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Welcome!

Thank you for becoming a member of Reno Family Medical Group!
Please review the RFMG Membership agreement attached. This agreement will describe:

- Direct Primary Care services, billing, and expectations
- Notice of Patient Rights
- HIPAA Agreement
- Notice of Privacy Practices
- Permission to communicate via text and email
- Release of Information for family members
- Authorization for Release of Medical Information

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Direct Primary Care Services, Expectations, and Billing
Please Initial Each Section

You have elected to enroll in a Direct Primary Care Membership with Reno Family Medical Group. This is sometimes referred to as "DPC" or "Concierge Medicine." While these practices can be implemented in a variety of ways the baseline premise is this: making payments directly to the medical group instead of paying through insurance, in exchange for increased access to care.

At Reno Family Medical Group (RFMG), this means paying a set, recurring rate instead of paying per visit. There are no co-pays or hidden fees, and insurance is never billed.

APPOINTMENTS _____ (*Initial)*

RFMG is not a walk-in clinic and appointments are required. We strive to offer same-day or next-day appointments. We also offer telehealth over Zoom or Google Meet, and communication via phone calls, emails, and text. The *fastest* way to make an appointment is to book online at www.renofamilymedicalgroup.com. You can also text or call us at 775.881.8189. There is no cap or limit on appointments.

Please note the following:
RFMG is open Monday – Friday from 8:00 am to 4:00 pm, with a lunch break from 12:00 – 1:00. We will not respond to patient communication after hours. If urgent care is needed after hours or on the weekends, please go to an urgent care or Emergency Department and follow-up with us on Monday.

A note about self-scheduling:
We offer longer appointments than conventional practices. If you are a person who likes to take your time and not feel hurried, please book a 60-minute appointment. We strive to respect the appointment times of our members. If a 30-minute appointment is scheduled and turns out not to be enough, we will schedule a time for you to return rather than delay the appointment of the patient after you.

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SERVICES _____ (*Initial)*

RFMG is a Nurse Practitioner run practice. A Nurse Practitioner is a Master's Degree or Doctorate-qualified nurse who underwent advanced clinical training in their field. In the State of Nevada, Nurse Practitioners have the same Scope of Practice as General Practitioner Physicians. A Nurse Practitioner can prescribe a patient's medication, sign their forms, send their referrals, etc. Nurse Practitioners do not require the oversite of a physician. This is called "Full Practice Authority." As such, there are no MDs or DOs practicing with RFMG.

Here is a list of services we provide:

Primary Care

- Chronic condition management such as hypertension, high cholesterol, diabetes, thyroid disorders, gout, autoimmune
- Pediatric Health, starting at 48 hours of age (pediatric vaccines not offered)
- Annual wellness exams
- Men & Women's Health, including breast exams, prostate exams, and pap smears
- LGBTQIA+ Health and Gender-affirming Care
- Medication management and prescribing
- Mental Health support assessments and treatment for depression, anxiety, and ADD/ADHD
- Cognitive Assessments
- Health condition education and planning
- On-site administration of medication, as needed

Urgent Care

- Minor illness and injury including antibiotics, wound care, stitching, splinting, and rapid testing
- Rapid testing: COVID, UTI, Flu, Urine, Blood Sugar

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Documentation

- Physical clearances
- Work/School Notes
- Travel clearances
- FMLA and Short-term Disability

Coordination of Care

- Referrals for imaging/labs
- Referrals to specialists
- Follow-up hospital or urgent care visits

Please note:
RFMG is not an insurer. If you choose to get lab work, receive diagnostic imaging, or see a specialist you will be subject to that agency's billing policies. Our staff will do their best to find in-network services or to negotiate cash-pay prices on a patient's behalf. **Reno Family Medical Group is not responsible for bills received from an outside agency for services rendered off-site.**

RFMG does offer some additional services for an extra cost, including:

- Trigger-point injections (muscle)
- Steroid or lidocaine injections (joint)
- IV rehydration
- Kenalog (allergy) shots
- Cosmetic treatments
- Testosterone programs
- Weight loss programs

These treatments would never be administered without clear communication about the extra cost and signing of consent forms.

