement and am duly authorized to execute the above, and I accept the terms as described. I understand this consent/agreement is effective until revoked in writing.

_____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

_____

WITNESS SIGNATURE DATE

NORTHERN NEVADA HOPES *your partner in health.*

FOR OFFICE USE ONLY: PLEASE CHECK ONE

| | |
|---|---|
| ADULT PRIMARY CARE | |
| PEDIATRIC PRIMARY CARE | |
| ADULT BEHAVIORAL HEALTH | |
| PEDIATRIC BEHAVIORAL HEALTH | |

# **PATIENT** | Household Dependents

Please complete the following information for all partners, children, and others living in your home:

1. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

2. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

3. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

4. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

5. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

6. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

**COMMENTS:**

_____

_____

_____

_____

_____

_____

NORTHERN NEVADA HOPES *your partner in health.*

# **NOTICE** | 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. A copy of this policy is also available on our website at nnhopes.org.

## Privacy Practices

This page describes the type of information we gather about you, with whom the information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law, or permitted by law without your authorization.

If the practices described in this notice meet your expectations, there is nothing you need to do. If you prefer additional limitations on the use of your medical information, you may request them following the procedure below.

If you have any questions about this notice, please contact our Privacy Officer at the address below.

The regulations also require that we make a good faith effort to obtain your written acknowledgement that you have received this Notice. This is why you will be asked to sign this form at the end.

## Who Will Follow This Notice

This notice described practices of all of the persons and entities at Northern Nevada HOPES regarding the use of your medical information and that of:

- Any health care professional employed and contracted by Northern Nevada HOPES who is authorized to enter information into your medical record.
- All departments and units of Northern Nevada HOPES you may visit.
- Any member of a volunteer group that you are involved in at HOPES.
- All employees, staff and other personnel who may need access to your information.
- All entities, sites and locations of Northern Nevada HOPES follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes as described in this notice.

## Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Northern Nevada HOPES, whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Keep confidential any medical information that concerns your condition or treatment, how your care is paid for and demographic information, if such information is used to identify you;
- Give you this notice of our policies, procedures and information privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

## Nevada Law

In addition to federal law, Nevada law places more stringent limitations on the disclosure and use of mental health information, genetic information, communicable disease information and blood and urine tests.

Nevada's Communicable and Sexually Transmitted Disease Act ("the Act") is set out in NRS 441A. NRS 441A.220 governs the disclosure of "all information of a personal nature" about or provided by any person who has one of 66 listed communicable diseases. It authorizes only certain disclosures of that information. Disclosure is allowed:

1. For statistical purposes, provided that the identity of the person is not discernible from the information disclosed;
2. In a prosecution for violation of a provision of the Act;
3. In a proceeding for an injunction pursuant to the Act;
4. In reporting the actual or suspected abuse or neglect of a child or elderly person;
5. To any person who has a medical need to know the information for his own protection or the well-being of a patient or dependent person, as determined by the county health authority in accordance with regulations;
6. If the patient consents in writing to the disclosure;
7. By the health authority, to the victim and the arrested, suspected perpetrator of a sexual offense, or to their parents or guardians where they are minors;
8. By a provider to a law enforcement officer or agent, correctional officer, emergency medical attendant or fireman pursuant to a court petition;
9. To the state department of human resources, where a patient diagnosed as having AIDS/HIV is a Medicaid recipient;
10. To firemen, police officers and emergency medical service personnel, where the state board of health has determined the information to be disclosed relates to a communicable disease significantly related to that occupation; or
11. Where authorized or required by a specific statute.

The statute makes it very clear that disclosure for any purpose not specifically listed is forbidden, even pursuant to a subpoena, search warrant or discovery order. Uses and disclosures of information relating to patients with communicable diseases for treatment, payment and operations purposes will be limited

to our treatment, payment and operations purposes, and disclosures will not be made to other providers, even where allowed by the HIPAA 'Standards for Privacy of Individually Identifiable Health Information" (the "Privacy Standards"), except pursuant to a specific written patient authorization. Marketing, fund-raising and research uses and disclosures will not be made, unless very specific authority to release the information is obtained from the patient (e.g., "you agree that any and all information, including information about any communicable disease, including HIV, AIDS or other sexually transmitted diseases you may have, may be used and disclosed for fund-raising, marketing or research purposes, so long as such information will not be made public"). Disclosures to law enforcement will only be made as specifically allowed by the statute above. Medical information containing information about a patient's communicable disease will not be disclosed to an attorney in response to a subpoena, except where the attorney provides a signed authorization from the patient.

