Sierra Nevada Holistic Services, LLC ("SNVHS")

407 W. Robinson St.
Carson City, NV 89703
775-720-2563

Medical Patient Intake Form

Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____ □ Male □ Female □ Gender Neutral

Address: _____

City: _____, State_____ Zip: _____

Telephone: ( ) ____ - _____Email address: _____

Occupation: _____ Employer/School _____

Emergency Contact: _____ Telephone: ( ) _____ - _____

Social Security Number: _____-_____-_____ Blood Type _____

Marital Status: Single Married Separated Divorced Widowed Domestic Partner Spouse

Spouse/Partner's Name: _____

Children (ages, names): _____

_____

Do you have - Living Will: □**YES** □**NO** Healthcare POA: □**YES** □**NO** POLST Order: □**YES** □**NO**

DNR: □**YES** □**NO**

Race/Ethnicity(circle): White/Caucasian Black/African Amer. Asian Hispanic/Spanish Other Race
Native Hawaiian/Other Pacific Islander Amer. Indian/Alaska Native Ashkenazi Jewish Descent

MEDICAL HISTORY AND MEDICAL INFORMATION

Height: _____Weight: _____Avg. blood pressure _____/_____ Avg. pulse rate _____

What are your health goals? _____

Any allergies to medications, foods, environmental (seasonal allergies), lotions, oils, or essences?

□**YES** □**NO:** _____

Are you currently under the care/supervision of a primary care physician and/or alternative medicine provider (ex. Chiropractor, Oriental Medical Doctor, Medical specialist)? □**YES** □**NO**

May we contact them to coordinate care, if necessary? □**YES** □**NO**

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Please list any and all medications (prescribed OR over-the-counter), herbs, supplements, and vitamins that you are currently taking. **Please bring all medication bottles with you to your appointment.**

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

Medication: _____Reason for taking it: _____

*Please mark an **(X) by all current conditions** and **(P) for all past conditions***

__ Abdominal/digestive problems
__ Allergies
__ Anxiety
__ Arthritis/tendonitis
__ Asthma or lung cond.
__ Athlete's foot
__ Blood clots
__ Cancer
__ Chronic pain
__ Circulatory/heart Problems
__ Cholesterol issues
__ Constipation/diarrhea
__ Depression
__ Diabetes
__ Drugs/Alcohol Use
__ Fatigue
__ Headaches, migraine
__ Hearing problems
__ Hernia
__ Blood pressure
__ Jaw pain/TMJ pain
__ Muscle/bone injuries
__ Muscle/joint pain
__ Numbness/tingling
__ Pain (Chronic or Acute)
__ Pregnancy Weeks/Trimester: ____
__ Rash/fungus
__ Sexual issues
__ Sinus problems
__ Sleep difficulties
__ Spinal disorders
__ Sprain/strain
__ Tension/stress
__ Thyroid (High/Low)
__ Vision problems
__ Varicose veins
__ Other _____
_____

Please list any recent injuries or surgeries within the past 5 years:

_____

_____

Please list your stress-reduction activities, hobbies, exercise and/or sport participation:

_____

Date of last Medical Exam(s): _____ Last Eye exam: _____Last Mammogram:_____

Last Pap Smear: _____ Prostate/PSA exam/test: _____ Colonoscopy: _____

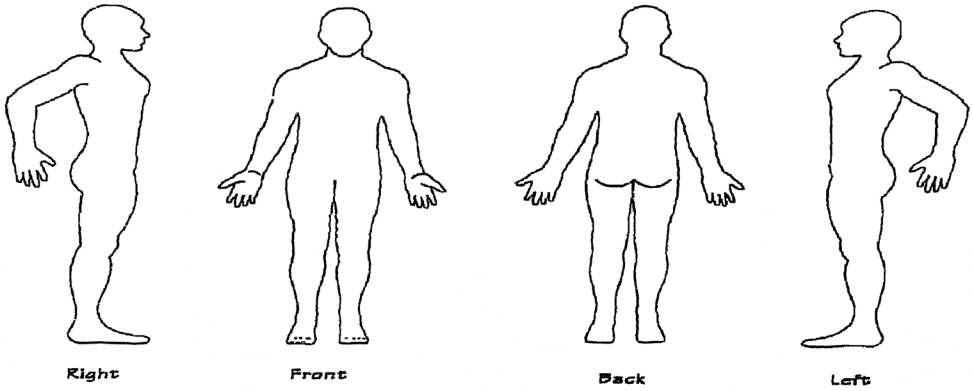
Last Skin exam: _____ Last DEXA Scan: _____ Last Dental exam:_____

