ALAMO MEDICAL CLINIC
PATIENT INFORMATION

Date:_____

Name (last)_____(first)_____(mi)_____

Address_____Apt#_____

City_____State_____Zip_____Sex _____

Home Phone_____Cell Phone_____Date of Birth_____

Age _____SSN_____Single_____Married_____

Language _____Race _____

REQUIRED INFORMATION **Ethnicity (circle one): Hispanic or Latino, Non Hispanic or Latino, Other or Undetermined**

Occupation_____Employer_____

Work Address_____Work Phone_____

PARENT/SPOUSE/EMERGENCY CONTACT INFORMATION

Parent/Spouse's Name_____SSN_____

Date of Birth (Parent/Spouse)_____Cell Phone_____

Employer_____Work Address_____

Occupation_____

_____
City/state/zip

Emergency Contact (not living with you) Name_____

Address_____Phone_____

Relationship_____

REFERRAL INFORMATION

Physician/Person Who Referred You_____

INSURANCE INFORMATION

Primary Insurance Name:_____Policy Holder_____

Secondary Insurance Name_____Policy Holder_____

STATEMENT OF FINANCIAL RESPONSIBILITY

ALAMO MEDICAL CLINIC

A. I hereby apply for treatment by the above facility. Such treatment is to include all office procedures as necessary.

B. I, _____ (patients name), accept responsibility to pay for all services rendered on my behalf.

C. In the event of default on any payments due to Alamo Medical Clinic, I agree to pay all costs of collection including attorney's fees.

D. Pursuant to NRS 629 my health care records may be destroyed after 5 years.

INSURANCE ASSIGNMENT

A. This will authorize the filing of any insurance in force and the direct payment to Alamo Medical Clinic, of any amounts due on my claim under the above stated policy (policies).

B. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Alamo Medical Clinic for any fees not covered by insurance.

C. I hereby authorize Alamo Medical Clinic to release any information acquired in the course of examination or treatment to:

_____

(NAME OF INSURANCE COMPANY OR OTHER PARTY)

I agree to all of the above and acknowledge receipt of this agreement.

Signature of Patient _____ Date _____

Witness _____

Please notify receptionist if you have any Primary/Secondary or Supplement affiliated with **HPN / HMO / FHP / HUMANA / SENIOR DIMENSIONS / SENIOR HORIZONS**

Patient Name_____

Chief Complaint_____

PAST HISTORY	**YES**	**NO**
Disease of Heart, Arteries, Veins or Chest Pain	_____	_____
High Blood Pressure	_____	_____
Cancer, Tumor or Polyp, Where _____	_____	_____
Diabetes, , Albumin or Blood in Urine	_____	_____
Asthma, bronchitis, Tuberculosis, Lung Disease	_____	_____
Ulcers, Colitis, DisordeRs of the Stomach, LiveR, Gallbladder	_____	_____
Nervous Breakdown, Mental nervous Disorders	_____	_____
Epilepsy, Unconsiousness, Dizziness	_____	_____
Kidney Stones, Kidney, Bladder Urinary Disease	_____	_____
Arthritis, Rheumatic Fever, Gout, Paralysis Disease	_____	_____
Deformity of Bones	_____	_____
Disease of the Thyroid, Lymph Glands, Anemia, Leukemia or other Blood Disorders	_____	_____
Drugs: Cocaine, barbiturates, or other controlled Substances	_____	_____

HAVE YOU EVER SMOKED?_____DRINK CAFFENIATED BEVERAGES?_____

IF YES, then _____(#) of packs per day. For how many years? _____

Are you still smoking? _____

ALLERGIES TO MEDICATIONS OR OTHER? _____

Alcohol: Yes_____ No_____ How much daily?_____

FAMILY RECORD MED PROBLEMS	AGE IF LIVING	AGE AT DEATH	CAUSE
FATHER			
MOTHER			
GRANDMOTHER			
GRANDFATHER			

SURGERIES (Please list surgeries and dates, or other significant procedure/medical problems, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

