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.*

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.*

Pediatric Patient Registration

_____ _____/_____/_____

DATE SOCIAL SECURITY NUMBER

_____

FIRST NAME MIDDLE NAME LAST NAME

_____

NICK NAME (IF APPLICABLE) PHONE NUMBER

_____

HOME ADDRESS CITY STATE ZIP CODE

_____

AGE DATE OF BIRTH PLACE OF BIRTH SEX AT BIRTH

_____

FORM COMPLETED BY RELATIONSHIP TO PATIENT

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 _____

How did you hear about us?

☐ By a current HOPES patient ☐ Billboard ☐ HOPES Website ☐TV Ad ☐Social Media

☐ Other_____

Student Status:

☐ Full-Time Student ☐ Part-Time Student ☐ Not a Student

Employment Status:

☐ Employed ☐ Not Employed ☐ Retired ☐ Active Military Duty ☐ Unknown

INSURANCE INFORMATION:

Have you applied for Medicaid ☐ **Yes** ☐ **No** **If Yes, in which State**_____

Insurance Gender: ☐ **M** ☐ **F**

Primary Insurance Company (Include Medicare/Medicaid)_____
Address_____
Telephone #_____ Birth Date____/____/____
Subscriber_____ Employer_____
Group Number_____ ID/Subscriber Number_____
Medicare/Medicaid Number_____ State_____

Secondary Insurance Company (Include Medicare/Medicaid)_____
Address_____
Telephone #_____ Birth Date____/____/____
Subscriber_____ Employer_____
Group Number_____ ID/Subscriber Number_____
Medicare/Medicaid Number_____ State_____

Parent/Legal Guardian Information #1

_____
PARENT/LEGAL GUARDIAN NAME(S) RELATIONSHIP TO PATIENT PARENT/LEGAL GUARDIAN'S DOB

_____
BEST PHONE NUMBER ADDITIONAL PHONE NUMBER EMAIL ADDRESS

_____
HOME ADDRESS CITY STATE ZIP CODE

Permission to Contact Parent/Legal Guardian #1 _____ (Initial)

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
Leave text messages (SMS)?*	☐ Yes	☐ No	Ask for survey participation?	☐ Yes	☐ No

* Fees may be applied by your service carrier.

Parent/Legal Guardian Information #2

PARENT/ LEGAL GUARDIAN NAME(S) | RELATIONSHIP TO PATIENT | PARENT/LEGAL GUARDIAN'S DOB

BEST PHONE NUMBER | ADDITIONAL PHONE NUMBER | EMAIL ADDRESS

HOME ADDRESS | CITY | STATE | ZIP CODE

Permission to Contact Parent/Legal Guardian #2 _____ (Initial)

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
Leave text messages (SMS)?*	☐ Yes	☐ No	Ask for survey participation?	☐ Yes	☐ No

* Fees may be applied by your service carrier.

Emergency Contact Information

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. I understand that any fields that are left blank will be recorded as 'unknown' in my health records.

PATIENT SIGNATURE | DATE

PARENT/ LEGAL GUARDIAN SIGNATURE | DATE

Authorization for Third Party to Consent to Treatment of Minor

I am the
____Parent
____Guardian
____Other person having legal custody_____
(*Describe legal relationship)*

of_____, a minor.
(Print *Name of Minor)*

I hereby authorize_____, to act as my agent to consent to all health
(*Print Name of Agent)*
services which are recommended by, and delivered under any licensed provider at Northern Nevada HOPES, whether such diagnosis, treatment or transport/referral for hospital care is required.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or transport/referral for hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or transport/referral for hospital care which a licensed provider, from Northern Nevada HOPES, recommends.

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 for one year from today, or until revoked in writing, whichever is sooner.

Signature: _____ Date/Time:_____
(***Parent, guardian, other person above having legal custody)***

Print Name: _____
(***Parent, guardian, other person above having legal custody)***

Witness to Signature:_____ Date/Time:_____

Print MINOR's Name: _____ Date of Birth:_____

_____ Copy given to Agent _____ Consent scanned in Minor's chart _____ Original sent to Compliance Department

---

I acknowledge that I have the right to revoke these authorizations at any time, (Which may be 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.