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BILLING _____(*Initial)*

Billing is made to be as easy as possible. Members are sent a customized link through which they enter their credit card information, and the funds are automatically withdrawn on the same day each month. If members prefer to pay months or years at a time this can be done online, in person, or over the phone.

The rate is set. It doesn't fluctuate based on use. Think of it like a gym membership: you pay the same amount whether you go every day or practically never.

We do everything we can to make this service as valuable to you as possible, for the cheapest price possible. In return, we ask that you respect the following billing conditions. Please initial each line:

_____A minimum membership commitment is three months, regardless of use. After the first 90 days of membership a valiant effort will be made to collect any unpaid membership fees. Unpaid fees will result in cancellation of the membership and a $35 invoice fee. If a member's balance is not paid by the 120th day, it will be sent to collections.

_____Members may pay monthly, quarterly, semi-annually, or annually. Monthly memberships have a three-day grace period for declined transactions. Quarterly memberships have a seven-day grace period. Semi-annual memberships have a two-week grace period. Annual memberships have a 30-day grace period. Members are always encouraged to communicate with RFMG staff about payment needs, arrangements, or changes in payment method.

_____We understand that life happens. Cards decline and payments are sometimes late. After two payment issues, the third payment issue will result in a 10% increase in the membership rate moving forward. Please understand that dealing with billing issues takes time away from patients.

_____RFMG requires seven business days to cancel upcoming card payments. Please plan ahead if you need to make a change or cancel your membership.

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Collaboration and Mutual Respect _____(*Initial)*

Our goal is to create a partnership with you based on mutual respect and trust. We want to listen to you, collaborate with you on treatment plans, help you understand your treatment options, and develop a plan of care together with you.

Here's what you can expect from us:

- Nonjudgemental acceptance
- Personalized attention – everyone has different needs
- Unhurried exams
- Appointments free of distractions (we won't answer the phone)
- Above-and-beyond coordination of care
- Fast response times
- Reasonable attempts to keep patients with their designated provider
- Ability to change providers if you're uncomfortable with your designated provider
- Reasonable effort to coordinate with your insurance and keep your budgetary needs in mind
- Education regarding conditions, treatment options, etc. You can always request printed handouts or online resources as well

Here's what we expect from you. Please initial each line:

_____There's no cancellation fee for members. As such, please do your best to keep appointments, be on time, and communicate if your plans change.

_____Unkind behavior toward staff, other patients, or neighbors – real or perceived – will not be tolerated. Inappropriate behavior may result in immediate cancellation of the appointment and could result in cancellation of the membership in addition to police involvement.

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_____The providers do their best to answer their own phones. This is a personal choice made by staff in an effort to prioritize direct communication with patients. We do not use an answering service. For this reason, it is more likely that you will have to leave a voicemail and wait for a return phone call than you would experience in a conventional Primary Care setting. We request some extra grace in this area and ask that you don't call more than once. If a matter is urgent, texting is typically a faster way to get a response.

_____We try our hardest to keep patients with their designated providers. However, our providers are also humans who have sick days, vacations, family emergencies, and professional obligations such as meetings or training. We expect our patients to understand and maintain a courteous attitude at all times.

_____ We are a teaching clinic. In support of the company's mission to empower Nurse Practitioners, our providers are committed to nurturing a learning environment and act as student preceptors as part of their contract with RFMG. We expect our patients to treat students with respect and to allow students to shadow their appointments. If you are uncomfortable with students in the room, please tell the provider at the start of your appointment.

RATES _____(*Initial)*

Your rate will increase by the national inflation rate every year. If you pay monthly, your monthly rate will not change but you will receive an additional one-time fee for the difference when you begin a new year of membership. For instance, if your rate is $100 per month and the inflation rate is $3, rather than charging $103 per month you will receive a one-time charge of $36 on your 1-year anniversary of membership.

If you pay in advance, your increase will be added at the time of billing.

If you discontinue your membership and wish to reenroll later your membership will restart at the current membership rate and you may be placed with a different provider.

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Notice of Patient Rights

I have received a copy of this form:_____ *(Sign & Date)*

As a patient of our practice, you have the following rights:

1. Right to Respect and Dignity: You have the right to be treated with respect and dignity at all times.
2. Right to Privacy: You have the right to privacy and to have your medical information kept confidential.
3. Right to Informed Consent: You have the right to be fully informed about your medical condition, treatment options, and the risks and benefits of any treatment. You have the right to give or withhold your informed consent for any treatment.
4. Right to Refuse Treatment: You have the right to refuse any treatment, including life-sustaining treatment, and to be informed of the consequences of your decision.
5. Right to Access Your Medical Records: You have the right to access your medical records and to receive a copy of them.
6. Right to Amend Your Medical Records: You have the right to request that your medical records be amended if you believe they are inaccurate or incomplete.
7. Right to a Second Opinion: You have the right to seek a second opinion from another healthcare provider.
8. Right to Continuity of Care: You have the right to receive continuity of care and to be informed in advance of the continuity of care arrangements that we will make.
9. Right to Freedom from Restraints: You have the right to be free from physical or chemical restraints unless they are necessary to treat your medical condition.
10. Right to Voice Complaints: You have the right to voice complaints and grievances about your care without fear of retaliation.
11. Right to Accommodation for Disabilities: You have the right to accommodations for disabilities, including access to sign language interpreters, auxiliary aids, and communication devices.
12. Right to Cultural and Religious Beliefs: You have the right to be treated with respect for your cultural and religious beliefs.

If you feel that any of these rights have been violated, please bring it to the attention of the healthcare provider or our office staff. If you have any questions about your patient rights or how they are upheld in our practice, please contact us at: 775.881.8189.

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HIPAA Agreement

I have received a copy of this form: _____ *(Sign & Date)*

Introduction: The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that was enacted to protect the privacy and security of patient information. As a primary care office, it is important that you comply with HIPAA regulations to safeguard your patients' sensitive health information. This handout provides some basic HIPAA practices that you should follow in your office.

1. Protect Patient Information: Ensure that all patient information is stored and transmitted securely. This includes electronic health records (EHRs), paper records, faxes, emails, and any other communication. Make sure that all devices are password-protected and that access to patient information is limited to authorized personnel only.
2. Training: Train all employees on HIPAA regulations and their role in protecting patient information. This training should be provided regularly and documented. All employees should sign a confidentiality agreement and acknowledge that they have received HIPAA training.
3. Notice of Privacy Practices (NPP): Provide a Notice of Privacy Practices to all patients that explains how their protected health information (PHI) is used and disclosed. This NPP should be easily accessible, and patients should be asked to sign an acknowledgement that they have received the NPP.
4. Patient Access: Patients have a right to access their own health information. Develop policies and procedures for providing patients access to their records while ensuring that the information is protected.
5. Business Associates: Any third-party vendor or service provider that has access to PHI must sign a Business Associate Agreement (BAA). This BAA should outline the vendor's responsibilities for protecting patient information.
6. Incident Response: Develop an incident response plan in case of a breach of PHI. This plan should include steps for mitigating the breach, notifying patients, and reporting the breach to the appropriate regulatory authorities.
7. Risk Analysis: Conduct a periodic risk analysis to identify potential threats and vulnerabilities to PHI in your practice. Use the results of this analysis to develop a plan for addressing any security gaps.

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Notice of Privacy Practices

I have received a copy of this form:_____ *(Sign & Date)*

Effective Date: February 21, 2023

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR OBLIGATIONS:

We are required by law to:

- maintain the privacy of your health information;
- provide you with this notice of our legal duties and privacy practices with respect to your health information; and
- follow the terms of our notice that is currently in effect.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We may use and disclose your health information for the following purposes:

- Treatment: We may use or disclose your health information to provide you with medical treatment and services. For example, we may share your health information with other healthcare providers involved in your care.
- Payment: We may use or disclose your health information to obtain payment for the services we provide to you. For example, we may share your health information with your health insurance company.
- Healthcare Operations: We may use or disclose your health information for our healthcare operations. For example, we may use your health information to improve the quality of care we provide.
- Required by Law: We may use or disclose your health information when we are required to do so by law.
- Public Health Activities: We may use or disclose your health information for public health activities, such as reporting of communicable diseases.
- Law Enforcement: We may use or disclose your health information to law enforcement officials for certain purposes, such as identifying a suspect or a missing person.
- Health Oversight: We may use or disclose your health information to health oversight agencies for certain purposes, such as audits and inspections.

