NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:	Date of Birth:
Location of Patient:	Medical Record #:
Physician Name:	Location:

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Nevada Health Centers providing healthcare services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Nevada Health Centers HIPAA Privacy Officer at 3325 Research Way, Carson City, NV 89706. As long as this consent is in force (has not been revoked) Nevada Health Centers may provider healthcare services to me via telemedicine without the need for me to sign another consent form.

_____ _____

Signature of Patient
(or person authorized to sign for patient)

Date

_____

If authorized signer, relationship to patient

_____ _____

Witness

Date

I have been offered a copy of this consent form – Patient's Initials: _____

NEVADA
HEALTH CENTERS

PARENTAL AUTHORIZATION FOR THE EVALUATION AND TREATMENT OF A MINOR CHILD

As parent / legal guardian of _____,
Minor Child's Name

I, _____ authorize his/her evaluation and treatment.
Parent / Legal Guardian Name

As parent / legal guardian, I understand I have the right to request information concerning the minor child's evaluation and treatment.

_____ _____
Parent / Legal Guardian Signature Date

_____ _____
Witness Date

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
PATIENT DEMOGRAPHICS
(All information is strictly confidential)

Last Name | First | Middle Initial | Birth Date: / /

Street Address | Apt # | City | State | Zip

Mailing Address / P.O. Box | Apt # | City | State | Zip

Student?: ☐ No ☐ Full Time ☐ Part Time | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner | Veteran: ☐ Yes ☐ No

Cell Phone Number ( ) | Daytime Phone Number ( ) | Alternate Phone Number ( ) | Primary Language: _____ Ethnicity: ☐ Hispanic ☐ Non Hispanic

E-mail Address:

Birth Sex:	Gender Identity:	Sexual Orientation:	Preferred Pronoun(s):
☐ Male	☐ Male	☐ Lesbian or gay	☐ He, Him, His
☐ Female	☐ Female	☐ Straight (not lesbian or gay)	☐ She, Her, Hers
Current Gender:	☐ Transgender Male / Female-to-Male	☐ Bisexual	☐ They, Them, Theirs
☐ Male	☐ Transgender Female / Male-to-Female	☐ Something else	☐ Ze, Hir
☐ Female	☐ Other	☐ Don't know	☐ Decline to Answer
☐ Undifferentiated	☐ Chose not to disclose	☐ Chose not to disclose	☐ Other

Which of the following groups do you feel you belong to? ☐ American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ Refused to report

Emergency Contact (REQUIRED) | Phone ( )

Responsible Party (Parent, or legal guardian information. If patient is 18 years or older please print the patient's information.)

Last Name | First | Middle Initial

Street Address | Apt # | City | State | Zip

Mailing Address / P.O. Box | Apt # | City | State | Zip

Home Phone ( ) | Annual Income: (We need this information for statistical purposes)
☐ $24,000 or less ☐ $25,000 to $49,999 ☐ $50,000 to $74,999
☐ $75,000 to $99,999 ☐ $100,000 or more ☐ Refused to report (Initials _____)

Employer's Name | Employer's Address (street address, city and state) | Phone ( )

Medical Insurance

1 - Primary Insurance Company | ID # | Group # | Address

Name of Insured | DOB | Insured's Employer | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

2 - Secondary Insurance Company | ID # | Group # | Address

Name of Insured | DOB | Insured's Employer | Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

I hereby voluntarily consent to outpatient care with Nevada Health Centers, Inc., encompassing routine, minor surgical and diagnostic procedures. I furthermore consent to the performance of examination and procedures by the medical staff and their assistants, including physician assistants and advanced practice nurses. I understand that physician assistants and advanced practice nurses are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I agree to the release of medical records and information including those related to medical treatment, surgical procedures, laboratory testing, psychological services and consultations to any person or entity responsible for payment to NVHC.

Signature of Patient, Parent or Legal Guardian _____ Date _____

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
FINANCIAL AGREEMENT

I authorize the direct payment of any benefits due to me for the services provided by Nevada Health Centers, Inc. be paid directly to Nevada Health Centers, Inc. by my insurance company.

I realize that although Nevada Health Centers, Inc. may be billing my insurance company on my behalf, I am ultimately responsible for the balance on my account.

