Hope
Christian
Health Center

Hope Christian Health Center Registration Form

Patient Legal Name (Last, First ,Middle):

Home Address:

City:	State:	Zip Code:
Date of Birth:	SSN:	Today's Date:
Phone:	Email:	

Patient / Legal Guardian Name(s) if under 18:
1.
2.

Sex at Birth:
☐ Male ☐ Female

Languages Spoken
☐ English ☐ Spanish
☐ Other :___________

Preferred Method of Contact:
☐ Phone Call ☐ Text
☐ E-Mail

Are you a US Veteran? ☐ Yes ☐ No

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status:
☐ Single
☐ Married
☐ Partner
☐ Divorced
☐ Widowed
☐ Legally Separated

Sexual Orientation:
☐ Straight or heterosexual
☐ Lesbian, gay, or homosexual
☐ Bisexual
☐ Do not know
☐ Choose not to disclose
☐ Something else, please describe:
____

Primary Insurance Name:
Member ID: ___________
Group Number: ___________

Secondary Insurance Name:
Member ID: ___________
Group Number: ___________

Race:
☐ White/Caucasian
☐ Asian
☐ American Indian/Alaska
☐ Native Black/AfricanAmerican
☐ Native Hawaiian/Pacific Islander

Barriers to Communication:
☐ Auditory Impairment
☐ Visual Impairment
☐ Speech Difficulty
☐ Limited English Proficiency
☐ Difficulty Writing
☐ Difficulty Reading

Emergency Contact:
Name:
Relationship:
Phone Number:

How did you hear about us?
☐ Friend/Family/Coworker
☐ Insurance/ Provider List
☐ Health Fair/ Event
☐ Google/ Yelp/ Social Media
☐ Other___________

Do you consent to receive communications from our electronic health record (eCW)?
☐ Text Message ☐ Email
☐ I do not wish to receive electronic communications

Sliding Fee Discount Program Acknowledgement:
I understand that this health center offers a Sliding Fee Discount Program based on family size and income. I have been informed of my right to apply and understand that I may request additional information at any time.
☐ Yes ☐ No

Employer Name & Address:

Pharmacy Name & Address:

Housing Status:
☐ Rent ☐ Other___________
☐ Own
☐ Living w/ Family or Friend

Do you need help with a Medicaid or SNAP application?
☐ Yes ☐ No

Do you have an Advance Directive or Durable Power of Attorney?
☐ Yes ☐ No

In the last 6 months, has lack of transportation kept you from attending medical appointments?
☐ Yes ☐ No

Which income bracket describes your situation best?
☐ < $25,000
☐ $25,501-$45,000
☐ $45,001-$65,000
☐ $65,000-$80,000
☐ > $80,000+

Prayer Request: ___________
____
____
____
____

Hope Christian Health Center

Hope Christian Health Center - Patient Health

Patient Name:			Date of Birth:		
Significant Illnesses	***Y***	***N***	***HealthScreening***	***Y***	***N***
1. Diabetes 1 or 2			4.Mammogram		
2. Cancer: ___________________________			5.BoneDensity		
3. High Blood Pressure			6.Colonoscopy		
4. Gout			7.ChestX-ray		
5. Heart Disease			8. Tetanus Vaccine		
6. Kidney Disease			9. MMR Vaccine		
7. Anxiety/Depression			10. TB Test		
8. Stroke/TIA			11. Prostate Exam		
9. Asthma/COPD			12.EKG		
10. High Cholesterol			13. Hepatitis Vaccine		
11. Other: ____________________________			14. Pneumonia Vaccine		
Health Screening	***Y***	***N***	15. Flu Vaccine		
1. Physical			16.ChildhoodImmunization		
2. Eye Exam			17. Shingles Vaccine		
3. Pap Smear			18.STDS		

List Allergies	***List Current Medications***
1	1
2	2
3	3

Hospitalizations (List Reasons for Visit)	***Year***
1	
2	
Surgery History	***Year***
1	
2	

PHQ2	***Y***	***N***	***Additional Info***
Over the past 2 weeks have you had little pleasure in doing things?			
Over the past 2 weeks have you been feeling down, depressed and hopeless?			
Do you feel safe in your household?			
Do you have an Advance Directive?			
Would you like an Advance Directive?			

