Reno Location:
670 Sierra Rose Drive
Reno, Nevada 89511
Phone: 775-322-4550
Fax: 775-322-4776

Carson City Location:
2340 South Carson St, Suite A
Carson City, NV 89703

Endocrinology New Patient Packet

Patient Name:_____DOB:_____

Preferred Pharmacy: _____

*If more room is needed, continue on back or attach a list.

Prescriptions	Dosage	Times per day

Over the counter meds	Dosage	Times per day

Drug Allergies:	Reaction:

Patient medical history	Yes	No	How long		Yes	No	How long
Kidney disease				Bipolar Disorder			
High blood pressure				Thyroid Nodule/ Cancer			
Diabetes				Low/ Elevated Thyroid Levels			
Cancer				Pituitary Problems			
Seizures				Adrenal Problems			
Stroke				Reproductive Problems			
Heart attack				Glaucoma			
Heart disease/failure				Lung Problems			
Kidney stones				Bladder/Prostate problems			
Stomach/bowel problems				Gallstones			
Depression				Arthritis/Back problems			
Eating Disorder				Sexually Transmitted Infection			
Bipolar Disorder				Other:			
Psychosis				Other:			

Previous surgeries	Hospitalizations (last 3yrs)

Family History	Living?	Deceased?	Current Health Concerns:
Mother			
Father			
Brothers			
Sisters			
Children			

Other information	Yes	No	How often	Yrs.		Yes	No
Do you smoke?					Former smoker?		
Do you use Alcohol?					Do you have any special diet?		

Women		
Started menstruating at age: _____	Interval between cycles: _____ days Flow: __ light __normal __heavy	Date of last pap:_____ __ normal __abnormal
Bleeding between cycles: __yes __no	Vaginal discharge: __yes __no	Date of last period:_____
Number of pregnancies:_____	Number of live births:_____	Number of miscarriages:_____

Men		
Impotence or poor erections: __yes __no	Swollen testicle: __yes __no	Last PSA (Prostate blood test): _____

Have you had any of the following during the last six (6) months?					
GENERAL HEALTH	**Yes**	**No**	**EARS, NOSE, THROAT**	**Yes**	**No**
Good general health			Earache or drainage		
Weight gain			Ringing in the ears		
Weight loss			Decreased Hearing		
Fever or chills			Nasal/Sinus congestion		
Fatigue			Sore throat		
EYES	**Yes**	**No**	**RESPIRATORY**	**Yes**	**No**
Blurry vision			Frequent coughing		
Eye irritation			Spitting up blood		
Eye discharge			Shortness of breath		
Vision loss (central)			Asthma or wheezing		
Vision loss (peripheral)					
CARDIOVASCULAR	**Yes**	**No**	**GASTROINTESTINAL**	**Yes**	**No**
Chest pains			Nausea		
Palpitations			Vomiting		
Difficulty breathing			Frequent Diarrhea		
Fainting			Constipation		
Swelling of feet			Abdominal Pain		
GENITOURINARY	**Yes**	**No**	**NEUROLOGIC**	**Yes**	**No**
Frequent Urination			Headaches		
Burning or painful urination			Light headed or dizzy		
Blood in urine			Paralysis		
Getting up at night to urinate			Convulsions or seizures		
Incontinence or dribbling			Sensation changes		
MUSCULOSKELETAL	**Yes**	**No**	**SKIN**	**Yes**	**No**
Joint pain or stiffness			Rash		
Joint swelling			Itching		
Muscle Weakness			Un-healing wounds		
Muscle pain or cramps			Changes to skin color		
Back pain			Skin dryness		

PSYCHIATRIC	Yes	No	HEMATOLOGICAL/LYMPHATIC	Yes	No
Memory Loss			Slow to heal after cuts		
Anxiety			Enlarged glands		
Depression			Easily to bruise or bleed		
Suicidal ideations			Anemia		
Hallucinations			Blood transfusions		
ENDOCRINE	**Yes**	**No**	**ALLERGIC/IMMUNOLOGIC**	**Yes**	**No**
Cold intolerance			Skin itching		
Heat intolerance			Skin rashes		
Excessive thirst			Hay fever symptoms		
Excessive hunger			Chronic infections		
Excessive urination			Reactions to medications		
KNOWN FOOD ALLERGIES?				**Yes**	**No**
List foods:					

Patient signature:_____ Date:_____

Sierra Nevada
SPECIALTY CARE

Last Name: _____ First Name: _____ Initial: _____

Previous Name:_____ Preferred First name:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph:( ) _____ Cell Ph:( )_____ Work Ph:( )_____

Email: _____ Marital Status: □ single □ married □ widowed
□ divorced □ legally separated

Ethnicity: □ African American □ American Indian □ Hispanic/Latino □ White □ Other

Date of Birth: _____ Social Security #: _____-_____-_____ Current gender identity is:_____

Sexual Orientation is:_____ Sex assigned at birth was:_____ Pronouns are:_____

Primary Care Doctor: _____ Phone Number: _____

Referring Doctor:_____ Phone Number: _____

Primary Insurance Company: _____

ID #: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____ SS#: _____

Employer Name: _____ Employer Phone: (_____) _____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____ SS#: _____

Employer Name: _____ Employer Phone: (_____) _____

Financial Policy

- We are providers for many local and national health plans. We will work with your insurance carrier to file and collect payment for claims; however, you are responsible for all copayments and deductibles. These are due at the time services are provided. You need to keep the billing department updated with all your current insurance information.