Any abnormal findings from the above? □**YES** □**NO** If so, what was it? _____

Do you return for follow-up appointments? □**YES** □**NO**

When was the last time you took antibiotics? _____For what? _____

Please indicate areas you experience pain/discomfort:



Pain Characteristics/Description: _____
Examples: Throbbing, shooting, stabbing, cutting, pressing, cramping, pulling, dull, sharp, hot, tingling, aching, tiring, annoying, intense, numb, electric, pulsating…

When did, your pain start? _____
What do you think was the cause? _____

Pain Qualities: Continuous (24hrs non-stop)_____ OR Intermittent (comes & goes)____
If it is intermittent, how long does it last? _____

Pain Scale: On a scale of 1 through 10, with 10 being the worst pain you have ever had in your life, how would you rate your pain right now?_____/10

Any other symptoms or problems you have during the painful time (i.e., sweating, crying, nausea, anxiety, increased BP or respiration rate, exhaustion, etc.) _____
_____

Pain Radiation: Does the pain travel to other areas? Where? _____
_____

Pain Provokers: What makes the pain worse? _____
_____

Pain Relievers: What lessens/reduces AND/OR relieves/stops the pain? _____
_____
What pain relieving techniques/methods/treatments have you tried in the past that failed? _____
_____
The worst pain you had over the last week? _____/10
The best/least pain you had over the last week? _____/10
Does your pain interfere with your life? □**YES** □**NO**
If yes, how so (i.e., mood changes, social functioning, basic daily living activities, work/school, family issues, etc.)? _____
_____
On your current pain relieving/reducing treatments (Including prescription, over-the-counter medications/topicals, and other remedies/measures), are you happy with your current treatment program? □**YES** □**NO** If yes, tell why? _____
If no, what would you prefer to see happen with your treatment program?_____
Are you seeing a pain specialist? □**YES** □**NO** If yes, who_____
If no, do you want a referral? □**YES** □**NO**

SEXUAL HEALTH

The following are a few questions about your sexual health and sexual practices. I understand that these questions are very personal and can be uncomfortable or embarrassing to answer. Just so you know, I ask these questions to all of my adult patients, regardless of age, gender, or marital status. These questions are as important as the questions about other areas of your physical, social, mental, and spiritual health. Like the rest of this form, this information is kept in strict confidence.

Are you currently sexually active? (Are you having sex?) □**YES** □**NO**
If yes, are your sex partner(s) men, women, both, non-gendered? _____

If no, have you ever been sexually active? □**YES** □**NO**
If no, do you imagine your partner(s) as men, women, both, non-gendered? _____

How many partners have you had in the past month? _____ Six months? _____ Lifetime? _____

Do you have, or have you ever had, any risk factors for HIV or Hepatitis C? (List blood transfusions, needle stick injuries, IV drug use, partners who may have placed you at risk.) □**YES** □**NO** **If yes, what and when?**
_____
Have you ever been immunized against Hepatitis C? □**YES** □**NO** Would you like to be? □**YES** □**NO**

