Registration Form

SECTION I: PATIENT INFORMATION

NAME (*LAST, FIRST, MI*):

DOB (MM/DD/YYYY):	SSN:	GENDER: ☐M ☐F ☐Other

ADDRESS:

CITY:	STATE:	ZIP:

PHONE: ☐Home ☐Work ☐Cell	PHONE: ☐Home ☐Work ☐Cell

EMAIL ADDRESS:

MARITAL STATUS: ☐Never Married ☐Married ☐Domestic Partnership ☐Separated ☐Widowed ☐Divorced

IF STUDENT, NAME OF SCHOOL:

ALLERGIES ☐Yes ☐No -- IF YES PLEASE SPECIFY:

EMERGENCY CONTACT:

PHONE: ☐Home ☐Work ☐Cell	RELATIONSHIP TO PATIENT:

SECTION II: RESPONSIBLE PARTY INFORMATION

NAME (*LAST, FIRST, MI*):	RELATIONSHIP TO PATIENT:

ADDRESS (If different from above):

CITY:	STATE:	ZIP:

PHONE: ☐Home ☐Work ☐Cell	PHONE: ☐Home ☐Work ☐Cell

SECTION III: INSURANCE INFORMATION

NAME OF INSURED:	INSURANCE CARRIER:
DOB:	POLICY #:
STATE:	

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐NO ☐YES IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED:	☐Self ☐Spouse ☐Parent
DOB:	SSN:

INSURANCE NAME:	STATE:	ID #:

****PLEASE NOTE:** Never Give Up only accepts some insurances. If you have another insurance plan in Nevada or any other state, even if it's in addition to Nevada Medicaid or a Nevada MCO, please, be aware that you will be responsible to pay in full all the services rendered. To avoid any misunderstandings, please, make sure you completely fill out "SECTION III" of this page.

Please, sign that you have read and understand this notice:

Signature:	Date:

SECTION IV: DEMOGRAPHICS

PRIMARY LANGUAGE:

ETHNICITY/RACE: ☐ American/Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian/Pacific Islander ☐ Hispanic/Latino ☐ Non- Hispanic Latino ☐ White ☐ Other (identify):

HIPAA POLICY

This policy describes how medical and Drug and Alcohol related information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Information regarding your health care including payment for health care is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d *et seq.*.45C.F.R. Parts 160 & 164, and the Confidentiality law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Under these laws, Never Give Up Behavioral Health Services (NGUBHS) may not disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

NGUBHS must obtain your written consent before it can disclose information about you for payment purpose. For example, NGUBHS must obtain your written consent before it can disclose information to your health insurer in order to be paid for services.

Generally, you must also sign a written consent before NGUBHS can share information for treatment purposes or for health care operations. However, federal law permits NGUBHS to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/business associate;
2. For research, audit, or evaluations;
3. To report a crime committed on NGUBHS premises or against NGUBHS personnel;
4. To medical personnel in a medical emergency;
5. To appropriate authorities to report suspected child abuse or neglect;
6. As allowed by a court order.

For example, NGUBHS can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care for you, as long as there is a qualified service organization business associate agreement in place.

NGUBHS can use or disclose any information about your health in manner that is not described above. It must first obtain your specific written consent allowing the disclosure. You may revoke any such written consent in writing.

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. NGUBHS is not required to agree to any restrictions your request, but if it does agree, then it is bound by that agreement and may not use or disclose any information that you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. NGUBHS will accommodate such request that are reasonable and will not request an explanation from you. Under HIPAA, you also have the right to inspect and copy your own health information maintained by NGUBHS, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or other limited circumstances as defined in 42 C.F.R.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in NGUBHS records and to request and receive an accounting of disclosures of your health related information made by NGUBHS during the six years prior to your request. You also have the right to receive a paper copy of this notice.

NGUBHS is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. NGUBHS is required by law to abide by the terms of this notice. NGUBHS reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Upon request, NGUBHS will mail you our most recent notice.

____ ______________________
Signature of Patient (If patient is a minor, Parent/ Legal Guardian signature required) Date

A copy of this notice will be provided to you.

PATIENT RIGHTS

As a patient for treatment services, you have the following rights regarding your medical information, if requested on the form(s) provided by the Never Give Up Behavioral Health Services (NGUBHS):

- **Right to request restriction**. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information..

- **Right to confidential communications.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

- **Right to inspect and copy.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
  We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- **Right to request amendment.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

- **Right to accounting of disclosures.** You may request a list of the disclosures of your health information that have been made to persons or entities during the past six (6) years prior to the request, except for disclosures for health care treatment, payment and operations, and disclosures based on patient authorization, or as required by law. After the first request, there may be a charge.

- **Right to restrict certain disclosures to a Health Plan**. You may request a restriction of certain disclosures of your protected health information to a health plan if you have paid out of pocket in full for the health care item or service.

- **Right to a copy of this Notice**. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.

- **Right to choose provider**. You understand your right to select a qualified provider of your choosing.