- Research: We may use or disclose your health information for research purposes, but only if the research has been approved and safeguards are in place to protect the privacy of your health information.

YOUR RIGHTS:

You have the following rights regarding your health information:

- Right to Access: You have the right to access your health information in our possession, and to receive a copy of it.
- Right to Amend: You have the right to request an amendment to your health information if you believe it is incorrect or incomplete.
- Right to Accounting: You have the right to request an accounting of the disclosures of your health information.
- Right to Request Restrictions: You have the right to request restrictions on the use and disclosure of your health information.
- Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information in a certain way or at a certain location.
- Right to File a Complaint: You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with us, or with the Secretary of Health and Human Services.

CONTACT INFORMATION:

If you have any questions about this notice or how your health information is used or disclosed, please contact us at: 775.881.8189

CHANGES TO THIS NOTICE:

We reserve the right to change our privacy practices and this notice. We will provide you with a revised notice if the changes materially affect your privacy rights. The revised notice will be available upon request.

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Permission to Communicate via Text and Email

I understand that sending communication regarding my Protected Health Information via text and email is not secure and could result in piracy of my information without my permission.

I OPT IN to communicating via text and email. I understand the risks and will not hold Reno Family Medical Group or its staff responsible in the event of a data breach.

_____	_____	_____
Printed Name	Signature	Date

OR

I OPT OUT of communicating via text and email. Please only communicate with me via phone call or in person.

_____	_____	_____
Printed Name	Signature	Date

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Release of Information for Family Members

The following people have my permission to receive and review my Protected Health Information:

Printed Name	Relationship	DOB
Printed Name	Relationship	DOB
Printed Name	Relationship	DOB

This form releases Reno Family Medical Group and its staff from litigation related to release of Protected Health Information to the parties listed above.

Patient Name	Signature	Date

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Authorization for Release of Medical Information

Requesting information FROM:

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1. PATIENT INFORMATION:

Patient Name:	Phone Number:	Date of Birth:

2. ACTION: Up to two outside care providers can have permanent authorization to obtain copies of medical records. This authorization may be revoked at any time upon your request. If the below named individual is not a healthcare provider, please skip this step.

◯ **Add New Care Provider** - Please give the below named care provider access to my medical records.
◯ **Replace Authorized Care Provider** - Replace existing care provider _____with the below named care provider.
◯ **Remove Authorized Care Provider** - Please remove the below named care provider's access.

3. RELEASE INFORMATION TO: Who do you want to receive the requested records - **Full Mailing Address Required.** Phone and fax are optional. All other fields are required

Name:			Phone #:
Reno Family Medical Group			775.881.8189
Address:			Fax #:
3650 Mayberry Dr., Ste. 102			775.637.9059
City:	State:	Zip Code:	Country:
Reno, Nevada 89509 USA			

4. INFORMATION TO BE RELEASED: *Review options and check appropriate box(es):*

DATES OF SERVICE TO BE RELEASED: From _____ to _____

☐ **Clinical Notes**
☐ **Radiology Reports**
☐ **Radiology Images** (will be released on a CD)
☐ **Pathology Reports**
☐ **Lab results**
☐ **Other Diagnostic Test Results** (Cardiac, Pulmonary Function, Neurological Testing, etc.)
☐ **Other (Please Specify)** :

5. THE PURPOSE OR NEED FOR DISCLOSURE (Continued Care, Personal Use,etc): Continued Care

6. AUTHORIZATION: Permission is hereby granted to the National Institutes of Health Clinical Center to release medical information to the individual/organization as identified above. *Note: submission of this form authorizes future disclosures to the same individual and/or entity within **one year** from date of signature.*

Patient/Authorized Signature	Print Name	Date