Community Outreach
MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

Male ☐ Female ☐ Non-gender ☐

New/Annual Patient Packet

Date _____

Name _____
Last First Middle

Address _____
Apt # City Zip

Date of Birth _____Age _____ Social Security No: _____

Home/Mobile Phone Number _____ Email Address: _____

Pharmacy Name/Address/Telephone: _____

Primary Insurance: _____ ID # _____ Group # _____

Secondary Insurance: _____ ID # _____ Group # _____

Insured Responsible Party Name: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____ Telephone: _____

RACE / ETHNICITY:

	RACE Check only one	**ETHNICITY** Check if also Hispanic
A. American Indian or Alaska Native	☐	☐
B. Asian	☐	☐
C. Black or African American	☐	☐
D. Native Hawaiian or other Pacific Islander	☐	☐
E. White	☐	☐

TO THE BEST OF MY KNOWLEDGE I AFFIRM THE INFORMATION ABOVE IS CORRECT. I WILL INFORM COMMUNITY OUTREACH MEDICAL CENTER OF ANY CHANGES TO THE ABOVE INFORMATION.

Signature of Patient/Legal Representative_____ Date _____

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Health History Form

Patient Name: _____ Birthdate: _____ Age: _____

What is the reason for today's visit? _____

How were you referred to COMC? _____

Current Gender Identity: ☐ Male ☐ Female ☐ Non-gender

Sex at Birth: ☐ Male ☐ Female

☐ Transgender Male-to-Female (MTF) ☐ Transgender Female-to-Male (FTM)

☐ Transgender (trans*, gender queer, gender non-conforming) ☐ Other: _____

Medical History: Please check all that apply to you

	Diabetes		Lung Problems		Seizure Disorder
	Heart Disease/Angina/Chest Pain		Pneumonia		Sexually Transmitted Infections
	Heart Attack		Tuberculosis		Cancer-Please Specify:
	High Blood Pressure		Heartburn/Acid Reflux		Depression/Anxiety
	Stroke		Diarrhea/Constipation/ Abdominal Pain/Blood in Stool		Snoring/Sleep Disorder/Insomnia
	High Cholesterol		Pancreatitis		Pregnancy
	Visual Changes/Glaucoma		Hepatitis A/B/C		Gynecological Problems/Menstrual Irregularities
	Ear Problems/Hearing Loss		Kidney Disease/Bladder Problems		Breast Symptoms
	Throat Problems		Anemia/Blood Disorders		Pelvic Symptoms
	Thyroid Disorder		Autoimmune Disease/Lupus		Other Please Specify
	Asthma/Allergy		Arthritis/Joint Pain		
	COPD		Skin Disorder/Rashes/Lumps/ Enlarged Lymph Nodes		
	Cough		Neurological Problems/Nerve Pain/Headache/Migraine		

Surgical procedures (include minor surgeries) & approximate date(s):

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

Hospitalizations (include reason for hospitalization, dates & where hospitalized):

Reason	Dates	Hospital	Reason	Dates	Hospital
1.			4.		
2.			5.		
3.			6.		

Allergies to medications, food, or substance including type of reaction:

Allergy	Reaction	Allergy	Reaction
1.		3.	
2.		4.	

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Health History Form

Patient Name: _____ Birthdate: _____

Current medications, dose, instructions & approximate date started. Please include prescription, non-prescription & vitamins/herbal preparations (please attach separate sheet if necessary).

Medication	Dose	Instructions	Date	Medication	Dose	Instructions	Date
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Family History:

Father	Please list major medical conditions:	**Mother**	Please list major medical conditions:
Paternal Grandparents	Please list major medical conditions:	**Maternal Grandparents**	Please list major medical conditions:
Siblings	Please list major medical conditions:	**Children**	Please list major medical conditions:

Tobacco Use: Current smoker? YES NO If yes, how many packs/day? _____ For how long? _____

Have you ever smoked? YES NO If yes, what is the year you quit? _____

Alcohol Use: Do you drink alcohol? YES NO If yes, type: BEER WINE OTHER

Please indicate # of drinks and frequency: DAILY____WEEKLY____MONTHLY____YEARLY____

