Community Outreach MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

Patient Intake Packet

☐ New Patient ☐ Patient Update Date: _____

PATIENT NAME

Last Name	First Name	Middle Initial	Nickname	Suffix

IDENTIFICATION

Date of Birth	SSN	Driver's License No.	Driver's License State

County of Birth	State of Birth	Country of Birth

Mother's Maiden Name	Veteran ☐ Yes ☐ No

ADDRESS

Street Address	Apt/Unit

City	State	Zip Code

Address Type (Please check one) ☐ Home ☐ Work ☐ Shelter ☐ Homeless ☐ Foreign ☐ Unknown

CONTACT INFORMATION

Cell Phone Number	Consent to Receive Text Messages ☐ Yes ☐ Decline Consent to Receive Voice Messages ☐ Yes ☐ Decline

Email	Contact Preference (select 1 at minimum) ☐Phone (Call/Text) ☐Email ☐ Letter/Mail

DEMOGRAPHICS

Healthcare Employee? ☐ Yes ☐ No

Shared Housing/Housing Facility? ☐ Yes ☐ No

Sex Assigned at Birth
☐ Female ☐ Male ☐ Other ☐ Unknown

Gender Identity
☐ Male
☐ Female
☐Genderqueer
☐ Transgender Male-to-Female (MTF)
☐ Transgender Female-to-Male (FTM)
☐ Decline
☐ Other _____

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

# of Dependents Under 18 _____

# of Dependents Over 18 _____

Race
(Check all that apply)
☐Alaskan Native
☐American Indian
☐Asian
☐Black/African American
☐Native Hawaiian
☐Other Pacific Islander
☐White/ Caucasian
☐Decline

Ethnicity
(Check only 1)
☐Hispanic/Latino
☐Not Hispanic/ Latino
☐Decline

Preferred Language
☐ English
☐ Spanish
☐ French
☐ Other
_____

How'd you hear about us?
☐Website
☐Family/Friend
☐Doctor
☐Newsletter
☐Advertisement
☐Flyer
☐Social Media
☐Walk In
☐Other: _____

ACCOMMODATIONS			
Disability (Check all that apply, or None)			
☐Visual Impairment	☐ Speech/Language Impairment	☐ Medical Disability	☐ Other _____
☐Hearing Impairment	☐ Learning Disability	☐ Psychological/Psychiatric	☐ None

EMERGENCY CONTACT	
Name	**Relationship**
Contact Phone Number	**Email**

INSURANCE INFORMATION		
Primary Insurance	**ID#**	**Group#**
Secondary Insurance	**ID#**	**Group#**

PRIMARY PHARMACY	
Pharmacy Name	**Address**
Phone Number	**Fax**

_____ *I authorize the person(s) listed below to have access to my medical records (HIPAA Contact) including health information, treatment and/or condition. This authorization is valid for one year from the date signed unless otherwise specified here:* _____

Full Name	Relationship	Phone Number	Date of Birth

Health Information may include: Information regarding communicable diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), alcohol and drug use, behavioral health or mental health treatment.

To obtain information by telephone, the person(s) calling must be able to validate ALL of their personal information as listed AND provide two (2) of the following patient identifiers:

- Patient Date of Birth (DOB)
- Patient Phone Number
- Patient Address

_____ ***I understand any person(s) attending my medical appointments are privy to all health information discussed during my appointment and if I do not wish for my health information to be disclosed during my appointment, it is my responsibility that I ask my guest to remain in the lobby.***

CONSENT FOR TREATMENT

The following information is to be acknowledged by the patient, or the patient's legally authorized representative/parent:

- ✓ I consent to physical or mental health treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that there are certain risks connected with all forms of treatment and care. I understand that the Community Outreach Medical Center (COMC) will share patient health information according to federal and state law for treatment, payment, and operations.
- ✓ I understand that it is my responsibility to obtain all recommended testing, further evaluation, and follow up recommended by my physician/practitioner. I also understand that if tests are taken for certain communicable diseases, sexually transmitted infections/diseases, law may require reporting of positive results to relevant public health agencies.
- ✓ I hereby release COMC its medical staff, its clinical staff, and employees from all liability arising out of or connected with my lack of follow up recommended for any abnormalities identified.
- ✓ I hereby consent to and request examination by COMC and ensure that, to the best of my knowledge, all information submitted by me is true.
- ✓ I understand that I may be discharged from COMC if I miss (3) consecutive clinic appointments or if I refuse to follow directions.
- ✓ I hereby certify that I have read and fully understand the above consent for treatment.

_____ *I consent to receive medical treatment from COMC*

ZERO TOLERANCE POLICY

COMC strives to deliver the highest quality services to all its eligible clients/patients and offers a comfortable and safe environment in which to obtain services.

We do however, reserve the right to suspend, alter or terminate a client's/patient's services and/or privileges for any of the following reasons:

- ✓ Threats and/or incidences of assault, theft, harassment, or abusive behavior towards COMC staff and or clients/patients.
- ✓ Providing falsified or fraudulent information to obtain services.
- ✓ Possession of weapons on COMC property, or COMC hosted events, used to intimidate or physically threaten client/patients or staff. Weapons are defined as any object which could be used in a manner to threaten bodily harm.
- ✓ Physical or verbal threats against other COMC clients/patients or COMC staff members, destruction/vandalism to COMC, or events having to do with COMC and/or COMC clients/patients.
- ✓ Sexual harassment/misconduct towards COMC staff and or clients/patients.

