BAMBOO Family Clinic LLC
98 East Lake Mead Parkway, Suite 307
Henderson, NV 89015
Office: (702) 483-2969
Fax: (702) 761-2339

New Patient Registration

Client Information

Patient Name (First and Last): _____

Date of Birth: _____ Age: _____ Sex: ____ Social Security #: _____

Email Address: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ ☐ Home ☐ Mobile

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

Work Phone: _____

Emergency Contact Name (First and Last): _____

Phone Number: _____ Relationship: _____

Spouse/Responsible Party

Spouse/Responsible Party Name (First and Last): _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone Number: _____

Patient Insurance Information

Primary Insurance: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy #: _____ Group #: _____

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General Medical History

When was the last time you had the following tests performed? (please check all that apply)

	Past Year	2 Years	10 Years	Never
Colonoscopy				
Routine Physical				
Eye Exam				
Breathing Test				
Bone Density				
Cholesterol Check				
Flu Shot				
Pneumonia Vaccine				
Women's Health				
Mammogram				
Pap Smear				

Do you have or have you ever been diagnosed with:

	YES	NO	Explain
Diabetes			
High Blood Pressure			
Heart Disease			
High Cholesterol			
Cancer			
Stroke			
Seizures			
Lung Disease (Asthma, COPD, etc.)			
Glaucoma			
HIV			
Other:			

Have you been hospitalized in the past year? ☐ Yes ☐ No

Explain:

_____

_____

_____

_____

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Do you see any specialists? ☐ Yes ☐ No (If yes, please provide name and reason below)

Specialist Name	Reason

Family History

Have any of your family members been diagnosed with:

	Yes	No	Relation (i.e. father)
Diabetes			
High Blood Pressure (Hypertension)			
Heart Disease			
High Cholesterol			
Cancer			
Stroke			
Seizures			
Lung Disease (Asthma, COPD, etc.)			
Other:			

Social History

a. What is your smoking status? ☐ Never ☐ Past Smoker ☐ Current Smoker

How many packs per day? _____ How many years of smoking history? _____

Vape/E-Cigarette Products? ☐ Yes ☐ No

b. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many drinks per week? ___

c. Have you or do you use any drugs for recreational use? ☐ Yes ☐ No

If yes, please explain: _____

d. Have you been exposed to any conditions/events that could potentially be damaging to your health (i.e. military combat, occupational hazards, etc.)? If yes, please explain: _____

_____

_____

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Do you have any food or drug allergies? ☐ Yes ☐ No (If yes, please list & describe below)

Food or Drug	Reaction

Please list all medications, including over-the-counter (OTC) medications and herbal supplements that you are currently taking:

Drug, OTC, or herbal supplement	Dosage & Frequency	Treatment Purpose

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address/Cross Streets: _____

_____

I certify that the above information is complete and accurate, to the best of my knowledge.

Patient Name/Responsible Party (printed): _____ Date: _____

Patient/Responsible Party Signature: _____

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General Consent for Care and Treatment Consent

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

Printed Name of Patient/Responsible Party	Date
Signature of Patient/Responsible Party	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

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Patient Rights and Responsibilities

As a patient, you have rights regardless of age, race, color, ancestry, language, creed, religion, gender, sexual orientation, marital status, citizenship, veteran status, physical or mental disability, cultural, economic, educational background or the source of payment.

Your Rights as a Patient:

As a patient you have the right to: get care that is appropriate for your health. Get good quality care that follows professional standards. We continually review and maintain our standards to ensure that you receive this. Get timely responses for requests that you make about your care. Get appropriate continuity of care and referrals. Get access to (and a copy of) your health records. Be treated with respect, dignity and concern. Not be pressured to choose a treatment, test or exam. Receive care that is free from all forms of: abuse or neglect, mistreatment, harassment or discrimination. Request a person you choose to be in the exam room with you. Ask visitors to leave before an exam or when your care is being talked about. Be told why people who are not directly involved in your care are in your exam room. Receive proper care instructions before leaving the clinic. Get care instructions once you're discharged from any of our departments. Access protective and advocacy agencies. Expect communications and records about your health to be kept private. The items below are considered confidential and will be handled discretely: case discussion, consultation, exams, and treatment. Be provided with an interpreter during visits and exams. Get full information spoken in plain language about: Your diagnosis, treatment and prognosis, any alternative treatment, possible known side effects or complications from treatment. Have a caregiver of your choosing receive health information if you're unable.

