Health Center
at Touro University Nevada

Name: _____ DOB: _____

Circle any you may have or have had:

Arthritis	Drug Abuse	Miscarriages
Asthma	Alcohol Abuse	Pneumonia
Bleeding Tendency	Heart Disease	Scoliosis
Blood Transfusions	Hepatitis (B,C)	Skin Disease
Cancer	High Cholesterol	Stroke
Cataract	HIV	Tuberculosis
COPD	Hypertension	Ulcers
Diabetes	Kidney Disease	Sexually Transmitted
Blood Clot	Mental Illness (Depression/Anxiety	Disease
Thyroid Disease	Osteoporosis	

Explain any circled items or add any other problems you may have had.

_____

_____

_____

_____

FAMILY HISTORY: *(List any diseases by family member (i.e. hypertension, diabetes, heart attack, stroke or cancer)*

Relative / Relationship **Illness/Medical Condition**

Mother_____

Father_____

_____

CURRENT MEDICATIONS: *(prescription and over the counter)*

Name **Strength** **Frequency**

_____

_____

_____

_____

_____

_____

If you have any further medications, please list them on the back of this form.

ALLERGIES (*Medications, foods, etc. and list the reaction*)

_____

_____

_____

_____

Name: _____ DOB: _____

SURGICAL HISTORY

Year	**Operation**	**Reason for Surgery**	**Hospital/Location**

SOCIAL HISTORY

Do you currently smoke?_____ How much per day?_____ How many years?_____
Are you a previous smoker?_____ When did you quit?_____
Do you drink alcohol? _____
Do you use any narcotics or addicting medications?_____
Do you use caffeine (coffee, soda, tea?)_____
What is your marital status? Single Married Divorced Separated Widowed Partner
What is your occupation? _____
Are you in danger either from yourself or someone else? ____ Yes ____ No

PREVENTIVE CARE

When was the last time you had each of the following? (circle if it was normal or abnormal)

Pap Smear? _____ Normal /Abnormal
Mammogram? _____ Normal /Abnormal
Bone Density Scan?_____ Normal /Abnormal
Colonoscopy?_____ Normal /Abnormal
Cholesterol check?_____ Normal /Abnormal
Prostate exam?_____ Normal /Abnormal
EKG?_____ Normal /Abnormal
Chest Xray?_____ Normal /Abnormal

IMMUNIZATIONS

Tetanus shot? ____Yes ____No _____Date
Pneumonia? ____Yes ____No _____Date
Flu? ____Yes ____No _____Date
Shingles? ____Yes ____No _____Date

PREGNANCY HISTORY

How many pregnancy's?_____
How many were? Live Birth_____ Miscarriage_____
Termination_____ Tubal_____

Please list all other physician's names, address, phone number and fax number that you currently see.

_____
_____
_____

Name_____ Date_____

Review of Systems: Are you currently having any problems related to the following systems? Check Yes or No

General

Feeling well □ Yes □ No
Weight loss □ Yes □ No
Weight gain □ Yes □ No
Fatigue □ Yes □ No
Fever □ Yes □ No

Integumentary (skin)

New or changing moles □ Yes □ No
Itching □ Yes □ No
Rash □ Yes □ No

HEENT

Eye pain □ Yes □ No
Visual loss □ Yes □ No
Decreased hearing □ Yes □ No
Ear pain □ Yes □ No
Runny nose □ Yes □ No

Respiratory

Cough □ Yes □ No
Snoring □ Yes □ No
Difficulty breathing □ Yes □ No

Breast

Breast mass □ Yes □ No
Breast pain □ Yes □ No
Nipple discharge □ Yes □ No

Cardiovascular

Chest pain □ Yes □ No
Palpitations □ Yes □ No
Swelling in legs □ Yes □ No

Gastrointestinal

Abdominal pain □ Yes □ No
Black or bloody stool □ Yes □ No
Constipation □ Yes □ No
Diarrhea □ Yes □ No
Heartburn/indigestion □ Yes □ No
Nausea □ Yes □ No
Vomiting □ Yes □ No

Genitourinary-Female

Change in urination stream □ Yes □ No
Menstrual irregularities □ Yes □ No
Urinating at night □ Yes □ No
Painful urination □ Yes □ No
Urgency to urinate □ Yes □ No
Vaginal discharge □ Yes □ No
Vaginal bleeding □ Yes □ No

