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.*

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

* Fees may be applied by your service carrier.

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

Employment Status:

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

Have you been in the military? ☐ Yes ☐ No

Student Status:

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

How did you hear about us?

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

☐ Other_____

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

☐ Yes ☐ No

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_____

_____

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 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.*

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 and dis-enroll in care at any time
- Know the names and titles of the staff 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
- To be receive information regarding changes in or termination of programs at HOPES
- 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 and referral to external dentists is available
- 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
- Know about philosophy and characteristics of the patient management program
- Have personal health information shared with the patient management program only in accordance with state and federal law
- Identify the program's staff members, including their job title, and to speak with a staff member's supervisor if requested
- Speak to a health professional
- Receive information about the patient management program
- Receive administrative information regarding changes in, or termination of, the patient management program
- Decline participation, revoke consent, or dis-enroll at any point in time

_____ INITIAL _____ DATE

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 medical problems
- Inform HOPES about changes on contact information
- 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 plan
- Submit any forms that are necessary to participate in the program, to the extent required by law
- Give accurate clinical and contact information and to notify the patient management program of changes in this information
- Notify their treating provider of their participation in the patient management program, if applicable

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.

NORTHERN NEVADA HOPES *your partner in health.*

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
_____ 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

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:

_____

_____

_____

_____

_____

_____