Patient Demographic Information

Today's Date:	Email Address:		D.O.B:
Patient's Last Name:	Middle:	First:	SSN:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widow ☐ Divorced	Sex at Birth: ☐ Male ☐ Female	Sexual Orientation: ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Do not wish to report

Current Gender: ☐ Male ☐ Female ☐ Other ☐ I do not wish to report	Race: ☐ Black/African American ☐ White ☐ Native ☐ Hawaiian/Pacific Islander ☐ Other ☐ Decline ☐ Alaskan Native/ American Indian	Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Home Address (Street, City, State):	Zip Code:
Check one: Homeowner Rent Homeless Seasonal worker/migrant worker	Telephone:

Primary Insurance Name:	Identification Number:	Group Number:
Primary Insurance Address:		
Secondary Insurance Name:	Identification Number:	Group Number:
Secondary Insurance Address:		
Pharmacy Name & Address (cross streets):		

Guarantor		
Name:	Relationship:	Phone Number:
In Case of Emergency		
Name of relative/friend:	Relationship:	Phone Number:
How did you hear about FirstMed Health & Wellness?		

HIPAA PRIVACY PRACTICE NOTICE

This notice describes how your medical information may be used, disclosed, and how you can get access to this information.
All requested information should be relevant to the care and well-being of the individual served and should be considered Protected Health Information (PHI), in accordance with the Federal Health Insurance Portability & Accountability Act (HIPAA) of 1996.
Signature of the Privacy Notice shall serve as acknowledgement that FIRSTMED HEALTH & WELLNESS CENTER may use and/or share information for treatment, payment, and overall healthcare operations that may include linkage of care, counseling, billing, and quality assurance. The use of sharing of any information not directly related to services and support shall have prior authorization.
Only in life threating medical emergency will the sharing of medical information be necessary without written consent or authorization.
Rights of the Individual: The individual, in writing, may request restrictions on the use or sharing of any information, received confidential communication, inspect and receive copies of shared information, receive an accounting of shared information, and amend or revoke authorization.
Duties of Covered Entity: Maintain privacy and provide notice of legal duties and privacy practice, abide by this effective notice and any restriction agreements and provide notice of revised privacy practices.

Patient/Legal Guardian Signature:	Printed Name:	Date:

Patient Responsibility Form

Please initial in the boxes below to confirm that you have read and understood all the FirstMed Health & Wellness Office Policies and Financial Responsibilities.

Office Policy	
	I understand that it is my responsibility to call 24 hours prior to my appointments to reschedule, cancel or confirm my appointments. If I am a No-Show to my appointment it will put me on a walk-in status.
	I understand that it is my responsibility as a patient to arrive 10 – 15 minutes prior to my appointment. I understand that arriving late for my appointment without calling will be considered a no-show and another patient may be placed in my appointment slot.
	I understand that it is my responsibility to schedule an appointment for prescription refills. Refills require an appointment with a provider.
	I acknowledge that I have received the HIPAA Notice of Privacy Practices and have been given an opportunity to review it. I understand that if I have any questions regarding this Notice, I may contact the Clinic Administrator.
Financial Responsibility	
	I understand that I am financially responsible for all the charges that are not covered by my insurance such as copays, deductibles, and coinsurance.
	I understand that it is my responsibility to confirm with my insurance carrier the participating provider status of FirstMed Health & Wellness Center and I will be responsible for any charges incurred from Out of Network status.
	I hereby authorize FirstMed Health and Wellness Center to release information necessary to file and/or process a claim with my insurance company.
	*I understand that if I cannot pay my bill in full, I am obligated to the payment plan agreement and apply for the Sliding Fee Scale Discount.
	I hereby authorize the assignment and payment directly to FirstMed Health & Wellness Center.

I hereby grant FirstMed Health & Wellness Center to treat and diagnose the name below as deemed professionally/medically advisable.

I have read and understand the above information and agree to comply with the terms above for services rendered by FirstMed Health & Wellness Center.

Sign:	Date:	Relationship to Patient: ☐ Self ☐ Parent ☐ Other

*Refer to Sliding Fee.

Patient Medical History

Patient Last Name:	Middle:	First:	Date of Birth:
Reason for visit:			

Past medical HX: (Check all that apply)

☐ Hypertension	☐ Epilepsy/Seizures	☐ Cataracts	☐ Diabetes
☐ Liver Disease	☐ Osteoporosis	☐ Cardiac	☐ Anemia
☐ Peptic ulcer disease	☐ CVA/Stroke	☐ Mental illness	☐ Kidney Disease
☐ COPD/Emphysema	☐ Depression	☐ Sinus/Asthma	☐ Arthritis
☐ Thyroid disease	☐ ADHD	☐ Cancer (type): _____	
☐ Other: _____			

Current Medications: (Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplments.

