

Welcome!

Silver State Health Services provides family medical care to patients. We are pleased that you have chosen our health center to obtain your medical care. This letter is to give you the information that is needed to establish medical care in our health center.

APPOINTMENTS

- Silver State Health Services only serve patients with appointments. Our service schedule at the 2255 Renaissance Dr. Ste A Location is from 9 am to 7 pm Monday through Friday and 9 am to 3 pm Saturday.
- New patients need to arrive 30 minutes early prior to appointment time.
- Established patients need to arrive 15 minutes before their appointment time.
- Please remember to always sign in when coming in for your appointment.
- Patients that are late for their appointments may be rescheduled.
- Please give at least 24 hour notice before cancelling your appointment.
- 3 no call no shows will cause the removal of repeat appointment slot.
- Multiple cancelations will lead to losing a recurring spot.
- If you are planning on going out of town please report that so it does not impact repeat spot.
- Children under 13 must not be left unattended in the building.
- Check your follow up appointment before leaving the agency.
- Be respectful of others and not use fowl language in the lobby
- No eating in the lobby
- No changing diapers in the lobby as respect for others

FINANCIAL INFORMATION

- We accept Medicaid, private insurance and private pay patients on a sliding scale that qualify. It is your responsibility to verify that our health center accepts your insurance.
- Co-payments need to be made at the time of your appointment. We accept cash, credit card, and personal checks with identification. There is a \$ 25 return checks fee.
- If you or your child has a pending case with Medicaid or private pay, we require that you provide sliding fee documents at the time of the visit. If your child or you are approved for Medicaid, this will be reimbursed to you by our billing company.
- If you have insurance, Medicaid, Nevada Check Up or commercial insurance, you are responsible to make sure you or your child are assigned to our health center before the first appointment.

Documents you need to bring to the first appointment in order to establish care:

- Picture ID-adults
- Uninsured patients will have to bring proof of address (receipt of electricity, or telephone), check stubs and/or tax return.

Payment Due at Time of Services:

- All co-payments and sliding fee portions are due and payable at the time of check-in. If you don't have all the criteria when applying for sliding fee discount you will be responsible to pay the full amount of the visit without a discount.

Thank you

Patient's/Legal Guardian's Signature

Date

Registration Form

Name of patient: _____ Date of Birth: ____/____/____

Name of Parent/ guardian: _____ Do you have custody papers: yes___ No___

Address: _____ Apt/Unit _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cellular: _____ Cellular Carrier: _____

Emergency contact name/relationship: _____ Phone number: _____

How would you like to be reminded of your appointment: Text: _____ Phone call: _____

Email: _____

When is the best time to call you? _____

How did you find out about our agency? _____

Do you have a Primary Care Doctor? _____ If yes, doctor's name: _____

Your medical care is important for our health center. For this reason, we ask that all patients be seen at least annually.

Have you had a complete physical in the last year? _____ When? _____

Do you have a Psychiatrist? _____ If yes, doctor's name: _____

Do you need transportation for your appointment? _____

Primary Insurance: _____ #ID number _____ # Subscription: _____

Person responsible of insurance: _____ Date of Birth: ____/____/____

Relation to the patient: _____ **SS#** _____

Address _____ Apt/Unit _____

City: _____ State: _____ Zip code: _____

Secondary Insurance: _____ # ID number _____ #Subscription: _____

Person responsible of insurance: _____ Date of Birth: _____

Relation to the patient: _____ **SS#** _____

Address: _____ Apt/Unit: _____

City: _____ Nevada: _____ Zip code: _____

Signature: _____ **Date:** _____

Patient Socio Cultural History

Which of the categories best describes your current annual income? Please check the correct category:

< \$10,000 \$10,000-14,999 \$15,000-19,999 \$20,000-29,999 \$30,000-49,999 \$50,000-79,000 Over \$80,000

Family size* (Including self) _____ Brothers: _____ Sisters: _____ Position in the family: _____

**SSHS defines a family household member as anyone including self, spouse, or partner; any dependent children under 18 years of age; and anyone within the residence; that the head of household provides support for.*

Race: American Indian or Alaska Native Asian Native Hawaiian or other Pacific Islander Black or African America White
 Hispanic Other Race Other Pacific islander Unreported/Refused to report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Refused to Report Veteran: Yes No

Sexual Orientation: Straight Gay or Lesbian Bisexual Something Else Don't Know Choose Not to Disclose

Gender Identification: Male Female Transgender Male to Female Transgender Female to Male Other Choose Not to Disclose

Education Level: Elementary High School Vocational College Graduate/Professional

Current Living Situation (Check all that Apply): Single Family H Multi-Generational Household Homeless Shelter Other: _____

Smoking/Tobacco Use Current Past Never Type: _____ Amount/Day: _____ Number of Years: _____

Alcohol: Current Past Never Drinks/Week: _____

Recreational Drug Use: Current Past Never Type: _____

Are you sexually active? Yes No Have you ever had a sexually transmitted disease (STD)? Yes No

Are there any personal problems or concerns at home, work, or school you would like to discuss? Yes No

Are there any cultural or religious concerns you have related to our delivery of care? Yes No

Are there any financial issues that directly impact your ability to manage your health? Yes No

How often do you get the social and emotional support you need? Always Usually Sometimes Rarely Never