Genitourinary-Male

Change in bladder habits □ Yes □ No
Impotence □ Yes □ No
Urine leakage □ Yes □ No
Excessive urinating at night □ Yes □ No

Musculoskeletal

Back pain □ Yes □ No
Joint pain □ Yes □ No
Have you given up any activity due to pain? □ Yes □ No

Neurological

Numbness/tingling □ Yes □ No
Difficulty speaking □ Yes □ No
Headaches □ Yes □ No

Psychological

Difficulty with sleep □ Yes □ No
Anxiety □ Yes □ No
Depression □ Yes □ No

Endocrine

Excessive thirst □ Yes □ No
Heat intolerance □ Yes □ No
Cold intolerance □ Yes □ No

Hematology

Easy Bruising/ □ Yes □ No
Nosebleeds (Epistaxis) □ Yes □ No

Health Center at Touro University Nevada

PATIENT INFORMATION

Name:	**Home Tel:**
Address One:	**Work Tel:**
APT #:	**Cell #:**
City:	**Sex:**
State: Zip:	**DOB:**
Usual Provider:	**SS#:**
Referring Physician:	**Employer:**
Referring Physician Address:	**Email:**
Ste:	**Marital Status:**
City:	**Relation to Guarantor:**
State: Zip:	**Race:**
Referring Physician Phone:	**Ethnicity:**
Primary Care Doctor:	**Language:**
Primary Care Doctor	**How Did You Hear About Us:**
Ste:	**TUN:**
City:	
State: Zip:	
Primary Care Doctor Phone:	

GUARANTOR INFORMATION

Name:	**Home Phone#:**
Address One:	**Work Phone#:**
Address Two:	**Cell Phone#:**
City:	**Sex:**
State: Zip:	**DOB:**
	SS#:
	Employer:
	Relationship to Patient:

Emergency Contact

Emergency Contact Name:	**Emergency Contact Home Tel:**
Emergency Contact Address:	**Emergency Contact Work Tel:**
APT #:	**Emergency Contact Cell:**
City:	**Relation To Patient:**
State: Zip:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**
Sub DOB: Sub Sex: M F	**Sub DOB: Sub Sex: M F**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider, Touro University when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Touro University to release any information necessary for my course of treatment.

_____ _____

Signature (patient or parent if minor) Date

Health Center
at Touro University Nevada

General Consent to Treat / Patient Authorization / Acknowledgement of Benefits Release

The following are the conditions for services provided by Touro University Nevada Health Center for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/We voluntarily consent to medical treatment and diagnostic procedures provided by the Health Center at Touro University Nevada and its associated physicians, clinicians, and other personnel. I/We consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/We also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law. I/We fully understand that, as part of a teaching institution, information may be collected from the patient encounter or chart in order to collect data. I/We understand that personal health information may be used or disclosed for the purposes of carrying out treatment, evaluating the quality of services proved and any administrative operations related to treatment or payment. I/We understand that I/we have the right to restrict how the personal health information is to be used and disclosed for treatment, payment and administrative operations if I/we submit a written request. I/We understand that each request will be considered for restriction on a case-by-case basis.

ASSIGNMENT OF INSURANCE BENEFITS

I/We guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the Health Center at Touro University Nevada. I/We understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/We understand that the Health Center at Touro University Nevada can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/We have provided all necessary information for proper assignment of Medicare benefits.

ROUTINE PHYSICAL APPOINTMENTS

I understand a routine physical appointment cannot be accompanied with any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed with the physician the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

_____***Initials***

LAB DISCLAIMER

It may be necessary to perform or request lab work (cultures, pap smears, biopsies, lab work, etc.). Our office may send you directly to the Lab of your choice. Our office may send out a specimen to a Lab of the Physician's choice, but will consider your insurance carrier. Each test may have more than one fee depending on the complexity. Your insurance carrier may not cover certain tests. It is your responsibility to know your benefits. We cannot change any coding (CPT Procedure Codes or ICD-9 Diagnosis Codes) to conform to your plan's coverage or benefits.

Below check the Laboratory that is contracted with your insurance.

_____ Lab Corp
_____ Quest
_____ CPL
_____ Other _____.

_____ ***Initials***

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION

I understand that Nevada Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the NV Code NRS616C.050. I/We authorize the Health Center at Touro University Nevada to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.

