RENEWED
HEALTH & WELLNESS

Dear Patient:

Thank you for choosing Renewed Health & Wellness Medicine, LLC as your health care provider. Enclosed you will find the paperwork to be completed prior to your initial appointment. Please review all forms in their entirety. It is important that you provide as much information as possible to maximize the benefits from your visit.

Please make sure the following is completed when sending in your paperwork:

1. **Fill out the entire Patient Information and Registration Form.**
2. **Read, sign and date the Consent for Treatment, Financial Policy, as well as the Permission and Release for Filming.**
3. **Thoroughly read and complete the Assignment of Insurance Benefits and Emergency Contact forms, then sign at the bottom of the pages.**
4. **Read, sign and date the HIPPA Notice of Privacy Practices.**
5. **Complete the Release of Medical Record form if you feel we may need information from any previous providers.**

Make sure you let us know how you heard about us. We look forward to working with you and providing your medical care.

Sincerely,

Renewed Health & Wellness Medicine, LLC staff

15 McCabe Drive, Suite 203 Reno, NV 89511 661 Sierra Rose Drive
Phone: 775-853-7669 fax: 855-313-0186 website:www.renewed-health.org

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Patient Information and Registration

Chief complaint: _____

Patient Name: _____ Date of Birth: ____/_____/_____
Last First Middle Initial

Sex: □ M □ F Marital Status: □ S □ M □ D □ W Today's Date _____/_____/_____

Patient Social Security #: _____-_____-_____ Responsible Party SS# _____-_____-_____

Primary Address:_____
Street City State Zip

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address: _____
*Email address will be used for the patient portal-this is optional, not a requirement

Names of Parent/Guardian: _____ Date of Birth: ____/_____/_____
(if patient is minor)

Name of Responsible Party: _____

Driver License #: _____ Occupation: _____

Employer: _____ Work Phone: ( ) _____ -_____

Address: _____
Street City State Zip

Primary Health Insurance

Carrier: _____ Phone ( ) _____ - _____

Policy ID #:_____Group #:_____

Secondary Health Insurance

Carrier: _____ Phone ( ) _____ - _____

Policy ID #:_____Group #:_____

Preferred Pharmacy:_____ Phone ( ) _____ - _____

Preferred LAB (circle one) **Lab Corp** **Quest** **Renown**

Relative Not Living with You: _____ Phone ( ) _____ - _____

Address: _____ Relationship: _____

How did you hear about us? _____

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Consent for Treatment

I authorize the Medical and Nursing Staff of Renewed Health & Wellness Medicine, LLC to perform diagnostic tests, administer medicine, and implement treatment plans for any and all medical conditions. I fully recognize and understand that the advanced medical treatments I will receive may include nutrient, herbal, oxidative, functional, integrative, alternative, preventative and/or conventional therapies.

I also understand that Renewed Health & Wellness Medical Staff will NOT provide hospitalized care in cases where hospitalization is necessary.

_____
Patient's Name (print)

_____ _____/_____/_____
Patient's Signature Date

_____ _____/_____/_____
Representative of Renewed Health & Wellness Medicine, LLC Dat

Assignment of Insurance Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Renewed Health & Wellness Medicine, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by my insurance carrier.

I hereby authorize said assignee to release all information necessary to secure payment. I understand that I am responsible for the balance and remaining fees not paid by my insurance.

Thank you for choosing us as your health care provider. Our main goal is to provide you the treatment needed to restore and maintain your health. We sincerely appreciate your trust in us. The opportunity to care for our patients is something we take very seriously.

I have read the above Financial/Appointment policy and Assignment of Insurance Benefits accepting full financial responsibility for payment of professional fees and any of my medical treatments. I recognize that some of the services rendered to me may not be covered by my insurance company.

_____
Patient's Name (print)

_____ _____/_____/_____
Patient's Signature Date

_____ _____/_____/_____
Representative of Renewed Health & Wellness Medicine, LLC Date

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Financial/Appointment Policy

The physicians and staff of Renewed Health & Wellness Medicine, LLC are dedicated to providing you with the best care and service, and your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

Basic Policy: Payment for services is due, in full at the time services are provided in our office. All patients will be asked to provide valid identification prior to treatment. We accept cash, check, Visa, Master Card, Discover and American Express for your convenience. Returned checks will be subject to an additional collection fee of $40 per check and will not be reprocessed. Any accounts over 120 days will be subject to a collection process. All attorney/collection agency fees incurred from such action as the responsibility of the patient/responsible party.

