# *Southern Nevada Occupational Health Center*

4060 N. MARTIN LUTHER KING BLVD., Ste 101
N. LAS VEGAS, NV 89032
PHONE: (702) 380-1712
FAX: (877) 361-1165

REGISTRATION SHEET

**NAME:** ______________________________ **DATE OF BIRTH:** ______________

**SS#:** ______-______-______ **GENDER: M / F** **MARITAL STATUS:** ______________

**RACE:** ____________ **CELL:** ________________ **Phone:** ____________________

**DRIVERS LICENSE:** ____________________

**EMAIL ADDRESS:** ______________________________________

**ADDRESS:** ______________________________________ **APT#:** ____________

**CITY/STATE:** ______________________________________ **ZIP:** ____________

**NAME OF EMPLOYER:** ______________________ **WORK PHONE:** ____________________

*Thankyou.*

*SOUTHERN NEVADA OCCUPATIONAL HEALTH CENTER*

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North Las Vegas, NV 89032
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## CONSENT TO TREATMENT AND CONDITIONS OF ADMISSION

**GENERAL POLICY:** All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping conditions.

**My primary language is** ___________________________________________

Initial: _____ **PERSONAL VALUABLES:** This facility does not assume responsibility for lost or stolen items. The facility encourages that personal valuables be left at home or given to family or friends for safekeeping.

Initial: _____ **NON-SMOKING POLICY:** In accordance with regulatory agency standards, this facility is a non-smoking facility. I have received smoking cessation information. If I wish assistance on quitting smoking I may contact the Nevada Tobacco Users Helpline at (1-800-784-8669)

**CAMERAS AND SURVEILLANCE EQUIPMENT:** Patient has been advised the facility uses cameras and other surveillance equipment to monitor patient/employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

**EMERGENCY DEPARTMENT only/ PPO PHYSICIAN NOTIFICATION:** It is the responsibility of the patients to inform the hospital of the primary care physician. If the hospital is unable to contact or utilize the services of your physician, a non-PPO physician may be assigned to you. This could result in an increase in cost to you, the patient.
My Primary Care Physician is: ____________________________________________________

Initial: _____ **USE OF THE EMERGENCY DEPARTMENT:** I understand that my insurance carrier/ 3rd party payor have the right to review my record for the use of emergency department. I understand that if the reason for my visit is determined by my insurance/ 3rd party payor to be a non-emergency, I will be responsible for the bill. I will be responsible for my triage bill, if after triage I decide to leave the Emergency Department without being evaluated by an ER physician.

**HMO/PPO CLAIM REVIEW:** If the patient is a member of a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), the insurance plan may not cover the physicians' or hospital's services or the benefits may be reduced if the physicians or hospital are not participating providers with insurance organizations. Many HMO/PPO Health Plans review emergency visit claims retrospectively. The health plans review board will determine whether the situation was an emergency. This could occur even if the undersigned's physician directed facility and physician charges. The facility is not responsible for determining whether the patient has used a participating provider for their insurance plan.

Initial: _____ I have received information on my Rights and Responsibilities as a patient and on the grievance process.

X________________________________________ Unable to sign: ☐ Serious Condition
Signature of Patient/ Representative / Legal Guardian ☐ ____________

Date: __________ Witness: ________________ Hospital Representative: ________________ Date: __________