Family Doctors
OF GREEN VALLEY
Where your family comes first.

Patient Information (Self Pay)

Last Name: _____ First Name: _____ MI:_____

Social Security #: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone Number: _____

E-mail Address: _____

Pharmacy Name:_____ Pharmacy Phone Number: _____

Employer Information of Patient

Employer:_____ Phone Number:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Occupation: _____

Responsible Party (if other than patient): Relationship to Patient: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____

Street Address *Apt No.* *City* *State* *Zip Code*

Who we can thank for referring you to Family Doctors of Green Valley

☐Doctor:_____ ☐Patient:_____ ☐Friend:_____ ☐Attorney:_____

☐Hospital_____ ☐Search Engine_____ ☐Internet/Online _____

☐Social Media_____ ☐Website:_____ ☐Insurance Co: _____

☐Henderson Phone Book ☐Sun City/Anthem Phone Book ☐Driving By

By signing below, I certify the above information is correct.

_____ _____

Signature of Patient or Responsible Party Date

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Due to HIPAA (Health Information Portability & Accountability Act) we have had difficulties contacting patients. By filling out and signing below, you are authorizing the release of medical information.

Date: _____
Patient Name: _____
Date of Birth: _____
Social Security #: _____

Check all that apply:

☐ I authorize my medical information to be released to the following person (s):

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

☐ When calling to release test results, what is the **BEST** number to contact you?

_____ Daytime Phone Number _____ Evening Phone Number

And in the event you are unable to be reached, may we leave a message?

☐ Yes ☐ No

☐ Authorizing medical information and/or newsletters pertaining to the practice to be released by e-mail.

_____ E-Mail Address

_____ Patient Name (Please Print) _____ Patient Signature

NOTE: In the event that we are unable to contact you by either phone or e-mail, after several attempts your results will be mailed to you. If you have any questions, please contact the Nursing Department at (702) 616-9471.

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291 N. Pecos
Henderson, NV 89074
Phone 702-616-9471; Fax 702-616-9681

HIPPA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

For Office Use Only:

Authorizing Release from:

Name of Doctor or Facility			
Address			
Phone Number		Fax Number	

Authorizing Release to:
Family Doctors of Green Valley
291 N Pecos Road
Henderson, NV 89074
(702) 616-9471 Phone
(702) 616-9681 Fax

Information to be Released: ☐ Entire Record ☐ Office ☐ Visits Labs ☐ Procedure Reports

☐ Diagnostic Results ☐ Medications ☐ Billing ☐ Other (Specify): _____

Purpose of disclosure: _____

Risk of disclosure: I understand that if the person(s) and/or organization (s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information any be re disclosed without my authorization.

Patient rights and authorization:

1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "Authorizes" persons above. 3) I understand a photocopy of this authorization is to be considered as valid as the original, 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. 5) I understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of: Alcohol, drug abuse and/ or psychiatric records, sexually transmitted disease and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by the authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer.

Expiration Date: It is understood that a photocopy of this Authorization shall be considered as effective as the original. This authorization shall remain in full force and effect until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes for a period of 1 year from the date signed.

Signature of Patient or Legal Representative: _____ Date_____
If signed by other than patient, select authority and provide documentation:

____Parent of minor child ____ Power of Attorney ____ Representative of Deceased's Estate ____ Representative of incapacitated adult

____ Other (Specify):_____

Witness: _____

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Acknowledgement of Policies

I have read, understand and agree with all of the listed policies below:

- **Family Doctors of Green Valley's Financial Policy**
- **Patient Consent for use and disclosure of Protected Health Information (PHI) form**
- **Family Doctors of Green Valley's Office Policy Acknowledgement Form**

_____ _____

Patient or Legal Guardian Signature Date

_____

Printed Name of Patient

Optional:
If you would like to receive a copy of our Privacy Practices forms, please sign below

Acknowledgement of Receipt of Privacy Practices

I _____ have received a copy of Family Doctors of Green Valley's notice of Privacy Practices which became effective on April 14, 2003.

_____ _____

Patient or Legal Guardian Date