Regarding mental health information, NRS 433A.360 governs the release of clinical records for "clients." The term "clients" is defined to include persons who seek treatment or training in a private institution offering mental health services. Private institutions which provide mental health services to "clients" must keep "clinical records." "Clinical records" are records including "information pertaining to the client's admission, legal status, treatment and individualized plan for habilitation."

NRS 433A.360 provides that no part of the clinical record may be released except in certain specified circumstances. Release is authorized:

1. To physicians, attorneys and social agencies as specifically authorized in writing by the client, his parents or guardians;
2. As ordered by a court;
3. To a qualified member of the staff of a facility run by the division of mental health and developmental services of the department of human resources, or to a division employee, or a member of the staff of a Nevada agency established pursuant to the federal Developmental Disabilities Assistance and Bill of Rights Act or the Protection and Advocacy for Mentally Ill Individuals Act of 1986;
4. For statistical and evaluative purposes, if the information disclosed is abstracted in such a way as to protect the identity of individual clients; or
5. To the extent necessary to make, or allow the client to make a claim for aid, insurance or medical assistance.

Uses and disclosures of information for treatment, payment and operations purposes will be limited to our purposes, and disclosures will not be made to other providers without client consent, even where allowed by the Privacy Standards. Marketing or fund-raising uses and disclosures will not be made, unless very specific authority to release such information is obtained from the patient. Research disclosures will only be made pursuant to 4 above. Disclosures to law enforcement will not be made without a court order. Disclosures to an attorney in response to a subpoena will not be made, except where the attorney provides a signed authorization from the patient.

## How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures, we will try to give some examples. Not every use or disclosure in a category will be listed.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. Different health care professionals may also share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may also disclose medical information about you to healthcare professionals outside Northern Nevada HOPES who may be involved in your medical care or who provide services that are part of your care.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, your insurance may need to know about care you received so they will pay us or reimburse you for the care. We may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance will cover the treatment, or to undertake other tasks related to seeking payment for services provided. We may also disclose medical information to another health care provider who is or has been involved in your treatment, so that the provider may seek payment for services rendered. You have the right to restrict disclosure of information to a health plan if you or anyone other the health plan has paid for your treatment in full out of pocket.

**For Health Care Operations Purposes.** We may use and disclose medical information about you for health care operations purposes. This is necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you, or to otherwise manage and operate efficiently. We may also disclose information to doctors, nurses, technicians, training doctors, medical students, and other personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

**Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

**Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care, only with a written and signed consent.

**Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the premises of Northern Nevada HOPES. Otherwise, we will always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at Northern Nevada HOPES.

**As Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**To Schools.** HOPES may disclose proof of immunization to a school when State or other law requires the school to have such information prior to admitting you as a student. Written authorization is not required to permit this disclosure. However, HOPES is required to obtain a verbal agreement prior to disclosing information to a school from a parent or guardian or from you if are an adult or emancipated minor. HOPES must document this agreement in your chart. You can revoke this agreement in writing anytime you wish.

## Special Situations

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

**Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;

- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

**Health Oversight Activities.** We may disclose medical 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 overall health care system, the conduct of government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** We may disclose medical information about you in response to a subpoena, discovery request, or other lawful order from a court.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical 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 may also release medical information about patients of Northern Nevada HOPES to funeral directors as necessary to carry out their duties.

**Protective Services for the President, National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

**Right to Request, Inspect and Copy.** You have the right to request, inspect and copy medical information in electronic or paper form, that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer at the address below. If you request a copy of the

information, we have 30 days to respond to your request and we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Copies of PHI may be given to you in any form that you request, including electronic (MS Word, Excel, text, HTML or PDF).

We may deny your request to inspect and copy in certain very limited circumstances. In some circumstances, if you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Northern Nevada HOPES 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 that 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 our Privacy Officer. 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. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the "designated record set" kept by Northern Nevada HOPES;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. This accounting will not include many routine disclosures, including those made to you or pursuant to your authorization; those made for treatment, payment and operations purposes as discussed above; those made for national security and intelligence purposes; and those made to correctional institutions and law enforcement in compliance with law.

To request this list of accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request additional restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations. To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. 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. If complying with your request entails additional expenses over our usual means of communication, we may ask that you reimburse us for those expenses.