PATIENTS WITH INSURANCE: This does not include patients with worker's compensation insurance, unless your claim has been denied, or you have not supplied us with the appropriate information. Patients are responsible for making sure a referral is in place before services are received.

We will bill most group insurance carriers on your behalf, if the proper paperwork and/or identification cards are provided to us. We will also bill most secondary carriers for you. Co-payments, co-insurance and/or deductibles are due at the time of service. If an insurance carrier has not paid with 90 days, professional fees are due and payable, in full, by you. You, as the responsible party, must furnish our office with up-to-date insurance information. A copy of your identification and insurance card is required at each visit. Please report any changes in your insurance immediately upon arrival.

MEDICARE PATIENTS: We will bill Medicare and secondary carriers on your behalf. Medicare HMO patients, all copayments are due and payable at the time services are provided.
MEDICAID PATIENTS: All patients must provide a current, valid Medicaid card prior to being seen.
MINOR PAIENTS: An adult must accompany minor patients in order for treatment to be rendered. We require a copy of the parent/guardian valid identification and copy of the insurance card.

There may be additional fees associated with the completion of disability forms, other insurance forms, copies of medical records and copies of x-rays.

Appointment Cancellation Policy: Please be courteous and call 48 hours prior to your appointment. Failure to notify us regarding your missed appointment will result in a charge of $45. This fee is not covered by any insurances. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of all of our patients.

If you are requesting letters to be written, forms to be completed, or documents to be compiled, there may be a $25 fee assessed for this office visit. This fee is not covered by any insurance and is due prior to your office visit.

Our office complies with NRS 629.051 with regard to maintaining your health records. Please contact our office at (775) 853-7669 with any questions.

_____ _____/_____/_____
Patient's Signature Date

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLES AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for an office procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the visit.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your mane and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health oversight: abuse or Neglect: Food and Drug Administration requirements: Legal Proceeding: Law Enforcement: Coroner, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

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You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use to disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to who you want the restriction to apply. Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provide in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

_____
Patient's Name (print)

_____ _____/_____/_____
Patient's Signature Date

_____ _____/_____/_____
Representative of Renewed Health & Wellness Medicine, LLC Date

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Request for Release of Medical Records

Date:_____

Patient Name:_____ Date of Birth:____/____/____

To (Institution or Physician_____

Physician's Phone: ( ) _____- _____ Fax Number: ( ) _____ - _____

The above named patient has requested to have a copy of their medical records sent to our office. Please fax or mail the following records to us as soon as possible:

_____ The last 2 (most recent) EKG's
_____ All recent (last 3 months) lab work
_____ Reports of Vascular Studies if applicable
_____ Stress test / Echocardiogram reports if applicable
_____ Most recent doctor's notes / history and physical if available
_____ Any imaging reports done within the last 3 years

The reason for the request is: _____

Please fax to (855) 313-0186 or mail this information to the address below. We greatly appreciate your help and thank you in advance for your prompt attention to this matter.

Patient Request and Consent for Release of Medical Records

I, hereby authorize the release of any medical records, diagnostic tests or treatment history requested by Renewed Health & Wellness Medicine, LLC. Please send this information to their office as soon as possible.

Thank you.

Signature of Patient: _____ Date:____/_____/_____

*The request expires 365 days from the date that it was signed.

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Consent to Discuss Medical Information

I, _____ (Patient Name), give the physician, nurse practitioners and office staff of Renewed Health & Wellness Medicine, LLC permission to discuss my medical condition and treatment with the following individual(s):

_____, who is_____
Name of person Relationship to patient

Signature of Patient: _____ Date:____/_____/_____
*This may be revoked at any time by writing the HIPAA Privacy Officer of Renewed Health & Wellness

Preferred Method of Contact/Permission to Leave Messages

( ) _____-_____ ( )_____-_____
☐ Primary contact telephone number ☐ Alternate telephone number

Place √ (check) next to the phone numbers where a detailed voice mail message may be left.

If you would like to receive text messages to confirm your appointments or would like to communicate with your health care provider via text messages, please provide a mobile phone number. Text messaging rates may apply. Renewed Health & Wellness is not responsible for these rates and fees. ( ) _____-_____

Emergency Contact/Next of Kin

Name: _____ Relationship: _____

Phone Number: ( ) _____- _____

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