CONTROLLED SUBSTANCE PRESCRPTIONS

The Health Center at Touro University Nevada reserves the right not to prescribe narcotic medications. If you take narcotic medications for pain control on a regular basis, you must see a pain management physician. No narcotic prescriptions will be given for new patients on the initial visit until a complete work up has been performed and old records have been received. Controlled substance medications (narcotics, anti-anxiety, sleeping mediations, etc.) are very useful, but have high potential for misuse and abuse. These drugs are closely controlled by local, state, and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If you are prescribed such medications to help manage pain, you are responsible for the controlled substance medication. If the prescription is lost, misplaced, stolen, or use up medication sooner than prescribed, it will not be replaced. You cannot request nor accept substance medication from any other physician or individual while you are receiving this medication from your doctor. Prescription Refills of controlled substance cannot be called in to the pharmacy. They must be hand written and you must attend your scheduled appointment. You will be informed by your doctor about any side effects, including normal psychological effects of tolerance and dependence.

INFORMATION RELEASE

Other Person(s) authorized to discuss any medical information (including appointments, billing and insurance):

Full Name	Phone Number	Relationship

CONFIDENTIAL COMMUNICATION

You may request to receive confidential communications of Protected Health Information (PHI), i.e. Lab results, x-ray results, referral/prior authorization, prescription refills, in the method you prefer. ***Please select all that apply***.

I authorize the Health Center at Touro University to leave PHI messages at the following:

☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN A CALL
☐ Home Voicemail ( ) _____
☐ Cell Voicemail ( ) _____
☐ Work Voicemail ( )_____
☐ Patient Portal Web Message (email address required) _____

MEDICAL STUDENTS

You have the opportunity to assist future healthcare professionals by allowing them to participate with your physician in your appointment(s). **Please indicate below your preference to participate.**

☐ I will allow a medical student to participate in my appointment(s)
☐ I will not allow a medical student to participate in my appointment(s)

_____ *Initial*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/We have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

Signature of Patient, Parent, Guardian or Legal Representative	Print name of Patient, Parent, Guardian or Legal Representative / Relationship to patient	Date
Signature of Witness	**Please print name of Witness / Relationship to Patient**	**Date**

Health Center
at Touro University Nevada

Form Completion Policy

The Health Center at Touro University Nevada requires payment for the completion of forms the patient asks us to complete on their behalf. We receive many requests which require increased administrative time and financial resources in excess of what is normally needed to complete the medical record.

Instructions:

- Submit the form completion request well in advance of when they are needed. We will attempt to complete the forms as quickly as possible however, in order to properly address them we need adequate time to review the patient's records.
- Patient must complete all of their information on the form prior to giving the forms to us.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

We will make every effort to complete these forms within 5-7 business days; however we cannot make any assurance of completion with the patient's time frame(s). Payment is required prior to completion of all forms.

The following forms will be assessed a $45 fee for completion:

- FMLA
- Workers Compensation
- Disability
- Letter of Condition
- Misc. Patient requests

The following forms will be completed at no charge to the patient:

- DMV Disability Placard

By signing below I attest that I have read and understood the above consent. I have been provided a copy of this document for my records

_____ _____

Printed Name of Patient (and Patient's Representative if patient is a minor) Date

_____ _____

Signature of Patient (and Patient's Representative if patient is a minor) Date

Health Center
at Touro University Nevada
874 American Pacific Drive, Henderson, Nevada 89014
Phone 702.777.4809 | Fax 702.777.4822

Cancellation & No-Show Policy

It is the policy of the Health Center at Touro University Nevada that patients arrive on time for their scheduled appointments. In the event that a patient is unable to make their scheduled appointment the patient must give 24 hours advance notice to the receptionist by calling (702)777-4809.

It is the patient's responsibility to arrive 30 minutes prior to their appointment time. If an existing patient is late for their appointment time, the patient may not be treated that day and may have to reschedule. If the patient is treated they will be worked in between other patients that have arrived in accordance with their appointment time.

A patient who fails to keep 3 or more appointments in a twelve-month period- without prior notice of cancellation-may be discharged from the Health Center at the discretion of the patient's physician.

