

DOB:

Patient Name:

Please read and circle each that apply.
Have you experienced any of the following symptoms in the past 48 hours:
fever or chills
cough
shortness of breath or difficulty breathing
fatigue
muscle or body aches
headache
new loss of taste or smell
sore throat
congestion or runny nose
nausea or vomiting
diarrhea
Known COVID exposure
Patient Signature:
Patient Name (print):



We strive to provide excellent medical care to you and to all of our patients. Consistent with this, we have developed appointment cancellation and no-show policies that allow us to better schedule appointments for all patients. When an appointment is scheduled, that time has been specifically reserved for you and when it is missed that time cannot be used to treat another patient in need of care.

We sincerely appreciate your assistance and cooperation as this allows for a smooth office flow and more efficiently uses your time.

We request all new patients arrive 30 minutes prior to their scheduled appointment and 15 minutes prior for established patients.

Our Cancellation and No-Show Policy is as follows:

We request that you please give our office at least 24-hour notice if you need to reschedule your appointment. If you do not provide us with a 24-hour notice, or you do not show up for a scheduled appointment, you may be charged a \$40 rescheduling fee. Additionally, you may be offered limited appointment times.

A new patient who is a no-show two times, and an established patient who is a no-show three times may not be rescheduled for future appointments and may be dismissed from the practice.

Our Late Arrival Policy is as follows:

For new patients, if you have not arrived at least 15 minutes before your appointment time or an established patient and arrive 5 minutes or more late to appointment, the appointment may be canceled or rescheduled.

If you have any questions regarding these policies, please let our staff know and we will be glad to speak with you in more detail.

I have read and understand the Pinnacle Medical Group Cancellation and No-Show Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

1	(print name) have read and received a
copy of Pinnacle Medical Group's Cancellation Policy.	
Patient signature and date	



Name:	500-500-500-500-500-500-500-500-500-500		DO	DB:
Provider:		Berry Commence of the Commence		
Reason for today's visit:	A distributed by the state of t		00°-00°-00°-00°-00°-00°-00°-00°-00°-00°	100 ACC L 100 - C 100 C 100 ACC L 10
Medication currently taking inc	luding strength and frequency	(include over the counte	er medications	
	deladada de la companya de la compa			

Allergies and reaction:	(Circle and initial if no	allergies) NO KNOWN D	RUG ALLERGIE	Sinitial
	vyver ook (daamies kein servivenisele). Macroer ook reserver ook voor ook voor ook voor ook voor ook voor ook v	W70707070707070707070707070707070707070		
Past Medical History:				
Acid reflux	Cancer, type and	year	High choles	sterol
Allergies	***************************************		Irritable bo	wel syndrome
Anxiety	Depression		Migraines	
Asthma	Diabetes		Seizure disc	order
Atrial fibrillation	Gout		Skin disorde	er
Blood clots	Heart disease		Stroke	
COPD/emphysema	High blood press	ure	Thyroid	
Other conditions:		***************************************		
Past Surgical History:				
Appendectomy	C-section	Hysterectomy		Tonsillectomy
Back surgery	Gallbladder	Joint surgery:		***************************************
Cataract	Hernia		oint	
Other surgery:				
Hospitalizations:				
1103promeditions				
Family Medical History (only lis	t health conditions and age of	diagnosis (if known)):		
Father:				
Mother				
Pat. Grandfather:				
Pat. Grandmother:				
Mat. Grandfather:				

Social History:				
Tobacco use yes no				
Year started	year quit	type	amo	unt
Alcohol use yes no	History of alcohol use y	yes no	Quit date	
How often	1	amount	WWW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000WW.000W	
Caffeine yes no ty	pe	amount		
Non-prescription drugs yes				
Exercise: Type	how often		duration	
Are you CURRENTLY having an	y of the following symptoms	(circle all	that apply):	
Chills	Cough	F	FEMALE ONLY:	
Fatigue	Shortness of breath	{	Breast lump	Cold Extremities
Fever	Wheezing	Į.	Breast pain	Ulcerations
Weight gain		{	Breast discharge	Burning in feet
Weight Loss	Chest pain	•	Hot flashes	Numbness in fee
	Leg cramps with walking	ı	rregular periods	
Nasal congestion	Swelling in feet/legs	1	Pain with sex	Change in mole
Seasonal allergies	Irregular heartbeat	,	Vaginal discharge	Rash
Sneezing		1	Last period	
Blurry vision	Abdominal pain		MALE ONLY:	Dizziness
	Blood in stool	-	Difficulty with urine stream	Gait abnormality
Loss of smell	Change in bowels	1	Erectile dysfunction	Headache
Ear pain	Constipation	1	Urinating at night	Memory loss
Hoarseness	Loss of appetite			Tremor
Sinus Pain	Diarrhea		Blood in urine	
Sore Throat	Difficulty swallowing	İ	Frequent urination	Anxiety
Swollen glands	Heartburn		Leakage of urine	Depression
	Nausea		Pain with urination	Insomnia
Cold intolerance	Vomiting		Back pain	
Excessive thirst			Joint pain	
Hair loss	Easy bruising		Swollen joints	
Heat intolerance	Easy bleeding		Weakness	
Screening test – please specify	date and location		Vaccinations – please specify	dates
Colonoscopy		Wannish.	COVID	
Mammogram			Tetanus vaccine	
Pap smear			Influenza vaccine	
Bone density			Pneumococcal vaccine	
Labs			Shingles	
Name:			Today's Date:	NAMES AND ASSESSMENT OF THE STATE OF THE STA
Signature:				