Medicare Patients: I understand that Nevada Health Centers, Inc. accepts assignment with Medicare, however, I am responsible for a 20% copay at the time of service. Nevada Health Centers, Inc. will bill my supplemental insurance, as long as I provide all information necessary to do so. I understand that Medicare only pays for services it considers to be medically necessary and that the case may arise that I request services Medicare will not pay for, I would be responsible for payment in full.

Medicaid Recipients: Federal and State statutes require utilization of all other sources before billing Medicaid for medical services. Other sources include private or employer-provided health and accident insurance coverage. I certify under penalty of fraud that I do not have private or employer provided health and accident insurance, as a primary payer, for my dependents or myself. I understand that Medicaid only pays for services that are to treat a medical condition or illness.

Private Insurance Patients: I understand that I am responsible for knowing what benefits are covered by my insurance policy. I understand that Nevada Health Centers, Inc. will verify benefits, but does not guarantee any service will be a covered benefit. I understand that if my insurance does not cover any services received, I will be responsible for payment. I understand that my copay is due and payable at the time of service.

Self Pay Patients: I understand that it is the policy of Nevada Health Centers, Inc. to collect payment for services at the time of service.

Third-Party Collection Agency: If you have not responded to our attempts to reach you about any unpaid balances, we may opt to send your account to a collection agency.

_____ _____

Patient Signature / Parent (For Minor Patient) Date

_____ _____

Witness Date

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Nevada Health Centers and/or its affiliated facilities (each and all of them referred to as "NVHC" in this form).

Consent to Healthcare Services: I am requesting that healthcare services be provided to me (or my minor child or the patient named below) at NVHC. I voluntarily consent to all medical treatment, dental treatment, behavioral health treatment, and healthcare-related services that the caregivers at NVHC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my NVHC caregiver. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

Telemedicine: I understand that NVHC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine and, as always, my insurance carrier will have access to my medical records for quality review / audit. I understand that I will be responsible for any copayments or coinsurances that may apply to my telemedicine visit.

Uses and Disclosures of Health Information: I have received Nevada Health Centers' Notice of Privacy Practices. The Notice of Privacy Practices explains how Nevada Health Centers may use and disclose confidential health ~~information that identifies me (or the below-named patient). I consent to let Nevada Health Centers use~~ and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by NVHC, its or billing agents, collection agents, attorneys, consultants and/or other agents that represent NVHC or provide assistance to NVHC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient's) healthcare, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that NVHC has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to NVHC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from NVHC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from NVHC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to NVHC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by NVHC. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge NVHC, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Valuables/Limitation of Liability: I understand that I should not bring valuables (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to NVHC. If I choose to bring valuables to NVHC, I AGREE THAT NVHC SHALL NOT BE RESPONSIBLE FOR VALUABLES.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

In Person Consent

_____ _____

Signature of Patient or Responsible Party — Date/Time

_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) — Responsible Party's Relationship to Patient

Phone Number(s)

Home _____ Cellular _____

OR

Telephone Consent

_____ _____

Printed Name of Individual Providing Telephone Consent — Date/Time

_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) — Responsible Party's Relationship to Patient

Phone Number(s)

Home _____ Cellular _____

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
Administrative Office
3325 Research Way, Carson City, NV 89706 • 775.887.1590

Dear Patient:

The protection of your health information is important to us at Nevada Health Centers, Inc. (NVHC). As a requirement of the Health Insurance Portability and Accountability Act (HIPAA), NVHC has developed a Notice of Privacy Practices. We encourage you to thoroughly review the document and become familiar with how your personal health information will be used and safeguarded, as well as your rights regarding the protection of your personal data. The information in this notice is effective April 14, 2003.

Protected health information is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address, and relates to your past, present, or future physical or mental health or condition and related health care services. NVHC is required by law to do the following:

- Make sure that your protected health information is kept private.
- Give you notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice to you.

NVHC reserves the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A laminated copy of this notice is available in the clinic. You may obtain a Notice of Privacy Practices by accessing the NVHC web site, *nvhealthcenters.org*, or by calling the Privacy Officer and requesting a copy to be mailed to you, or by asking for a copy at the clinic.

You are being asked to sign to acknowledge receipt of information about NVHC Notice of Privacy Practices.

If you have any questions about the privacy notice, feel free to ask at the clinic or contact the NVHC Privacy Officer at Carson City Administration Office, 3325 Research Way, Carson City, NV 89706, or by phone at 775.887.1590. For additional information regarding your privacy rights, you may also visit the Nevada Health Centers web site at *nvhealthcenters.org*.

Sincerely,

Art Rempp
HIPAA Privacy Office

Nevada Health Centers, Inc.
Acknowledgement of Receipt Of Documents

I hereby acknowledge that I have received or read the following documentation:

- ☐ HIPAA *(Health Information Portability Act)*
- ☐ Nevada Health Centers, Inc. Financial Agreement

Signature of Patient or Personal Representative _____ *Relationship to Patient _____

Print Name _____ Date _____

Nevada Health Center Clinic: _____

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
DID NOT KEEP APPOINTMENT / NO-SHOW POLICY
PATIENT INFORMATION AND ACKNOWLEDGEMENT

Your providers want to make sure that you and other patients have access to high-quality care when you need it. To ensure maximum access to our services for all of our patients, please review the appointment policy information below, initial and sign as noted:

(Initials)_____**Scheduled Appointments:** Although we will make every effort to remind you of your upcoming appointment by phone or by mail, you are ultimately responsible for remembering your appointment date and time.

(Initials)_____**Canceling Appointments:** If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know so that we can offer your appointment to another patient. Failure to provide at least 24 hours' notice counts as a missed appointment.

(Initials)_____**Missed Appointments:** Because of the critical lack of access to medical, behavioral health or dental services in our area, missed appointments are taken very seriously.

1. Any time you miss an appointment, it will be docu¬mented as having missed the appointment.
2. **If you miss three appointments without proper notice within a 12-month time period, you will be placed on "no-show status" and will be seen on a walk-in/open access basis only for a period of three months.** This means that our scheduling staff will no longer be able to make an appointment for you, but will instruct you as to the most convenient time to come into the clinic to be seen on a "walk-in" basis. Although we can't guarantee you will receive care on that day, every effort will be made to see you.

Please talk to any of our front desk staff if you have questions about our **No-Show Policy**.

To be completed by Patient or Parent/Guardian:

I understand and agree to abide by this **No-Show Policy**.

_____ _____

Patient or Parent/Guardian Signature (for patients under 18) Date

_____ _____

Witness Signature Date

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
HEALTH HISTORY
(All information is strictly confidential)

Patient Name: Today's Date: / /

Date of Birth: / /

Which pharmacy do you use?

Address or cross streets: Phone number:

For patients 18 and up, do you have an Advanced Directive/Living Will in place? ☐ YES ☐ NO
If so, would you like to keep a copy on file with us? ☐ YES ☐ NO

What is the primary reason for your visit today?

When was your last mammogram? / / What were the results?

When was your last pap smear? / / Was it normal? ☐ YES ☐ NO

When was your last colon cancer screening? / / What were the results?

For diabetic patients only, when was the last time you had an eye exam? / /

Are you currently experiencing any pain today? ☐ YES ☐ NO
If you answered yes to the previous question, how would you rate your pain right now on a scale of 0-10? _____

For females only, when was the first day of your last menstrual cycle? / /

For patients aged 65 and up, have you had any falls in the past year? ☐ YES ☐ NO
If you answered yes to the previous question, how many falls have you had in the past year? _____
Did those falls result in injury? ☐ YES ☐ NO

Please list any medications (prescription & over the counter), supplements, or vitamins that you take:
(If you brought your medication list with you today, then please provide list to front office staff to copy and do not complete this section)

Medication Name	Strength	How often do you take it?

Please list any allergies:

Allergy	Reaction

Please check (✕) if you have recently been experiencing any of the following symptoms:

☐ Chills	☐ Fatigue	☐ Fever	☐ Unintentional weight loss	☐ Cough
☐ Shortness of breath	☐ Wheezing	☐ Chest pain	☐ Swelling of lower legs (edema)	☐ Abdominal pain
☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting	

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Check one answer for each question.

Little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

(All information is strictly confidential)

Please check (×) any medical conditions you currently have or have had in the past:

☐ Arthritis	☐ Asthma	☐ Blood clots	☐ COPD	☐ Depression
☐ Diabetes	☐ High cholesterol	☐ Heart disease	☐ Hepatitis/liver disease	☐ HIV
☐ High blood pressure	☐ Heart attack	☐ Kidney disease	☐ Stroke	☐ Thyroid disease

☐ Cancer: _____

☐ Other: _____

Please list any surgeries you have had in the past:

Surgery	Approximate Year Performed

Please list your family medical conditions:

Family Member	Are They Living?	Medical Conditions
Mother	☐ YES ☐ NO	
Father	☐ YES ☐ NO	
Sister(s)	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
Brother(s)	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	

Are you currently, or have you ever been a tobacco user? ☐ YES ☐ NO ☐ FORMERLY

If yes or formerly, what type of tobacco? _____

How much/often do or did you use? _____

If a former tobacco user, what age were you when you quit? _____

Do you consume alcohol? ☐ YES ☐ NO ☐ FORMERLY

If so, what type? _____

How often do you drink? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially

How much do you drink when you do? _____

When was your last drink? _____

I certify that the above information is correct to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Reviewed by Date

NEVADA HEALTH CENTERS

PARENTAL AUTHORIZATION FOR THE EVALUATION AND TREATMENT OF A MINOR CHILD

As parent / legal guardian of _____.
Minor Child's Name

I, _____ authorize his/her evaluation and treatment.
Parent / Legal Guardian Name

As parent / legal guardian, I understand I have the right to request information concerning the minor child's evaluation and treatment.

_____ _____
Parent / Legal Guardian Signature Date

_____ _____
Witness Date

NEVADA

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Nevada Health Centers, Inc.
Sierra Nevada Health Center – Telehealth Services
1789 College Parkway, Suite 125 / Carson City, NV 89703
Phone: 775-888-6611 / Fax: 775-887-7047

Release of Medical Information Authorization

(Autorización Para Obtener Copia del Expediente Medico)

Patient name_____ Date of birth_____
Nombre del paciente *Fecha de Nacimiento*

I authorize release of the above named patient's Healthcare Information ☒ To or ☐ From:
Yo autorizo que se den copias del expediente de salud del paciente nombrado arriba a/de:

Name *(Nombre)* *Spring Creek Middle School*

Address *(Dirección Ciudad, Estado, Zip.)* *14650 Lamoille Highway, Spring Creek, NV 89815*

Phone *(Teléfono)* *775-777-1688* Fax _____

☐ Entire record, or: ☐ Medication List ☐ Immunization Records ☐ Provider Notes
☐ Laboratory Results ☐ X-Ray ☐ Billing Records
☒ Other ***No information will be released, but I am aware the school nurse will be preparing my child for a telehealth consultation with a behavioral health provider. The nurse will not be present during the evaluation.***

☐ Healthcare records covering the period of _____ (date) to _____ (date)
Todo expediente desde *(fecha)* *A* *(fecha)*

Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

I ☒ DO ☐ DO NOT authorize release of confidential information concerning:
Yo autorizo que se compartan expediente a/de el que ha sido listado arriba aunque estos expedientes contenga información a cerca de (ponga inciales si aplica):

☐ Yes ☐ No Acquired Immunodeficiency Syndrome (AIDS)\Human Immunodeficiency Virus (HIV) infection
Síndrome de Inmunodeficiencia Adquirida (SIDA)\Infección del Virus de Inmunodeficiencia Humana (VIH)

☒ Yes ☐ No Behavioral health services\psychiatric testing, diagnosis, history and/or treatment
(Servicios de Salud Mental\exámenes psiquiátricos, diagnosis, historia y/o tratamiento)

☒ Yes ☐ No Alcohol or drug testing, diagnosis, history, and/or treatment
Exámenes de Alcohol o drogas, diagnosis, historia y/o tratamiento

☒ Yes ☐ No Social Services

Reason For Request: (Please check one) *(Esta información es por razón de):*

☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☒ Other: ***Behavioral health and coordination of care.***

I understand that I have a right to 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 Front Desk or Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____ IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS.

Patient or Authorized Guardian Signature _____
(Firma del paciente o guardián legal)
Date *(Fecha)* _____ Witness *(Testigo)*_____

For Office Use Only:
Request reviewed by provider: _____ Date: _____
(Provider signature)
Request completed by: _____ Date: _____
(NVHC Staff member signature)

Revised 8/2013

NEVADA HEALTH CENTERS

TELETHERAPY TREATMENT CONTRACT

The therapist and I have discussed my / my child's behavioral health referral. I was informed of the limitations, risks, and benefits of engaging in the use of teletherapy via the computer and the approximate length and purpose of treatment which includes the following methods and interventions:

For the purpose of:

_____ Stabilization
_____ Decrease and relieve symptomatology
_____ Improve coping, problem solving and use of resources
_____ Skill development
_____ Grief resolution
_____ Stress management
_____ Behavior modification and cognitive restructuring
_____ Other _____

I understand I have voluntarily elected to participate in-office teletherapy/technology as the means of engagement in lieu of an in-person, face-to-face therapy session.

I understand the possibility of technology failure and alternate methods of service delivery.

While I expect benefits from this treatment, I fully understand and accept that because of factors beyond the therapists' control, such benefits and desired outcomes cannot be guaranteed.

I understand that the therapist is not providing emergency service and I have been informed of whom/where to call in an emergency or during the evening or weekend hours.

I understand that regular attendance will produce the maximum possible benefits and that I am free to discontinue treatment at any time in accordance with the policies of the NVHC.

I understand that I am financially responsible for any portion of the fees not covered or reimbursed by my health insurance.

I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats of harm to myself or another person.

I am not aware of any reason why I/my child should not proceed with therapy and I/my child agree to participate fully and voluntarily.

I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and understand the treatment planned. Therefore, I agree to comply with treatment and authorize the following named therapist to administer the treatment(s) to me or my child.

_____
Patient Name

_____ _____
Patient Signature (age 18+) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist's Signature Date

NEVADA HEALTH CENTERS

LIMITS OF PATIENT CONFIDENTIALITY

NVHC Practitioners are required to disclose confidential information if any of the following conditions exist:

You are a danger to yourself or others.

You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.

Your Practitioner was appointed by the courts to evaluate you.

Your contact with your Practitioner is for the purpose of determining sanity in a criminal proceeding.

Your contact with your Practitioner is for the purpose of establishing your competence.

Your contact is one in which your Practitioner must file a report to the public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.

You are under the age of 16 years and are the victim of a crime.

You are a minor and your Practitioner reasonably suspects you are the victim of child abuse.

You are a person over the age of 65 and your Practitioner believes you are the victim of physical abuse. Your Practitioner may also disclose information if you are the victim of emotional abuse.

You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.

You file suit against your Practitioner for breach of duty or your Practitioner files suit against you.

You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.

You waive your rights to privilege or give consent-limited disclosure by your Practitioner.

Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with your Practitioner before signing.

I have read and agree to the aforementioned conditions. I am consenting to (or my dependent) receiving outpatient treatment.

Patient Signature (age 18+) _____ Date _____

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

NEVADA HEALTH CENTERS

DUTY TO WARN

Although confidentiality and privileged communication remain rights of all patients of Mental Health Practitioners according to the law, some courts have held that if an individual intends to take harmful acts or dangerous action against another human being, or against themselves, it is the Practitioners duty to warn the person who is likely to suffer the results of harmful behavior or the family of the patient who intends to harm him/herself of such an intention.

I, _____ have read the above statement
(Print name in full)
and understand the Practitioner's responsibility to make such decisions when necessary.

_____ _____
Patient Signature (age 18+) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Practitioner Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or 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 are 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 figety 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	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee	Social Security Number	Telephone Number

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)

What is the nature of the injury or occupational disease?	List any body parts involved:

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

Did the employee leave work because of the injury or occupational disease? ____ YES ____ NO	If yes, when (date and time)?	Has the employee returned to work? ____ YES ____ NO	If yes, when (date and time)?

Was first aid provided? ____ YES ____ NO	If yes, by whom?	Name and address of treating physician, if applicable or known

Did the accident happen in the normal course of work? (if applicable) ____ YES ____ NO	

Was anyone else involved? ____ YES ____ NO	Names of others involved

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee