Welcome to Duncan Family Healthcare!   
  
We are honored you have chosen us for you and/or your families healthcare needs. We offer a variety of services in our clinic to help ensure you are getting the most efficient, up-to-date care.   
  
**Please take the time to thoroughly and completely fill out this registration packet.**  
  
If you need assistance with any part of this form, please do not hesitate to ask one of our helpful staff members.  
  
Also, while you are waiting for your appointment, please make sure to **sign in to our Patient Portal**, where you will be able to view your lab results, schedule your next appointment, request medication refills, review your medical records, and so much more! Just ask one of our staff members for information on how to access the **Patient Portal!**  
  
If there is any way we can make your visit better, please do not hesitate to ask!  
  
On behalf of our entire team! Thank you for choosing us!!!  
  
Duncan Family Healthcare Team

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

SSN: \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Sex: M F

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (circle one): Never Married Married Partnered Widowed Divorced

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino

Race (circle all that apply): Black White Asian American Indian or Alaskan Native Hawaiian/Pacific Islander

Language (circle one): English Spanish Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we send information to your email? : Yes No

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years Employed: \_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Work Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact you at work? : Yes No

Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? : Primary Care Doctor Family or Friend Facebook Ad Internet Other

In case of emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*COMPLETE THIS SECTION ONLY IF SOMEONE ELSE IF FINNCIALLY RESPONSIBLE\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bottom of Form

**Insurance Information**

**Primary insurance**

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Policy ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary insurance**

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Policy ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our office will file insurance claims for all reimbursable services, to your primary and secondary insurance carriers. Please remember that you’re responsible for all deductible, co-pay, and non-covered service amounts. In the event that you should receive payment from your insurance carrier for services rendered by Duncan Family Healthcare PLLC, that check should immediately be forwarded to our office as to avoid a balance with Duncan Family Healthcare PLLC.

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*ASSIGNMENT OF BENEFITS\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

I hereby assign all rights, title, and interest of my primary and secondary insurance to Duncan Family Healthcare PLLC for the treatment of my medical services.

Signature of Responsible Party/Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Printed Name of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient, if different (please print): \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Medical and Nursing Treatment, Uses, Disclosures & Privacy Practices**

I give my permission to Duncan Family Healthcare PLLC (”Provider”) and its employees volunteers, agents, and independent contractors to educate, interview, examine, perform laboratory procedures and to treat my condition, as they deem necessary. I understand that in case of a life-threatening emergency, this consent may be implied for the time of the emergency.

I understand Duncan Family Healthcare PLLC is a teaching institution, therefore nurse practitioner students, nursing students, and medical assistant students may participate in my care under the supervision of a nurse practitioner. I understand that other outside medical professionals may also be consulted as deemed necessary for my care.

For coordination of my care and services, I understand that I may be provided with referrals to off site specialists who may assist other treating medical providers in provision of my care.

**Informed Consent:** If my condition requires an outpatient surgical procedure, the practitioner responsible for my care will explain to me the procedure to be performed, the general nature and extent of risks involved in such procedure and the alternative methods, if any.

**Consent for Minors:** If you are a minor, we must have the signature of the parent or legal guardian (appointed by a court of law) on this form before any general treatment may begin, and such consent must be effective until you reach legal age in the State of Nevada (18 years old). Your parent or legal guardian must sign this consent form and receive a Notice of Privacy.

**Exemptions to this consent are** life-threatening emergency, treatment for emancipated minors with court supporting documents and per **NRS 442.255** and **NRS 129.060** for family planning and contraceptive methods, screening for sexually transmitted infections, counseling and treatment of alcohol and substance abuse.

I understand and agree that Duncan Family Healthcare may use or disclose protected health information for treatment, payment, and operation in accordance with the Notice of Privacy Practices that I have received, and any posted amendments to that Notice. I understand that Duncan Family Healthcare PLLC will not use or disclose protected health information for any purposes other than as allowed in the Notice of Privacy Practices, unless law authorizes such disclosure, or I have provided a written authorization.

In the process of receiving health care at Duncan Family Healthcare PLLC I may receive follow-up phone calls and a letter may be sent to continue care. Also, patients may receive phone calls to remind them of scheduled appointments.

I understand that if I agree to participate in a research study, I will be provided with a separate authorization to participate. I have the option to choose not to participate or to withdraw from the study at any time.

I understand that I have the right to revoke this consent in writing, unless Duncan Family Healthcare PLLC has already used or disclosed my information in reliance on the consent.

In understand that I have the right to request restrictions on certain uses and disclosures of my health information to carry out treatment, payment, or healthcare operations and that Duncan Family Healthcare is not required to agree to the restrictions requested.

