Community Outreach
MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

CLIENT HISTORY

Full Name_____Today's Date_____

Other Names Used / Preferred Name _____

Address_____ City/Town_____ Zip_____

Home phone _____ Cell phone _____

Email Address_____

Date of Birth _____ Age_____ Marital Status: S M D W Sep

Pharmacy Address and Phone/Fax: _____

DEMOGRAPHICS

Current Gender Identity: ☐ Male ☐ Female ☐ Unknown | Sex at Birth: ☐ Male ☐ Female

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

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

Ethnicity: _____ Race: _____

Language(s) Spoken _____

Occupation_____Social Security_____

Name of Spouse or Significant Other (if applicable) _____

Who should we contact in an emergency? _____Relation _____Phone_____

Father's Name _____Phone _____

Address_____ City_____ Zip_____

Mother's Name _____

Address_____ City_____ Zip_____

Where did you have HIV testing done? _____ Date _____

Was it Positive? Yes No

What physician are you currently seeing? _____ Phone _____

Address_____ City_____ Zip_____

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SYMPTOMS

Please make a check mark next to anything, which you have experienced in the past 3 months.

					COMMENTS
Fever Higher Than 100	Y		N		
Drenching Night Sweats Degrees	Y		N		
Unexplained Weight Loss Of More Than 10 Lbs.	Y		N		
Unusual Skin Rashes	Y		N		
New Bumps Or Spots On The Skin	Y		N		
Swollen Lymph Nodes	Y		N		
Easy Brushing Or Bleeding	Y		N		
Swollen Feet (Shoes Don't Fit)	Y		N		
Cough	Y		N		
Shortness Of Breath Walking Or Climbing Stairs	Y		N		
White Patches In The Mouth	Y		N		
Pain Behind Breastbone When Swallowing	Y		N		
Severe Abdominal Pain Or Cramps	Y		N		
Three Or More Watery Stools Per Day	Y		N		
Painful Bowel Movements	Y		N		
Blood In Stools	Y		N		
Loss Of Bowel Control	Y		N		
Painful Urination	Y		N		
Usually Frequent Urination	Y		N		
Loss Of Urine Control	Y		N		
Persistent, Severe Headaches	Y		N		
Unusual Numbness Or Pain In The Hands Or Feet	Y		N		
Weakness In The Legs Or Difficulty Standing Up	Y		N		
Trouble Thinking Or Concentrating	Y		N		
Changes In Your Vision	Y		N		
Hallucinations	Y		N		
Depression	Y		N		
High Blood Pressure	Y		N		
Diabetes	Y		N		
Stomach Ulcer	Y		N		
Anemia Or Bleeding Problem	Y		N		
Pancreatitis	Y		N		
Herpes Zoster ("Shingles")	Y		N		
Herpes Simplex (Oral Or Genital Herpes)	Y		N		
Syphilis	Y		N		
Gonorrhea	Y		N		
Vaginal Infection Or Chlamydia	Y		N		
Venereal Warts	Y		N		
Tuberculosis Or A Positive Skin Test	Y		N		
Hepatitis (What Type?)	Y		N		
Mental Illness (What Type?)	Y		N		
Attempted Suicide	Y		N		

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Medical History

Please answer the following questions about your past medical history. If you don't understand any of the questions please ask your nurse or doctor to explain the question(s).

Previous Operations or Surgery	Date	Hospital

Hospitalizations / Illness	Date	Hospital

Medical Problems (past or present) & approximate date when diagnosed/first occurred

Condition	Date	Condition	Date
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Current Medications

Medication	Dose	Instructions	Date	Medication	Dose	Instructions	Date
Ex. Atenolol	*50 mg*	*1 daily*	*1/1/11*	6.			
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			

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

Allergy	Reaction	Allergy	Reaction
Ex. Penicillin	*Rash, Shortness of breath*	3.	
1.		4.	
2.		5.	

How much beer, wine, or hard liquor (circle any you use) do you drink each day (average)?