FOR FEMALES ONLY DATE

LAST MENSTRUAL PERIOD _____

LAST PAP SMEAR _____

LAST MAMMOGRAM _____

NUMBER OF PREGNANCIES _____

NUMBER OF LIVE BIRTHS _____

Patient Name _____

Date of Birth_____

Pharmacy Name_____
Pharmacy Address_____
Phone Number_____

Medication:	Dosage:	Frequency:	Purpose:	Prescribing Doctor:

NOTES:

IMPORTANT PLEASE READ

The physicians at the Alamo Medical Clinic have tailored their practice to Adult Family Medicine, so an underlying diagnosis and condition will be referred to the appropriate specialist or entities.

All female patients will be required to have a primary gynecologist for their yearly Pap smear/pelvic and mammograms/breast exams. These examinations are not done by the physicians at the Alamo Medical Clinic. The clinic staff will help in any insurance referral or requirements needed.

Important, please initial after reading and understanding each (4) items.

1. **Initials:** _____ Physicians at the Alamo Medical Clinic **will not prescribe** long – term daily use of **sedatives and sleep medications** such as **Valium, Xanax, Ativan, Halcion, Ambien, Lunesta, Temazepam, Restoril,** etc.

2. **Initials:** _____ Long-term **pain medications** required on a daily basis **will not be prescribed** by the physicians at the Alamo Medical Clinic. These medications have such common names as **Lortab**, **Tylenol No. 3 and No. 4, Percocet, Vicodin, Darvocet, Morphine, Oxycontin, Demerol, Methadone, Fiorinal, Esgic,** etc.

3. **Initials:** _____ The physicians at the Alamo Medical Clinic **will not prescribe** any type of **diet or appetite suppressants** that require a prescription, e.g. **Redux, Fastin, Pondimin,** etc.

We understand that certain medical issues or conditions may necessitate the use of some of these medications. Physicians at the Alamo Medical Clinic will, if needed, prescribe on a short-term basis only those medications necessary. If it becomes necessary to take on a daily basis or longer term, then you will be referred to the appropriate specialist and specialist care.

_____ _____

Patient Signature Date

ALAMO MEDICAL CLINIC
56 N. Pecos Road., Ste. A,
Henderson, Nevada 89074
Telephone: (702) 456-4011
Fax: (702) 454-5224
www.alamoclinic.com

TONY ALAMO, M.D.

- Graduate of the University of Southern California (USC) School of Medicine
- Current Chairman of the Nevada Gaming Commission
- Past Chairman/Commissioner of Nevada Athletic Commission
- Tactical Physician L.V. Metropolitan Police Dept. (SWAT)
- Past Diplomate of the American Board of Internal Medicine

ANGELA S. MILLER, M.D.

- Diplomate of the American Board of Internal Medicine
- Graduate of the University of Kansas School of Medicine
- Member of the American College of Physicians (ACP)

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL RECORDS

I, _____Date of Birth _____ a patient of Alamo Medical Clinic, Hereby authorize the release of the following:

_____ Lab

_____ Diagnostic Testing

_____ Office Notes

_____ Hospital In-patient Stay

_____ Emergency Room Visit

_____ Urgent Care

Patient Name: _____

Signature of Patient: _____

Date: _____

Medical Records Request from the following Party:

Physician Name: _____

Name of Facility: _____

Telephone Number: _____

Facsimile Number: _____

Please send requested records to:

Alamo medical Clinic
56 N. Pecos Road, Ste A
Henderson, NV 89074
Telephone: 702-456-4011
Facsimile: 702-454-5224

Alamo Medical Clinic Tony Alamo, M.D Angela S. Miller, M.D.

To be more efficient notifying patients of results and pertinent medical information; we require a phone number with a voice mail system that has assured privacy for you.

Having a cell or private voice mail phone number on record, has been found to be beneficial for patient care so as to allow pertinent medical messages to be left on those voice mail systems. We may use your listed cell phone for appointment reminders via text and/or voicemail.