You have the right to file a formal complaint or grievance with Bamboo Family Clinic by calling 702-483-2969 or www.bamboofamilyclinic.com

Your Responsibilities as a Patient:

Give accurate and complete information about your health. Follow your provider and care team's instructions for treatment and medicine safety. Ask questions about any directions or procedure you don't understand. Accept responsibility for your health outcome if you refuse treatment or don't follow your care plan. Keep your scheduled appointments or reschedule within 24 hours of your appointment. Follow all safety guidelines given forth by the Clinic. Be considerate of other patients and staff. Speak to staff and other patients with respect. Respect the property of others and Bamboo Family Clinic. Supervise your children or other persons brought with you to the Clinic. Stay calm and composed when interacting with staff and other patients. Abusive behavior will lead to discharge from the clinic.

Signature of Patient/Responsible Party	Printed Name of Patient/Responsible Party
Date	Relationship to Patient

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HIPPA Release Form

I, _____, direct my health care providers and payers to disclose and release my protected health information described below to:

Name: _____

Relationship: _____

Contact Information: _____

Health Information to be disclosed upon the request of the person named above -- (**Circle either A or B**):

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

B. Disclose my health record, as above, BUT do not disclose the following (circle as appropriate): Mental health records, Communicable diseases (including HIV and AIDS), Alcohol/drug abuse treatment, Other (please specify): _____

_____

Form of Disclosure (**Circle choice**): An electronic record / access through an online portal OR Hard copy

This authorization shall be effective until (**Circle one**): All past, present, and future periods, OR until date :_____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization Date of Birth

_____ _____

Signature of the Individual Giving this Authorization Date

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Medical Records Release

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary of my protected health information, to the Provider/person/facility listed below.

Patient Name:_____ Date of Birth:_____

The information that may be released subject to this signed release is as follows:

- ☐ Complete Records
- ☐ Progress Note
- ☐ Pathology Reports
- ☐ Hospital Records
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Operative Reports
- ☐ Medication Record

Release my protected health information to the following provider/person/facility and/or those directly associated in my medical care:

Name: Bamboo Family Clinic
Address: 98 East Lake Mead Pkwy. Henderson, NV 89015
Phone #: 702-483-2969
Fax: 702-761-2339

Name and Relationship: _____

Address: _____

Phone Number: _____

_____
Print Patient Name

_____
Signature of Patient

_____
Date Signed

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Appointment Cancellation Policy

We value our time spent with each and every patient we see. Appointments are scheduled so the providers can spend an appropriate amount of time with each patient. We understand there are situations that may come up when the patient needs to cancel or reschedule their appointment. Please be courteous to the staff and other patients by reading and acknowledging the cancellation policy.

Late Appointments

If you are more than 15 minutes late to your scheduled appointment, it will need to be rescheduled. Please call ahead if you know you will surpass this time limit, the provider may have time to fit you into their schedule, otherwise you may need to reschedule at that time.

No Show Appointments

If you do not show up for your scheduled appointment you may be charged a **$25 cancellation fee**. If you NO SHOW more than 3 appointments, you will lose your appointment privileges and will have to be seen as a walk in only.

Rescheduling Appointments

If you need to reschedule your appointment, please do so 24 hours in advance. If you are unable to reschedule your appointment 24 hours before your appointment time you may be subject to a **$25 late cancellation fee**. *We understand emergencies arise and we will work with your situations appropriately.*

By signing this document, you are agreeing to the appointment cancellation policy, and all mentioned in this document. The policy is effective on the date of your signature.

_____
Printed Patient Name

_____
Signature of Patient

_____
Date

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Bamboo Family Clinic Financial Policy

We are overjoyed that you chose Bamboo Family Clinic as your healthcare provider. We appreciate your trust in us and the opportunity to carry out our mission statement, "to facilitate quality and compassionate care in a family focused environment, built on trust, mentorship, and communication."