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:		DATE:-	······································	
Over the last 2 weeks, how often have you been				
bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. If you checked off any problems, 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?		Somewl Very dif	icult at all nat difficult ficult	



PINNACLE MEDICAL GROUP CONTROLLED SUBSTANCE POLICY

Pinnacle Medical Group providers may not prescribe long term-controlled substances except in rare instances. There is no proven long term health benefits from these medications and Nevada statutes prohibit this practice. Also, there is the substantial risk of potential bodily harm when these medications are taken long term.

Chronic pain medications such a hydrocodone and oxycodone may not be prescribed long term. Patients currently taking these may be put on a weaning protocol or must establish with pain management to continue to get these medications. Patients will be offered alternative treatment options which can include physical therapy, acupuncture, Tylenol, Lidocaine patches, topical capsaicin, or other medications such as Cymbalta.

Benzodiazepines taken for anxiety may not be continued. These medications include Xanax (alprazolam), Ativan (Lorazepam, Valium, diazepam) and several others. These medications are associated with long term memory impairment and increased risk of falls. If a patient is currently taking a high dose, a weaning protocol or substitution may be made until you are safely off these medications. Other treatment options will be implemented which may include medications approved to treat anxiety, cognitive behavioral therapy, or a psychiatric referral.

If a patient is taking medications for insomnia such a Xanax (alprazolam), Ativan (lorazepam), Restoril (temazepam), Valium (diazepam), Ambien (zolpidem), Lunesta (eszopiclone), or Sonata (zaleplon) these may not be continued. These act on the same receptors as the benzodiazepines which are associated with memory impairment, increased risk of falls, delirium, and accidents. Safe alternatives include trazodone and Rozerem (ramelteon), or a referral for cognitive behavioral therapy.

By signing below, you agree to the terms of our prescribing practices at Pinnacle Medical Group.

Patient Name (Please Print)	Date of Birth
, and the second	
 Patient Signature	 Date
Tallette Signature	
Provider Signature Provider Signature	Date



PINNACLE MEDICAL GROUP REGISTRATION FORM

Today's Date: PCP: PATIENT INFORMATION												
PATIENT INFORMATION												
Patient's last name:		Fir	rst:				Middle:		M	arital status		
Race:	Ethnicity	·		T	Preferred Language:	auenal	St. Attraction of transportation and Assertation and Statement	Birth da	Birth date:		Age:	Sex
									54558 8900000			OMOF
Address:												
Social Security no.:			Home phone no.:		73		***************************************	С	elp	hane no :		
Occupation:			Employer:					£	mp	oyer phone	no:	
EMAIL ADDRESS:	annanana dan samur ah-Ammanni	gaacaaaa		eacediness were	PHARMACY NAME A	NO	STREET:					
		************	00000000000000000000000000000000000000		URANCE INFORMATION		y.k.yb4004-00000000000000000000000000000000	***************************************	**********	***************************************	**************************************	oogaanaanaanaanaalaan marannaatii mii 1856 saattii anoosaatiin mii 1866 saattii anoosaatiin marannaa 1866 saattii
			(Please give	·	r insurance card to the	rec	eptionist.)					
Person responsible for bill:	Birth da	ete:		Add	ldress (if different):			Home phone no				
Is this person a patient here?	O Yes	0	No	(s t)	this patient covered by insurance?			O Yes O No				
Occupation:	Employ	/er:		Em	Employer address:			Employer	phone no.:			
Please indicate primary insuran	ce: (Choo	se an il	tem] Other: [Othe	rins	urance]							
Subscriber's name:		Subsc	riber's S.S. no.:		Birth date:	Gre	oup no.:			Policy no.:	0000001/	Co-payment:
Patient's relationship to subscri	ber:			***************************************				***************************************		Bassacco	***************************************	ti de la companya de
Name of secondary insurance (i	f applical	ole):			Subscriber's name:					Group no.	*	Policy na.:
Patient's relationship to subscri	ber: [Cho	ose an	item] Other: [Rel	ation	ship to subscriber)							
	***************************************				CASE OF EMERGENCY			•••••	*************	95-93	opremon-essentérenmeurouside	***************************************
Name of local friend or relative (not living at same address): Relationship to patient:					ient:	Home ph	on€	? no.;	Work ph	one no.:		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize (Name of Practice) or insurance company to release any information required to process my claims.												
Patient/Guardian signature Date												



CONSENT FOR TREATMENT/ FINANCIAL RESPONSIBILITY (REQUIRED)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pinnacle Medical Group or insurance company to release any information required to process my claims. I hereby voluntarily consent to the rendering of care, including treatment, administration of anesthesia and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of Pinnacle Medical Group and it is the responsibility of the staff to carry out instruction of its physicians/providers.

Patient/Guardian Signature		Date
	PATIENT AGREEMENT	
This AGREEMENT confirms your responsibilities		
Medical Group which is available for me at this the Health Insurance Portability and Accountal protected health information. I understand that	s and subsequent visits to pility Act of 1996 (HIPAA) I at this information can and	have certain rights to privacy regarding my d will be used to:
 Conduct, plan & direct my treatment ar treatment 	nd follow up among the m	ultiple health providers involved in my
 Obtain payment from third party payer 	S	
 Conduct normal healthcare operations 	such as quality assessmen	ts and physical certifications
 I understand that as part of my health of 	are, Pinnacle Medical Gro	oup may need to reach me by phone.
() I DO authorize Pinnacle Medical Group to laboratory/test results and imaging studies. He require medication follow-up or discussion will () I DO NOT authorize Pinnacle Medical Groany type of testing results. I will accept the results.	owever, I understand that I require that I make an ap up to leave message on m	sensitive information and/or results that will pointment with the physician. y telephone (home, cell, or work) regarding
Please list all relatives, friends, in which we ma	ay discuss your results with	h:
Name	Phone Number	Relationship
1.	LANGE AUGUST AUG	
2		
3.		Alak Alak III
Patient Name:		DOB:
(Please Print)		



Release of Information (initials) My physician and authorized staff may disclose all corporation which is or may be liable under a contract to the physemployer of the patient of physician(s) charges, including but limit	sician(s) or to the patient or to a family member or ted to, insurance companies, worker's compensation
Patlent Portal(initials) I am aware that by providing my doctor's office wit medical chart via the patient portal. I will be able to access my ap non urgent medical questions, lab results, and more.	
Electronic Prescribing(initials) Pinnacle Medical Group is enrolled in an electron our providers with understanding what medications our patients treatment. I give Pinnacle Medical Group permission to request a healthcare providers.	are currently using and to provide the best possible
Fee for Service(initials) Services are rendered to the patient, not the insuclaim. All CO-PAYS and DEDUCTIBLES are due in full at the time of patient's responsibility to follow up with their insurance carrier a responsibility. Payment will be due in full.	f service. For unpaid claims over 45 days, it is the
Non-Covered Services (initials) It is the responsibility of the patient to know what will be covered or excluded from your policy. If a service is NOT of that service. Pinnacle Medical Group and its providers are not resunder your insurance policy. By signing, you agree to accept full the determined by the health care service plans not to be covered. The Medical Group to obtain necessary health care service authorizate considered medically covered services by my health plan and pay Assignment of Benefits (initials) I authorize the release of any information necessary nealth care service plans. The undersigned agrees that I am in	sovered, the patient will be responsible for payment of sponsible for knowing policy coverages and exclusions financial responsibility for all services, which are the undersigned agrees to cooperate with Pinnacle tions. I understand that not all services provided are ment will be due at the time of service. Sary to process my insurance claims and assign and ad that Pinnacle Medical Group with multiple but not dividually obligated to pay the full charges of all
services rendered to me by Pinnacle Medical Group if I belong to Group.	
Patient Name:	DOB:

(Please Print)



Medicare Assignment of Benefits (Medicare Patients Only) (initials) I request that payment of authorized Medicare benefits services furnished me by Pinnacle Medical Group. I authorize an release to the Health Care Financing Administration and its agents a benefits payable for related services. I understand my signature recretease of medical information necessary to pay the claim. If other 1500 form or elsewhere on other approved claim forms, my signature recreased insurer or agency shown. Pinnacle Medical Group accepts the charge charge, and I am responsible only for the deductible, coinsurance a deductible are based upon the charge determination of the Medical Medigap (Medicare Patients Only) (initials) I understand that if a Medigap policy or other health form or elsewhere on other approved claim forms, my signature and agency shown. I request that payment of authorized secondary instances to me I HAVE READ AND FUPINNACLE MEDICAL GROUP PATIENT AGREEMENT AND THE INFORPACKET AS INITIALED BY ME.	by holder of medical information about me to any information needed to determine these quests that payment be made and authorizes health insurance is indicated in Item 9 of the HCFA are authorizes releasing the information to the ge determination of the Medicare carrier as the full not non-covered services. Coinsurance and are carrier. The insurance is indicated in Item 9 of the HCFA 1500 athorizes release of the information to the insurer or urance benefits be made on my behalf to Pinnacle DLLY UNDERSTAND AND ACCEPT THE TERMS OF THE
PACKET AS INITIALED OF IVIE.	
Patient Signature	Date

Patient Name:_____

(Please Print)

DO8:____



For	Internal	Use	Only:	MRN
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Patient Consent Form for Electronic Exchange of Individual Health Information

		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	988 988 sedent (1980 to 1980 to
Please read through the	consent form and provide the folk	owing information: (Please Print)	
PATIENT NAME	First	Middle	
PREVIOUS NAME(S)		GENDER: M	
STREET ADDRESS / P.O. BOX			
CITY	STATE	ZIP CODE	
PHONE NUMBER	EMAIL	VIII. 100 100 100 100 100 100 100 100 100 10	
DATE OF BIRTH(MM)	(DD) (YYY)	Y)	
Nevada Medicaid Patients Pleas or insurance pursuant to the Children's identifiable health information disclosed recipient, it is the patient's responsibility indicate your acknowledgement.	Health Insurance Program may rd electronically" (NRS 439,539). V	not opt out of having his or her indi When a patient is no longer a Medi	vidually caid
Consent Choices: (CHECK ONE) N Your choice to give or to deny conse	levada Medicaid Patients are on the may not be the basis for deni	exempt from making a selection ial of health services.	n.
I CONSENT for all HIE participant information) in connection with provide	ts to access ALL of my electron ling me any health care service:	nic health information (including se, including emergency care.	sensitive
I CONSENT ONLY IN CASE OF A health information (including sensitive	AN EMERGENCY for all HIE pa information) ONLY in the event	articipants to access ALL of my e t of a medical emergency.	lectronic
I DO NOT CONSENT for any HIE the event of a medical emergency.	participants to access ANY of	my electronic health information	EVEN in
		Date Time	
Signature of patient or authorized rep			
If I sign this form as the Patient's Authori "my" refer to the Patient.	zed Representative, I understand	d that all references in this form to	'I", "me" or
Name of Authorized Representative (Pri	nted) Relationship	Date	Time
Address of authorized representative sig	ining this form (please print):		
Phone number of authorized representa	tive		
FOR INTERNAL USE ONLY Name of Organization: As a witness to this Consent, I attest that the satisfactory photo ID, insurance card, or other contents.	Name of V	to me or has established his/her identi	ty with me by



### **Medical Records Consent**

Patient Name:		DOB:
Today's Date:		
Patient Name:		MANAGEMENT CONTRACTOR OF THE C
Address:		
City, State, Zip:	annochaitheannann ann ann ann ann ann ann ann ann	
Patient Phone Number:		
Please send my medical information	to:	
Pinnacle Medical Group:	Facility to Obtain/Sen	d Records:
(fax)		
775-204-4000 (phone)	ALL AND	
Reason for Request/Release:		
Above- listed patient authorizes the continuation of care:	following healthcare facility to the release	ase/request record disclosure for
Entire Record	Lab Reports	Diagnostic Reports
Radiology Reports	Discharge Summary	History and Physical reports
Pathology Reports	Medication List	Consultation Reports
Psychiatry/Mental Health	Progress Notes	Other:
acquired immunodeficiency syndrom	ealth record may include information rela e (AIDS), or human immunodeficiency vir rvices, and treatment for alcohol and dru	us (HIV). It may also include information
writing and present my written revocation will not apply to information that the revocation will not apply to a claim under my policy. Unless othe signature. I understand that authorize authorization. I need not sign this for the information to be used or disclost carries with it the potential for an unconfidentiality rules. If I have question individual or organization making discontinuous will be used or disclost carries with it the potential for an unconfidentiality rules. If I have question individual or organization making discontinuous	ration to the health information managent ion that has already been released in responsion that has already been released in responsion with a property of the law property of the disclosure of this health information in order to assure treatment. I understed, as provided in CFR 164.524. I understeauthorized redisclosure and the informations about disclosure of my health informations.	conse to this authorization. I understand vides my insurer with the right to contest pire 180 days following the date of ion is voluntary. I can refuse to sign this cand that I may inspect or obtain a copy or and that any disclosure of information ion may not be protected by federal tion, I can contact the authorized
	an is free of charge, however, if we relea facility then there will be a 0.60 fee char	
I have read the above foregoing Authwith and fully understand the terms		do hereby acknowledge that I am familia
Patient Signature		Date