By signing below I attest that I have read and understand the above Cancellation & No-Show policy. I have been provided a copy of this document for my records

_____ _____

Printed Name of Patient (and Patient's Representative if patient is a minor)

_____ _____

Signature of Patient (and Patient's Representative if patient is a minor) Date

Welcome to our Practice

Our Mission

The mission of the Health Center at Touro University Nevada is to provide quality patient care in a compassionate, timely and confidential manner, emphasizing holistic, osteopathic principles, preventative health care, patient education and shared decision making.

Appointments

Appointments for the clinic are scheduled Monday thru Thursday (8am – 5:00pm) and Fridays (8am – 3:00pm). Appointments are scheduled according to the treating physician. **New patients** must arrive **45 minutes** prior to their scheduled appointment to fill out the proper paperwork or they will be rescheduled. **Existing Patients** must arrive 30 **minutes** prior to their scheduled appointment and must not be late or they may be rescheduled. Any special appointment times are to be given directly from the doctor.

Referrals

If a referral is required, we will complete the necessary paperwork and submit to your health plan for authorization. It has been our experience that each health plan varies in its response timeliness.

Financial Policy

Our physicians are providers with traditional insurance health plans. If you have any questions about whether any of our physicians are participants in your health plan, please call or directly speak with our office staff and your insurance company. Co-payments/Deductibles are due at the time of service.

Emergency / Non-Emergency Care

If you believe you have an emergency, please call **911**. Your health plan may require that any non-emergency health care received outside of our office also receive prior authorization from your health plan and your physician. If authorization is not obtained, you may be financially responsible for the services rendered.

Billing

Insurance is billed as a courtesy to the patient. Please direct all billing inquiries and account questions to (702)777-3197. Patients without insurance are required to pay for services in full at the time of service. A minimum of $125 will be collected at check-in. If the total amount of the visit is more than $125, the balance is due at checkout. If the total amount is less than $125, the balance is refundable at checkout. Power of Attorney verification is expected at the first visit. Any medical records or test results requested by another physician's office may be sent by fax/mail at no charge. Patients requesting medical records/test results will be charged $.60 per page. Payment is expected prior to the release of records.

ROUTINE PHYSICAL APPOINMENTS

I understand a routine physical appointment cannot be accompanied with any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed with the physician the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

The Health Center at Touro University Nevada announces
a convenient way to communicate with us!

Dear :

Touro Health Center is thrilled to announce that we have launched a new solution that enables you to communicate with us more quickly, easily, and on your schedule. This new solution is a secure patient portal that delivers self-service capabilities for you to manage your healthcare at your fingertips.

- Some of the things you can accomplish with this new solution include:
- Review your medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- View test and lab results, and read medical notes from your doctor
- Update your health information (allergies, medications, conditions, etc)
- Request Rx refills
- Receive email care reminders
- Request or change appointments
- Fill out and submit forms prior to appointments
- Create proxy accounts for children or dependent adults
- View and pay bills

Patient Benefits:

- Review your medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- View test and lab results, and read medical notes from your doctor
- Update your health information (allergies, medications, conditions, etc)
- Request Rx refills

- Receive email care reminders
- Request or change appointments
- Fill out and submit forms prior to appointments
- Create proxy accounts for children or dependent adults
- View and pay bills

The portal service is also available on your Apple iPhone or Android mobile device. Download the free portal app at your Apple or Android store. Enter FollowMyHealth in the search field.

It's quick and easy to sign up: just provide us with your email address. You will receive an email invitation instructing you on how to register.

- Check your Email. You will receive an email from "noreply@followmyhealth.com." Click the registration link and follow the onscreen prompts.
- Click Create an Account. If you already have a portal account and want to add an additional provider, click Add This Connection.
- Choose a Login Method. You can create a username and password specifically for your portal account by clicking the FMH Secure Login icon. - OR - You can log in by using an existing username and password if you have one of the following accounts: Facebook | Gmail | Yahoo | Windows Live | CernerHealth. Click on the respective icon and enter your username and password for that account.
- Get Connected. Follow the on-screen prompts on the next four screens to complete your connection. These screens include accepting our Terms of Service, entering your Invite Code (last four digits of your social security number*) and accepting the Release of Information.
- Registration and Connection is Now Complete. Your health record will now begin to upload. Please note this may take a few minutes.
- View the First Time Walk-Through Video. Learn about all the tools your portal has to offer by watching the 3-minute video that appears when you first log in. If you wish to view this video later, you can always access it by clicking on the My Account dropdown in the right hand corner and selecting Preferences.