Our office does their best in submitting claims to the insurance companies for timely payment. There are circumstances when this does not happen, due to these we have implemented a new financial policy. Please read in its entirety and sign the form, acknowledging you understand and agree.

Patient Payments

Co-payments are due at time of service. If you or your child have an outstanding balance please be prepared to settle the balance or talk with the office manager to set up a payment plan if needed. We accept cash, credit/debit card and payment through the Kareo Patient Portal.

First Statement

Your insurance policy is a contract between you and your insurance company. This contract requires the Clinic to collect specified co-payments depending on your insurance carrier. If you change insurance companies while you have a balance or accrue a balance during a change in insurance carriers, you are responsible for that balance. We will notify you of a balance by mail, email or Kareo Patient Portal. Please settle the balance as soon as received or set up a payment plan as needed.

Subsequent Statement and Unpaid Balance

If you continue to have a balance another statement will be sent out to you with a $5 statement fee added. Please pay your balance as soon as possible or arrange a payment plan. If there is an outstanding balance for 90 days, we are forced to send the balance to an outside collection agency, once your account is in collections we are unable to provide services to you. We will give 30 days of emergent healthcare services while you find another provider and pay the balance to the collection agency.

Insurance Coverage

Bamboo Family Clinic makes a good faith effort to verify your insurance coverages, in some cases we are given the wrong information regarding your benefits. In these instances, we are not liable for the misinformation. It is ultimately the insured's responsibility to know what services may or may not be covered by your insurance carrier.

I agree to provide Bamboo Family Clinic with the most current and up to date insurance information as it applies to the patient's account. I will notify the office when changes occur as to not create lapse in coverage and incur a balance. If insurance payment is delayed by inadequate

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information on your part, you may be asked to pay in full and request reimbursement from your insurance provider.

Third Party Payers

Our office does not bill third party payers, such as secondary insurance, motor vehicle accident claims or worker's compensation claims. If you wish to see our providers for a visit that warrants billing a third-party payer, you must pay for the visit as a cash pay patient and we will provide you with documentation to help you submit your claims.

Bamboo Family Clinic Reserves the Right to Charge the Following Fees:

Medical Records	.60 cents per page
Schools/Sports/Camp/Daycare	$5.00
Authorization for service/Medication	$5.00
FMLA Paperwork	$25.00

Please ask to speak with the office manager if you have any questions, comments or concerns regarding our financial policy. We are grateful for the opportunity to continue to provide quality and compassionate care to you and your family.

By signing below, you agree to the financial policy in its entirety and will direct questions to the office manager.

_____
Print Patient Name

_____
Signature of Patient

_____
Date

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PHQ-9

		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 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

Total Score_____

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ____ = Add Columns ____ + ____ + ____

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
☐	☐	☐	☐

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Controlled Substances Prescription Agreement

This agreement refers to medicines belonging to any of the following categories: Benzodiazepines, Hypnotics (non-benzodiazepines and stimulants).

Controlled substances can be dangerous. If they are not used carefully, you can become addicted to them or overdose on them. An overdose can cause death. Because of these dangers, it is important for you to understand the rules for using these medicines. This document describes our policy for prescribing these medicines and what your role is to keep yourself safe and get the best results if you use controlled substances.

Initial in each blank below indicating that you understand:

____ The risks, benefits, alternatives, and side effects of my controlled substance medicines have been explained to me, and I understand the explanation.

____ I understand that the medicines may help me function better. If my activity level or general function get worse, my provider may change or stop the medicines.

____ I understand medicines are only part of an effective treatment plan for me. I will also participate in other treatments that my provider recommends, such as behavioral health, psychotherapy, increase activity levels, weight control, and avoidance of alcohol and tobacco. I will comply with the treatment plan as prescribed by my provider.

____ I will take my controlled substance medicines the way my provider prescribed them. I will not change how I take these medicines without first talking to my provider.