- Managed health care plans require pre-authorization for many procedures and treatments. We will contact your primary care physician and insurance carrier to obtain authorizations. Ultimately, it is the responsibility of the patient to ensure all authorizations are in place before the service is provided.

- Uninsured patients are required to pay at the time services are provided. There are several payment options available. Please contact our billing department to discuss your account.

- If we do not receive payment from you or your insurance carrier within 30 to 90 days, your account will be considered delinquent. No patient may carry a balance over 90 days without payment arrangements with the billing department.

- We understand that each patient has unique circumstances that can affect their ability to pay. Each account will be considered individually, and we may request proof of income before your account is given financial hardship status.

- Accounts are turned over to our collection agency only as a matter of last resort. In our experience these accounts are the result of patients not communicating with the billing department. We are willing to assist you to ensure your account remains in good standing.

- Any patient whose account has been turned over to collections will receive 30 days emergency care only and must transfer their care to another Nephrologist not associated with our group.

I authorize the release of any medical information necessary to process my claim, and authorize payment of medical benefits to the undersigned physician or supplier for the services rendered.

Signature:_____ Date:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act) of 1966 law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

This information may be released to: I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

□ Spouse name_____

□ Child(ren) name_____

□Other/name _____

Emergency Contact: _____ Relationship: _____ Ph: _____

□ Information is NOT TO BE RELEASED TO ANYONE.

May we phone, email, or send a text message to you to confirm appointments? □ YES □ NO

May we leave a message on your answering machine at home or on your cell phone? □ YES □ NO

This consent was signed by: _____

(PRINT NAME PLEASE)

SIGNATURE:_____ Date: _____

Patient Responsibilities

We at Sierra Nevada Specialty Care would like to thank you for the opportunity to provide care to you and your family. At SNSC we view healthcare as a collaborative approach between you, the patient, and our healthcare providers.

- After your first appointment with a physician and once your treatment plan has been established, you may be scheduled with one of our nurse practitioners in order to provide you with high-quality care, personalized health counseling, education and accessibility. This physician/nurse practitioner collaboration will continue for as long as you are an SNSC patient.

- For all appointments, please bring a current insurance card, a photo ID and all current medications.

- For prescriptions refills, please call your pharmacy. They will contact us via fax or by phone with the necessary information. Please allow 24-48 hours for all refills. Refills will not be called in after normal operating hours or on weekends. You will need to allow longer if a prescription requires a prior authorization.

- If you should need to cancel your appointment, please provide our office with at least 24 hours notice. Multiple no-shows can lead to dismissal from this practice.

- All co-pays, deductibles, and payments for non-covered services are <u>due at check-in.</u>
  If the co-payment cannot be paid, the office has the right to reschedule your appointment. We accept cash, check, and credit cards. We do not accept debit cards.

- If you would like to have your labs reviewed you will need to call and make an appointment with a nurse practitioner or wait until your next scheduled appointment. Routine labs will not be reviewed over the phone.

- If you require a surgical risk assessment letter, please allow at least 72 hours from request to pick-up. Depending on the date of your last appointment and lab work, and the nature of the surgery, we might require that you be seen in our office to evaluate your surgical risk.

Consent to Access Medical Records for Clinical Research Screening

Sierra Nevada Specialty Care participates in clinical research trials. As part of this effort, we screen patient records to identify if they are eligible for participation.

I understand that by checking the "YES" box, I am giving my permission for SNSC to access my medical records for the purpose of identifying whether or not I am eligible to participate in a clinical trial. By checking the "NO" box, I am stating that I am not willing to participate in clinical research and do not want my information to be used for identifying whether or not I am eligible to participate in a clinical trial.

□ **YES -** I do give my permission to SNSC to screen my medical records for the purpose of identifying if I am eligible for participation in clinical research.

□ **NO -** I do not give my permission to SNSC to screen my medical records for the purpose of identifying if I am eligible for participation in clinical research.

_____ _____

Printed name Signature

_____ _____

Date Signature of parent/guardian

**We reserve the right to make changes to this notice at any time. In the event that there is a material change to this notice, the revised notice will be posted.

**If you have any complaints concerning our privacy practices you may contact our Privacy Officer, by mail at the above address or phone.

Sierra Nevada
SPECIALTY CARE

Acknowledgement of Receipt

By signing below you acknowledge you:

- ✔ Received the following patient documents:
    1. Notice of Privacy Practices
    2. Patient Responsibilities
    3. Financial Policy
- ✔ Completed the following patient documents:
    1. HIPAA Compliance Consent Form
    2. Clinical Research Consent Form (New patients only)

Patient/Guardian Name: _____

Signature: _____Date: _____