I understand that if I request restriction that may impede the ability of Duncan Family Healthcare PLLC to provide proper care, or which restricts the release of information required by law to be released, that Duncan Family Healthcare PLLC is unlikely to agree to the restriction and may cancel further services. Further, I understand that if I request a restriction that does not allow Duncan Family Healthcare PLLC to release necessary information to insurance providers, it may affect my ability to obtain reimbursement for medical services.

I acknowledge receipt of a copy of the Notice of Privacy Practices, which contains a more complete description of uses and disclosure of patient health information.

I understand Duncan Family Healthcare PLLC reserves the right to change the Notice of Privacy Practices and a revised copy will be posted and available when requested. The changes will be applied to all prior and subsequent health information.

**Pain Medication and/or Controlled Substance Agreement**

**It is very important that you read and understand the following policies and procedures.**

**They must be followed for your provider to treat you safely and effectively!**

* Medication must be used as prescribed and directed unless discussed with your provider. It is life threatening to chew or take a partial tablet of a long acting medication. Increasing your dose without close supervision of your provider could lead to drug overdose, causing severe sedation, respiratory depression and death.
* If you have a reaction to your medication **DO NOT FLUSH IT OR THROW IT AWAY**. You may be required to bring the remainder to the office to replace with a new prescription.
* Per the Board of Medical Examiners Regulations, Sec. 1 Chapter 630 and our office policy, controlled substance medications are to be obtained from only one provider.
* You should discuss any medication changes with your provider at your appointments and inform them of any new medication allergies.
* Allow for **3 WORKING DAYS** for preparation of a written prescription for pick-up. Allow **48 HOURS** for all call in prescriptions. If someone is to pick up the prescription for you in your place, they must be on your HIPAA release.
* Lost, stolen or misplaced prescriptions or medications may not be replaced. Early requests for refills will not be provided unless you have called and discussed this prior to running out of medication. Selling medication or sharing medication with family, friends, or any other person is illegal and will not be tolerated. You should protect and care for your medication as you would any extremely valuable possession. If you run out of your medication, either because of poor planning or because of taking in excess of what was prescribed, you are responsible for the consequences, including poor pain control and any withdrawal symptoms.
* PRESCRIPTION REQUESTS WILL BE ADDRESSED MONDAY THROUGH THURSDAY, 9‐5 ONLY. Prescriptions are not available Friday, weekends, holidays or after office hours.
* Notify your provider if you are pregnant.
* The use of alcohol or recreational drugs while on opioids or other controlled substances is not allowed. Our office will not provide medications under these circumstances.
* Duncan Family Healthcare reserves the right to Urine Drug Screen ALL new patients at the time of their initial visit. You may also be randomly tested to ensure medication compliance. Failure to provide at sample the time it is requested could result in termination from the practice and no further medications to be ordered.

**We expect you to take the above patient responsibilities seriously.**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: / /**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Communication with Family Members Policy**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the following family members access to my medical records and financial information. I understand these persons can contact Duncan Family Healthcare on my behalf.

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Financial Policy**

The following information is a summary of some of the important aspects of our full Financial Policy.  
  
**Payment methods** include cash, check and credit card. Payment plans can be arranged in advance.

**Insurance Reimbursement:** In the event you receive reimbursement from your insurance company for services rendered by Duncan Family Healthcare PLLC, that payment is due and payable to DFH and should be immediately forwarded to our billing department.  
 **Insurance Deductible:** Deductibles or co-pay’s are to be paid in full prior to services being rendered.

**If you do not have insurance** payment is due in full at the time of service.

**Fee for returned checks:** The fee for returned checks is $30. The fee may be added to your account and payment is required in full by cash or credit card.

**Prior Authorization:** If your insurance requires a prior authorization for any services or procedures at DFH, and if this authorization has not been obtained prior to your visit, you will be expected to pay for all charges incurred at the time of your visit. If your insurance subsequently reimburses DFH for those services, you will be refunded of any monies paid to DFH. If your insurance requires prior authorization for any services not performed but ordered by DFH, we will make every attempt to receive authorization for those services. It is the patient’s responsibility to ensure those authorizations are actually obtained.

If you have any questions about the above policies, please ask any staff member or call (775) 221-7400.

**CANCELLATION AND NO-SHOW POLICY**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours’ notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours’ notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $30.00 cancellation fee. Procedure cancellations require 5-7 business day advance notice; without notification, they may be subject to a $100.00 cancellation fee. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a $30.00 fee for office appointment No Show and $100.00 procedure No Show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good provider/patient relationship is based upon understanding and good communication.

Questions about cancellation and no show fees should be directed to the Billing Department (775-221-7400).