____ I will keep my controlled substance medicines in a safe place and away from children.

____ I will get prescriptions for my controlled substance medicines only from my provider at and at _____pharmacy.

____ I will tell other health care providers I see that I am taking controlled substance medicines.

____ I will not get controlled substance medicines from other clinics or Emergency Rooms.

____ I will make follow-up appointments as directed and will not miss appointments.

____ I will **not** ask for extra or early refills of my controlled substance prescription if I run out early for any reason, or if my controlled substance medicines are lost or stolen.

____ I understand that refills will **not** be made as an "emergency." A minimum of four days' notice is needed for prescription refill requests to be processed.
____ I understand that changes in prescriptions/refills will only be made during scheduled appointments and not by phone, which includes after clinic hours, on weekends, or holidays.

____ I will not drink alcohol, use Marijuana, use illegal drugs (cocaine, heroin, methamphetamines) or use any controlled substances my provider did not prescribe for me.

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____ I will not share, sell, or trade my controlled substance medicines with anyone.

____ I will allow random urine tests to check what drugs are in my system.

____ I agree to bring my medicine(s) in their original bottles to the clinic if my provider requests.

____ I understand that if there is reason to believe I have engaged in illegal activity, my provider may notify the proper authorities.

____ I agree that my provider may contact other health care providers or pharmacists involved in my care to discuss my progress and share information about this agreement.

____ I am responsible for the safety of my driving and the operation of heavy machinery or power tools. The drug(s) may have sedating side effects and may not allow for driving. I will follow all state laws regarding driving while under the influence.

____ (Females only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately notify my provider. I am aware that, should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that withdrawal from opiates can be life threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during treatment with controlled substances.

Termination of Care

I understand that if I violate any of the above conditions, my treatment with controlled substances will be terminated **immediately**, without notice. If the violation involves obtaining controlled substances from another person or selling them to another individual or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriate legal authorities. I am responsible for any withdrawal syndrome associated with my misuse of the narcotics and/or termination of care. I have read this contract and the same has been fully explained to me by my provider. I agree fully with this contract and will accept the consequences if I violate the terms. I understand that if I do not follow the agreement above, I will no longer receive controlled substance medicine prescriptions from any provider at any time.

_____ _____
Provider Signature Date and Time

_____
Print Provider Name

_____ _____
Patient Name Date and Time

_____ _____
Signature of Patient Date of Birth

( ) Copy Given to Patient ( ) Patient refused copy

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Notice of Risk

The use of controlled substances may be associated with certain risks such as, but not limited to:

- Central Nervous System: Sleepiness, decreased mental ability and confusion. Your ability to make decisions may be impaired.
- Cardiovascular: Mild to severe irregular heart rhythm.
- Respiratory: Slowing of your breathing and the possibility of inducing wheezing causing difficulty in catching your breath or shortness of breath in susceptible individuals.
- Gastrointestinal: Constipation may be severe. Nausea and vomiting may occur as well.
- Dermatological: Itching and rash.
- Endocrine: Decreased testosterone and other female hormones, dysfunctional sexual activity.
- Urinary: Urinary retention (difficulty urinating).
- Pregnancy: Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.
- Drug Interactions: May alter the effect of other medications and cannot predict reliability.
- Tolerance: Increasing doses of drug(s) may be needed over time to achieve the same pain-relieving effect.
- Physical dependence and withdrawal: Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur including nausea, vomiting, sweating, generalized malaise, abdominal cramps, palpitations. All controlled substances (narcotics) need to be slowly weaned (tapered off) under the direction of your physician.
- Addiction (Abuse): This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.
- Allergic reactions: Are possible with any medication. This usually occurs early after beginning to use the medication. Most side effects can be controlled by continued therapy or the use of other medications.

By initialing and signing below, you confirm that we discussed, and you understand the above stated information. I asked you if you wanted more detailed explanation of the proposed treatment, the alternatives and the materials risks, and you (Initial One):

_____ was satisfied with that explanation and desired no further information.
_____ requested and received, in substantial detail, further explanation of the treatment, alternatives and material risks.

_____ _____
Patient Signature Date

Explained by me and the above was signed in my presence.

_____ _____
Provider Signature Date