**Right to a Paper Copy of This Notice.** You have a 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 of this notice. To obtain a paper copy of this notice, please request one in writing from our Privacy Officer at the address below.

**Right to Protected Information After Death.** By law, HOPES has to protect your health information for 50 years following the date of your death. However, HOPES may disclose protected information without your consent for research purposes following your death. HOPES may disclose your Protected Health Information to family members and others who were involved in the care or payment for care prior to death, unless doing so is inconsistent with any prior expressed preference.

## Changes to This Notice

We reserve the right to change our policies and practices concerning the privacy of your medical information and this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will always post a copy of the current notice near main client entrances at all facilities. The notice will contain the effective date on the first page.

## Complaints/Breach

If you believe your privacy rights have been violated, you may file a complaint with Northern Nevada HOPES or with the Secretary of the Department of Health and Human Services. To file a complaint with Northern Nevada HOPES, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You have a right to be notified if your PHI has been disclosed without your consent in all circumstances except when:

- HOPES conducts a risk assessment that establishes that there is a “low probability” of compromise of the PHI
- Unintentional good faith use of PHI by a employee of HOPES
- Inadvertent disclosure between two individuals who are otherwise authorized to access the PHI
- Disclosure to an unauthorized person who would not reasonably have been able to retain such information.

NORTHERN NEVADA HOPES *your partner in health.*

Northern Nevada HOPES (HOPES) takes grievances (complaints) seriously and invites discussions with clients about their concerns. HOPES will provide a forum to address grievances, striving for a satisfactory resolution prior to a formal grievance being filed. In the event a satisfactory resolution is not achieved, a client may file a formal grievance. During the formal grievance HOPES strives to work with clients to find a mutually satisfying conclusions. If you would like a copy of the grievance procedure, please contact the Privacy Officer.

## Other Uses of Medical Information

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 permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will 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 permission, and that we are required to retain our records of the care that we provided to you.

## Privacy Officer

Northern Nevada HOPES' Privacy Officer is:

Gail Thompson, BSN, RN
580 West 5th Street
Reno, NV 89503
Phone: 775-786-4673
Fax: 775-348-2889
Email: GThompson@nnhopes.org
Website: nnhopes.org

| PnP #: AD0003v2 | Complaints and Grievance Procedure | |
|---|---|---|
| Initial Date: 1/22/13 | Latest Version Date: 4/30/2014 | Approved Date: 9/23/2014 |
| Prepared by: Ivy Spadone, COO | Revised by: Ivy Spadone, COO | Approved by: Douglas Brewer, Board President |

**POLICY: Complaints and Grievance**

Northern Nevada HOPES (HOPES) takes complaints and grievances seriously and invites discussions with clients about their concerns. HOPES will provide a forum to address complaints and grievances, striving for a satisfactory resolution prior to a formal grievance being filed. Complaints are issues that can be addressed by department Directors and Coordinators, which would not involve changes in policies and procedures. A grievance is defined as any unresolved issue regarding a policy, practice or procedure. Grievances are formal, written requests that will be forwarded to the Chief Compliance Officer for review.

**PROCEDURE:**

I. **Complaints.** A client of Northern Nevada HOPES who has a complaint about HOPES or a HOPES staff member may file a complaint verbally with any employee at HOPES, within fourteen (14) days of the event giving rise to the complaint. Complaints not filed in a timely manner are waived. The employee will then address the complaint with his/her immediate supervisor to ameliorate the issue.

Upon the initiation of a complaint, the client is asked to provide HOPES with the following information:

a. Name, address, and telephone number;

b. A brief statement of the nature of the matter, the reason(s) for the complaint, and why client feels that the complaint is justified

Within 72 business hours of HOPES receiving the complaint, it will be given to the respective department director who will contact the client to gain a better understanding of the nature of the complaint and begin the resolution process. The department coordinator will attempt to resolve the matter with the client.

HOPES will make a final determination regarding the complaint as soon as reasonably possible but not more than ten (10) days after receiving it unless more time is required for fact-finding. Client will be informed of the resolution of the complaint by either a Director or Coordinator verbally.

If the determination of the complaint is not acceptable to the client and they wish to pursue the matter further, a Formal Grievance may be filed. If the compliant results in a policy change, the Director or Coordinator will initiate the process of changing the policy.

**II. Formal Grievance Process.** The formal grievance must be submitted in writing to HOPES within 10 days the incidence giving rise to the formal grievance or 10 days after the dissatisfaction with a complaint determination. Formal grievances not filed in a timely manner will be deemed waived.