Requirements Regarding This Notice. NGUBHS is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. NGUBHS may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future. Each time you register at NGUBHS for health services, you may receive a copy of the Notice in effect at the time.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with:

Never Give Up Wellness Center
ATTN: Christina Parise, CSW-Intern
2675 S. Jones Blvd. Suite 102
Las Vegas, Nevada 89146

Office of Civil Rights
U.S Department of Health and Human Services
200 Independence Ave., S.W. Room 509, HHH Building
Washington, D.C. 20201

We will not penalize or retaliate against you in any way for making a complaint to NGUBHS or to the Department of Health and Human Services. We will notify you in the unlikely event of a breach of your unsecured protected health information. Contact NGUBHS at (702) 951-9751 if:

- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.

____ ____________________

Signature of Patient (If patient is a minor, Parent/ Legal Guardian signature required) Date

A copy of this notice will be provided to you.

By initialing each of the bolded items below, I agree to conform to these policies.

____ **CONSENT OF SERVICE (S)**
I understand I am entitled to treatment and rehabilitative care, which includes referrals to appropriate medical, psychological, and training services as a part of my treatment.

I will be informed of the nature, consequences, and purposes of the services available to me and any alternative plans and resources available.

I have a responsibility to comply with the conditions of admission to the program.

I understand that admission into the program does not grant power of attorney to Never Give Up Behavioral Health Services (NGUBHS).

I hereby grant consent for participation in evaluation and/or treatment at NGUBHS. This consent shall include all services provided by NGUBHS, except as excluded in writing.

If the individual named is a minor or an adult who has been adjudicated legally incompetent, I certify that I,____, am the legal guardian of such person and have the legal right to approve such services.

____ I authorize NGUBHS to leave phone messages, emails, text messages, including voicemails and answering messages, about scheduling, cancelling, or confirming appointments.

____ **APPOINTMENTS**
If you would like to schedule an appointment please call the office during our normal business hours, Monday through Friday, 9am- 5pm. Our telephone number is (702) 951-9751.

____ **CANCELLATION**
Regular attendance in therapy is crucial. We understand that things happen and illnesses occur, so we recommend that you only cancel when absolutely necessary. We ask that you inform the office staff ***as soon as you know you are unable to make an appointment.*** At minimum, please notify us of any cancellation 24 hours prior to your appointment, this allows us schedule other individuals in that time slot.

Please call and cancel if you or your child has any contagious illness or skin condition/rash. Also, if you or your child is so ill that you are unable to put forth the effort in therapy, please cancel and re-schedule your session for another day.

If you cancel three consecutive times or no-show for three appointments, please be advised that your therapist/counselor may place you on a waitlist or discharge you from care.

____ **FEES, BILLING, AND PAYMENT**
I hereby assign all medical benefits to which I am entitled to NGUBHS in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principle amount owed and all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney’s fees and all court costs and balances over thirty days old. I authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of NGUBHS as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability except in the case of negligence.

____ **NON-DISCRIMINATION**
As a patient of NGUBHS, I understand that NGUBHS, as a social service agency does not discriminate against any individual based upon a person’s race, age, sex, national origin, religious preference, disability, or sexual orientation.

By initialing each of the bolded items below, I agree to conform to these policies.

____ **CONFIDENTIALITY**

Federal Law and regulations protect the confidentiality of client records maintained by this agency. Generally, NGUBHS may not disclose to a person outside of the program that a client attends the program, or disclose any information identifying a client as such unless:

- The client consents in writing through a "release of information" form indicating the name of the person the disclosure is made, the program name of the person authorizing the disclosing of information, the specific information to be disclosed, and the timeframe of the release is valid.
- The disclosure is by court order.
- The disclosure is made to medical personnel in a medical emergency or to qualified personal for research, audit, or program evaluation

I give Never Give Up Behavioral Health Services permission to release information, verbal and written in the patient's medical records, and any other related information, to my insurance company, case manager, attorney, school personnel, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance and educational purposes.

Authorized Designees:

Name :____Relationship:________________________________

Name :____Relationship:________________________________

Name :____Relationship:________________________________

Name :____Relationship:________________________________

____ **LIMITS OF CONFIDENTIALITY**

The information we obtain about you will be kept confidential and will not be shared without your written permission. You have the right to cancel your permission at any time, either verbally or in writing. There are certain situations, mandated by law, when your information can be shared without your permission. Listed bellows are those situations:

1. If you threaten suicide
2. If you threaten to harm another person(s), including murder, assault, physical beating and sexual abuse.
3. If you report elderly abuse.
4. If you report sexual exploitation by your counselor.
5. If you are under 18 years of age and you report suspected child abuse or neglect, including but limited to physical beating and sexual abuse.
6. If you provide information about crimes you have committed or plan to commit.
7. Medical emergencies
8. Research activities
9. Program audits or evaluations
10. Court order
11. Litigation

IN CASE OF MEDICAL EMERGENCY

I, ______________________________ (name if Patient or Parent/Legal Guardian if Patient is a minor), give permission for contracted personnel of Never Give Up Behavioral Health Services to authorize medical treatment for myself or my child, ______________________________________(name if Child), in case of medical emergency.

____ ______________________

Signature of Patient (If patient is a minor, Parent/Legal Guardian signature required) Date