Have you ever needed treatment for alcohol misuse? YES NO

Recreational Drug Use: YES NO List your drug(s) of choice:_____

Last Used: CURRENTLY W/IN 12 MONTHS W/IN 1-5 YRS MORE THAN 5 YRS

Have you ever needed treatment for substance misuse? YES NO

Mental Health: Have you ever been emotionally or physically abused by your partner or someone important to you? YES NO CURRENT PAST

Are you currently being treated for a mental health problem? YES NO CURRENT PAST

Have you ever needed treatment for alcohol misuse? YES NO

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Health History Form

Patient Name: _____ Birthdate: _____

Sexual Health: Are you currently sexually active? YES NO

Please circle who you have sex with: MALE FEMALE BOTH TRANSGENDER

Within the past 3 months have you had sex with more than one person? YES NO

For Women: When was your last menstrual period? _____

Are your periods normal? YES NO Last normal period _____

# of pregnancies: _____ # of abortions: _____ # of miscarriages: _____

Have you had: Please check all that apply

	Health Screening/Procedure	Date		Health Screening/Procedure	Date
	Eye Exam			Mammogram	
	Dental Exam			Pap Smear	
	Endoscopy			HIV Test	
	Colonoscopy			Hepatitis C Test	

Vaccine History: Please check all that apply

	Vaccine	Date		Vaccine	Date
	Influenza/Flu shot			MMR (Measles, Mumps, Rubella)	
	Tdap (Tetanus, Diptheria, Pertussis)			Meningococcal/Meningitis	
	Hepatitis A			Pneumococcal/Pneumonia	
	Hepatitis B			Hib/Haemophilus Influenza B	
	Zoster			BCG/Tuberculosis	
	HPV (Human Papilloma Virus)			Varicella	
	Polio			Other	

Signature

To the best of my knowledge, I (patient) certify the information provided is correct. I will not hold The Community Outreach Medical Center or any of its staff responsible for any errors or omissions that I may have written during the completion of this form.

_____

Patient/Legal Representative Signature Patient Printed Name Date

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CONSENT FOR TREATMENT

The following information is to be completed by the patient, or the patient's legal representative/parent:

- I (patient) consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that there are certain risks connected with all forms of treatment and care. I understand that the Community Outreach Medical Center will share patient health information according to federal and state law for treatment, payment, and operations.
- I understand that it is my responsibility to obtain all recommended testing, further evaluation, and follow up recommended by my physician/practitioner. I also understand that if tests are taken for certain communicable diseases, sexually transmitted infections/diseases, law may require reporting of positive results to relevant public health agencies.
- I hereby release the Community Outreach Medical Center, its medical staff, and employees from any and all liability arising out of or connected with my lack of follow up recommended for any abnormalities identified.
- I hereby consent to and request examination by the Community Outreach Medical Center and ensure that, to the best of my knowledge, all information submitted by me is true.
- I understand that I may be discharged from Community Outreach Medical Center if I miss 3 consecutive clinic appointments or if I refuse to follow the plan of care.
- I hereby certify that I have read and fully understand the above consent for treatment.

Signature of Patient/Legal Representative: _____ Date: _____

Relationship of Legally Authorized Representative to Patient: _____

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NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

WHAT DOES THIS NOTICE COVER?

Information about your health condition, healthcare treatment, or payment for healthcare treatment **that could reasonably identify who you are;**

Information in the possession of Community Outreach Medical Center. This applies to all personnel, volunteers, contractors, trainees or anyone working at Community Outreach Medical Center who might have access to your health information.

HOW COMMUNITY OUTREACH MEDICAL CENTER WILL USE YOUR HEALTH INFORMATION

Community Outreach Medical Center is permitted to use or to disclose to others outside Community Outreach Medical Center, your health information without permission from you for basic types of activities and a number of specific situations or circumstances. They are described below:

Treatment – We are permitted to use your health information or disclose it to others outside Community Outreach Medical Center in order to provide proper medical care to you.