Have you ever (check those true for you):

- Drank enough to lose consciousness
- Been arrested for driving under the influence of alcohol or drugs
- Been in Alcoholics Anonymous or a similar program

Have you ever smoked? (circle) Y N If yes, how many packs per day (average)? _____

Do you smoke now? Y N How many years have you smoked? _____

Do you use marijuana, cocaine, or other non-prescription drugs? Y N

If yes, which ones? _____

Have you ever used drugs in the vein or skin? Y N

First year you used injectable drugs _____

Last time you used injectable drugs _____

Does anybody in your family have (circle those that apply):

Diabetes High Blood Pressure Cancer (type) _____

High Cholesterol Heart Disease Sickle Cell Anemia or Trait

List date of most recent immunizations:

Tetanus _____

Hepatitis B _____

Influenza _____

Pneumococcus _____

Have you ever received a transfusion? Y N If so, when and where? _____

For women: Last menstrual period _____ Last Pap _____ Are periods regular? Y N

A benefit of coming to this clinic is that you may be eligible to receive treatment with drugs or other therapies not available to the general public. Would you be interested in participating in studies of new drugs or other therapies? (saying yes does not obligate you to participate, and you will receive full care whether you chose "yes" or "no".) YES NO

Social History

Where were you born? _____

Where have you lived in the past 15 years? _____

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Where do you live? (check one) ☐ Hotel ☐ Board and care ☐ Own home ☐ Rent/Lease ☐ Homeless ☐ With friends ☐ With Family ☐ Other

Who lives with you? _____

Support network (check all that apply)

☐ None ☐ Health care Provider ☐ Counselor/Therapy

☐ Partner/Significant Other ☐ Spouse ☐ Neighbors ☐ Support Groups

☐ Friends ☐ Work/School Associates ☐ Family/Relatives ☐ Church/Clergy

How do you support yourself financially? _____

Are you presently sexually active? Yes No

Who do you have sex with? Men Women Both

Do you always use a condom during anal or vaginal intercourse? Yes No

Do you always use a spermicide? Yes No

Have you ever had sex with someone living with HIV (AIDS Virus)? Yes No Don't Know

Have you ever had sex with someone who uses injectable drugs? Yes No Don't Know

Do you have questions about safe sex? Yes No

What else would you like us to know about your health?

_____

_____

_____

Patients Signature _____ Date: _____

Witness's Signature _____ Date: _____

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Consent for Treatment

The following information is to be completed by the patient, or the patients legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that 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/diseases, law may require reporting of positive results to relevant public health agencies.

I hereby release 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.

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative to Patient: _____

Date: _____

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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.

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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.

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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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COMMUNITY OUTREACH MEDICAL CENTER ADVANCE DIRECTIVES AGREEMENT

1) I have received written information on state law concerning Advance Directives advising me of my right to make decisions concerning my medical care including the right to accept or refuse medical or surgical treatment, and formulate advance directives.

YES____ NO _____

2) I have formulated an Advance Directive:

YES (Declaration/Living Will) _____

YES (Durable Power of Attorney for Health Care _____

NO, I have not formulated any Type of Advance Directive _____

If YES, I have provided a copy of my Advance Directive to hospital.

YES _____ NO _____ (If no is marked a copy should be provided to the hospital as soon as possible).

Patient Signature: _____ Date_____

Family and/or Significant other (If patient is unable to sign) _____
Date _____

Hospital Representative _____ Date _____

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RYAN WHITE PROGRAM
ADVANCE DIRECTIVES, LIVING WILLS AND DURABLE POWER OF ATTORNEY

As a competent adult (18 years old and over) it is your right to make decisions regarding your health care after you have been informed of all important aspects of that care. You may accept or refuse care on your own desires.

The best time to determine your desires regarding your choice of health care is before you are admitted to a health care facility. If you are incapable of expressing your desires you may develop a written statement that will dictate how you want decisions made. These statements are called Advance Directives.