REVOKE AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I hereby revoke these authorizations for third party consent to treatment of said minor.

Signature: _____ Date/Time:_____
(***Parent, guardian, other person above having legal custody)***

_____ Copy given to Agent _____ Consent scanned in Minor's chart _____ Original sent to Compliance Department

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.*

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.*

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
- Change medical providers at Northern Nevada HOPES
- Get another opinion about your illness or treatment
- Respect for your cultural, social, spiritual, and personal values and beliefs
- Know the cost of your care and ways you may pay for your care
- Access the on-call doctor through an after-hours answering service
- 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.
- Use the REMSA Nurse Hotline at 775-858-1000
- Not be refused services due to inability to pay
- Be informed about your illness and treatment, including options for your care
- Know about services available through HOPES
- Know that HOPES does not provide dental services on site, but you can be referred to external dentists
- Ask for special arrangements if you have a disability
- Refuse to be included in any research program without limiting medical care or treatment
- 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
- Be informed of HOPES pharmacy hours and timelines for filling new and existing prescriptions
- Be informed of electronic access of your patient records through HOPES patient web portal
- Privacy of your health records as determined by HIPAA / 42 CFR Part 2
- Talk with a supervisor about any questions or problems with your care
- Know about legal reporting requirements
- Refuse treatment care and services as allowed by law
- File a complaint or a formal grievance, if you are not satisfied with the care at HOPES

_____ _____

INITIAL DATE

**** Continued On Next Page ****

NORTHERN NEVADA HOPES *your partner in health.*

Patient Rights and Responsibilities (Continued)

As a patient, you have the responsibility to:

- Inform 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
- 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
- Use medications or medical devices for yourself only
- Inform a medical provider if you become worse or have an unexpected reaction to a medication
- Follow prescriber's directions on all aspects of prescriptions
- 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
- Pay your co-pays and bills on time
- Meet with financial counselors to set up payment plans

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

_____

PATIENT NAME

_____

PATIENT/LEGAL GUARDIAN 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	

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.

FOR OFFICE USE ONLY: PLEASE CHECK ONE

PEDIATRIC PRIMARY CARE	
PEDIATRIC BEHAVIORAL HEALTH	

NORTHERN NEVADA HOPES *your partner in health.*

Pediatric 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

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

NORTHERN NEVADA HOPES *your partner in health.*

Email Consent: Non-Secure E-Mail/Text (SMS) Messaging

_____

PATIENT NAME DATE OF BIRTH

_____

PATIENT EMAIL ADDRESS

Northern Nevada HOPES' team cannot guarantee the security and confidentiality of an e-mail or text (SMS) message transmission. Employers and online services have the right to access and archive e-mail and text (SMS) transmitted through their systems. If your e-mail is a family address, other family members may see your messages. If you allow others access to your cell phone they may see your messages. Therefore, please be aware that you e-mail and/or text (SMS) 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 or text (SMS) messages. Northern Nevada HOPES and your health care provider are not liable for breaches of confidentiality caused by yourself or a third party.

Northern Nevada HOPES will only send text (SMS) messages pursuant to the Federal Communications Commission's (FCC) Declaratory Ruling and Order. HOPES will not receive text (SMS) messages.

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 and text (SMS) messages.