Payment – We are permitted to use your health information or disclose it to others outside Community Outreach Medical Center in order to submit bills for the services you receive.

Health care operations – We are also permitted to use your health information or disclose it to others outside Community Outreach Medical Center in order to run the program and ensure high quality services.

Appointment Reminders – We may use or disclose your health information to send you reminders that you have an appointment for treatment.

Health-Related Benefits and Services – We may use or disclose your health information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities – We may use or disclose your health information to contact you for fundraising activities for Community Outreach Medical Center, by Community Outreach Medical Center, or on our behalf by others.

Participant Directory – We may include certain limited information about you in the agency's participant directory while you are a participant at the agency such as your name, program of the agency and your religious affiliation.

Individuals Involved in Your Care or Payment for Your Care – We may disclose your health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Research – Under certain circumstances, we may use and disclose your health information for research purposes.

As Required By Law – We will disclose your information when required by law.

To Avoid a Serious Threat to Health or Safety – We may use and disclose your health information to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Organ and Tissue Donation – If you are an organ donor and/or recipient, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to support the process.

Workers' Compensation -We may release medical information about you for workers' compensation or similar programs.

Public Health Risks - We may disclose medical information about you to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recall of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and/or to notify the appropriate government authority if we believe a participant has been the victim of abuse, neglect or domestic violence.

Military and Veterans – If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Health Oversight Activities - We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement - We may release medical information if asked to do so by a law enforcement official in response to court order, subpoena, warrant summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing persons; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the clinic; and, in emergency circumstance to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

- ***Coroners, Medical Examiners and Funeral Directors -*** We may release medical information to a coroner or medical examiner.

National Security and Intelligence Activities - We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others - We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmate – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement officials.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Authorization to Use Your Information – In order for us to use or disclose your information, other than as described above, we will need to obtain your written authorization which you may revoke at any time to stop any future uses and disclosures.

Right to Have Access to Your Information – You have the right to review and photocopy and/all portions of your healthcare information except for: psychotherapy notes, information that may be used in a civil, criminal or administrative action, or where prohibited by law.

Right to Amend Your Information – You have the right to make changes to your healthcare information.

Right to Request Confidential Information be Provided in a Certain Way – You may request that when we send your information to you, we do so in a specific way that is convenient for you.

Right to Restrict Your Information: You have the right to restrict the use of your confidential healthcare information. However, the organization may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency.

Right to an Accounting of Our Disclosures of Your Information – You have the right to know who has accessed your confidential healthcare information and for what purpose.

Right to a Paper Copy of This Notice - You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

COMC'S DUTIES REGARDING YOUR HEALTH INFORMATION

We are required to protect the privacy of your information, establish Policies and Procedures that do so, provide this Notice about our privacy practices, and to follow the practices described in this Notice. We reserve the right to change our Policies and Procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this Notice and post the new Notice in waiting rooms and registration areas. You can request a written copy of the most recent version of this Notice at any time. Community Outreach Medical Center may deny you access to your protected health information if a licensed health care provider determines that releasing it could endanger you or someone else; your protected health information refers to a third party and releasing it could harm that person; or providing access to a personal representative could harm you or another person.

HOW TO MAKE A COMPLAINT ABOUT HOW YOUR INFORMATION IS USED

If you believe we have not properly protected your privacy, violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may contact the Community Outreach Medical Center Privacy Officer in writing within 90 days of this discovery. You also may send a written complaint to the U.S. Department of Health and Human Services within 180 days of discovery. The Community Outreach Medical Center Privacy Officer can provide you with the appropriate address upon request. You will not be penalized for filing a complaint. To act on any of the information provided in this Notice or for more information about our privacy practices, you may contact the Community Outreach Medical Center Privacy Officer: Phone: (702) 657-3873; Fax: (702) 636-0787; and mail: Community Outreach Medical Center Privacy Officer, 1090 E. Desert Inn Rd. Suite 200, Las Vegas, NV 89109.

THE EFFECTIVE DATE OF THIS NOTICE: This Notice was issued on January 1, 2021.

