

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

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

Patient Registration

_____		_____/_____/_____	
DATE		SOCIAL SECURITY NUMBER	

FIRST NAME	MIDDLE NAME	LAST NAME	

OTHER PREFERRED 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	PREFERRED 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	

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

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



FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	

Privacy Practices and Complaint/Grievance Procedure Acknowledgement

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.

Adult Authorization: Release of Information

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	☐ Hospital records
☐ Medication lists	☐ Psychiatry notes
☐ Substance use notes	☐ Lab results
☐ HIV/AIDS or other	☐ Psychotherapy notes
☐ Diagnostic test results	☐ D/C summary
☐ Other (be specific)	

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 where 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
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REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information.

_____ PATIENT/LEGAL GUARDIAN SIGNATURE	_____ DATE
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Email Consent: Non-Secure E-Mail

PATIENT NAME

DATE OF BIRTH

PATIENT EMAIL ADDRESS

Northern Nevada HOPES' team cannot guarantee the security and confidentiality of an e-mail transmission. Employers and on-line services have the right to access and archive e-mail transmitted through their systems. If your e-mail is a family address, other family members may see your messages, therefore, please be aware that you e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. Northern Nevada HOPES and your health care provider are not liable for breaches of confidentiality caused by yourself or a third party.

E-mail is best suited for routine matters and simple questions. You should not send e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail, but cannot guarantee that an e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone. Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the "Subject" line of your message.

All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health record.

Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the Health Team without your authorization.

In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

You are responsible for protecting your password or other means of access to e-mail.

SIGNATURE OF PATIENT

DATE

SIGNATURE OF WITNESS

DATE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
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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:
