In-House Primary Care

PATIENT DEMOGRAPHIC FORM

Patient Information

Name (Last, First, MI) | Date

Street Address | City | State | Zip

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

SSN | Date of Birth | Gender ☐Female ☐Male | Marital Status ☐ N/A (Child) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Religion (optional) | Ethnicity (optional) | e-mail address

Financially Responsible Party

Is patient responsible party/guarantor? ☐ Yes ☐ No

Name (Last, First, MI) | Relationship to patient

Street Address | City | State | Zip

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

Occupation | Employer | Date of Birth

Emergency Contact

Name | Relationship to Patient

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

Referral Info

Referring Physician's Name | Physician Phone Number

Physician Address | How did you hear about us? ☐ Physician ☐ Friend ☐Website ☐Newspaper ☐Radio/TV ☐ Other _____

PCP Info

Primary Care Physician's Name ☐ Same as Referring Physician above | Physician Phone Number

Insurance Info

Primary Insurance Company | Policy # | Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐Other _____ | Name of Subscriber (if other than patient)

Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone

Secondary Insurance Company | Policy # | Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐Child ☐ Other _____ | Name of Subscriber (if other than patient)

Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____

Guarantor Signature (if other than patient): _____ Date: _____

In-House Primary Care
1880 E Warm Springs Rd, Ste 135, Las Vegas, NV 89119
Phone: 702-894-9505 | Fax: 702-894-4158
Email: hello@in-houseprimarycare.com

Patient Acknowledgment and Consent Summary

Please initial each section below to indicate you have received, read, and/or consent to the following notices and policies:

- [ ] Consent to Treat and Release of Information: I authorize In-House Primary Care to provide medical treatment and share necessary information for my care.
- [ ] Patient Rights and Responsibilities: I have received and understand my rights and responsibilities as a patient. I have received a summary of my rights and responsibilities under the Nevada Medicaid program (if applicable).
- [ ] Nondiscrimination and Civil Rights Notice: I understand In-House Primary Care does not discriminate based on race, color, national origin, disability, age, or other protected status.
- [ ] Grievance Policy and Complaint Process: I have been informed of the process to file a complaint with In-House Primary Care, the Nevada DPBH, CMS, or HHS OCR.
- [ ] Advance Directives and End-of-Life Planning: I have received information about my right to make healthcare decisions and complete advance directive forms.
  Please indicate your current advance directive status below:
  - ☐ I have an advance directive (please provide a copy to our office).
  - ☐ I do not have one, but I would like more information.
  - ☐ I do not have one and do not wish to complete one at this time.
- [ ] Notice of Privacy Practices (HIPAA): I acknowledge receipt of the HIPAA privacy notice and understand how my health information may be used and shared.
- [ ] Billing and Financial Responsibility Agreement: I authorize In-House Primary Care to bill my insurance company directly for services rendered and to receive payment of medical benefits on my behalf. I understand that I am financially responsible for any charges not covered by insurance.
- [ ] Chronic Care Management (Medicare Only): I consent to participate in CCM and understand how services may be billed (if applicable).
- [ ] Telemedicine Consent: I consent to receive healthcare services via telehealth and understand the benefits and risks involved.
- [ ] Electronic Communication Consent: I consent to receive electronic communication from In-House Primary Care and I understand that I can revoke this consent at any time by submitting a written request.
- [ ] I consent to clinical photographs for documentation, my identity will be protected.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

POA/Responsible Party (if applicable): _____ Relationship: _____

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Consent to Treat and Release of Information

Consent for Medical Evaluation and Treatment

I voluntarily consent to receive medical services, evaluations, treatments, and procedures as deemed necessary by the healthcare providers at In-House Primary Care. This consent includes, but is not limited to, routine physical examinations, diagnostic procedures, laboratory tests, medical treatments, telemedicine services, and other procedures deemed necessary by my clinician.

Authorization to Release Medical Information

I authorize In-House Primary Care to use and disclose my protected health information (PHI) for the purposes of treatment, payment, and healthcare operations in accordance with federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA).

I authorize In-House Primary Care to release or obtain my medical records to/from any other provider, facility, insurer, or entity involved in my medical care or healthcare coordination. This includes hospitals, specialists, laboratories, pharmacies, insurance companies, and government health programs (Medicare, Medicaid, etc.).

Revocation and Expiration

This authorization is valid for the duration of my treatment with In-House Primary Care unless revoked in writing. I understand that revocation does not affect any disclosures made prior to receipt of the revocation.

Patient Rights and Responsibilities

As a patient receiving care from In-House Primary Care, you have the right to:

1. Be treated with respect, dignity, and consideration.

2. Be informed of your rights before treatment begins and throughout your care.

3. Participate in, be informed about, and consent or refuse care in advance of and during treatment.

4. Be informed, in advance, of the care to be furnished, the disciplines that will furnish care, and the frequency of visits.

5. Receive a timely response from your provider when care is needed or requested.

6. Be informed of your clinical status, diagnosis, and treatment options.

7. Receive care without discrimination as to race, color, religion, sex, age, sexual orientation, disability, or national origin.

8. Voice grievances about care or lack of respect without fear of discrimination or reprisal.

9. Have your property treated with respect.

10. Be informed in writing about advance directives and the agency's policies regarding their implementation.

11. Be informed about and participate in decisions regarding your plan of care, including the right to refuse treatment.

12. Be informed of your financial liability, including any costs not covered by Medicare or insurance.

13. Have access to your medical records and request an amendment if the record is inaccurate or incomplete.

14. Receive privacy and confidentiality of all communication and records related to your care.

15. Be informed of any experimental treatment or research affecting your care and the right to refuse participation.

16. Choose your healthcare provider and change providers if desired.

17. Be free from abuse, neglect, and exploitation.

18. Receive effective communication, including interpretation services if you have a communication barrier.

19. File complaints or grievances with the Nevada State Board of Nursing or other applicable oversight agencies.

Nevada Medicaid Patient Rights and Responsibilities

As a recipient of Nevada Medicaid services, you have certain rights and responsibilities. In-House Primary Care is committed to ensuring you understand and can exercise these rights.

Your Rights as a Nevada Medicaid Patient

• To be treated with respect and dignity, regardless of age, race, color, disability, sex, religion, national origin, sexual orientation, or gender identity.

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• To receive medically necessary covered services, including preventive services.

• To be informed about your health condition, treatment options, and to participate in decisions regarding your care.

• To refuse treatment (unless required by law) and be informed of the consequences.

• To receive care and services in a language you understand, including access to interpreter services at no cost.

• To request and receive a copy of your medical records and request that they be amended or corrected.

• To file complaints, grievances, or appeals without fear of retaliation.

• To request a fair hearing if your services are denied, reduced, or terminated.

• To choose your primary care provider from the Medicaid provider network.

• To access emergency care 24 hours a day, 7 days a week.

• To receive information about advance directives and make decisions regarding your end-of-life care.

• To be free from any form of abuse, neglect, or exploitation.

Your Responsibilities as a Nevada Medicaid Patient

• To provide accurate and complete health information to your providers.

• To follow agreed-upon treatment plans and instructions.

• To treat healthcare providers and staff with courtesy and respect.

• To notify your provider and Medicaid if you have changes to your address, phone number, or insurance coverage.

• To keep appointments or notify the provider if you must cancel or reschedule.

• To carry your Medicaid ID card and show it when receiving services.

• To use Medicaid benefits only for yourself and report any suspected fraud or abuse.

Need Help or Have a Complaint?

If you believe your rights have been violated or you need help, you can contact:

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Email: hello@in-houseprimarycare.com

Nevada Division of Welfare and Supportive Services (DWSS)
Medicaid District Office – Southern Nevada
3330 E. Flamingo Rd, Suite 55, Las Vegas, NV 89121
Phone: 702-486-1646
Website: https://dwss.nv.gov

You may also contact your Medicaid Managed Care Organization (MCO), if enrolled in one.

Notice of Nondiscrimination and Civil Rights

In-House Primary Care complies with applicable federal and Nevada civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or expression, or source of payment. In-House Primary Care does not exclude people or treat them differently because of these characteristics.

We Provide:

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters

- Written information in other formats (large print, audio, accessible electronic formats)

Free language services to people whose primary language is not English, such as:

- Qualified interpreters

- Information written in other languages

If you need these services, please contact our office at 702-894-9505 or notify any staff member.

How to File a Complaint

If you believe that In-House Primary Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or source of payment, you can file a grievance by contacting:

Compliance Officer
In-House Primary Care
1880 E Warm Springs Rd, Ste 135, Las Vegas, NV 89119
Phone: 702-894-9505

Fax: 702-894-4158
Email: hello@in-houseprimarycare.com

You may also file a complaint with the state of Nevada at:

Nevada Division of Public and Behavioral Health (DPBH)
4150 Technology Way, Carson City, NV 89706
Phone: 775-684-4200
Website: https://dpbh.nv.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Grievance Policy and Complaint Process

In-House Primary Care is committed to providing high-quality, respectful care. If you have a concern, complaint, or grievance regarding the care or services you received, we encourage you to let us know so we can address and resolve the issue promptly.

How to File a Grievance or Complaint

You may submit your concern in any of the following ways:

• Verbally to any staff member or provider.

• In writing to: Compliance Officer, In-House Primary Care, 1880 E Warm Springs Rd, Ste 135, Las Vegas, NV 89119.

• By phone at 702-894-9505 or by fax to 702-894-4158.

• By email to: hello@in-houseprimarycare.com

All grievances will be acknowledged within 5 business days. A written resolution will be provided within 30 calendar days unless additional time is necessary to investigate and resolve the concern. Retaliation of any kind for filing a complaint is strictly prohibited.

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You Also Have the Right to File a Complaint With:

Nevada Division of Public and Behavioral Health (DPBH):

Office of Health Facilities
4150 Technology Way, Suite 300, Carson City, NV 89706
Phone: 775-684-1030
Website: https://dpbh.nv.gov

Centers for Medicare & Medicaid Services (CMS):

CMS Regional Office
90 7th Street, Suite 5-300, San Francisco, CA 94103
Phone: 415-744-3501
Website: https://www.cms.gov/Medicare/Medicare

U.S. Department of Health and Human Services – Office for Civil Rights (OCR):

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019 | TDD: 1-800-537-7697
Online complaint portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Advance Directives and End-of-Life Care Planning

Federal and Nevada laws give you the right to make decisions about your own medical care, including the right to accept or refuse medical treatment and the right to make advance healthcare decisions. In-House Primary Care supports and respects your choices.

What is an Advance Directive?

An advance directive is a legal document that states your preferences about medical treatment if you are unable to communicate those wishes yourself. It may include a Living Will, Durable Power of Attorney for Healthcare, Do Not Resuscitate (DNR) orders, or Nevada's MOST (Medical Orders for Scope of Treatment) form.

Your Rights as a Patient

• To receive information about advance directives.

• To complete or update an advance directive at any time.

• To appoint someone you trust to make healthcare decisions on your behalf (healthcare proxy).

• To have your wishes regarding life-sustaining treatment honored to the extent permitted by law.

• To receive care regardless of whether or not you have an advance directive.

Our Responsibilities

We are required by law to ask if you have an advance directive and to include it in your medical record. If you do not have one, we can provide resources to help you complete one. Your provider will discuss your wishes with you, especially if you are seriously ill or at risk of life-threatening conditions.

Nevada-Specific Forms and Resources

The following forms are recognized in Nevada and available upon request:
- Durable Power of Attorney for Health Care Decisions
- Living Will Declaration
- Do Not Resuscitate (DNR) identification
- Provider Order for Life-Sustaining Treatment (POLST)

Notice of Privacy Practices (HIPAA)

Effective Date

This Notice is effective as of July 1, 2025.

Purpose of This Notice

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. In-House Primary Care is required by law to maintain the privacy of your health information and to provide you with this notice.

Your Rights

You have the right to:
- Get a copy of your medical record
- Correct your medical record
- Request confidential communication
- Ask us to limit what we use or share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

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Our Uses and Disclosures

We typically use or share your health information in the following ways:
- To treat you and coordinate your care
- To bill for your services
- To run our organization and improve services

We may also share your information to:
- Comply with the law
- Respond to organ donation requests
- Work with medical examiners or funeral directors
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it.

Contact Information

If you have questions about this notice or wish to file a complaint, contact:
Privacy Officer – In-House Primary Care
1880 E Warm Springs Rd, Ste 135, Las Vegas, NV 89119
Phone: 702-894-9505

Billing, Insurance, and Financial Responsibility Agreement

Patient Financial Responsibility

I understand that as a patient of In-House Primary Care, I am financially responsible for all medical services provided to me. I agree to pay any charges that are not covered or reimbursed by my insurance company, including but not limited to deductibles, copayments, coinsurance, and non-covered services.

Insurance Authorization and Assignment

I authorize In-House Primary Care to bill my insurance carrier(s) on my behalf for services rendered. I also authorize the release of any medical or other information necessary to process insurance claims and coordinate care. I assign directly to In-House Primary Care all insurance benefits payable to me for services provided.

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Coverage Limitations and Changes

I understand that it is my responsibility to provide accurate and up-to-date insurance information, and to notify the office of any changes to my insurance coverage. Failure to do so may result in the denial of claims and I will be responsible for the resulting charges.

Non-Covered Services

I understand that certain services may not be covered by my insurance plan. In such cases, I agree to pay for all services deemed medically necessary or requested by me that are not covered.

Payment for Outstanding Balances

I understand that payment is due upon receipt of a statement unless other arrangements have been made. In-House Primary Care may charge interest on any overdue balances and pursue collections if payment is not made.

CHRONIC CARE MANAGEMENT (CCM) CONSENT

For Medicare Patients Only

As a patient with two or more chronic conditions (such as heart disease, lung disease, kidney disease, depression, anxiety, or infectious disease), you may benefit from the Chronic Care Management (CCM) program offered by In-House Primary Care. The goal of this program is to ensure you receive coordinated, comprehensive care to help manage your conditions and improve your overall health.

Through CCM, our practice can:

- - Coordinate your visits with other providers, facilities, labs, radiology, or other testing
- - Speak with you by phone about your symptoms
- - Assist with medication management
- - Provide a comprehensive care plan

Medicare allows us to bill for these services during any month we provide at least 20 minutes of non-face-to-face care coordination. Your consent is required annually.

You Agree and Consent to the Following:

- - As needed, we will share your health information electronically with others involved in your care, in full compliance with privacy laws.

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- - We will bill Medicare once a month for this service. You may not come into the office monthly, but your account will reflect the charge and you will be responsible for any copayment or deductible.
- - Our practice will maintain records of the care coordination time spent each month and can provide this information upon request.
- - Only one provider can bill Medicare for CCM services per month. If another provider has offered CCM, you must choose which one will coordinate your care.

Your Rights:

- - To receive a written Comprehensive Care Plan
- - To discontinue participation in this program at any time for any reason by signing a cancellation form

We believe in building a strong patient-provider partnership through ongoing engagement in your health, treatment, and lifestyle decisions.

My signature confirms that I consent to participate in the Chronic Care Management program and understand the information presented above.

Telemedicine Consent

Telemedicine involves the delivery of healthcare services using electronic communications, information technology, or other means between a healthcare provider and a patient who are not in the same physical location. Telemedicine may be used for diagnosis, treatment, follow-up, or education, and may include interactive audio, video, or other electronic media.

Consent for Telehealth Services

By signing this form, I voluntarily consent to receive medical and/or mental health care services via telehealth from In-House Primary Care. I understand that telehealth may involve audio and video communication, transmission of medical records, images, or other personal health information. I understand that I have the right to refuse telehealth services at any time without affecting my right to future care or treatment.

Risks and Limitations

I understand there are potential risks to using telehealth technology, including interruptions, unauthorized access, and technical difficulties. I understand that if the provider believes the telehealth services are not adequate for my case, an in-person visit may be recommended.

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Privacy and Confidentiality

I understand that my privacy is protected under HIPAA and that all information shared during telehealth visits will be kept confidential and secure. The same laws and regulations that apply to in-person visits apply to telemedicine visits.

Financial Responsibility

I understand that telehealth services may be billed to my insurance (including Medicare or Medicaid) and that I am responsible for any copayments, deductibles, or non-covered services, just as I would be for in-person services.

