Absolute Primary Care

Patient Registration Form

☒ New Patient
☐ Patient Update

NAME Last _____ First _____ Middle _____

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 _____

Relationship _____ ★[Patient Pharmacy:]★

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

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 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 reasonable attorneys' fees and other collection costs incurred by Absolute Primary Care Center, unless specifically rescinded in writing by me.

PATIENT SIGNATURE: _____ **DATE:** _____

RELATIONSHIP OF PATIENT: Self.

4218 W Charleston Blvd. Las Vegas, NV 89102 3413 S. Eastern Ave. Las Vegas, NV 89102 3440 W Cheyenne Ave, Ste 100. Las Vegas, NV 89032 (702)885-7185 - Fax (702)243-0117 - @ absolute@apcclv.com

Absolute Primary Care

RELEASE OF INFORMATION

I _____, _____ hereby
(Name) (Date of Birth)

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:

☒ All Labs	☒ All Imaging	☒ All Consults
☒ MRI Only	☒ CT Only	☒ X-Rays Only
☒ Films	☒ Follow-up Notes	☒ Discharge Report

Other Information:

_____

_____

_____

Please send all information via:

☒ FAX (702) 243 0117 ☐ Mail: 4218 W Charleston Blvd, Las Vegas, NV 89102

_____ _____
Patient Name Date

_____ Self. _____
Authorize Signature Relationship

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 have share your information
- Get a copy of this privacy notice
- 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:

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

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 request
- Work with a medical examiner or funeral doctor
- Address worker's compensation, law enforcement and other government requests
- Respond to lawsuits and legal actions
- We never market or sell persona 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: _____ **DATE:** _____

SIGNATURE: _____

Absolute Primary Care Center

OFFICE POLICIES

Appointments / Scheduling

- Patient appointments are preferred to ensure prompt and dedicated service, although walk-ins are accepted depending on the office availability.
- Initial visits must be in-person, ID and insurance card will be required in your first appointment.
- Patients arriving late for their appointments without prior notification may be requested to reschedule the appointment to maintain the efficiency of the clinic schedule.
- If your address, phone number, preferred pharmacy or personal information has changed, please let us know while scheduling your next appointment

Cancellation / No-Show Policy

- Our office requires at least 24 hours' notice to cancel or reschedule an appointment.
- Patients missing multiple appointments (typically 2+ or 3+ within a 12-month period) may be dismissed from the practice.

Financial Policy / Insurance / Payments

- Co-pay, co-insurance or deductibles, and any account balances are due at the time of service.
- Patients must notify the office of any changes regarding insurance information; failure may result in being considered as self-pay. If this information is not provided within three (3) weeks, it leads to billing delays and the patient will be held financially accountable for the services rendered.
- Patients with dual insurance coverage—such as Medicare and Medicaid, or two commercial insurance plans—our office will bill both, your primary and secondary insurance. However, if your secondary insurance denies payment for any reason, you will be responsible for the remaining balance. We encourage you to review your insurance policies and coordination of benefits to avoid unexpected charges
- Self-pay or uninsured patients must pay in full prior to the visit a $65 fee.

Prescription Refills / Medication Management

- Please allow 24 to 48 business hours for the processing of prescription refill requests. For new prescriptions, please note that they will typically be ready for pickup at your designated pharmacy after 5:00 PM on the day they are sent. To avoid delays, we encourage patients to request refills well in advance of running out of medication.
- Refills may not be authorized if the patient is overdue for a checkup or monitoring lab work. If you have not been seen in our office for more than 3 months for chronic disease and need a refill on medication, please schedule an appointment.
- For patients with pain, anxiety, depression, insomnia, etc. Referrals will be sent to the appropriate specialist. Providers do not prescribe or **r**efill controlled substances.

Referrals & Authorizations Policy

- ***Emergency Referrals:*** **I**n the event of a medical emergency, staff must instruct the patient to call 911 or proceed immediately to the nearest emergency room. Our office does not handle emergency medical care and will not delay appropriate emergency services.
- ***Urgent Referrals:*** Urgent referrals are for medical issues that require prompt attention but are not life-threatening. These referrals will be evaluated and processed within 48 hours. Providers and staff should prioritize documentation and communication to ensure timely coordination of care.

- ***Routine Referrals:*** Routine referrals pertain to non-urgent specialty care or services. These referrals will be evaluated and completed within 7 to 14 business days. Patients should be informed of this timeline and encouraged to follow up if they have not been contacted within that period.
- **Prior Authorizations:** These may take 7 to 14 business days, depending on your insurance provider and the urgency of the request. We appreciate your patience as we work with your insurer to obtain the necessary approvals.
- **Insurance Responsibility:** Patients are responsible for verifying that the referred specialist accepts their insurance. We recommend contacting the specialist directly before your appointment.
- **Referral Compliance:** Failure to follow through with a referral may result in delays in future referrals for the same or related conditions.

Medical Records & Privacy

- Medical records, including laboratory results, imaging, and radiology reports, will not be released via email due to privacy and security concerns. Email is not a secure or encrypted form of communication, and we are committed to protecting your personal health information in accordance with HIPAA regulations.
- Privacy Notices and information on rights are available per HIPAA and federal standards.
- Patients may request copies of their medical records via signed release; nominal of fee $0.60 per page may apply.

Minors & Consent

- Minors must have a parent or legal guardian present or provide written consent in order to receive medical treatment. Please note that our practice may limit services to minors based on age and requires parental supervision during their visits.