The formal grievance shall contain the following client information:

a. Name, address, and telephone number;

b. A brief statement of the nature of the matter, the reason(s) for the appeal, and why the client feels that the grievance is justified;

c. How the client would like the matter resolved.

Northern Nevada HOPES will investigate the grievance within ten (10) days of receiving the grievance. Investigation activities may include:

a. Individual meeting with the client

b. If the grievance is against a staff member, a meeting with the client and the staff member; with a neutral staff member present to act as mediator

c. A meeting with the client and their treatment team

d. Interviewing other staff and/or clients

When the investigation is complete, the client will be informed in writing of the resolution within ten (10) days of the conclusion of the investigation. HOPES will retain a copy of the letter for their records.

If a client has a grievance against the Chief Executive Officer of Northern Nevada HOPES, they may file their grievance with the Northern Nevada HOPES Board of Directors OR Chief Compliance officer. The grievance must be submitted in writing to HOPES within 10 days of the event giving rise to the grievance. Grievances not filed in a timely manner will be deemed waived.

The Grievance shall contain the following client information:

a. Name, address, and telephone number;

b. A brief statement of the nature of the matter, the reason(s) for the appeal, and why the client feels that the grievance is justified;

c. How the client would like the matter resolved.

The grievance should be mailed to Northern Nevada HOPES, Attention: Board of Directors, 467 Ralston St., Reno, NV, 89503; or faxed to the following: 775-348-1301.

Northern Nevada HOPES Board of Directors will investigate the grievance within ten (10) days of receiving the grievance. When the investigation is complete, the client will be informed in writing of the resolution within ten (10) days of the conclusion of the investigation.

If a client is a participant of the Ryan White Program and wishes to bypass this process, they may file a grievance directly with the State of Nevada, Ryan White Part B Program by mailing their grievance to:

State of Nevada Health Division

Bureau of Child, Family & Community Wellness

Ryan White Part B Program Manager

4150 Technology Way, Suite 106

Carson City, NV 89706

See the State of Nevada website for more information regarding Ryan White Part B Grievance Procedure

NORTHERN NEVADA HOPES *your partner in health.*

FOR OFFICE USE ONLY: PLEASE CHECK ONE

| | |
|---|---|
| ADULT PRIMARY CARE | |
| PEDIATRIC PRIMARY CARE | |
| ADULT BEHAVIORAL HEALTH | |
| PEDIATRIC BEHAVIORAL HEALTH | |

# **ACKNOWLEDGEMENT** | Privacy Practices and Complaint/Grievance Procedure

I hereby acknowledge that I have received a copy of the Privacy Practices and Grievance Policy.

_____

PATIENT NAME PATIENT SIGNATURE DATE

## ACKNOWLEDGEMENT REFUSED

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy Practices and Grievance Policy.

_____

PATIENT NAME DATE

Reason for refusal/failure: _____

_____

_____

_____

_____

_____

SIGNATURE OF HOPES EMPLOYEE DATE

**A signed copy of this page is to be filed with the patient's record.**

NORTHERN NEVADA HOPES *your partner in health.*

# **PATIENT** | Rights and Responsibilities

**As a patient, you have the right to:**

- Take part in your healthcare and treatment
- Know the names of the people caring for you
- Be treated with respect and dignity in a safe and private setting
- Be informed about your illness and treatment, including options for your care
- Change medical providers at Northern Nevada HOPES
- Get another opinion about your illness or treatment
- Privacy of your health records as determined by HIPAA
- Talk with a supervisor about any questions or problems with your care
- Know about services available through HOPES
- Respect for your cultural, social, spiritual, and personal values and beliefs
- Know about legal reporting requirements
- Ask for special arrangements if you have a disability
- Refuse treatment care and services as allowed by law
- Know the cost of your care and ways you may pay for your care
- Refuse to be included in any research program without limiting medical care or treatment
- File a complaint or a formal grievance, if you are not satisfied with the care at HOPES
- Access the on-call doctor for an answering service after hours
- Be informed that HOPES does not manage chronic pain issues
- Be informed that HOPES does not provide disability assessments
- Be informed that taping your office visit with your provider without disclosing the same does not foster a trusting provider-patient relationship
- Access interpretive services if you do not understand English, or other assistance if you are hearing or sight impaired. Such services are free of charge.
- Not be refused services due to inability to pay
- Use the REMSA Nurse Hotline at 775-858-1000