To understand your risk for STDs, over the last 12 months:
What kind of sexual contact do you have or have you had? Circle all applicable: Genital (penis in the vagina)? Anal (penis in the anus)? Oral (mouth on penis, vagina, or anus)?
Do you and your partner(s) use any protection against STDs? □**YES** □**NO** _____
How often do you use this protection? _____
If not, could you tell me the reason? _____
If "sometimes," in what situations or with whom do you use protection? _____
Have you ever been tested for HIV, or other STDs? □**YES** □**NO**
Would you like to be tested? □**YES** □**NO**
Have you ever had any sexually-related diseases? □**YES** □**NO** _____
When? How were you treated? _____
Have you had any recurring symptoms or diagnoses? □**YES** □**NO** _____
Has your current partner or any former partners ever been diagnosed or treated for an STD? □**YES** □**NO**
Did you get tested for the same STD(s)? □**YES** □**NO**
Do you or your partner(s) use any devices or substances to enhance your sexual pleasure? □**YES** □**NO** **If yes, What are they?** _____
Please circle/mark the best answer: How satisfied with your (and/or your partner's) sexual functioning are you?
Very Mostly Somewhat Neutral Somewhat Dissatisfied Mostly Dissatisfied Frustrated
Has there been any change in your (or your partner's) sexual desire or the frequency of sexual activity? □**YES** □**NO**
Cause for the change? _____
Any history of sexual, mental, or physical abuse? □**YES** □**NO**
Circle all that apply: sexual, mental, emotional or physical abuse
Do you have any questions or concerns about your sexual functioning? □**YES** □**NO**
_____

Women: Do you ever have pain with intercourse? □**YES** □**NO**
If yes, when (upon initial penetration, throughout penetration, during deep penetration, during orgasm, after sex)? _____
Anything that helps or worsens this? _____
Do you have any difficulty achieving orgasm? □**YES** □**NO**

Men: Do you have any difficulty obtaining and maintaining an erection? □**YES** □**NO**
Difficulty with ejaculation? □**YES** □**NO** _____

REPRODUCTIVE HEALTH

FEMALE:

Do you have any problems with your genitals, such as burning or pain during urination, vaginal discharge, bumps or sores on your genitals, or pain or lumps in your genital area? □**YES** □**NO**
If yes: What color is the discharge? _____; are the sore(s) painful or itchy? □**YES** □**NO** □**BOTH**
When did you first notice the discharge or sore(s)? _____
Has there been a change in the discharge or sore? □**YES** □**NO**

Age at first period ____Date of last period _____ Number of pregnancies ____ Number of miscarriage/abortions_____; Number of live births ____ History of abnormal Pap tests? □**YES** □**NO** What was abnormal? _____ Did you have this treated? □**YES** □**NO**
When? _____ What treatment was done?_____
History of irregular periods? □**YES** □**NO**
Menstrual cycle length: ____ days. Duration of menstrual period: ____ days.
Do you experience significant menstrual cramping? □**YES** □**NO**
Is heavy bleeding a problem? □**YES** □**NO**
Do you have a history of endometriosis? □**YES** □**NO**
Do you have a history of yeast infections or urinary tract infections? □**YES** □**NO** **If yes, which? _____**
Do you have a history of infertility? □**YES** □**NO**
Do you have excessive unwanted hair growth? □**YES** □**NO**
Do you have a tendency toward premenstrual syndrome? □**YES** □**NO** If yes, please describe symptoms:
_____

Do you do routine self-exam of your breasts? □**YES** □**NO** Describe any current breast problems: _____
_____
Describe any current menstrual or menopausal symptoms or concerns: _____
_____
Do you use any type of menstrual or menopausal supplements or herbs? □**YES** □**NO** What? _____
_____
Did/do you breast feed? □**YES** □**NO**

MALE:

Do you have any problems with your genitals, such as burning or pain during urination, discharge from your penis, bumps or sores on your genitals, or pain or lumps in your genital area? □**YES** □**NO** If yes: What color is the discharge?_____; are the sore(s) painful or itchy? □**YES** □**NO** When did you first notice the discharge or sore(s)? _____Has there been a change in the discharge or sore? □**YES** □**NO**
Do you have any pain, lumps, or heaviness in your testicles? □**YES** □**NO**
Do you do routine self-exam of your testes and genitals? □**YES** □**NO**

ALL:

1. During the past three months, have you leaked urine (even a small amount)? ❑ **Yes** ❑ **No**
2. During the past three months, did you leak urine: **(check all that apply)** ❑ **A.** When you were performing some physical activity, such as coughing, sneezing, lifting, or exercising? ❑ **B.** When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough? ❑ **C.** Without physical activity and without a sense of urgency?
3. During the past three months, did you leak urine most often: (check only one) ❑ **A.** When performing some physical activity, such as coughing, sneezing, lifting, or exercising? ❑ **B.** When you had the urge or feeling that you needed to empty your bladder, but you could not get to the toilet fast enough? ❑ **C.** Without physical activity and without a sense of urgency? ❑ **D.** About equally as often with physical activity as with a sense of urgency?
4. Do you have lower abdominal pain? □**YES** □**NO**
5. Do you have dark urine or any yellowing of your skin or eyes? □**YES** □**NO**
6. Do you have any history of genital injuries or surgery? □**YES** □**NO** _____

NUTRITIONAL HEALTH

Describe any food intolerances you have: _____
_____
Describe any digestive problems: _____
Your usual bowel movement frequency is (check one):
□ >2 times daily □ 1 time daily □ 1 time every 2 days □ <1 time every 2 days.
Do you usually have to strain to have a bowel movement? □**YES** □**NO**
Are your bowel movements chronically loose? □**YES** □**NO**
Do you ever have blood with bowel movements? □**YES** □**NO**
Are your stools ever black or tarry? □**YES** □**NO**
Describe your typical: breakfast _____
lunch_____
dinner_____
snack _____
How frequently do you dine out: □ Daily □ Weekly □ Monthly □ Rarely □ Never
How frequently do you eat fast food: □ Daily □ Weekly □ Monthly □ Rarely □ Never
How much water do you drink daily: □ < 1 qt. □ 1 qt. □ 2 qt. □ > 2qt.
Is it filtered water? □**YES** □**NO**
Foods you avoid and why (i.e. allergies, diet, dislike): _____
Foods you crave: _____
Do you have (or have you had) an eating disorder? □**YES** □**NO** Diagnosis? _____
Did you receive treatment? □**YES** □**NO** If yes, when: _____
Do you drink coffee? □**YES** □**NO** If yes, how many cups daily of decaf _____ and caffeinated _____ Do you drink tea? □**YES** □**NO** If yes, what kind _____ and how many cups do you drink daily ____ Do you drink soda? □**YES** □**NO** If yes, what kind _____ and how many do you drink daily: _____

DEVELOPMENTAL HISTORY

Early Health History
List any known problems your mother had during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery): _____
Were you breast fed? □**YES** □**NO**. If yes, please indicate duration if known _____ Was your home life as a child loving/supportive? □**YES** □**NO** If there were significant stressors in your home, please describe
_____
Please check if you had any of the following childhood illnesses: □ Frequent ear infections □ Colic □ Eczema □ Recurrent colds □ Bronchitis □ Pneumonia □ Asthma □ Meningitis □ Other _____
As a child were you on frequent or prolonged antibiotic therapy? □**YES** □**NO**
Did you receive childhood immunizations? □**YES** □**NO** Did you experience any adverse reactions to immunizations? □**YES** □**NO** □**N/A** If yes, please describe _____
Are you up-to-date on your current vaccinations/immunizations? □**YES** □**NO**
If not, why: _____

PSYCHOSOCIAL HEALTH

Current Stress Factors

Please indicate if any of the major stresses listed below apply to you **(check all that apply):** □ Job □ New retirement □ New baby □ Change of marital status □ Health problems □ Family stress □ Financial concerns □ Abusive relationship □ Other:_____.

Please describe the quality of major relationships in your life: _____

_____

Indicate job satisfaction (if applicable): □ Excellent □ Good □ Fair □ Poor

Have you experienced physical, emotional, sexual, or verbal abuse in the past? □**YES** □**NO**

Are you experiencing fearfulness of being home because of a specific person, unwanted/hurtful physical, emotional, sexual, or verbal treatment at home? □**YES** □**NO**

Lifestyle Habits

Describe your sleep pattern: Time arise _____Time retire _____ Naps? _____

Your quality of sleep is:□ Well-rested □ Tired upon awakening □ Awaken during night.