Drug allergies: ☐ No ☐ Yes To what?_____

Name of drug	Dose	How long have you been taking this?

Pharmacy:	
Name:	Phone:
Address:	Major Cross Streets:

Surgeries:

Type	Date

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Hospitalization:	
Type	Date

Patient/Legal Guardian Signature:	Date:

Rev: 12.30.16

Authorization of Use and Release of Records

Patient Last Name:	Middle:	First:	Date of Birth:
Address:		City & State:	Zip code:

Please list any family members, friends, significant others, or medical providers whom we may inform about your medical condition or release of medical records or information to:	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I hereby authorize _____ to release my medical/behavioral health records to FirstMed Health & Wellness Center. My medical/ behavioral health record is to include the following:

- ☐ Doctor's Notes
- ☐ Behavioral Health Records
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Other:

Duration: This authorization shall become effective immediately and shall remain in effect until for one year.
Revocation: My written revocation will be effective upon receipt, but will not be effective to the extent the requester or others have acted in reliance upon this authorization.
Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This information is requested for following purposes (Check all that apply)

☐ Medical ☐ Legal ☐ Personal ☐ Behavioral Health ☐ Other: _____

Patient/Legal Guardian Signature:	Date:

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Rev: 3.14.17

CONSENT FOR MEDICAL TREATMENT		
I, _____ (Name of Patient), consent to any medical diagnosis and treatment, laboratory, x-ray examination, Rx history, evaluation by in-house caseworker, and referral to other healthcare providers that is deemed necessary and advisable by a licensed physician or nurse practitioner at FirstMed Health & Wellness Center. I have the right to consent or refuse consent to any proposed or therapeutic course, absent emergency circumstances.		
Patient/Legal Guardian Signature:	Printed Name:	Date:

CONSENT FOR MEDICAL TREATMENT OF A MINOR		
I, _____ (Parent or legal guardian) hereby authorize, consent to Rx history, medical diagnosis and treatment, laboratory, x-ray examination, evaluation by in-house caseworker, and referral to other healthcare providers for _____ (Name of Minor) that has been deemed necessary and advisable by a licensed physician or nurse practitioner at FirstMed Health & Wellness Center. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency circumstance.		
Patient/Legal Guardian Signature:	Printed Name:	Date:

To Our Valued Patients of FirstMed Health & Wellness Center

Last Name:	Middle:	Last:	Date:
FirstMed Health & Wellness Center recognizes the multiple barriers a patient faces in obtaining access to healthcare. In regard, we have prepared a Resource Book, which will provide information about the many non-clinical services that we offer as a Community Health Center.			

Please mark which resources you are interested in obtaining or learn about during your visit. Our Case Worker will be happy to assist you to obtain the information you may need.	
☐ How to enroll in Nevada Insurance Exchange through Nevada Health Link	☐ How to determine if you are Medicaid eligible thru Nevada Health Link
☐ Home Energy Assistance	☐ Employment Support
☐ How to enroll in Medicaid	☐ Legal Help
☐ Medicare Beneficiary (A or B) which is available to pay for Medicare Part D prescription drug costs including premiums, deductibles, and co-pays	☐ Access to Women's Health Connection which provides free pap smears and/or mammograms for uninsured women 40 and older who meet certain requirements
☐ How to obtain a Nevada ID	☐ Special Programs and Services
☐ Transportation	☐ Patient assistance programs, if available, can help pay for certain medications
☐ Housing	☐ SNAP
☐ Rental Assistance	☐ Please indicate any other resources you may need assistance with: _____

Disclaimer:

The following facts/details do not guarantee service and/or approval and are purely for information purposes only. Individuals who want of any of the services listed above must contact the agency/office directly and adhere to their existing rules, requirements, and policies.

The information is brought to you as a complimentary service of FirstMed Health & Wellness Center.

I _____, certify that the above information has been presented and discussed with me by the Case Worker of FirstMed Health & Wellness Center.

OR

I _____, decline and waive my right to the information contained in the Resource Book of FirstMed Health & Wellness Center and the assistance of their Case Worker.

Consent Form for Controlled Substances

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF CONTROLLED SUBSTANCES: You should be aware of potential side effects of controlled substances such as decreased reaction time, clouded judgement, drowsiness, and tolerance, among others, and the possibility that the medication will not provide complete pain relief. Also, you should know about the possible danger associated with the use of controlled substances while operating heavy equipment or driving.

