Prime Cardiology of Nevada

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Receive Information Prime Cardiology of Nevada	
Street Address 2911 N Tenaya Way Suite #104 , Las Vegas NV 89128	
Phone Number 702-463-9855	Fax Number **702-268-7605**

I authorize the release of my entire medical record with the exception of the following (initialed):

( ) Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis

( ) HIV-Related Treatment

( ) Mental Health Information or Psychological Conditions

( ) Alcohol or Substance Abuse Treatment

( ) Genetic Testing

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below.

Signature of Patient or Personal Representative	Date Signed:	Description of Personal Representative's Authority:

Prime Cardiology of Nevada

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Medicare] ❑ [Medicaid] ❑ [SH&L] ❑ [HPN] ❑ [BCBS] ❑ [Commercial] ❑ [Aetna] ❑ [Worker's Comp] ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicia n. I understand that I am financially responsible for any balance. I also authorize Prime Cardiology or insurance to release any information required to to process my claims.

_____ _____

Patient/Guardian signature *Date*

Prime Cardiology of Nevada

PATIENT RIGHTS AND RESPONSIBILITIES

Prime Medical Group is committed to delivering a safe, respectful, and effective healthcare environment. In order to establish trust and maintain collaboration with our Providers, and help maximize the quality and efficiency of your care, we have established the following Patient Rights and Responsibilities:

Patient Rights

As a Prime Medical Group, patient you have the right to:

- Information
  - Know the name and qualifications of all individuals involved in your Care Team;
  - Have access to your medical information in a form you understand;
  - Be provided copies of your medical records upon request;
  - Be informed of estimated costs prior to treatment;
  - Know what resources are available to help manage your health care; and
  - Receive a copy of these Rights and Responsibilities.
- Access to Care
  - Have your new, acute, and chronic healthcare needs addressed through preventive screenings, vaccinations, comprehensive examinations, care management for disease specific conditions, and/or follow-up evaluations;
  - Have access to services, providers, specialists and hospitals within the Prime Medical Group Network;
  - Exercise choice in obtaining Medicare services; and
  - Appeal a health plan coverage determination.
- Respect
  - Be treated with dignity and respect at all times;
  - Be protected against unethical practices or discriminatory treatment;
  - Obtain an advance directive to enable you to communicate your healthcare wishes should you become incapacitated;
  - File a complaint and receive a response according to our grievance process;
  - Be free from any form of restraint or seclusion, unless medically necessary, authorized by a provider, and professionally implemented;
  - Have a family member or friend present during any office examination; and
  - Have your privacy and confidentiality respected and maintained by all Prime Medical Group team members.

Patient Responsibilities

As a Prime Medical Group, patient you have the responsibility to:

- Actively participate your care management
  - Provide accurate and complete information regarding your health;
  - Inform your Provider(s) of any medication allergies and/or side effects;
  - Follow the directions and treatment plans given by your Provider(s);
  - Communicate any barriers which may prevent the directions and/or treatment plan from being followed;
  - Make healthy lifestyle choices;
  - Educate yourself about your own healthcare and your health plan;
  - Be knowledgeable regarding prescribed and over-the-counter medications, vitamins and supplements; and
  - Call the office at least three (3) days prior to when refills are needed.
- Be considerate and courteous
  - Communicate in a constructive manner; and
  - Be respectful and cooperative with Providers and other patients.
- Ensure accurate records and timely payment for services:
  - Inform your Provider if your contact or personal information changes;
  - Pay all copayments, deductibles, and/or past due balance at the time of service; and
  - Bring your insurance card and photo identification to every office visit for verification.

These Rights and Responsibilities may be subject to limitation or modification under applicable state or federal law.

Prime Cardiology of Nevada

Patient HIPAA Acknowledgment and Consent Form

Patient Name (Printed): _____ Date of Birth: _____

Notice of Privacy Practice/clinics

_____ (**Patient/Representative initials)** I acknowledge that I have received the practice's/clinic's Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other affiliated providers may be made available to subsequent affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Communications about My Healthcare

I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide the Practice/Clinic an email or text address at which I may be contacted, I consent to receiving instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained or, at any text number forwarded or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at anytime. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

Revised 2.5.2020