**As a patient, you have the responsibility to:**

- Tell your medical provider about your illness or problems
- Ask questions about your illness or care
- Show respect to both caregivers and other patients
- Cancel or reschedule appointments so that another person may have that timeslot
- Pay your co-pays and bills on time
- Use medications or medical devices for yourself only
- Inform a medical provider if you become worse or have an unexpected reaction to a medication
- Give written permission to release your health records when necessary
- Provide HOPES a copy of your living will or durable power of attorney for health care matters
- Meet with financial counselors to set up payment plans
- Inform the hospital or ER that you're a patient of HOPES for coordination of care
- Not arrive at Northern Nevada HOPES or my appointment intoxicated or under the influence of drugs

If you have any questions, please ask a HOPES employee.

_____

PATIENT NAME PATIENT/LEGAL GUARDIAN SIGNATURE DATE

NORTHERN NEVADA HOPES *your partner in health.*

# **ADULT PATIENT AUTHORIZATION** | Patient Release of PHI

This form authorizes the release of Protected Health Information (PHI) pursuant to CFR Parts 160 and 164.

_____

PATIENT NAME PATIENT ID DATE OF BIRTH

*I authorize Northern Nevada HOPES to exchange information with the following agencies and/or individuals:*

☐ Renown Health ☐ St. Mary's Health ☐ Northern Nevada Medical Center

☐ Carson Tahoe Hospital ☐ Banner Churchill Hospital ☐ Northern Nevada Adult Mental Health

☐ West Hills Other: _____

**Information to be released (please initial all that apply):**

_____ Clinic progress notes
_____ Medication lists
_____ Substance use notes
_____ HIV/AIDS or other
_____ Diagnostic test results
_____ Other (be specific)

_____ Hospital records
_____ Psychiatry notes
_____ Lab results
_____ Psychotherapy notes
_____ D/C summary

**Purpose for Release:** _____

**Dates to include: all dates of service or from** _____ to _____

**Authorization expiration date:** _____

**Notice to the Recipient of the Information**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2 and CFR part 164). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2 or 45 CFR part 164. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Patient**

I understand that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, but in that event information cannot and will not be released. I also understand that treatment by this provider is not conditioned on my signing this authorization, although exceptions will be made for a) research related treatment and b) except for psychotherapy notes, for health plans were payment is conditioned on an authorization to use Protected Health Information to determine payment. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I acknowledge that I have the right to revoke this authorization at any time, and I understand that once the information is disclosed, it may no longer be protected by federal privacy law. (You may revoke this authorization in writing, in person, or by certified mail to the provider at the address above. The revocation will be affected only upon receipt, except to the extent that the Provider has acted in reliance on the authorization. Further information on the right to revoke may be provided from time to time in the Provider's Notice of Privacy Practices).

_____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

# REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information.

_____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

FOR OFFICE USE ONLY: PLEASE CHECK ONE

| | |
|---|---|
| PEDIATRIC PRIMARY CARE | |
| PEDIATRIC BEHAVIORAL HEALTH | |

NORTHERN NEVADA HOPES *your partner in health.*

# **PEDIATRIC PATIENT AUTHORIZATION** | Patient Release of PHI

This form authorizes the release of Protected Health Information (PHI) pursuant to CFR Parts 160 and 164.

_____

PATIENT NAME PATIENT ID DATE OF BIRTH

*I authorize Northern Nevada HOPES to exchange information with the following agencies and/or individuals:*

☐ Renown Health ☐ St. Mary's Health ☐ Northern Nevada Medical Center

☐ Carson Tahoe Hospital ☐ Banner Churchill Hospital ☐ Northern Nevada Adult Mental Health

☐ West Hills

| Type | Family Member |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | Family Member |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | Foster Family |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | Guardian Ad Litem |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | Therapist |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | Schools |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | Child Care Provider |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | Primary Care Provider |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

| Type | |
|---|---|
| Name | |
| Address | |
| Address Line 2 | |
| Phone/Fax | |

**Information to be released (please initial all that apply):**

_____ Clinic progress notes
_____ Medication lists
_____ Substance use notes
_____ HIV/AIDS, other communicable diseases
_____ Diagnostic test results
_____ Other (be specific)_____

_____ Hospital records
_____ Psychiatry notes
_____ Lab results
_____ Psychotherapy notes
_____ D/C summary

**Purpose for Release:** _____

**Dates to include: all dates of service or from** _____ to _____

**Authorization expiration date:** _____

### Notice to the Recipient of the Information

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2 and CFR part 164). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2 or 45 CFR part 164. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

### Notice to Patient

I understand that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, but in that event information cannot and will not be released. I also understand that treatment by this provider is not conditioned on my signing this authorization, although exceptions will be made for a) research related treatment and b) except for psychotherapy notes, for health plans were payment is conditioned on an authorization to use Protected Health Information to determine payment. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I acknowledge that I have the right to revoke this authorization at anytime, and I understand that once the information is disclosed, it may no longer be protected by federal privacy law. (You may revoke this authorization in writing, in person, or by certified mail to the provider at the address above. The revocation will be affected only upon receipt, except to the extent that the Provider has acted in reliance on the authorization. Further information on the right to revoke may be provided from time to time in the Provider's Notice of Privacy Practices).

_____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

## REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information.

_____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

PATIENT NAME DATE AGE

# ADULT HEALTH HISTORY FOR NEW PATIENTS

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

**Main reason for today's visit:** _____

**Other concerns:** _____

**What are your health goals for the next year?** _____

**Where were you getting your care before?** _____

In the past **2 weeks**, have you been bothered by: Little interest or pleasure in doing things? □ **No** □ **Yes**
Feeling down, depressed or hopeless? □ **No** □ **Yes**

**REVIEW OF SYMPTOMS:** Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

*General*
____Unexplained weight loss / gain
____Unexplained fatigue / weakness
____Fall asleep during day when sitting
____Fever, chills
____**No problems**

*Skin*
____New or change in mole
____Rash / itching
____**No problems**

*Breast*
____Breast lump / pain / nipple discharge
____**No problems**

*Ears/Nose/Throat*
____Nosebleeds, trouble swallowing
____Frequent sore throat, hoarseness
____Hearing loss / ringing in ears
____**No problems**

*Eyes*
____Change in vision / eye pain / redness
____**No problems**

*Cardiovascular*
____Chest pain / discomfort
____Palpitations (fast or irregular heartbeat)
____**No problems**

*Respiratory*
____Cough / wheeze
____Loud snoring / altered breathing during sleep
____Short of breath with exertion
____**No problems**

*Gastrointestinal*
____Heartburn / reflux / indigestion
____Blood or change in bowel movement
____Constipation
____ **No problems**

*Genitourinary*
____Leaking urine
____Blood in urine
____Nighttime urination or increased frequency
____Discharge: penis or vagina
____Concern with sexual function
____ **No problems**

*Musculoskeletal*
____Neck pain
____Back pain
____Muscle / joint pain _____
____**No problems**

*Endocrine*
____Heat or cold sensitivity
____**No problems**

*Hematologic/Lymphatic*
____Swollen glands
____Easy bruising
____**No problems**

*Neurological*
____Headache
____Memory loss
____Fainting
____Dizziness
____Numbness / tingling
____Unsteady gait
____Frequent falls
____**No problems**

*Allergic/Immune*
____Hay fever / allergies
____Frequent infections
____**No problems**

*Psychiatric*
____Anxiety / stress / irritability
____Sleep problem
____Lack of concentration
____**No problems**

*Women only*
____Pre-menstrual symptoms (bloating cramps, irritability)
____Problem with menstrual periods
____Hot flashes / night sweats
____**No problems**

**IMMUNIZATIONS:** Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. □

Tetanus (Td) _____ With Pertussis (Tdap) _____Varicella (Chicken Pox) shot *or* illness _____Pneumovax (pneumonia) _____

Influenza (flu shot) _____Hepatitis A _____Hepatitis B _____MMR _____Meningitis _____ Zostavax (shingles) _____HPV _____

**Women's Health History:**

Total number of pregnancies:____ Number of births:___ Date of last menstrual period if you are still menstruaing: _____

Age at begging of periods (menstruation) _____ Age at end of periods (menopause)____

**MEDICATIONS:** Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

□ **TAKE NO MEDICATIONS**

Medication Dose (e.g. mg/pill) How many times per day?