Patient Rights

I have the right to:
- Withdraw my consent to telehealth services at any time.
- Request an in-person visit if available.
- Ask questions and receive answers regarding telemedicine procedures and technology.

Electronic Communication Consent

In-House Primary Care may use various electronic platforms to communicate with patients, including email, text messaging, voicemail, patient portals, and telemedicine applications. Devices may include computers, tablets, and smartphones. File transfers may also occur through secure apps, CDs, or USB drives.

Advantages of Electronic Communication

• A convenient and effective way of connecting—many doctors and patients use it regularly.
• Allows many questions and issues to be handled without a phone call or visit.
• Messages can be sent and received without both parties being online at the same time.
• Messages can be saved, copied, and forwarded, providing a communication record.
• Many systems are encrypted to protect privacy.
• Many systems allow attachments such as photographs or audio recordings.

Disadvantages of Electronic Communication

• Messages may be lost, sent to the wrong recipient, or be vulnerable to privacy breaches.
• There may be no confirmation that a message was received.
• Typing mistakes and auto-correct errors can cause confusion.
• Delays can occur if the receiving device is turned off or unattended.
• Risk of false messages or impersonation by malicious parties.
• No real-time clarification of misunderstandings.
• Messages may carry malware or viruses.
• Some medical questions/issues cannot be resolved electronically.

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Patient Name: _____ DOB: _____

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (e.g., Benzodiazepines, Hypnotics, Stimulants) are tightly regulated due to their potential for misuse. In-House Primary Care prescribes these medications only when medically necessary to manage symptoms and improve function. As a patient receiving controlled substance prescriptions, I agree to the following:

TREATMENT GOALS

My goal is to manage symptoms and improve my quality of life through a combination of medication, healthy habits (e.g., exercise, nutrition, tobacco/alcohol avoidance), and psychotherapy when recommended. I will follow my provider's treatment plan.

PATIENT RESPONSIBILITIES *(Initial each line)*

[ ] I am responsible for safeguarding and properly using my controlled medications. Lost/stolen medications will not be replaced.

[ ] I authorize my provider to communicate with other clinicians and pharmacies involved in my care.

[ ] I will use one pharmacy for all refills and provide the pharmacy name/number to my provider.

[ ] I understand telephone or fax refill requests are not accepted.

[ ] I agree to random pill counts during office hours. Missing pills without explanation may result in discharge.

[ ] I understand that driving may be restricted while using controlled medications.

[ ] I agree to random urine drug testing within 24 hours of request. Positive results or failure to test may lead to discharge or tapering.

[ ] I will not obtain similar medications from another provider. I will not share/sell my medication.

[ ] I will submit prescriptions within 2 weeks. Expired scripts will not be reissued until the next cycle.

REFILL POLICY *(Initial each line)*

[ ] Refills will be provided in person during regular business hours, not on weekends/holidays.

[ ] Refills will not be given early or for lost/spilled/stolen medication.

[ ] I will not request emergency refills; I will plan 24 hours in advance.

RISKS OF USE

Chronic Benzodiazepines: May cause dependence, sedation, tolerance, falls, memory issues. Long-term use is not always effective.

Chronic Stimulants: May affect cardiovascular health and growth (in children). Requires EKG monitoring.

Chronic Hypnotics: Associated with insomnia, daytime drowsiness, falls. Benefits are limited.

Concomitant Use: Combining opioids, benzos, hypnotics, or other sedatives increases overdose risk and may result in discharge.

(For Female Patients)

[ ] I understand I must inform my doctor if I am pregnant or plan to become pregnant due to potential risks to the fetus.

ACKNOWLEDGEMENT

I understand the risks of physical and psychological dependence. I agree to taper medications under supervision if needed. My provider is not responsible for withdrawal symptoms due to inappropriate use.

TERMINATION

Violation of this agreement (e.g., medication misuse, illicit drug use, threats, noncompliance) may result in immediate discharge and reporting to appropriate entities. I accept these consequences.

Patient Name: _____ DOB: _____

POA/Representative Name (if applicable): _____

Signature: _____ Date: _____