_____

SIGNATURE OF PATIENT DATE

_____

SIGNATURE OF WITNESS 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	

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:

_____

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY: PLEASE CHECK ONE

PEDIATRIC PRIMARY CARE	
PEDIATRIC BEHAVIORAL HEALTH	

NORTHERN NEVADA HOPES *your partner in health.*

PEDIATRIC | Initial Health History

Today's Date:_____

_____

CHILD FIRST NAME MIDDLE NAME LAST NAME

_____

Nickname AGE DATE OF BIRTH

Form completed by: _____

Previous healthcare provider? _____

Specialists (past or present)? _____

Living Arrangements:

Who does the child live with? (ex. Mother, Father, Siblings, Grandparents)

_____

_____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

_____

FAMILY STRESSORS – Please check any stresses in your home or environment:

☐ Job difficulty ☐ Separation/divorce ☐ Domestic Violence ☐ Mental Illness

☐ Drug/alcohol abuse ☐ Incarceration ☐ Difficulty getting enough food

☐ Difficulty with safe, adequate housing

Additional Comments:

_____

_____

BIRTH HISTORY

Birth weight: _____ lbs _____oz Birthplace:_____

When was the baby born? ☐ At term ☐ Early ☐ Late If early, how many weeks gestation? _____

Did the mother have any illness or problem with her pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

During pregnancy, did the mother:

Smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use drugs? ☐ Yes ☐ No Medications? ☐ Yes ☐ No

If yes to the above, what and when? _____

Date of adoption (if applicable): _____

Delivered? ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Did the baby have any problems right after birth? ☐ Yes ☐ No If yes, please explain:_____

How was the initial feeding given? ☐ Breast ☐ Bottle If breastfed, how long?_____

Did the baby go home with the mother from the hospital? ☐ Yes ☐ No

If no, please explain: _____

Other comments:_____

GENERAL

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain: _____
Does your child have any medical conditions?	☐ Yes	☐ No	Explain: _____
Has your child had serious injuries or accidents?	☐ Yes	☐ No	Explain: _____
Has your child ever been hospitalized?	☐ Yes	☐ No	Explain: _____
Has your child ever had surgery?	☐ Yes	☐ No	Explain: _____
Is your child allergic to any medicines or drugs?	☐ Yes	☐ No	Explain: _____
Does your child take any medications regularly?	☐ Yes	☐ No	Explain: _____
Are your child's vaccines up to date?	☐ Yes	☐ No	Explain: _____
Are any family members smokers?	☐ Yes	☐ No	Explain: _____
Are there any guns in the home?	☐ Yes	☐ No	Explain: _____

PAST HISTORY – if applicable, does your **child** have or has he/she ever had:

Frequent ear infections/hearing loss	☐ Yes	☐ No	Explain: _____
Problems with eyes or vision	☐ Yes	☐ No	Explain: _____
Asthma, bronchitis, pneumonia	☐ Yes	☐ No	Explain: _____
Nasal allergies	☐ Yes	☐ No	Explain: _____
Environmental or food allergies	☐ Yes	☐ No	Explain: _____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain: _____
Anemia	☐ Yes	☐ No	Explain: _____
Frequent abdominal pain/constipation	☐ Yes	☐ No	Explain: _____
Bladder or kidney infection/malformation	☐ Yes	☐ No	Explain: _____
Bed wetting (after 5 years old)	☐ Yes	☐ No	Explain: _____
(F) Has she started her menstrual period?	☐ Yes	☐ No	Explain: _____
(F) Problems with periods	☐ Yes	☐ No	Explain: _____
Chronic or recurrent skin problem	☐ Yes	☐ No	Explain: _____
Frequent headaches	☐ Yes	☐ No	Explain: _____
Congenital cataracts or retinoblastoma	☐ Yes	☐ No	Explain: _____
Convulsions or neurological problems	☐ Yes	☐ No	Explain: _____
Diabetes	☐ Yes	☐ No	Explain: _____
Thyroid or other endocrine problems	☐ Yes	☐ No	Explain: _____

Alcohol/Drug use	☐ Yes	☐ No	Explain: _____
Head injuries/concussion/loss of consciousness	☐ Yes	☐ No	Explain: _____
Bleeding or clotting problems	☐ Yes	☐ No	Explain: _____
Blood transfusion	☐ Yes	☐ No	Explain: _____
Chickenpox	☐ Yes	☐ No	Explain: _____
Organ transplant	☐ Yes	☐ No	Explain: _____
Cancer or bone marrow treatment	☐ Yes	☐ No	Explain: _____
Chemotherapy	☐ Yes	☐ No	Explain: _____
Gender transition	☐ Yes	☐ No	Explain: _____
Sexual transmitted infection	☐ Yes	☐ No	Explain: _____
Sleep problems	☐ Yes	☐ No	Explain: _____
Persistent snoring	☐ Yes	☐ No	Explain: _____
Obesity	☐ Yes	☐ No	Explain: _____
Dental decay	☐ Yes	☐ No	Explain: _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	Explain: _____

Developmental delay (physical, social, language, learning)

☐ Yes ☐ No Explain: _____

Any other significant problems?

☐ Yes ☐ No Explain: _____

FAMILY HISTORY – have any family members had the following:

Childhood Hearing Loss	☐ Yes	☐ No	Who: _____	Comments: _____
Nasal Allergies	☐ Yes	☐ No	Who: _____	Comments: _____
Food Allergies	☐ Yes	☐ No	Who: _____	Comments: _____
Asthma	☐ Yes	☐ No	Who: _____	Comments: _____
Tuberculosis	☐ Yes	☐ No	Who: _____	Comments: _____
Heart Disease (before 50)	☐ Yes	☐ No	Who: _____	Comments: _____
Sudden Cardiac Death	☐ Yes	☐ No	Who: _____	Comments: _____
High blood pressure	☐ Yes	☐ No	Who: _____	Comments: _____
High cholesterol	☐ Yes	☐ No	Who: _____	Comments: _____
Anemia	☐ Yes	☐ No	Who: _____	Comments: _____
Kidney disease	☐ Yes	☐ No	Who: _____	Comments: _____
Liver disease	☐ Yes	☐ No	Who: _____	Comments: _____
Diabetes (before 50)	☐ Yes	☐ No	Who: _____	Comments: _____
Epilepsy/convulsions	☐ Yes	☐ No	Who: _____	Comments: _____
Alcohol/Drug abuse	☐ Yes	☐ No	Who: _____	Comments: _____
Tobacco Use	☐ Yes	☐ No	Who: _____	Comments: _____
Mental illness/depression	☐ Yes	☐ No	Who: _____	Comments: _____
Developmental delay	☐ Yes	☐ No	Who: _____	Comments: _____
ADHD	☐ Yes	☐ No	Who: _____	Comments: _____
Immune problems	☐ Yes	☐ No	Who: _____	Comments: _____
HIV/AIDS	☐ Yes	☐ No	Who: _____	Comments: _____
Cancer (before 55)	☐ Yes	☐ No	Who: _____	Comments: _____
Gastrointestinal problems	☐ Yes	☐ No	Who: _____	Comments: _____
Bleeding Disorder	☐ Yes	☐ No	Who: _____	Comments: _____
Clotting Disorder	☐ Yes	☐ No	Who: _____	Comments: _____
Obesity	☐ Yes	☐ No	Who: _____	Comments: _____

Additional Comments:

_____
_____
_____
_____
_____

For Internal Use Only: MRN_____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME_____
Last *First* *Middle*

PREVIOUS NAME(S)_____ **GENDER:** M____ F____

STREET ADDRESS / P.O. BOX_____

CITY_____ **STATE**_____ **ZIP CODE**_____

PHONE NUMBER _____ **EMAIL**_____

DATE OF BIRTH _____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____
Signature of patient or authorized representative Date Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Name of Authorized Representative (Printed) Relationship Date Time

_____
Address of authorized representative signing this form (please print):

_____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:_____ Name of Witness:_____
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.

Patient Consent Form for Electronic Exchange of Individual Health Information

HealtHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healtHIEnevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services.
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.
2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealtHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases
3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.
5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

NORTHERN NEVADA HOPES *your partner in health.*

Privacy Practices Notice

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.

NORTHERN NEVADA HOPES *your partner in health.*

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:

Linda Barnes
580 W 5th St
Reno, NV 89503
Phone: 775-997-7509
Fax: 775-236-1448
Email: lbarnes@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