POSSIBLE SIDE EFFECTS OF CONTROLLED SUBSTANCES, but not limited to:

- Confusion or other change in thinking abilities
- Nausea/Vomiting
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation or depression
- Sleepiness or drowsiness
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX CONTROLLED SUBSTANCES WITH OTHER DRUGS, INCLUSING ALCOHOL.

Risks:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
    - Runny Nose
    - Diarrhea
    - Sweating
    - Rapid heart rate
    - Difficulty sleeping for several days
    - Abdominal cramping/constipation
    - 'Goose bumps'
    - Nervousness
- Psychological dependence. Stopping the drug may cause you to miss to crave it.
- Tolerance. This means you may need more and more drug to get the same effect.
- Addiction. Addiction problems may develop based on genetic or other factors.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy inform provider.
- For Males: Your testosterone level may decrease in relation to chronic controlled substance use which can affect your mood, stamina, physical performance, and sexual desire and performance.
- I am also aware of the possible risks/benefits of other treatments that do not include controlled substances.

I will inform my provider of all medications and treatments that I am and will be receiving.
I will not be involved in activities harmful to me/others if I am drowsy/not thinking clearly.
I will inform this healthcare provider of my (and my family's) complete and honest drug history.

RECOMMENTDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication does, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that I already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read or had this consent form read to me and I understand all the information here. I had a chance to have my questions answered to my satisfaction. With my voluntary signature, I consent to the treatment of my pain with controlled substance medications. I understand if I do not follow this agreement, I will waive my expectation of controlled substance therapy.

_____ _____ _____

Patient Printed Name Date Witness

_____

Patient Signature

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CONTRACT AGREEMENT FOR CONTROLLED SUBSTANCES USE

Participant Name: _____

Date: _____

A controlled substance treatment for chronic pain is used to reduce pain and improve what you can do each day. However, long-term use remains controversial in relation to long-term benefits. The extent of risk for addiction is also uncertain. Hence, along with a controlled substance treatment, there medical care may be prescribed to help improve your ability to do daily activates. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

1. I understand that I have the following responsibilities:
    a. Will take medications only at the dose and frequency prescribed.
    b. I will not increase or change medications without the approval of this provider.
    c. I understand that if I stop taking my controlled substances abruptly, withdrawal symptoms ill Kiely occur.
    d. I will actively participate in return-to-work efforts and in any program designed to improve function (including social, physical, psychological, and daily or work activities).
    e. I will not request controlled substances or any other pain medicine from others, except from this provider.
    f. I will inform this provider of all medications that I am taking including adverse effects, and medical conditions.
    g. I will obtain all medications from one pharmacy and will notify the center of any change, I give full consent for my provider to talk as needed with the pharmacist given, and other professionals providing healthcare to me by signing this agreement.
    h. I will protect my prescriptions and medications at the highest possible degree. I will keep all medications from children. Early refills are not given and will not be replaced. If stolen, a police report will be completed before a new prescription will be given.
    i. I agree to participate in psychiatric or psychological assessments if necessary.
    j. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:
        i. Consultation with an Addiction Specialist ii. Individual counseling. Iii. Inpatient or outpatient treatment
2. I understand that in the event of an emergency, this center should be contacted and the problem can be discussed with the emergency tom or other treating physician. I am responsible for signing consent to request record transfer to this provider. No more than 3 days of medications may be prescribed by the emergency room without prior approval of this provider.
3. I understand that if I lose my prescription paper or the prescription itself it may not be replaced.
4. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. If unauthorized substances are detected, I will be referred for assessment of addictive disorder.
5. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment. I will bring original containers of my medications at each visit. I understand that renewals of my medications depend on keeping scheduled appointments. I will not call for prescriptions after hours or weekends.
6. I understand that the providers of this center may stop prescribing controlled substances or change the treatment plan if anything in this agreement or the following items are not followed:
    a. I do not show any improvement in pain from controlled substances or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlines in #1 above.
    c. I give, sell or misuse the controlled substances medications.
    d. I develop rapid tolerance or loss of improvement from the treatment.
    e. I obtain controlled substances from anyone other than this provider.
    f. I refuse to cooperate when asked to get a drug screen.
    g. If an addiction problem is identified because of prescribed treatment or any other addictive substance.
    h. If I am unable to keep follow-up appointments.
7. I understand that any medical treatment is initially a trial, and that continued prescription depends on evidence of benefit.
8. I affirm that I read (or had it read to me) and I understand the risks and potential benefits or controlled substances. I also confirm that I read (or had I read), understand, and accepted all the terms in this agreement and all my questions were answered to my satisfaction. I have full power and right to sign and be bound by this agreement.

