Absolute Primary Care

Patient Registration Form

☐ New Patient
☐ Patient Update

NAME First _____ Middle _____ Last _____

Social Security # ___ - ___ - _____ Date of Birth _____ Sex ☐ M ☐ F Married ☐

Address _____ City _____ State ____ Zip _____

Phone Home # _____ Cell # _____ Work # _____

Email _____ Occupation _____

Employer & Address _____

Race ☐ Decline ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Pacific Islander ☐ Others

Ethnic Group ☐ Decline ☐ Hispanic/Latino ☐ Not Hispanic/Latino Language _____

Emergency Contact _____ Cell # _____ Home # _____

Address _____ City _____ State ____ Zip _____

Patient Pharmacy:

Relationship _____

Primary Insurance _____ Phone _____

Address _____ City _____ State ____ Zip _____

Name of Policy Holder _____ Date of Birth _____

Relationship to Patient _____ Employer _____

Member Id # _____ Group Id _____ Social Security # ___ - ___ - ____

Secondary Insurance _____ Phone _____

Address _____ City _____ State ____ Zip _____

Name of Policy Holder _____ Date of Birth _____

Relationship to Patient _____ Employer _____

Member Id # _____ Group Id _____ Social Security # ___ - ___ - ____

We will not share your personal health information unless to prevent serious risk to you or others or required to do so by law. You have the right to access your medical records and you have the right to revoke any written authorization given to us. Such request must be in writing and acknowledged by us.

I hereby authorize the release of complete medical information to my insurance company, and to other medical professionals and medical institutions that I may be referred to for treatment. I authorize my insurance benefits to be paid directly to Absolute Primary Care Center. I have verified with my insurance company that Absolute Primary Care Center is a participating provider and I am fully responsible if there are any unpaid claims by my insurance company for any reason.

Patient Signature _____ Date _____

Absolute Primary Care

Patient Medical History

☐ New Patient
☐ Patient Update

Patient Name _____ Date of Birth _____

Have you ever been diagnosed with any of the following?

Alcohol/Drug Use	☐	Kidney Stones	☐
Anemia	☐	Liver Disease	☐
Arthritis	☐	Lung Disease	☐
Asthma/COPD	☐	Neurologic Disease	☐
Cancer	☐	Rheumatic Fever	☐
Chronic Pain	☐	Seizures	☐
Diabetes	☐	Sleep Disorder	☐
Depression	☐	Smoking History	☐
Genital Disease	☐	Stomach Ulcers	☐
Heart Disease	☐	Stroke	☐
Hepatitis	☐	Tuberculosis	☐
High Blood Pressure	☐	Urologic Disease	☐

Injuries _____ Date _____

Illnesses _____ Date _____

Surgeries _____ Date _____

Allergies

1. Medication _____ Reaction _____

2. Medication _____ Reaction _____

Chief Complaints

Chief Complaint _____

When did your symptoms appear? _____

If you are pregnant, last menstrual period? _____

Medications you are currently taking:

1. Medication _____ Dosage _____ Frequency _____

2. Medication _____ Dosage _____ Frequency _____

Advanced Directive (Circle one): Yes No

Please provide a copy if answer is yes

Absolute Primary Care Center

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint to Secretary of Health and Human Services if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition: Yes / No If yes please specify below
    - Name : _____ Phone:
    - Address : _____
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services or for collection of unpaid dues
- Help with public health and safety issues
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- We never market or sell personal information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Print Name: _____

Signature: _____

Date: _____

Absolute Primary Care Center

Authorization for Claims Payment and Reviews

a. **Assignment and Coordination of Insurance Benefits -** I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Absolute Primary Care Center for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Absolute Primary Care Center for services rendered to me during the applicable periods of medical care.

b. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider a service rendered during this visit or has not authorized the service, they will not pay for the service rendered during this visit. I agree to be fully responsible for payment to Absolute Primary Care Center for any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

c. **Interns, Medical & Nurse Practitioner Students**- I understand that interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of Absolute Primary Care Center's education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Absolute Primary Care Center. I understand and agree this document will remain in effect for all office visits to Absolute Primary Care Center, unless specifically rescinded in writing by me.

PATIENT SIGNATURE: ---------- DATE: ----------

RELATIONSHIP TO PATIENT: ----------SELF----------

4218 W Charleston Blvd, Las Vegas, NV 89102 ■ Tel (702) 885 7185 ■ Fax (702) 243 0117

Absolute Primary Care Center

Release of Information

I _____ (Name), _____ (Date of Birth) hereby authorize Absolute Primary Care Center to obtain my protected health information from the facilities listed below. This release of information will be valid for one year unless revoked in writing by the patient.

_____ (Facility Name), _____ (Date of Service)

_____ (Facility Name), _____ (Date of Service)

_____ (Facility Name), _____ (Date of Service)

Information Requested:

[X] All Labs	[X] All Imaging	[X] All Consults
[X] MRI Only	[X] CT Only	[X] X-rays only
[X] Discharge Report	[X] Followup Notes	[X] Films

Other Information:

_____

_____

_____

Please send all information via:

[X] FAX (702) 243 0117

[ ] Mail: 4218 W Charleston Blvd, Las Vegas, NV-89102

_____ Patient Name

_____ Date

_____ Authorized Signature

SELF Relationship