**Please initial next to each policy, stating you have read, understand, and agree to each policy.**

\_\_\_\_\_\_\_ Assignment of Benefits Agreement

\_\_\_\_\_\_\_ Consent for Medical and Nursing Treatment, Uses, Disclosers & Privacy Practices

\_\_\_\_\_\_\_ Pain Medication and/ or Controlled Substance Agreement

\_\_\_\_\_\_\_ Statement of Financial Policy

\_\_\_\_\_\_\_ Cancellation and NO SHOW Policy

Signature and Responsible Party/ Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: / /

Printed Name of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient, if different (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_/\_\_\_\_\_\_/ \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Duncan Family Healthcare to (circle one) SEND TO or RECEIVE FROM the below entity:

Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission History Progress Notes Entire Record Laboratory Reports Radiology XRay

Emergency Room Records Consultations Radiology Films/CDs Operative Reports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatry:** Admission Assessment Progress Notes Psychotherapy Notes Psychiatric Conditions

Discharge Plan/Summary Drug/Alcohol Abuse History & Physical Exam Report Lab Results

Medical Conditions HIV or AIDS Related Information Nursing/Psychosocial/Risk Assessments

Specific Information Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This information may be disclosed and used by the following individual or organization: I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  
Signature of Patient / Parent / Guardian or Authorized Representative   
  
(Guardian or Authorized Representative must attach documentation of such status.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Duncan Family Healthcare PLLC**

6630 S. McCarran Blvd #A12 | Reno, NV 89509

Phone 775 221 7400 | Fax 775 657 6551

[www.duncanfamilyhealthcare.com](http://www.duncanfamilyhealthcare.com/)

**Medical History**

Check the condition(s) that apply to **YOUR PAST MEDICAL HISTORY:**

**Cardiovascular Pulmonary**

\_\_\_ Congestive Heart Failure \_\_\_ Pulmonary Embolism

\_\_\_ High Blood Pressure \_\_\_ Pneumonia  
\_\_\_ Angina \_\_\_ COPD

\_\_\_ Arrhythmia \_\_\_ Asthma

\_\_\_ Atrial Fibrillation \_\_\_ Sleep Apnea

\_\_\_ High Cholesterol

\_\_\_ Blood Clots **Infectious Disease**

\_\_\_ Heart Attack \_\_\_ Hepatitis A, B or C

\_\_\_ Peripheral Vascular Disease \_\_\_ HIV/AIDS

\_\_\_ Tuberculosis

**Hematological**

\_\_\_ Anemia **Oncology**

\_\_\_ Blood Clots \_\_\_ Cancer

\_\_\_ Bleeding Disorders

**Gastrointestinal**

**Neurological** \_\_\_ Liver Disease

\_\_\_ Seizures \_\_\_ Irritable Bowel Syndrome

\_\_\_ Peripheral Nerve Disorder \_\_\_ Heartburn

\_\_\_ Headaches \_\_\_ Gastric Reflux

\_\_\_ Parkinson’s Disease \_\_\_ Ulcer

\_\_\_ Tremors

\_\_\_ Stroke **Musculoskeletal**

\_\_\_ Down Syndrome \_\_\_ Osteoporosis

\_\_\_ Arthritis

**Psychiatric** \_\_\_ Back Problems

\_\_\_ Bipolar Disorder \_\_\_ Fibromyalgia

\_\_\_ Depression \_\_\_ Rheumatoid Arthritis

\_\_\_ Anxiety

\_\_\_ Personality Disorder **Endocrine**

\_\_\_ Schizophrenia \_\_\_ Diabetes Type I

\_\_\_ Dementia \_\_\_ Diabetes Type II

\_\_\_ Substance Abuse \_\_\_ Thyroid (Hypo or Hyper)

\_\_\_ Autism

**Social History**

**Profession/Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking Status:** Current Past Never Packs per day: \_\_\_\_\_\_\_

**Alcohol Use:** Current Past Never Drinks per day: \_\_\_\_\_\_\_

**Illicit Drug Use:** Current Past Never Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**

**Preferred Lab Facility**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy: Defaulted to Valley Pharmacy; They Deliver for Free!**

**Other Pharmacy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Strength** | **How often do you take?** |
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**Over the Counter Medications**

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Strength** | **How often do you take?** |
|  |  |  |
|  |  |  |
|  |  |  |
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**Allergies**