Family Medical History (Has any blood relative, including children, had):			
History of:	**Y**	**N**	**Relationship**
Anemia			
Cancer			
Diabetes			
Epilepsy			
Heart Disease			
High Cholesterol			
Stroke			
Tuberculosis			
Colon Polyps			
Asthma or COPD			
Drug Abuse			
Alcohol Abuse			
Mental Illness			

Social History	Y	N	Frequency
1. Tobacco			Number of years: ________ Number of cigarettes per day: ________
2. Alcohol			Drinks in a week:
3. Caffeine			Cups in a day:
4. Recreational Drugs			Times used a week:
5. Exercise			
6. Number of Adults and Children in home			Adults: _______ Children: _______
7. Religion			8. Education Level __________________________

Sexual History	Y	N	Additional Info
Are you sexually active?			
Within the past year?			
With: ☐ Men ☐ Women ☐ Both			
Do you use protection?			
Type: ☐ Condom ☐ Abstinence ☐ Other			
Have you had an STD or STI?			

Spiritual History	Y	N	Additional Info
Do you have spiritual beliefs that help w/ stress?			
Do your beliefs influence your phys. health?			
Are you part of a spiritual community?			
If yes, which one?	Spiritual comm./Church:		
Does this help support you?			
Would you like this addressed in your care?			

Additional Health Behaviors	Y	N
When was your last dental visit? Date:		
Do you have a regular sleep schedule?		
Are you exposed to chemicals at work?		

Hope Christian Health Center

Review of Systems

Patient Name:				Date of Birth:	
General	✓	***Men Only***	✓	***Ear, Nose, Throat***	✓
Swollen Glands		Erection Difficulties		Mouth Pain	
Lack of Energy		Lump in Testicles		Jaw Pain	
Fatigue		Sore on Penis/Scrotum		Pain in Teeth	
Fever		Penis Discharge		Sore Throat	
Night Sweats		Other:		Difficulty Swallowing	
Sleep Disturbance		***Gastrointestinal***	✓	Hearing Loss	
Weight Gain		Nauesa		Ringing in Ears	
Weight Loss		Vomiting		Ear Pain	
Allergy/Immunology	✓	Diarrhea		***Neurologic***	✓
Nasal Congestion		Abdominal Pain		Numbness	
Sneezing		Bloody Stools		Dizziness	
Runny Nose		Change in Bowel Habits		Frequent Headache	
Frequent Nosebleeds		Nausea/Vomiting		Memory Loss	
		Constipation		Seizures	
		Endocrine	✓	Tremor	
Women Only	✓	Thyroid Problems		***Respiratory/Cardio***	✓
Abnormal Pap Smear		Goiter		Cough	
Bleeding Between Periods		Frequent Urination		Shortness of breath	
Extreme Menstrual Pain		Abnormal Thirst		Swelling	
Breast Lumps		Change in Appetite		Fast heartbeat	
Nipple Discharge		Delayed Wound Healing		Skipping heartbeat	
Painful Intercourse		***Psychiatric***	✓	***Skin***	✓
Hot Flashes		Anxiety		Acne	
Vaginal Discharge		Depression		Skin Rashes	
Date of LMP: _________________		Mood Swings		Skin Lesions	
Date of Pap smear: ____________		Suicidal Thoughts		Abnormal Bruising	
Are you pregnant? _____________				Itching	
Number of children? ___________		***Ophthalmologic***	✓	Concerning Moles	
Last mammogram? ____________		Changes in Vision		***Muscle/Joint/Bone***	✓
		Blurred Vision		☐ Arms ☐ Hips ☐ Arthritis	
		Eye Pain		☐ Back ☐ Legs ☐ Shoulder	
		Eye Irritation		☐ Feet ☐ Neck ☐ Chest pain	
				☐ Hands ☐ Joint pain/weakness	

Hope
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Authorization to Disclose Medical Information

Patient Name:	Date of Birth:
I voluntarily authorize Hope Christian Health Center to disclose my health information to the recipient/s that I have identified below: Name:________________________ Relationship:________________ Telephone:_______________ Name:________________________ Relationship:________________ Telephone:_______________	
Protected or Sensitive Information I understand that certain information cannot be released without specific authorization as required by State/Federal law: ☐ Drug Abuse Diagnosis/Treatment ☐ Sexually Transmitted Diseases (to include AIDS/HIV) ☐ Alcoholism Diagnosis/Treatment ☐ Mental Health/Treatment	
This authorization for release of information covers the period of healthcare from: ☐ (a)__________________________ to __________________________ ☐ (b)All past, present and future periods.	

Right to Revoke: I understand I have the right to revoke this authorization at any time. I understand to revoke this authorization I must do so in writing. I understand that this revocation will not apply to information that has already been released.

*This form is valid 12 months from the date of signature unless revoked prior to that date.

Signature:____ Date: ________________
(Signature of Patient or Authorized Legal Representative)

Office Policies and Financial Agreement

ABOUT US: Our vision is to be a movement of God's people who, in response to His grace, choose daily to promote healing as they take part in the redemptive work of Christ among those who feel economically, socially, and spiritually marginalized in Las Vegas. Hope Christian Health Center (HCHC) provides affordable and excellent healthcare for all. Should you have any questions about our policies, please call the office during business hours.

LATE POLICY & CANCELLATIONS: Please provide at least 24 hours' notice if you cannot keep your appointment. If you are running late, please call us to inform us. If you arrive more than 15 minutes late, we may need to reschedule your appointment. If you accumulate 3 missed appointments, your scheduling privileges may be limited to scheduling same-day appointments only.

CONFIDENTIALITY: We strictly control access to your information, and any unauthorized use would be considered a breach of trust. All information provided to any staff member or volunteer is protected under the HCHC Confidentiality Policy.

Our clinic uses Commure AI Medical Scribe, an AI-assisted documentation tool, to help ensure accurate and efficient documentation of your medical visits. Commure AI Medical Scribe is HIPAA-compliant and protects your health information in accordance with federal privacy regulations. If you do not wish to participate, please let your healthcare provider know.

Staff at HCHC are mandated reporters in cases where there is suspicion that a client or another named individual is the perpetrator, observer, or victim of physical, emotional, or sexual abuse, or neglect. We are also mandated reporters for threats or attempts to commit suicide, serious bodily harm, or death to another person, or if someone behaves in a way that poses a substantial risk of serious bodily injury.

If you need a copy of your medical records, including labs, X-rays, or other tests, please provide HCHC with at least 30 days notice before picking up your records. You will be required to sign a release of information form.

Please note: HCHC is not a pain management clinic

REFERRALS: Please allow 7-10 business days for all referrals to be processed.

PAPERWORK: Requests for patient forms are typically processed within 7–10 business days. This timeframe may be extended if further testing, specialist consultation, or review of medical records is necessary. Documents will be filled out at your provider's discretion.

EMERGENCY CARE: Patients discharged from the hospital are to return to HCHC within 1-2 weeks for follow-up.

INSURANCE: It is the patient's responsibility to provide the clinic with current insurance information. If you are not insured by any medical insurance carrier, please ask about our Sliding Fee Scale Program (SFSP). If your visit requires lab tests, X-rays or other radiology procedures performed outside our facility, these services will be billed to you directly by the provider. We will give the providers all your insurance information.

- I understand that I am responsible for all charges not covered by my insurance company, including those resulting my failure to obtain the necessary referral and/or authorizations from my primary care.
- I hereby authorize HCHC to release the information necessary to file and/or process a claim with my insurance company.
- I understand that if I cannot pay my bill in full, I am obligated to sign a promissory note.

COPAYMENTS, DEDUCTIBLES & CO-INSURANCE: All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your co-payments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan. If you're unable to make your payment, please ask about our Sliding Fee Scale Program.

FORMS OF PAYMENT: We accept cash, checks, & credit/debit cards.

