New Patient Registration

Alpine Healthcare

First Name	Middle Name	Last Name		
Address		City	State	Zip
Marital Status	Date of Birth	Male/Female	Social Security Number	
Mobile Phone	Home Phone	Email		
Referred By:	Previous Primary Care Provider	Pharmacy Name		
Pharmacy Phone	Pharmacy Address or Cross streets			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Name	Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company Name		Plan Type	
Insurance ID Number	Group Number	Subscriber's Employer	
Subscriber's Name		Relation to Patient	Subscriber's Phone Number
Subscriber Address		City	State	Zip
Subscriber's Social Security		Subscriber's Date of Birth	

Secondary Health Insurance

Insurance Company Name		Plan Type	
Insurance ID Number	Group Number	Subscriber's Employer	
Subscriber's Name		Relation to Patient	Subscriber's Phone Number
Subscriber's Address		City	State	Zip
Subscriber's Social Security		Subscriber's Date of Birth	

Patient Name: _____ Gender____ Date of birth: _____ Age: _____

Reason for Visit

_____

_____

_____

Allergies

Do you have any allergies to medications?

Name	Reaction

Current Medications:

Name	Dosage	Frequency

Preventative Exams:

Last Colonoscopy: _____

Last Flu shot: _____ Pneumonia shot: _____

For Women only:

Last Pap smear: _____ Mammogram: _____

Last Menstrual Period: _____

Birth control method: _____

Past Medical History (Check only if applicable)

- ◯ Alcoholism
- ◯ Allergies
- ◯ Anemia
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ AIDS/HIV
- ◯ Back problems
- ◯ Bleeding issues
- ◯ Blood disease
- ◯ Blood transfusion
- ◯ Cancer
- ◯ Diabetes
- ◯ Depression
- ◯ Ear problems
- ◯ Eating disorder
- ◯ Epilepsy
- ◯ Glaucoma
- ◯ Gout
- ◯ Heart Disease
- ◯ Heart Attack
- ◯ Hepatitis
- ◯ High blood pressure
- ◯ High cholesterol
- ◯ Joint disorder
- ◯ Kidney disorder
- ◯ Liver disorder
- ◯ Lung disease
- ◯ Measles
- ◯ Migraines
- ◯ Osteoporosis
- ◯ Pneumonia
- ◯ Stroke
- ◯ Skin disorder
- ◯ STDs
- ◯ Substance abuse
- ◯ Thyroid disorder
- ◯ Tuberculosis
- ◯ Others: _____ _____ _____

Hospitalizations and Surgeries

Reason	Date

Family Medical History Only

Mom	
Dad	
Siblings	
Grandparents	
Others:	

Other Medical Providers/Specialist

What other providers or physicians do you see and what for?

Name	Reason

Social History

Are you sexually active? ◯ Yes ◯ No

# of partners in the last year? _____

Do you want to be checked for STDs? ◯ Yes ◯ No

Have you ever smoked? ◯ Yes ◯ No

# of years? _____ # packs/day _____

Do you smoke now? ◯ Yes ◯ No #pack/day _____

Do you use recreational drugs? ◯ Yes ◯ No

Types? _____ # times/week _____

How much alcohol do you drink per week? _____

How much caffeine do you drink per day? _____

How often do you exercise in a week? _____

Who do you live with at home? _____

Guarantor/Financial Responsibility ☐ **Same As Patient**

Person Responsible for Payment/Charges	Phone Number	Relation to Patient		
Address		City	State	Zip

I certify that I am the patient or duly authorized to complete this form. I understand that even though I have insurance coverage, I am responsible for any balances, co-pays or deductibles and or late fee's due on my account at the time of service.

I fully understand that I am responsible for notifying insurance of my provider information and assigning a primary care provider (PCP) PRIOR to my appointment. I also take full accountability in updating the provider office with updated insurance information. A failure to communicate with the payer may result in unpaid charges which are the full financial responsibility of the assigned guarantor.

I understand that there is a **$50.00 to $75.00 charge for appointments that are not cancelled 72 hours in advance, also a $50.00 to $100.00** charge for forms and/or medical necessity letters that need to be completed by our office. For example, FMLA (Family Medical Leave Act), Work Clearance forms, Physical exam forms and others. Payment is due before forms are accepted in blank form to be evaluated at the time of your appointment.

_____ _____

Signature of Patient or Authorized Guardian Date Today

Prescriptions and Refill Requests

WE DO NOT REFILL MEDICATIONS OVER THE PHONE. To refill your medication, you must set up an appointment and be seen by your provider. Medications are sent electronically to your pharmacy on file. It is your responsibility to keep your pharmacy updated prior to your appointment. We do not hand write or "call in" prescriptions. Please note that you are responsible for keeping track of the number of medication refills that are left on your prescriptions. You agree to bring a current list of medications, dosages, and directions with you at every scheduled appointment.