There are two forms of Advance Directives:

Living Will

The Living Will is only in effect when your attending physician determines that your condition is terminal and there is no chance for recovery. The Living Will allows you to state what level of care you wish regarding life support, life containment, and life enhancement. (See the checklist attached to assist you in developing your Living Will.)

When writing a Living Will you may direct your physician to carry out directives are known and carried out. This individual is only designated to make decisions regarding withholding or withdrawal of treatment.

Durable Power of Attorney

The second form is the Durable Power of Attorney for Health Care. This statement allows you to name an individual and an alternate that will make decisions in case you are unable. It is recommended that you discuss your wishes with these persons so they can best serve you. This individual may make decisions regarding your health care whenever your condition be terminal. (See checklist attached to assist you in developing your desires for health care.)

Absence of Advance Directives

In the case that you have not prepared an Advance Directive, the closet living relative would be asked to give consents and make decisions for your health care.

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GENERAL INFORMATION

- Advance Directives can be revoked at any time.

- The Living Will only become effective when it is communicated to the attending physician and you have been determined by that physician to be in a terminal condition and you are no longer able to make decisions regarding your health care.

- Durable Power of Attorney becomes effective when you are unable to communicate your desires, for example, you are in a coma.

- A Durable Power of Attorney must be notarized or witnessed by 2 adults.

- When you have developed an Advance Directive you should share it with:
    - Your physician
    - Your family
    - Your named persons in your Durable Power of Attorney
    - Any health care institution(s) you are being admitted to for health care

- The Living Will will not be effective in the case of a woman known to be pregnant as long as the fetus could develop to the point of a live birth.

- You may have either type pf Advance Directive or both. It is recommended that if you have a Durable Power of Attorney that you provide your representative with information that clearly describes your wishes. This can be done through a Living Will.

These are a few of the basic facts about Advance Directives. If you wish to know more information you may ask to view the movie “On Your Behalf”.

If you choose to develop a Living Will you may use one of the following samples or create your own. If you wish to develop a Durable Power of Attorney you may request the necessary forms from your nurse. This forms is the only State approved form.

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LIVING WILL

A declaration that designates another person to make decisions governing with withholding or with drawl of life-sustaining treatment may, but need not, be in the following form:

DECLARATION

If I should have an incurable and irreversible condition that without the administration of life sustaining treatment, will, in the opinion of my attending physician, cause my death within a short time, and I am no longer able to make decisions regarding my medical treatment, I appoint _____ or if he/she is not available or is unwilling to serve,_____, to make decisions on my behalf regarding withholdings or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to NRS 449.540 to 449.690. Inclusive, and sections 1 to 12 inclusive, of this act.

(If the person or persons I have appointed are not available or are unwilling to serve, I direct my attending physician, pursuant to those sections, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.)

Strike language in parentheses if you do not want it.

If you wish to include this statement, you must INITIAL the statement in the box provided:

(If the statement reflects your wants, initial the box next to the statement)

I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastro –intestinal tract if such a withdrawal would result in my death by starvation or dehydration. [____]

Signed this _____ day of _____,_____

Signature _____

Address _____

_____

The declarant voluntarily signed this writing in my presence.

Witness _____

Address_____

_____

Witness_____

Address _____

_____

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Living Will Worksheet

This is a worksheet checklist which may assist you in developing your Living Will.

Y = YES

N = NO

U = Undecided

Life Supporting | **Life Sustaining** | **Life Enhancing**

Conditions	CPR	Respirator Breathing Machine	Nutrition through veins or feeding tube	Kidney Dialysis	Surgery	Medications that may prolong life	Pain Medication	No Treatment
In a coma or persistent vegetative state with no hope to recover								
Have a progressive illness with loss of mental abilities which will result in death.								
Have a condition that results in loss of mental abilities that is permanment and cannot be improved or cured but is not terminal								
Have a chronic condition that will ultimately lead to death and treatments are no longer effective								

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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 offers a comfortable / safe environment in which to obtain services.