Community Outreach
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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices explains how we may use and disclose protected health information about you. As provided in our Notice, the terms of our Notice may change. Copies of our Notice will always be available at our office and will reflect any updates we make to our Notice in the future. Please sign and date below to indicate that you have received a copy of the Community Outreach Medical Center Notice of Privacy Practices and an explanation of what it contains.

_____ _____

Signature **Date**

_____

Printed Name

Please circle:

Participant **Parent** **Legal Guardian** **Personal Representative** **Agency**

Other_____

The following is to be completed by Community Outreach Medical Center personnel:

Please check the applicable box:

☐ The Notice of Privacy Practices was offered and accepted by the participant and the participant signed this Acknowledgment.

☐ The Notice of Privacy Practices was offered and accepted by the participant and the participant refused to sign this Acknowledgment.

☐ The Notice of Privacy Practices was offered and refused by the participant and the participant agreed to sign this Acknowledgment.

☐ The Notice of Privacy Practices was offered to and refused by the participant and the participant refused to sign this Acknowledgment.

Staff Representative:_____Title:_____ Date:_____

ADVANCED DIRECTIVES AGREEMENT

This statement serves to document the patient received information and or was presented the opportunity to create an Advanced Directive to assist in advance treatment decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment. By signing below the patient acknowledges if he/she/they would like to create an Advanced Directive or provide the COMC with my most current version, he/she/they will notify COMC to submit or complete an Advanced Directive.

_____

Patient/Legal Representative Signature Patient Printed Name Date

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ZERO TOLERANCE POLICY

Community Outreach Medical Center, (COMC), strives to deliver the highest quality services to all eligible clients/ patients and offer a comfortable and safe environment in which patients may receive services. **However, COMC reserves the right to suspend, alter or terminate clients'/patients' services and or privileges as consequence of any of the following offenses:**

a. threats and/or incidences of assault, theft, harassment, or abusive behavior towards COMC staff and or clients/patients.

b. providing falsified or fraudulent information in order to obtain services.

c. possession of weapons on COMC property, or COMC hosted events, used to intimidate or physically threaten client/ patients or staff. Weapons are defined as any object which could be used in a manner to threaten bodily harm.

d. physical or verbal threats against other COMC clients/ patients or COMC staff members, destruction/ vandalism to COMC, or events having to do with COMC and/or COMC clients/patients.

e. sexual harassment/misconduct towards COMC staff and or clients/patients.

_____

Patient/Legal Representative Signature Patient Printed Name Date

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PATIENT RESPONSIBILITIES

The Community Outreach Medical Center relies on you to be an active participant in your healthcare and treatment so that we can provide the most effective healthcare for you. The following are your responsibilities. Please read & initial each carefully, so that you will understand our expectations of you.

Initials	I will provide accurate and complete information about past & current health problems, hospitalizations, medications, treatment & any other matters relating to my health status.
Initials	I will let the staff know of any address, telephone number, or insurance changes I have.
Initials	If I do not understand something about my health problems, treatment, medications, their purpose, dosage and side effects, I will ask questions until I am satisfied I have enough information to make an informed decision.
Initials	I will bring *ALL* of my medication bottles with me to each of my appointments. These include (prescription, non-prescription, vitamin/herbal preparations. Please leave refrigerated medication at home).
Initials	My provider and I will discuss my treatment plan together and I will obtain ALL laboratory/radiology/diagnostic testing & follow up we agree I need. These tests will assist the provider make an accurate diagnosis of my condition and assist him/her to develop a treatment plan specifically me. Without my participation in my treatment plan, the provider will not be able to assist me to manage or resolve my health problems.
Initials	I understand that I will be provided with enough medication to last until my next appointment, and that I will obtain prescription refills at my follow up appointment.
Initials	I understand that I am responsible for finding out my test results as instructed by clinic staff, at my follow up appointment.
Initials	I will pay for all services provided to me before leaving the clinic.
Initials	I will be respectful and considerate to all clinic staff, fellow patients, clinic property, follow clinic rules and make sure that any persons with me will also comply.
Initials	I understand I am never to attend a visit with COMC staff under the influence of any substance, including narcotics or controlled substance, which can alter my ability to comprehend or that can compromise my judgment.