Do you: □ Sleep in total darkness □ Sleep near electric clock, outlet, or other electronic device.

Your typical sleep position is: □ Side □ Back □ Stomach

Is your mattress firm? □**YES** □**NO** Pillow type (check all that apply): □ Firm □ Soft □ Thick □ Thin □ Feather □ Synthetic □ Orthopedic

What is the frequency of your vacations: ____ times / year. How frequently do you travel: □ Annually □ Semi-annually □ Monthly □ Weekly

Do you live/work in a damp or moldy home/office? □**YES** □**NO**

Do you exercise? □**YES** □**NO** If yes, type: _____Frequency:_____

How do you relax or relieve stress? _____

Do you use tobacco? □**YES** □**NO** If yes, list amount you smoke/chew per day and week _____Years using tobacco _____. If you no longer use it, when did you quit _____ Do you currently use recreational drugs? □**YES** □**NO** If yes, list type and frequency: _____

Did you formerly use recreational drugs? □**YES** □**NO** If yes, specify _____

Do you drink alcohol? □**YES** □**NO** If yes, list kind and amount per day or week_____

Do you have (or have you had) a problem with alcohol or drug overuse or abuse or dependency? □**YES** □**NO**

Have you ever been treated for an addiction problem? □**YES** □**NO** If yes, when: _____

Answer the following questions indicating the number: **0** = Not at all **1** = Several days **2** = More than half the days **3** = Nearly every day

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
   a. Little interest or pleasure in doing things - _____
   b. Feeling down, depressed, or hopeless - _____
   c. Trouble falling/staying asleep, sleeping too much - _____
   d. Feeling tired or having little energy - _____
   e. Poor appetite or overeating - _____
   f. Feeling bad about yourself or that you are a failure or have let yourself or your family down - _____
   g. Trouble concentrating on things, such as reading the newspaper or watching television. - _____
   h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual. - _____
   i. Thoughts that you would be better off dead or of hurting yourself in some way. - _____
2. If you checked off any problem above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Choose 1 answer:

Not difficult at all - _____

Somewhat difficult - _____

Very difficult - _____

Extremely difficult - _____

SPRITUAL HEALTH

Do you use prayer in your life? □**YES** □**NO**
How do you express your spirituality?_____
How does your spiritual/religious beliefs affect your health or illness? _____
_____
What are your spiritual goals? _____
_____
Do you have rituals or other spiritual practices that you use for illness(es)? _____
_____
Does your family also have the same spiritual/religious practices? □**YES** □**NO**
Is your family supportive of your spiritual/religious practices? □**YES** □**NO**
Do you consider yourself spiritual or religious? □**YES** □**NO**
Is spirituality something important to you? □**YES** □**NO**
Do you have spiritual beliefs that help you cope with stress/ difficult times? □**YES** □**NO**
What gives your life meaning? _____
Has your spirituality influenced how you take care of yourself, your health? □**YES** □**NO**
Does your spirituality influence you in your healthcare decision making (e.g. advance directives, treatment etc.)? □**YES** □**NO**
Are you part of a spiritual and/or a religious community (i.e., churches, temples, and mosques, or a group of like-minded friends, family, or yoga, can serve as strong support systems for some patients)? □**YES** □**NO**
Is this of support to you and how? _____
Is there a group of people you really love or who are important to you? □**YES** □**NO**
Do you want your spirituality/religious believes incorporated into your care? □**YES** □**NO**
How would you like me, your healthcare provider, to address/incorporate your spirituality in your healthcare?