_____

_____

_____

Allergies or intolerance to medications (include type of reaction): _____

_____ □ **NONE**

**HEALTH MAINTENANCE SCREENING TESTS:**

| | | | | |
|---|---|---|---|---|
| Lipid (cholesterol) | Date _____ | | | |
| Sigmoidoscopy or Colonoscopy (circle one) | Date _____ | Abnormal? | □ **No** | □**Yes** |
| | | Polyp? | □ **No** | □**Yes** |
| ***Women only:*** | | | | |
| Mammogram | Date _____ | Abnormal? | □ **No** | □**Yes** |
| Pap smear | Date _____ | Abnormal? | □ **No** | □**Yes** |
| Bone Density Test | Date _____ | Abnormal? | □ **No** | □**Yes** |

**PERSONAL MEDICAL HISTORY**: Do you have now (current) or have you had (past) any of the following conditions? □ **NONE**

| ***Condition*** | ***Now*** | ***Past*** | ***Comments*** |
|---|---|---|---|
| Alcohol / Drug abuse | | | |
| Allergy (Hay Fever) | | | |
| Anemia | | | |
| Anxiety | | | |
| Arthritis (Rheumatoid) | | | |
| Arthritis (Osteoarthritis) | | | |
| Asthma | | | |
| Bladder / Kidney Problems | | | |
| Blood Clot (leg) | | | |
| Blood Clot (lung) | | | |
| Blood Transfusion | | | |
| Breast Lump (benign) | | | |
| Cancer Breast | | | |
| Cancer Colon | | | |
| Cancer Other Type | | | |
| Cancer Ovarian | | | |
| Cancer Prostate | | | |
| Cataracts | | | |
| Chicken Pox | | | |
| Colon Polyp | | | |
| Coronary Artery Disease | | | |
| Depression | | | |
| Diabetes (adult onset) | | | |
| Diabetes (childhood onset) | | | |
| Diverticulosis | | | |
| Emphysema | | | |
| Fractures (broken bones) | | | Where? |
| Gallbladder Disease | | | |
| Gastroesophageal Reflux (Heartburn/GERD) | | | |
| Glaucoma | | | |

| **PERSONAL MEDICAL HISTORY Continued:** ***Condition*** | ***Now*** | ***Past*** | ***Comments*** |
|---|---|---|---|
| Gout | | | |
| Gynecological Conditions (Endometriosis) | | | |
| Gynecological Conditions (Fibroids) | | | |
| Gynecological Conditions (Other) | | | |
| Heart Attack | | | |
| Hepatitis – Type A | | | |
| Hepatitis – Type B | | | |
| Hepatitis – Type C | | | |
| Hepatitis – Other | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Hip Fracture | | | |
| Irritable Bowel Syndrome | | | |
| Kidney Disease / Failure | | | |
| Kidney Stones | | | |
| Liver Disease | | | |
| Migraine Headaches | | | |
| Osteoporosis | | | |
| Pneumonia | | | |
| Prostate (enlargement) | | | |
| Prostate (nodules) | | | |
| Seizure / Epilepsy | | | |
| Skin Condition (Eczema) | | | |
| Skin Condition (Psoriasis) | | | |
| Skin Condition (Abnormal Moles) | | | |
| Sleep Apnea | | | |
| Stomach Ulcer | | | |
| Stroke | | | |
| Thyroid (Nodule) | | | |
| Thyroid High (Overactive) / Hyperthyroidism | | | |
| Thyroid Low (Underactive) / Hypothyroidism | | | |
| Other (list) | | | |
| Other (list) | | | |

**SURGICAL HISTORY** – Please check off any procedure or surgeries. List any abnormal finding or complications. □ **NONE**

| ***Surgical Procedure*** | ***No*** | ***Yes*** | ***Year*** | ***Comments*** |
|---|---|---|---|---|
| Abdominal Surgery | | | | |
| Appendectomy (appendix removal) | | | | |
| Back Surgery (lumbar) | | | | |
| Biopsy (location) | | | | |
| Breast Biopsy | | | | Circle: Right Left Both |
| Breast Surgery | | | | Circle: Right Left Both |
| Colonoscopy | | | | |
| Coronary Bypass | | | | |
| Coronary Stent | | | | |
| EGD (Stomach Endoscopy) | | | | |
| Cataract | | | | |
| Gallbladder Removal | | | | Circle: Laparoscopic |
| Heart Surgery (other than coronary bypass) | | | | |
| Hip Surgery | | | | Circle: Right Left Both |
| Hysterectomy (total, including ovaries) | | | | Circle: Laparoscopic Vaginal Abdominal |
| Hysterectomy (partial, ovaries left) | | | | Circle: Laparoscopic Vaginal Abdominal |

| ***SURGICAL HISTORY Continued:*** ***Surgical Procedure*** | ***No*** | ***Yes*** | ***Year*** | ***Comments*** |
|---|---|---|---|---|
| Knee Surgery | | | | Circle: Right Left Both |
| LEEP (Cervix Surgery) | | | | |
| Neck Surgery | | | | |
| Ovary Ligation ("Tubal") | | | | |
| Ovary Removal | | | | Circle: Right Left Both |
| Vasectomy | | | | |
| Sigmoidscopy | | | | |
| Sinus Surgery | | | | |
| Other (list) | | | | |

**Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to page 5 (Other Health Issues)**

**FAMILY HISTORY** – Indicate which relative has had the following diseases (parents and siblings are most important).

| **Disease** | **Mother** | **Father** | **Sister(s)** | **Brother(s)** | **Mom's Mom** | **Mom's Dad** | **Dad's Mom** | **Dad's Dad** | **Other Relatives** | **Comments** |
|---|---|---|---|---|---|---|---|---|---|---|
| **No significant history known** | | | | | | | | | | |
| Alcohol / Drug abuse | | | | | | | | | | |
| Allergic Disorder | | | | | | | | | | |
| Cancer | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Gastrointestinal Disorder | | | | | | | | | | |
| Heart Disease | | | | | | | | | | |
| Hypertension | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Mental Illness | | | | | | | | | | |
| Migraine Headache | | | | | | | | | | |
| Myocardial Disorder | | | | | | | | | | |
| Respiratory Disorder | | | | | | | | | | |
| Seizure Disorder | | | | | | | | | | |
| Stroke Syndrome | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | |

**OTHER HEALTH ISSUES:**

**Tobacco Use**
Smoke cigarettes: □ **Never** □ **No** □ **Yes**
(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Other tobacco: □ **Pipe** □ **Cigar** □ **Snuff** □ **Chew**

**Alcohol Use**
Do you drink alcohol? □ **No** □ **Yes**
# of drinks/week: _____ □ **Beer** □ **Wine** □ **Liquor**

**Drug Use**
Do you use marijuana or recreational drugs? □ **No** □ **Yes**
Have you ever used needles to inject drugs? □ **No** □ **Yes**

**Sexual Activity**
Sexually involved currently: □ **No** □ **Yes**

Sexual partner(s) is/are/have been: □ **Male** □ **Female**

Birth control method (circle below all that apply): □ **None needed**
Condom, pill, diaphragm, vasectomy, other _____

**Exercise:** Do you exercise regularly? □ **Yes** □ **No**
What kind of exercise? _____

_____

How long (minutes)? _____How often? _____

**Diet:** How would you rate your diet? □ **Good** □ **Fair** □ **Poor**
Would you like advice on your diet? □ **No** □ **Yes**

**Safety:** Do you use a bike helmet? □ **No bike** □ **Yes** □ **No**
Do you use seatbelts consistently? □ **Yes** □ **No**

Does your home have a working smoke detector? □ **Yes** □ **No**

If you have guns in your home, are they locked up?
□ **Not applicable** □ **Yes** □ **No**

Is violence at home a concern for you? □ **No** □ **Yes**

Have you completed an Advance Directive for Health Care (ADHC), **Living Will**, or **POLST** (Physician Orders for Life Sustaining Therapy)?
(Circle above all that apply) □ **Yes** □ **No**

**SOCIAL HISTORY:**

Occupation (or prior occupation): _____retired/unemployed/leave of absence/disabled (circle one)

Employer: _____Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____Number of children: _____Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____

Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel: _____

_____

_____

**Thank-you for taking the time to fill this out.**

# PATIENT NOTICE

Our goal at HOPES is to provide quality medical care. Because of our concern for your health and well-being, there are certain types of medications we may not be able to prescribe to you. Examples include the following:

- Oxycontin
- Oxycodone
- Hydrocodone
- Percocet
- Percodan
- Lortab
- Lorcet
- Morphine
- Tylenol #3
- Tylox
- Ultram/Tramadol
- Xanax
- Valium
- Restoril
- Klonopin
- Tranxene
- Ativan
- Ambien
- Soma
- Methadone
- Vicodin
- Stimulants for Adults

If you are already taking any of the above medications, your provider may want to talk to you about alternative treatments.

If you are a new patient, please be aware that it is highly unlikely we will be able to prescribe any of these medications for you.

If you have questions and concerns about this policy, please feel free to discuss them with your provider or with the Chief Medical Officer.

NORTHERN NEVADA HOPES *your partner in health.*