I fully understand and will comply with my patient responsibilities at Community Outreach Medical Center.

_____

Patient/Legal Representative Signature Patient Printed Name Date

Certain policies (regarding payment/fees) may not apply to Ryan White Program eligible patients. Please ask clinic staff for further clarification.

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Permission to Discuss Personal Health Information

Patient Name: _____ Birthdate: _____

In an effort to maintain the integrity of patient information, Community Outreach Medical Center requests your input on who to discuss your health information with. Please fill out the following to help our clinic best decide with whom to disclose your sensitive information to.

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient:

Name:	Relationship:

To obtain information by telephone, the party calling the clinic must share two of the following patient identifiers with the staff:

- **Patient Birthdate**
- **Patient Phone Number**
- **Patient Address**

By signing below, I understand persons attending my medical appointments are privy to ALL medical information discussed at my appointment(s). I understand if I do not want persons attending my medical appointments to be privy to ALL information discussed, I will ask the individual(s) not to attend my appointment(s) or remain in the lobby. I will update this form as change occurs.

_____

Patient/Legal Representative Signature Patient Printed Name Date

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CLINIC POLICIES

The Community Outreach Medical Center (COMC) is happy you have chosen our clinic to best serve your healthcare needs. As the clinic strives to make your medical experience with us both pleasant & productive, please familiarize yourself with the following clinic policies & procedures, and adhere to the instructions below.

Office Hours: Our office is open Monday – Friday from 8:00am to 5:00pm. We are closed between 12:00pm to 1:00pm for lunch, weekends & all federally observed holidays. We do not provide emergency care, urgent care or quick care services. For urgent medical needs, please call 911 and/or 411 to access the nearest acute care/emergency treatment facility.

Appointments: Please call (702) 657-3873 to schedule an appointment. Patients are seen by appointment, and dependent upon provider availability, may be seen as a walk-in patient. To make changes to your scheduled appointment we ask that you call at least 48 hours in advance.

Payment for Services: Payment for services is due in full at the time of service. Community Outreach Medical Center does not bill for any services (except for individuals with pre-established agreements). We accept credit/debit cards and cash for rendered services. **WE DO NOT ACCEPT CHECKS OF ANY KIND FOR PAYMENT OF SERVICES.** Services are available to Ryan White patients, regardless of a patient's ability to pay.

Medical Records: The clinic may take up to seven (7) business days to process your request for medical records. A current Release of Information form must be completed and signed by the patient or patient's legal representative for the clinic to process a request. Also, the patient will be charged a processing fee for medical records requests; $0.50 per copied page. Fees will be due prior to releasing copies of medical records. Fees will not be assessed for inter-agency requests.

Forms for Completion: The clinic may take a minimum of (fourteen) 14 business days to process the completion of letters verifying medical conditions, disabilities, FMLA and varying medical attestation forms. A $20 fee will be assessed for each request. Patients or patients' legal representatives will be required to resolve fees prior to releasing requested copies.

Prescription Refills: The clinic will ONLY provide prescription refills at follow-up appointments. Please have your pharmacy fax a refill request before your follow-up appointment. WE ARE NO LONGER ABLE TO PROCESS REFILL REQUESTS ON THE SAME DAY THEY ARE RECEIVED; please plan accordingly.

Test Results: ***PLEASE DO NOT call the clinic for test results or to ask if they are in.*** Your results will be discussed with you at your follow-up appointment or by letter (applicable to identified patients). Please contact the clinic if you have been awaiting a results letter within 2 weeks from the date of your test. If not otherwise advised, please do not pick up your results letter any sooner than 2 weeks after testing was complete. Please allow 2 weeks for us to receive your results and review indicating factors.

Nurse/Medical Assistant Call Backs: Nurses/Medical Assistants have a minimum of 72 business hours to return patient phone calls.

Certain policies (regarding payment/fees) may not apply to Ryan White Program eligible patients. Please ask clinic staff for further clarification.