Mental Health Information Sheet

Patient Name: _____

Are you currently receiving counseling/psychotherapy elsewhere? Yes No

Have you received counseling/psychotherapy in the past? Yes, Where? _____ No

Are you currently taking prescribed psychiatric medication (antidepressants or others)? Yes No

Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you had had suicidal thoughts in the past? Frequently Sometimes Rarely Never

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

Are you having any problems with your sleep habits? No Sleeping too little Sleeping too much Poor quality sleep
 Disturbing dreams Other: _____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No	Unexplained memory lapses	Yes / No
Dramatic mood swings	Yes / No	Alcohol/substance abuse	Yes / No
Extreme anxiety	Yes / No	Frequent body complaints	Yes / No
Panic attacks	Yes / No	Eating disorder	Yes / No
Phobias	Yes / No	Body image problems	Yes / No
Sleep disturbances	Yes / No	Repetitive thoughts	Yes / No
Hallucinations	Yes / No	Repetitive behaviors	Yes / No
Unexplained losses of time	Yes / No	Homicidal thoughts	Yes / No

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family experienced difficulties with the following?

Difficulty	Answer	Family Member
Depression	Yes / No	
Bipolar Disorder	Yes / No	
Anxiety Disorder	Yes / No	
Panic Attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

Please assess your family:	Poor	Fair	Good
Communication. Open, plentiful.			
Togetherness. Family outings, traditions.			
Appreciation. Express thanks.			
Encouragement. Providing support.			
Division of Responsibilities. Clear/equal tasks.			
Flexibility. Willing to compromise.			
Affection/Love. Physical expression.			
Community and Family Ties. Spirituality, extended family.			
Commitment. Loyalty, responsibility.			
Forgiveness. Willing to accept mistakes or apologies.			
Shared Interests. Enjoying activities together.			
Friendship. Closeness, companionship.			
Security. Confidence, well being.			
Trust. Reliance, faith.			
Warmth. Tenderness, kindness.			
Respect. Admiration, high opinion.			

Silver State Health Services

2255-A Renaissance Dr Las Vegas, NV 89119

T: 702-471-0420

Notice of Privacy Practices

1. 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. This notice briefly summarizes how we handle your health information and further details of our privacy policies and procedures.
2. How we may use and disclose your health information: We use health information we collect about you for treatment, to obtain payment for our services, for administrative purposes, and to evaluate the quality of care we provide you. Your health Information may be shared with other providers in such cases as referrals, via mail, fax, or electronically. Under the law, there may be instances when we are required to disclose your information without your authorization. Should you not want us to disclose your information, you can revoke your authorization at any time, please keep in mind this may affect your care.
3. Your rights: In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you, If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. Our legal duty: We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make significant changes to our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the number listed below.
5. Privacy complaints: If you are concerned that we violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The address can be requested by contacting the number listed below.

If you have any questions, please contact: Silver State Health Services at 702-471-0420

I, _____ have received a copy of this practice's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Consent for Treatment

I hereby agree to treatment at Silver State Health Services (SSHS).

I understand that all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency or individual without my knowledge and written consent, except when required by law. I understand that SSHS and my counselor are required to report knowledge of current child abuse. I also understand that SSHS and my counselor may be released from confidentiality statutes if there is a serious intent to harm myself or others. I have been provided a SSHS brochure, which includes an emergency hotline telephone number, and other emergency and crisis information.

I further understand that my counselor may consult with other professionals at SSHS in order to provide the best treatment possible for me. Staff and the consulting psychiatrist may also speak with each other, as necessary, concerning my care, and with Student Health if medical consultation is indicated.

Furthermore, since SSHS is also a training center and my counselor or service provider may be a student trainee, I understand that all trainees are supervised and that my situation will be discussed with my counselor's or service provider's supervisor. The intention of supervision is to promote the highest quality care. To that end I may be asked by my counselor to have my sessions videotaped and/or audio taped. If I am to be taped, that process will be discussed with me. I also understand that demographic data is collected and stored on a database for possible anonymous reports. At all times my privacy and care will be treated with the highest regard.

Also, from time to time SSHS may provide me or my child with transportation services (bus pass, taxi, Uber, SSHS Van etc.). In consideration for that service I release from liability and waive my right to sue SSHS for any harm I or my child may suffer, or which may result from participation in such services.

Additionally, I understand that as part of my healthcare record, I/my child will be photographed for internal identification purposes only. Client photographs are part of the client health care record intended for internal identification purposes only. Images cannot reproduce or released to anyone without expressed written consent of the client, their legal guardian or their designated representative.

Email is not a secure medium and confidentiality cannot be ensured; nor is it a reliable method of contacting counselors in crisis or non-crisis situations. Please telephone Silver State Health Services to ensure prompt, confidential staff response.

I have read, understand, and agree to the consent of treatment.

Print Patient Name _____

Patient DOB _____

Signature of Patient or Guardian _____

Relationship to Patient _____

Today's Date _____

Consent Form for ePrescribe Program

ePrescribe Program

- ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:
- Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions, and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Silver State Health Services as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at Silver State Health Services may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care' or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Silver State Health Services to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name _____

Patient DOB _____

Signature of Patient or Guardian _____

Relationship to Patient _____

Today's Date _____