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**Family History**

Check all that apply and \***state FAMILY MEMBER relationship\***

**Cardiovascular Pulmonary**

\_\_\_ Congestive Heart Failure \_\_\_ Pulmonary Embolism

\_\_\_ High Blood Pressure \_\_\_ Pneumonia  
\_\_\_ Angina \_\_\_ COPD

\_\_\_ Arrhythmia \_\_\_ Asthma

\_\_\_ Atrial Fibrillation \_\_\_ Sleep Apnea

\_\_\_ High Cholesterol

\_\_\_ Blood Clots **Infectious Disease**

\_\_\_ Heart Attack \_\_\_ Hepatitis A, B or C

\_\_\_ Peripheral Vascular Disease \_\_\_ HIV/AIDS

\_\_\_ Tuberculosis

**Hematological**

\_\_\_ Anemia **Oncology**

\_\_\_ Blood Clots \_\_\_ Cancer

\_\_\_ Bleeding Disorders

**Gastrointestinal**

**Neurological** \_\_\_ Liver Disease

\_\_\_ Seizures \_\_\_ Irritable Bowel Syndrome

\_\_\_ Peripheral Nerve Disorder \_\_\_ Heartburn

\_\_\_ Headaches \_\_\_ Gastric Reflux

\_\_\_ Parkinson’s Disease \_\_\_ Ulcer

\_\_\_ Tremors

\_\_\_ Stroke **Musculoskeletal**

\_\_\_ Down Syndrome \_\_\_ Osteoporosis

\_\_\_ Arthritis

**Psychiatric** \_\_\_ Back Problems

\_\_\_ Bipolar Disorder \_\_\_ Fibromyalgia

\_\_\_ Depression \_\_\_ Rheumatoid Arthritis

\_\_\_ Anxiety

\_\_\_ Personality Disorder **Endocrine**

\_\_\_ Schizophrenia \_\_\_ Diabetes Type I

\_\_\_ Dementia \_\_\_ Diabetes Type II

\_\_\_ Substance Abuse \_\_\_ Thyroid (Hypo or Hyper)

\_\_\_ Autism

**Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychotropic Medications**

**Patient’s Initials**

**Each line MUST be Initialed**

\_\_\_\_\_The nature of my mental condition and the reasons for prescribing the specific medication(s) have been explained to me in terms I

understand.

\_\_\_\_\_Alternative treatments and their benefits and disadvantages have been explained to me.

\_\_\_\_\_ The type of medication, dosage, the range of frequency, the route of administration (oral/IM), and the anticipated length of treatment have

been explained to me.

\_\_\_\_\_ I understand and accept the possible side effects of the following specific types of psychotropic medications which may include, but not

limited to:

**Common to psychotropic medications:** dizziness, drowsiness, rigidity of muscles, and

tremors

**Lithium:** blurred vision, diarrhea, impairment or coordination, increased urination,

muscular weakness, ringing of ears, and tremors.

**Benzodiazepine:** unsteadiness of gait, physical dependence, and after prolonged

use, should be withdrawn gradually.

**Carbamazepine:** lowering of blood cell count.

**Antidepressant (tricyclic or tetracyclic):** blurred close vision, constipation, difficulty

starting to urinate, dry mouth, feeling dizzy with quick movements, hand

shaking, heart palpitation, or irregular heartbeats.

**Antidepressants (SSRI-serotonin specific reuptake inhibitors):** decreased

appetite, diarrhea, headache, insomnia, nausea, and nervousness.

**Atypical antipsychotic medications:** decreased coordination and inflammation of the

nasal mucous membrane.

\_\_\_\_\_I understand and accept additional possible side effects that may occur when psychotropic medications are taken for extended periods (over

the months) include persistent, involuntary movements of the face, mouth, or extremities (hands, feet). These symptoms are potentially

irreversible and may appear after the medications have been discontinued.

\_\_\_\_\_I understand that psychotropic medication therapy may include certain lab tests on regular required basis.

\_\_\_\_\_I have informed the provider of all my known allergies.

\_\_\_\_\_I have informed the provider of all medications I’m currently taking, including prescriptions, over-the-counter remedies, herbal therapies and

supplements, aspirin, and other recreational drug or alcohol use.

\_\_\_\_\_I have been advised whether I should avoid drinking alcoholic beverages and consuming any or all of these medications while taking the

psychotropic medication(s).

\_\_\_\_\_I am aware and accept that no guarantees about the results of the treatment have been made.

\_\_\_\_\_I have been advised of the probable consequences of declining recommended or alternative therapies.

\_\_\_\_\_The provider answered all of my questions regarding this treatment.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct Duncan Family Healthcare PLLC to provide treatment with one or more of the above psychotropic medications.

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**Patient or Legal Representative Signature/Date/time Relationship to Patient**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Patient or Legal Representative Name Witness Signature/Date/Time**

I certify that I explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed treatment to the patient or the patient’s legal representative. I have answered all of questions fully, and I believe patient/legal representative fully understands what I have explained.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature Date: / /**