Use this copy for a step-by-step guide to creating a proxy account:

- To create a proxy account so you can access your child or dependent adult's portal account, please complete these steps after clicking on the link below.
- Click Create an Account. Enter YOUR contact information and click "I Accept." Reminder: Provide your information (name, email, birth date, zip code, etc.) when creating a proxy account – not your loved one's information.
- Log In to Your Portal Account.

- If you have an existing portal account: Login using your standard method.
- If you don't have your own portal account: You must create an account using one of the login options below:
- Create a username and password for your portal account by clicking on the green FMH Secure Login icon.
- …OR…Login by using an existing username and password if you have one of the following accounts*: Facebook | Gmail | Yahoo | Windows Live | CernerHealth. Click on the respective icon and enter your username and password for that account.
- With this option you are simply re-using your existing login credentials for your portal account so you don't have to create a new one. Your medical information is NEVER posted or shared with any of these accounts. Also, please note that if you forget your username or password, you must go through that account's recovery procedure as we do not store or have access to this information.
- Register as a Proxy: Follow the onscreen prompts. Step two of this process will ask you to enter an Invite Code. This is the number you were provided by our organization. Click "I Accept" on the next screen and you will be taken to YOUR portal account.
- At the top of the page, you'll see a dropdown arrow next to Hello, Name which lists the accounts you have proxy access to. Simply click on the name of the account you wish to access.

Congratulations! You can now access your health information and start managing your care online!

Once you register you can later access the portal by logging on to http://tun.touro.edu/community/patient-clinic/ and click on the Patient Portal button.

We look forward to providing you with this enhanced level of service!

Regards,

The Health Center
at Touro University Nevada

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY TOURO UNIVERSITY NEVADA HEALTH CENTER AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI):
Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI) we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act, 45CFR Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. This includes contacting you for appointment reminders and follow-up care.

YOUR HEATH INFORMATION RIGHTS: You have the right to:

- Request a restriction of the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of $.60 per page and the actual cost of postage per **NRS 629.061**, except that you are not entitled to access to, or to obtain a copy of psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the request amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax and/or telephone.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your protected health information, including information obtained prior to the change.
- Post notice of any changes in our Privacy Policy in the lobby and make a copy available to you upon request.
- Use or disclose your health information only with your authorization except a s described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your health information.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the designated Privacy Officer, Craig Seiden, at 874 American Pacific Drive, Henderson, NV 89014, 702-777-4794. If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

Treatment: e.g. we will use and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: e.g. we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment.

Health Care Operations: e.g. members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.

Other uses and disclosures not requiring authorization

- **Business Associates:** There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
- **Notification:** We may disclose limited health information to friends or family members identified by you as being involved in your care of assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
- **Legally Required Disclosures, Public Health & Law Enforcement:** We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, though in such circumstance you will not be personally identified), to an employer to evaluate whether an employee has a work related injury, and to public officials to report births and deaths. We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of a crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
- **Information Regarding Decedents:** We may disclose health information regarding a deceased person to: 1) Coroners and Medical Examiners to identify cause of death or other duties; 2) Funeral Directors for their required duties; and 3) to procurement organizations for purposes of organ and tissue donation.
- **Research:** We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
- **Marketing:** We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.
- **Fund Raising:** We may contact you as part of a fund raising effort.
- **Directory Information:** We may disclose limited information regarding your name and location for directory purposes to those persons who as for you by name or to members of the clergy. You may request that we not include your name in the directory.

Disclosures requiring authorization
All other disclosures of protected health information will only be made pursuant to your written authorization; which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.

Health Center
at Touro University Nevada

Name: _____ Date: _____
DOB: _____

Ht _____ Wt _____ BP ____/____ P_____ R_____ T_____ O/A/R LMP _____
Allergies: _____

Medications: _____

- ❑ **Mammogram Due**
- ❑ **Already Complete**
  Date _____ **Ordered by** _____
- ❑ **Prefers to discuss with provider**
- ❑ **Needs medication refills**
- ❑ **Would like to consult about medication**
- ❑ **Reviewed medications with patient**
- ❑ **Recent falls?** _____
- ❑ **Experiencing dizziness?** _____

CC: _____