FAMILY MEDICAL HISTORY

Adopted: ☐**YES** ☐**NO** ☐ **Unknown Family Medical History** ☐ **No Significant Family Medical History**

Family Member	**Illness(es)**	**Age of Onset/Diagnosis**	**Alive/Deceased**
Mother			
Father			
Brother (s)			
Sister (s)			
M. Aunt (s)			
M. Uncle (s)			
P. Aunt (s)			
P. Uncle (s)			
M. Grandma			
M. Grandpa			
P. Grandma			
P. Grandpa			

SNVHS Medical Care/Bodywork Clinic Policies

Sexual Harassment and/or Violence Policy

Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. The session will be terminated immediately, and you will be responsible for the cost of the session in full.

Acts or threats of physical violence, including intimidation, harassment and/or coercion, which involve or affect SNVHS, or which occur on Company property, will not be tolerated. This prohibition against harassment, threats and acts of violence applies to all patients and persons involved in the operation of SNVHS, including, but not limited to, SNVHS employees, contract and temporary workers and anyone else on SNVHS property. Violation of this policy, by any individual, will lead to immediate termination of the treatment relationship and/or legal action as appropriate. If termination occurs, you will be provided written notice of termination and a prescription for a one (1) month supply of any medications prescribed by SNVHS to give you an opportunity to find another provider.

Initials: _____

Personal responsibility and accountability

As patients or clients of SNVHS, you are agreeing to work together with your health care team. This means that in addition to coming to appointments/follow-ups as agreed, you will also agree to follow to the best of your ability the recommendations/directions provided by your health care team in relation to your agreed treatment plan(s). Changing or altering these recommendations/directions should be done in collaboration with your SNVHS health care team to ensure everyone on the team is knowledgeable of changes. If you choose not to comply with the health care team recommendations, it is SNVHS' right to terminate the relationship. If the relationship is terminated, you will be provided a prescription for a one (1) month supply of any medications prescribed by SNVHS to give you an opportunity to find another provider. You will also receive a letter indicating the termination date once the termination decision has been made.

Initials: _____

Cancellations & Late Fee Policy

Your business is valued and your cooperation is appreciated. We make a commitment to you to guarantee your appointment time and refusing all other's requests once you have made the appointment. A 24-hour cancellation notice is required for any scheduled appointments. Missed or no-call/no-show appointments will result in you being charged the FULL amount of the appointment (not to exceed $120). If you arrive late to your appointment, you may not receive the full session time allotted for the service booked, but full payment is required. Fees and all amounts owed must be paid prior to your next appointment. Emergency cancellations are allowed at the provider's discretion. Repeat no-shows or failure to provide appropriate time for cancellations, you may be asked to pay for your session at the time the appointment is made, OR SNVHS may choose to terminate services.

Initials: _____

Consent for Treatment of a Minor/Dependent

By my signature below, I hereby authorize a State Licensed Medical Provider at Sierra Nevada Holistic Services, LLC to administer care, treatment, and/or body work to my child or dependent, as they deem necessary.

Guardian Signature: _____ Date: _____

Your signature & initials indicate that you have read and agree to the terms listed herein.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, Sierra Nevada Holistic Services, LLC ("SNVHS") may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to SNVHS' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SNVHS reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at SNVHS, 407 W. Robinson St., Carson City, NV 89703.

With my consent, SNVHS may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist SNVHS in carrying out TPO, such as appointment reminder, and any call pertaining to my clinical care. With my consent, SNVHS may mail to my home or other designated location any items that assist SNVHS in carrying out TPO, such as appointment reminder cards, as long as they are marked "Personal and Confidential".

I have the right to request that SNVHS restrict how it uses or discloses my PHI to carry out TPO. However, SNVHS is not required to agree to my requested restrictions, but if it does, it is bound by this consent.

By signing this form, I am consenting to SNVHS use and disclosure of my PHI to carry out TPO.

SNVHS does not transmit any health care information in electronic form outside SNVHS. SNVHS does not file claims to any health plans, private or Medicare/Medicaid, or utilize a billing service or clearinghouse to file on their behalf. Nothing in these privacy procedures should be construed to voluntarily or involuntarily waive SNVHS' status as a "non-covered entity" under HIPAA. The HIPAA regulations are used merely as a guide for accepted privacy practices.