_____ *I acknowledge and understand COMCs Zero Tolerance Policy*

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Our Notice of Privacy Practices explains how we may use and disclose protected health information about you. As provided in our Notice, the terms of our Notice may change. Copies of our Notice will always be available at our office and will reflect any updates we make to our Notice in the future. Please sign and date below to indicate that you have received a copy of the Community Outreach Medical Center Notice of Privacy Practices and an explanation of what it contains.

_____ *I have received a copy of the COMC Notice of Privacy Practices*

ADVANCE DIRECTIVE – LIVING WILL AND DURABLE POWER OF ATTORNEY

An Advance Directive is a legal document that explains how you want medical decision about you to be made if you cannot make the decisions yourself. An advance directive lets your health care team and loved ones know what kind of health care you want, or who you want to make decisions for you when you can't. Advance directives only apply to health care decisions and do not affect financial or money matters. The laws around advance directives are different from state to state.

There are <u>two forms</u> of Advance Directives:

- Living Will – The living will is a legal document used to state certain future health care decisions only when a person becomes unable to make the decisions and choices on their own. The living will is only used at the end of life if a person is terminally ill or permanently unconscious. The living will describes the type of medical treatment the person would want or not want to receive (life support, life containment, life enhancement).
- Durable Power of Attorney – A durable power of attorney for health care, also known as a medical power of attorney, is a legal document in which you name a person to be a proxy (agent) to make all your health care decisions if you become unable to do so.
- For more information, talk to your health care provider or request further details from the front desk.

_____*I have received information regarding Advance Directives and my right to make decisions concerning my medical care.*

☐ I have an existing Advance Directive (specify type) ☐ Living Will ☐ Durable Power of Attorney ☐ Both
☐ I have provided a copy of my Advance Directive to the hospital (specify hospital)

_____

☐ I am interested in creating an Advance Directive and would like more information.

PATIENT RESPONSIBILITIES

COMC relies on you to be an active participant in your healthcare and treatment so that we can provide the most effective healthcare for you. The following are your responsibilities. Please read over your responsibilities carefully, so that you will understand our expectations of you.

- ✓ I will provide accurate and complete information about past & current health problems, hospitalizations, medications, treatment & any other matters relating to my health status.
- ✓ I will let the staff know of any address, telephone number, or insurance changes I have.
- ✓ If I do not understand something about my health problems, treatment, medications, their purpose, dosage, and side effects, I will ask questions until I am satisfied that I have enough information to make an informed decision.
- ✓ I will bring all my medication bottles with me to each of my appointments. These include (prescription, non-prescription, vitamin/herbal preparations (please leave refrigerated medication at home.)
- ✓ My provider and I will discuss my treatment plan together and I will obtain ALL laboratory/radiology/diagnostic testing & follow up we agree I need. These tests will assist the provider to make an accurate diagnosis of my condition and assist him/her to develop a treatment plan specifically for me. Without my participation in my treatment plan, the provider will not be able to assist me to manage or resolve my health problems.
- ✓ I understand that authorization for prescription refills will be available at my follow-up appointment ONLY.
- ✓ I understand that I am responsible for finding out my test results as instructed by clinical staff, at my follow up appointment.
- ✓ I will pay for all services provided to me upon checking in for my appointment.
- ✓ I will be respectful and considerate to all clinical staff, fellow patients, clinic property, follow clinic rules and make sure that any persons/guests with me, will also comply.
- ✓ I understand that I am never to attend a visit with COMC staff under the influence of any substance, including narcotics or controlled substance, which can alter my ability to comprehend or that can compromise my judgement.

_____ *I acknowledge and understand my responsibilities as a patient of COMC*

CLINIC POLICIES

COMC is happy you have chosen our clinic to best serve your healthcare needs. As the clinic strives to make your medical experience with us both pleasant & productive, please familiarize yourself with our clinical policies & procedures, and adhere to the instructions provided. Please indicate below that you have received a copy of the COMC Clinic Policies and an explanation of what it contains.

_____ *I have received a copy of the COMC Clinic Policies and agree to adhere to them.*

NO-SHOW, LATE AND CANCELLATION POLICY

Per COMCs *No-Show, Late and Cancellation Policy* patients will be assessed a fee of $50.00, per occurrence, due in full, prior to the patient being seen or scheduled for another appointment. Patients that accrue three (3) "No-Show" appointments within a single calendar year (January-December) are at risk of being discharged from care at COMC. NV Medicaid patients who incur instances of No-Show appointments or are frequently late to scheduled appointments are at risk of being reported to NV Medicaid as *non-adherent to care* and discharged from COMC.

_____ *I agree to adhere to COMCs No-Show, Late and Cancellation Policy*

SELF-ATTESTATION

I certify by indication of my initials above and my signature below, that the information provided is correct to the best of my knowledge. I will not hold Community Outreach Medical Center or any of its staff responsible for any errors or omissions that I may have made during the completion of this form. I will also inform COMC of any changes to the above information.

I fully understand the policies as listed above and agree to adhere to my responsibilities as a patient at Community Outreach Medical Center.

_____

Patient Signature or Legal Representative *Date*

If Legal Representative, please list relationship to patient: _____

**For patients eligible for services provided by NV Medicaid or the Ryan White Program, certain policies (regarding payment/fees) may not apply to you. Please inquire with a Front Office Specialist if you have any questions or concerns.*