PRESCRIPTION REQUESTS:

- Patients requesting new prescriptions or antibiotics must be seen for an appointment by a clinician. They are not prescribed over the phone.
- Please allow 48–72 hours to process prescription requests. Medications requiring pre-authorization may require additional time to process. Please plan ahead for refills during holidays and when traveling.

CONSENT FOR TREATMENT:

By signing below, I authorize Hope Christian Health Center (HCHC) to evaluate, treat, and diagnose as deemed medically appropriate. I understand that it is my responsibility to notify my provider at least 72 hours in advance for prescription refill requests.

I acknowledge that I have read, understand, and agree to the Office Policies and Financial Agreement.

Patient Name:____ **Date:** ________________________

Signature of Patient or Authorized Legal Representative____

Authorization to Disclose Protected Health Information

Name: ______________________________ DOB: ______________ Phone: ______________

I hereby authorize any or all of the parties below to release to Hope Christian Health Center my PHI (Protected Health Information), including diagnosis, records of treatment, consultation or examination, diagnostic laboratory testing results, radiology reports, ancillary resting reports, including mental health/substance abuse or HIV/AIDS related treatment rendered to me on the following dates listed below. I understand that Hope Christian Health Center might not be the ordering or referring provider for the above PHI, but as my PCP (primary care provider), I request a copy be disclosed to said provider/office. Authorizing this release of information is voluntary and I may refuse to sign this authorization. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand this release of information expires after 1 year from the date of signature. This authorization is revocable by me at any time.

Please send the following records as soon as possible for the date(s) ________________ / most recent:

☐ All Records	☐ Immunizations	☐ Progress Notes	☐ MRI/CT of ____________
☐ Lab Reports	☐ Colonoscopy	☐ Medications	☐ US of ________________
☐ Hospital Records	☐ Mammogram	☐ Psychiatric/	☐ X-ray of ______________
☐ Pap Smears	☐ History&Physical	Mental Health	☐ Other ________________

Please check below which facility we can acquire your medical records from:

Hospitals:

☐ UMC Hospital
☐ North Vista Hospital
☐ ER @ Aliante
☐ Centennial Hills Hospital
☐ Mountain View Hospital
☐ St Rose Dignity Health
☐ Desert Springs Hospital
☐ Valley Hospital
☐ Sunrise Hospital
☐ Guadalupe Medical Center
☐ Mike O'Callaghan Medical

Clinics:

☐ Care Now Urgent Care
☐ Nevada Health Centers
☐ Guadalupe Medical Center
☐ Southwest Medical Associates
☐ Intermountain Health
☐ VA Southern Healthcare System
☐ UMC Quickcare
☐ WHASN: _____________(location)

Radiology/Laboratory:

☐ Desert Radiologist (DR)
☐ Quest Diagnostics
☐ Simon Med
☐ LabCorp
☐ Pueblo Medical Imaging (PMI)
☐ Steinberg Diagnostic Medical Imaging (SDMI)

Other:

Facility/Provider: ____________________ Phone: __________ Fax: __________
Facility/Provider: ____________________ Phone: __________ Fax: __________
Facility/Provider: ____________________ Phone: __________ Fax: __________

______________________________________ ______________________________
Signature of Patient or Authorized Legal Representative Today's Date

______________________________________ ______________________________
Print Name Relationship to Patient (if not the patient)

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 9, 2026 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Office. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $0.20 for each page and the staff time charged will be $20 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider’s refusal of an individual’s request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities. Including the disclosure of your PHI in the event of transfer, merger, or sale of the existing practice to a new provider.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 0.10 for each page. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US: Hope Christian Health Center
Telephone: 702-644-4673 **Fax:** 702-902-5443 **Email:** fax@hopehealthvegas.org
Physical Address: 4040 N. Martin L. King Blvd Suite A. North Las Vegas, NV 89032

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature of Patient or Authorized Legal Representative

____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

______________________________ ______________________________

______________________________ ______________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

____

____

____

____ ________________

Employee signature *Date*

This form does not constitute legal advice and covers only federal, not state, law.