When my information is used or disclosed pursuant to this consent, it may be subject to redisclosure by the recipient and may no longer be protected by the applicable privacy laws. I have the right to revoke this consent in writing except to the extent that SNVHS have acted in reliance upon this consent. My written revocation must be submitted to SNVHS' Privacy Officer at SNVHS, 407 W. Robinson St., Carson City, NV 89703.

_____ _____

Date Signature of Patient or Legal Guardian

_____

Relationship to Patient

_____

Patient's Name

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Sierra Nevada Holistic Services, LLC 407 W. Robinson St., Carson City, NV 89703

Patient name: _____ **Date of Birth:** _____

Address: _____

SECTION A: Psychotherapy Notes

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, it must *not be* used as an authorization for any other type of protected health information.

SECTION B: The Use and/or Disclosure Being Authorized

Protected Health Information to be Used and/or Disclosed: Specifically, and meaningfully describe the protected health information you are authorizing to be used and/or disclosed:

☐ Discharge Summary
☐ Admission Note
☐ Psychiatric Assessment
☐ History & Physical
☐ Emergency Reports
☐ Consultations
☐ Operative & Pathology Reports
☐ Laboratory & Imaging Reports
☐ Treatment Plan & Evaluation
☐ Psychiatric/Psychological Assessment(s)
☐ Psychological Evaluation
☐ Treatment Plan Evaluation

Other: _____

_____

_____

SECTION C: Entities Authorized to Receive, Use or Disclose:

Name or specifically identify the persons or *organizations (or the classes of persons and/or organizations)*, including Sierra Nevada Holistic Services, LLC, who you are authorizing to receive, to make use of, and/or to disclose the protected health information described above. (Receipt of protected health information is limited to one health care provider per authorization form.)

I authorize information to be: *(check one or both)* ☐ released **TO: Sierra Nevada Holistic Services, LLC**
407 W. Robinson St., Carson City, NV 89703 Fax #: 775-884-4986

☐ released **FROM:** Sierra Nevada Holistic Services, LLC to

_____

(Name/Title/Organization) (Address)

_____ _____

(Name/Title/Organization) (Address)

_____ _____

(Name/Title/Organization) (Address)

_____ _____

(Name/Title/Organization) (Address)

SECTION D: Purpose

The information is being used/disclosed for the following purpose: Coordination of Care and Treatment Planning; continuity of care.

SECTION E: Expiration and Revocation

Expiration: This authorization will expire *(complete one)*:

☐ On_____(DD/MM/YR).

☐ On occurrence of the following event:
(which must relate to the patient or to the purpose of the use and/or disclosure being authorized)

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Sierra Nevada Holistic Services, LLC Privacy Officer. I understand that revocation of this authorization will *not* affect any action taken by Sierra Nevada Holistic Services, LLC in reliance on this authorization before my written notice of revocation was received. Written revocation should be sent to: Sierra Nevada Holistic Services, LLC Privacy Officer; 407 W. Robinson St., Carson City, NV 89703.

SECTION F: Alcohol & Drug Abuse Information

I understand that this authorization may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, or AID's-related information may be released.

SECTION G: Facsimile Communication

I understand that this information may be communicated by facsimile.

SECTION H: The Patient (or the Patient's Legal Representative) Confirming the Authorization

I understand that:

- this authorization is voluntary (you may refuse to sign);
- my health care and payment for my health care will not be affected if I do not sign this form;
- if the organization authorized to receive and/or use the information is not a health plan, health care provider, or health care clearinghouse subject to federal health information privacy laws, the released information may no longer be protected by federal privacy.
- information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected.

SIGNATURE:

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Sierra Nevada Holistic Services, LLC. I understand that, by signing this form, I am confirming my authorization that Sierra Nevada Holistic Services, LLC may receive, use, and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature of Patient:_____ Date: _____

Signature of Legal Representative: _____

42 CFR PART 2:

This information is from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of other information is not for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.