The Alamo Medical Clinic's staff maintains patient information under HIPPA Compliance and its rules. All critical information, pertinent medical, financial, and demographic information are kept in strict confidence.

Having a private phone number, can help us facilitate pertinent medical results to you in a timely fashion. This will give you better medical care.

If you do not have such a cell phone number or voice mail system that is assured to be private, then we will continue our current policies of correspondence and "live person" call backs. This will take longer to get important information to you. The Alamo Medical and its staff of doctors and employees cannot be held responsible for any time delay in notifying you of any critical, medical results if a private phone number with voice mail system is not made available to the staff.

[ ] Alamo Medical Clinic can send laboratory results to patients listed address.

[ ] Alamo Medical Clinic can send/receive communication to patients listed email address.

( ) _____

PATIENT'S EMAIL ADDRESS: _____

The Privacy Rule allows covered health care providers to communicate electronically, such as through e-mail, with their patients, provided they apply reasonable safeguards when doing so. See 45 C.F.R. § 164.530(c). For example, certain precautions may need to be taken when using e-mail to avoid unintentional disclosures, such as checking the e-mail address for accuracy before sending, or sending an e-mail alert to the patient for address confirmation prior to sending the message. Further, the Privacy Rule does not prohibit the use of unencrypted e-mail for treatment-related communications between health care providers and patients, as long as the patient agrees to opt in by providing a private email address above.

_____ _____ _____

Print Name Signature Date

Alamo Medical Clinic

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information will be used by staff members or disclosed to other health care professionals for the purpose of evaluation of your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information will be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information will be used as necessary to support the day-to-day activities and management of Alamo Medical Clinic (AMC). For example, information on the service you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law-enforcement agencies, without your permission—to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states' public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of you information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of you decision.

Addition Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information will be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the Federal Privacy Standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Alamo Medical Clinic Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in Federal and State Laws and Regulations. Whatever the reason for these revisions, we will provide you with the revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by Federal Regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist, or Cathy Mendoza, the Privacy Officer for Alamo Medical Clinic.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Cathy Mendoza
Alamo Medical Clinic
56 N. Pecos Road, Ste. A
Henderson, NV 89074

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.
You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practice is:

Cathy Mendoza
Alamo Medical Clinic
56 N. Pecos Road, Ste. A
Henderson, NV 89074
(702) 456-4011

Effective Date

This notice is effective on or after April 14th 2003

Consent to Use and Disclose of Protected Health Information

Use and Disclosure of Your Protected Health Information (PHI)
Your protected health information will be used by Alamo Medical Clinic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
This acknowledges your receipt and reading the AMC's Notice of Privacy Practices. You should review the Notice of Privacy Practices for more complete description of how your protected health information may be used or disclosed. You should review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of you protected health information.

AMC may or may not agree to restrict the use or disclosure of your protected health information.

If AMC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
AMC reserves the right to modify the privacy practices outlined in this notice.

Signature
I have reviewed this consent form and give my permission to AMC to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Representative

_____
Relationship of Patient Representative to Patient

Authorization of Use and Disclosure of Protected Health Information to Family Members or Selected Personal Caregivers

Information to be Used or Disclosed:

The information covered by this authorization includes:

All medical records and billing information and Protected Health Information (PHI)

Person Authorized to use or Disclose Information

Information listed above will be used or disclosed by:

Alamo Medical Clinic

Persons to Whom Information May be Disclosed

Information listed above will be used or disclosed to:

Authorization to disclose PHI to selected Family Members:

1. _____
   Name Date Initials

2. _____
   Name Date Initials

Expiration Date of Authorization

This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Alamo Medical Clinic. You should contact the Privacy Official to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Regulations.

Signature

_____
Name of Patient(Print or Type)

_____
Signature of Patient

_____
Signature of Patient Representative Relationship of Patient Representative to Patient