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	_____
Provider Printed Name	Provider Signature	Date

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Consent Form for Opioid Therapy

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS: You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgement, drowsiness, and tolerance, among others, and the possibility that the medication will not provide complete pain relief. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

POSSIBLE SIDE EFFECTS OF OPIOIDS, but not limited to:

- Confusion or other change in thinking abilities
- Nausea/Vomiting
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation or depression
- Sleepiness or drowsiness
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUSING ALCOHOL.

Risks:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
    - Runny Nose
    - Diarrhea
    - Sweating
    - Rapid heart rate
    - Difficulty sleeping for several days
    - Abdominal cramping/constipation
    - 'Goose bumps'
    - Nervousness
- Psychological dependence. Stopping the drug may cause you to miss to crave it.
- Tolerance. This means you may need more and more drug to get the same effect.
- Addiction. Addiction problems may develop based on genetic or other factors.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy inform provider.
- For Males: Your testosterone level may decrease in relation to chronic opioid use which can affect your mood, stamina, physical performance, and sexual desire and performance.
- I am also aware of the possible risks/benefits of other treatments that do not include opioids.

I will inform my provider of all medications and treatments that I am and will be receiving.
I will not be involved in activities harmful to me/others if I am drowsy/not thinking clearly.
I will inform this healthcare provider of my (and my family's) complete and honest drug history.

RECOMMENTDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication does, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that I already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read or had this consent form read to me and I understand all the information here. I had a chance to have my questions answered to my satisfaction. With my voluntary signature, I consent to the treatment of my pain with opioid medications. I understand if I do not follow this agreement, I will waive my expectation of opioid therapy.

_____ _____ _____

Patient Printed Name Date Witness

_____

Patient Signature

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CONTRACT AGREEMENT FOR OPIOID USE

Participant Name: _____

Date: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you can do each day. However, long-term use remains controversial in relation to long-term benefits. The extent of risk for addiction is also uncertain. Hence, along with opioid treatment, there medical care may be prescribed to help improve your ability to do daily activates. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

1. I understand that I have the following responsibilities:
    a. Will take medications only at the dose and frequency prescribed.
    b. I will not increase or change medications without the approval of this provider.
    c. I understand that if I stop taking my opioids abruptly, withdrawal symptoms ill Kiely occur.
    d. I will actively participate in return-to-work efforts and in any program designed to improve function (including social, physical, psychological, and daily or work activities).
    e. I will not request opioids or any other pain medicine from others, except from this provider.
    f. I will inform this provider of all medications that I am taking including adverse effects, and medical conditions.
    g. I will obtain all medications from one pharmacy and will notify the center of any change, I give full consent for my provider to talk as needed with the pharmacist given, and other professionals providing healthcare to me by signing this agreement.
    h. I will protect my prescriptions and medications at the highest possible degree. I will keep all medications from children. Early refills are not given and will not be replaced. If stolen, a police report will be completed before a new prescription will be given.
    i. I agree to participate in psychiatric or psychological assessments if necessary.
    j. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:
        i. Consultation with an Addiction Specialist ii. Individual counseling. Iii. Inpatient or outpatient treatment
2. I understand that in the event of an emergency, this center should be contacted and the problem can be discussed with the emergency tom or other treating physician. I am responsible for signing consent to request record transfer to this provider. No more than 3 days of medications may be prescribed by the emergency room without prior approval of this provider.
3. I understand that if I lose my prescription paper or the prescription itself it may not be replaced.
4. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. If unauthorized substances are detected, I will be referred for assessment of addictive disorder.
5. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment. I will bring original containers of my medications at each visit. I understand that renewals of my medications depend on keeping scheduled appointments. I will not call for prescriptions after hours or weekends.
6. I understand that the providers of this center may stop prescribing opioids or change the treatment plan if anything in this agreement or the following items are not followed:
    a. I do not show any improvement in pain from opioids or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlines in #1 above.
    c. I give, sell or misuse the opioid medications.
    d. I develop rapid tolerance or loss of improvement from the treatment.
    e. I obtain opioids from anyone other than this provider.
    f. I refuse to cooperate when asked to get a drug screen.
    g. If an addiction problem is identified because of prescribed treatment or any other addictive substance.
    h. If I am unable to keep follow-up appointments.
7. I understand that any medical treatment is initially a trial, and that continued prescription depends on evidence of benefit.
8. I affirm that I read (or had it read to me) and I understand the risks and potential benefits or opioids. I also confirm that I read (or had I read), understand, and accepted all the terms in this agreement and all my questions were answered to my satisfaction. I have full power and right to sign and be bound by this agreement.

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	_____
Provider Printed Name	Provider Signature	Date

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