_____ _____

Signature of Patient or Authorized Guardian Date Today

Diagnostic Orders

Our office utilizes several laboratories for blood tests, pap smears and urine specimens.
If your insurance requires you to utilize a specific laboratory, you will need to inform our medical staff during your intake prior to being seen by your provider.

It is your responsibility as a patient to be knowledgeable of your benefits. If you are unsure whether your insurance company requires you to use a specific laboratory, please contact them directly for that information.
Please note, it is our company's policy to discuss all test results including lab work, x-ray, ultrasound, CT scan, MRIs, etc. in the office during your visit with the provider. WE DO NOT DISCUSS RESULTS OVER THE PHONE.

Thank you for your cooperation.

_____ _____

Signature of Patient or Authorized Guardian Date Today

Alpine Healthcare
3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
Ph: (702) 438-5555 Fax: (702) 438-6666

HIPPA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment from designated third-party payers.

Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information available in office. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Authorized Guardian Date Today

Alpine Healthcare
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Controlled Substance Contract

The purpose of this contract is to prevent misunderstandings about certain medications you may be prescribed that is controlled (This includes controlled medications schedule I-V; for example, pain medications, benzodiazepines, sleep medications, stimulants, etc.). This is to help both you and your provider to comply with the state and federal regulations regarding controlled pharmaceuticals. This contract is essential to the trust and confidence necessary in the provider/patient relationship and treatment rendered.

Please read, **initial** and **sign**.

1. I understand that if I break this contract, my provider may stop prescribing me controlled medications. _____
2. I will communicate fully with my provider about my pain, anxiety and sleep issues and the effect this has on my daily life as well as how well the prescribed medication is helping to relieve my symptoms. _____
3. I will not use any illegal substances _____
4. I agree to use my medication only as the provider has prescribed it. _____
5. I agree to bring all my unused pain, anxiety or any controlled medication with me to each provider's visit. _____
6. I will not share, trade or sell my medications with anyone. _____
7. I will not attempt to obtain any controlled medications from any other provider, and I understand a Prescription Monitoring Report can be accessed at any time by my provider and pharmacy to confirm this. _____
8. I will safeguard my controlled medications from loss or theft, and I understand loss of stolen pain medications will not be replaced. _____
9. I agree to submit to a random blood or urine drug test, if requested by my provider, to determine my compliance with this contract. _____
10. I agree to use the same pharmacy for all my controlled medication refills. _____
11. I understand that the pharmacy has the right to hold my prescription until its validity can be verified and that the pharmacist has the right to refuse to fill my prescription at any time. _____
12. I authorize the provider and the pharmacy to cooperate fully with any city, sale or other diversion of my controlled medications. _____
13. I authorize Alpine Healthcare to provide a copy of this signed agreement to my pharmacy upon request. _____
14. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. _____
15. I agree to follow all these guidelines as they have been fully explained to me. _____
16. I agree that all my questions and concerns have been addressed adequately, and a copy of this signed contract will be provided to me. _____

This contract was entered into on _____ day of _____, _____.

_____
Patient Name Printed

_____
Signature of Patient or Authorized Guardian

_____
Provider Signature

Alpine Healthcare

3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
Ph: (702) 438-5555 Fax: (702) 438-6666

Authorization to Disclose Health Information to Family Members and Friends

Patient Name _____ Date of Birth____/____/____

I, _____ hereby authorize Alpine Healthcare to release my

Protected Health Information to_____

_____

either in person, telephone or in writing.

Protected Health Information ("PHI") may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I am not required to sign this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

_____ _____

Patient Signature or Responsible Party Date

Alpine Healthcare

3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
Ph: (702) 438-5555 Fax: (702) 438-6666

Patient Health Questionnaire (PHQ9)

Patient Name _____ **Date today** _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Having little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Column Totals: _____ + _____ + _____

Add Totals Together: _____

For office use only:
5-9 minimal
10-14 minor
15-19 moderate
>20 severe

Alexander F. Akhavan **Lance D. Mayor** **Mildred Balotro, APRN-CNP**
3061 S. Maryland Pkwy., Ste 104 Las Vegas NV 89109
Ph: (702) 438-5555 Fax: (702) 438-6666

MEDICAL RECORDS RELEASE FORM

Date: _____

Patient Name: _____ **DOB:** _____

I hereby authorize:

_____

_____

To disclose the following medical records:

- **Complete Hospital Records (Emergency Department, H&P, Discharge Summary, Testing Results, Etc.) Discharge Date:** _____
- **Medical Records (2 years of complete records)**
- **Last 3-4 Consult Notes**
- **Other:**

  _____

VIA: FAX: (702) 438-6666

Mail: Alpine Healthcare, 3061 S. Maryland Parkway, Suite 104, Las Vegas, NV 89109

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric or HIV testing results and information relating to my health. This authorization shall expire after the fulfillment of this request. This authorization may be revoked by me at any time except to the extent that action has been taken in compliance with it. The revoke authorization form must be completed and submitted to the HIM services department. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

Signature of Patient Date