Communication & Messaging

- Voicemail or text messaging policies may apply: text messaging is not secure and should not be used for urgent matters.
- Non-urgent calls are typically returned within 1–2 business days.

General Conduct Policies

- Patients are expected to maintain a respectful environment; disruptive or abusive behavior may lead to dismissal. We maintain a zero-tolerance policy for verbal abuse, threats, or inappropriate behavior toward the staff
- The clinic may enforce non-smoking rules, ask for silence in waiting or triage areas, and regulate cellphone use.
- For the health and safety of all patients, pets are not allowed in the clinic. However, service animals trained to assist individuals with disabilities are welcome, in accordance with the Americans with Disabilities Act (ADA).

Infection / Special Precautions

- Patients with transmissible illnesses may be scheduled at the end of the day to minimize exposure to others. We kindly ask these patients to practice respiratory etiquette, including **wearing a mask** and covering coughs or sneezes. Your cooperation helps us maintain a safe environment for all patients and staff.

Medical Office Fee:

- Please be advised that the following administrative services provided by our office carry a fee:

➢ Work, School & Sports Physical Paperwork – $65
➢ FMLA Form per Completion – $30

- ➢ TB Test (Quantiferon) – $30
- ➢ TB Skin Test – $30 per step
- ➢ DMV Form per Completion – $50

Services Not Provided by Our Office:
Please note that our practice does **not** offer the following services or documentation:

- **Emotional Support Animal (ESA) Letters:** These require evaluation by a licensed mental health professional. Our primary care providers do not provide ESA letters or complete related applications.
- **FMLA Forms for Specialty Care:** A second FMLA form must be completed by the appropriate specialist, if you have been previously referred please follow up with the specialist.
- **Motor Vehicle Accident (MVA) Visits:** We only assist established patients with care related to motor vehicle accidents. We do not accept new patients for MVA-related evaluations or treatments.
- **Medical Marijuana Certification:** Our providers do not prescribe, certify, or complete forms related to medical marijuana applications.
- **Certain Procedures:** Our providers do not perform ear lavage, suture removal, wound care, or dressing changes. Please contact an appropriate urgent care or specialist for these services.

Acknowledgment

By signing below, you confirm that you have read, understood, and agree to follow the clinic's policies.

These guidelines help ensure respectful communication, efficient care, and a safe environment for all.

Name: _____

Signature: _____

Date: _____

Absolute Primary Care Center

Clinic Policy on Schedule II Controlled Substances.

Out clinic is committed to providing safe, effective and evidence-based care for all patients. In order protect patient health, reduce the risk of misuse, and comply with best practice standards, our providers have adopted the following policy regarding controlled medications:

1. No Schedule II Prescription

This office does not prescribe any Schedule II controlled substance. These include, but are not limited to:

- Opioids (e.g., oxycodone, hydrocodone, morphine, fentanyl)
- Stimulants (e.g., amphetamine, dextroamphetamine, methylphenidate)
- Certain other high-risk medications classified as Schedule II by the DEA.

2. Alternative Management

- When appropriate, non-controlled or lower-schedule alternatives will be considered for treatment.
- Our providers will collaborate with patients to find safe and effective management strategies.

3. Specialist Referrals

- If a patient's condition requires treatment with a Schedule II medication, they will be referred to an appropriate specialist (e.g., pain management, psychiatry or neurology).
- This ensures that patients receive specialized evaluation and monitoring.

4. Patient Acknowledgment

- Patients are informed of this policy at the time of establishing care. Signing our clinic agreement indicates understanding and acceptance of this policy.

This policy reflects our clinic's commitment to safety, responsible prescribing, and high-quality care.

Name: _____

Signature: _____

Date: _____

3440 W Cheyenne Ave, Suite 100, North Las Vegas, NV 89032 - Tel: (702) 761 4430 - Fax: (702) 243 0117
8064 W. Sahara Ave. Suite 100 Las Vegas, NV 89117 - Tel: (702) 546 3960 - Fax: (702) 243 0117
4218 W Charleston Blvd, Las Vegas, NV 89102 - Tel: (702) 425 5050 - Fax: (702) 243 0117
3413 S Eastern Ave, Las Vegas, NV 89169 - Tel: (702) 800 6301 - Fax: (702) 243 0117

SMS/Text Messaging Consent Form

Absolute Primary Care Center

Absolute Primary Care Center offers patients the option to receive important updates via SMS/text messaging. These messages may include appointment reminders, scheduling updates, clinic notifications, and general non■sensitive healthcare communications. SMS messages are not encrypted and may be seen by others who have access to your mobile phone. Please do not use SMS/text messaging for medical emergencies. If you are experiencing a medical emergency, call 911 or seek immediate medical attention.

By signing this form, you consent to receive SMS/text messages from Absolute Primary Care Center at the mobile number you provide below. You understand and agree that: • Message frequency may vary depending on your interactions with the clinic. • Message and data rates may apply depending on your mobile carrier plan. • You may opt out of receiving SMS messages at any time by replying STOP to any message or by contacting the clinic. • You may request assistance by replying HELP or calling the clinic. • SMS messaging should not be used to send highly sensitive medical information.

Clinic Phone: 702■425■5050
Website: apcclv.com

Patient Name: _____

Mobile Phone Number: _____

Date of Birth: _____

Patient Signature: _____

Date: _____