



**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

Preferred Pronouns: He/Him/His; She, Hers, Her; They, Them, Their

**MEDICAL HISTORY AND MEDICAL INFORMATION**

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 and amounts (prescribed OR over-the-counter), herbs, supplements, and vitamins that you are currently taking. **Please bring all medication bottles with you.**

Medication: \_\_\_\_\_ Reason for taking it: \_\_\_\_\_

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Medication: \_\_\_\_\_ Reason for taking it: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason for taking it: \_\_\_\_\_

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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*

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

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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

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**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

### BOTH:

1. During the past three months, have you leaked urine (even a small amount)?  Yes  No
2. When do you leak urine: (check all that apply)  A. With physical activity like jumping, or exercising, during coughing, sneezing, lifting?  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 a sense of urgency?  D. About equally as often with physical activity as with a sense of urgency?
3. Do you have lower abdominal pain?  YES  NO
4. Do you have dark urine or any yellowing of your skin or eyes?  YES  NO
5. 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?

- Little interest or pleasure in doing things - \_\_\_\_\_
- Feeling down, depressed, or hopeless - \_\_\_\_\_
- Trouble falling/staying asleep, sleeping too much - \_\_\_\_\_
- Feeling tired or having little energy - \_\_\_\_\_
- Poor appetite or overeating - \_\_\_\_\_
- Feeling bad about yourself or that you are a failure or have let yourself or your family down - \_\_\_\_\_
- Trouble concentrating on things, such as reading the newspaper or watching television. - \_\_\_\_\_
- 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. - \_\_\_\_\_
- 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 - \_\_\_\_\_

## SPIRITUAL 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 beliefs incorporated into your care? YES NO

How would you like me, your healthcare provider, to address/incorporate your spirituality in your healthcare?

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## FAMILY MEDICAL HISTORY

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

<u>Family Member</u>	<u>Illness(es)</u>	<u>Age of Onset/Diagnosis</u>	<u>Alive/Deceased</u>
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.

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Date \_\_\_\_\_ Signature of Patient or Legal Guardian \_\_\_\_\_

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Relationship to Patient \_\_\_\_\_

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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:

- |   |  |
|---|--|
| <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Operative & Pathology Reports           |
| <input type="checkbox"/> Admission Note         | <input type="checkbox"/> Laboratory & Imaging Reports            |
| <input type="checkbox"/> Psychiatric Assessment | <input type="checkbox"/> Treatment Plan & Evaluation             |
| <input type="checkbox"/> History & Physical     | <input type="checkbox"/> Psychiatric/Psychological Assessment(s) |
| <input type="checkbox"/> Emergency Reports      | <input type="checkbox"/> Psychological Evaluation                |
| <input type="checkbox"/> Consultations          | <input type="checkbox"/> 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.**