We do however, reserve the right to suspend, alter or terminate a client's / patients Services/Privileges for any of the following:

a. Threats and/or incidences of assault, theft 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.

_____ _____

Client Signature Client UID/URD

_____ _____ _____

Staff Representative Title 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 and initial each carefully, so that you will understand our expectations of you.

_____ (initials) I will provide accurate and complete information about past and current health problems, hospitalizations, medications, treatment and 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, 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 (Prescriptions, 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 and 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 for 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 am responsible for finding out my test results instructed by clinic staff, by letter or 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, and follow clinic rules and ensure that any persons with me also comply.

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

Patient Signature	Signature of legal Authorized Representative	Date

For patients eligible for services provided by the Ryan White program, there may be certain responsibilities listed above that may not apply for you. Please ask staff if you have any questions.

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CLINIC POLICIES

We are happy you have chosen our clinic for your healthcare needs. The Community Outreach Medical Center strives to provide the best care for our patients, and desires to make your interactions with us both pleasant & productive. We feel that we can better serve your healthcare needs if you are familiar with the following policies & procedures of the clinic, and by following the instructions that we have provided.

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 & holidays. We do not provide emergency care, urgent care nor are we a quick care. If you need these services, please call 911 for Emergency Care or Information (411) for an Urgent/Quick care close to you.

Appointments: Please call (702) 657-3873 to schedule an appointment. Patients are seen by appointment only. We ask that you call at least 48 hours in advance if you need to cancel or reschedule your appointment.

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 those individuals referred by certain agencies with whom we have an agreement). We accept credit/debit cards and cash for payment. **WE DO NOT ACCEPT CHECKS OF ANY KIND FOR PAYMENT OF SERVICES.**

*******For Ryan White patients, services are available regardless of a patient's ability to pay and regardless of current or past health conditions.

Medical Records: We will need a minimum of seven (7) business days to process your request for medical records. A current Release Of Information must be completed/signed by you in order for us to process your request. In addition, as Nevada Revised statutes allows us to charge a minimal processing fee for this service, you may be charged accordingly and expected to pay before the records are released.

Forms for completion: As a number of our healthcare providers work at the clinic part time**, w**e will need a minimum of (fourteen) 14 business days to process your request for the completion of letters for verification of medical conditions, disability, FMLA, etc., forms. There will be a fee charged to you prior to releasing the completed forms to you. This fee is based on the number of pages we are required to complete.

Prescription refills: Due to the overwhelming amount of time our staff spends managing prescription refills, the clinic will be providing prescription refills at your follow up appointment ONLY. (For patients in certain programs who have kept follow-up appointments, have had lab work, diagnostic tests completed as ordered, have your pharmacy fax a refill request AT LEAST 2 WEEKS before your prescription runs out. **WE ARE NO LONGER ABLE TO COMPLETE/FAX REFILL REQUESTS ON THE SAME DAY AS THEY ARE RECEIVED. PLAN ACCORDINGLY).**

Test Results: ***DO NOT call the clinic for your results or to ask if they are in***. Your results will be discussed with you at your follow up appointment or by letter (for applicable patients only). If you are awaiting a result letter & have not received it in 2 weeks from the date of your test, please call the clinic to inform us. If you are picking up your letter, then you may do so no earlier than 2 weeks after your test was done. Please allow 2 weeks for us to receive your results.

***For patients eligible for services provided by the Ryan White Program, certain policies (regarding payment/fees) may not apply to you. Please ask clinic staff if there are any questions.

Nurse Call Backs: **N**urses will have a minimum of 48 hours to return your phone calls. Please remember that they have many responsibilities in the clinic and cannot stop to take your calls. When you want the nurse to return your call, be sure and provide the receptionist with a telephone number where you will answer when the nurse calls. If you are not available when the nurse calls, your call will drop to the bottom of the nurses' call back list and you will not be contacted again for 48 hours.