



PATIENT FORMS TABLE OF CONTENTS

If you are a new patient, please fill out the following forms and bring them with you to your appointment.

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The following forms are in regard to the confidentiality of your medical information. You do not need to fill out these forms unless they become pertinent to your care.

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PATIENT REGISTRATION

Preferred Pharmacy: _____ Location: _____ Pharmacy Phone: _____

Referring Physician: _____ Preferred Provider: _____

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____ Miss Mrs. Ms. DOB: ____/____/____ SS#: ____-____-____

Race: American Indian/Alaska Native Asian Black/African American Pacific Islander White Other

Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined Primary Language: _____

Marital Status: Single Married Divorced Domestic Partner Widowed

Street Address: _____ Apt./Ste./Unit: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____ Primary #: Home Cell Work

Fax #: _____ Email: _____ Preferred Communication: Phone Mail Email Text

Employer: _____

Associated Parties

Spouse's Name: _____ DOB: ____/____/____ Phone #: _____

Parent's Name (if minor): _____ DOB: ____/____/____ Phone #: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Insurance Information

Primary Insurance: _____

Policy Number: _____ Group Number: _____ Effective Date: ____/____/____

Name of Insured: _____ Relationship to Insured: _____ SS# of Insured: ____/____/____

Insured's Date of Birth: ____/____/____ Insured's Employer: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____ Effective Date: ____/____/____

Name of Insured: _____ Relationship to Insured: _____ SS# of Insured: ____/____/____

Insured's Date of Birth: ____/____/____ Insured's Employer: _____

-More on opposite side-

PLEASE READ THE FOLLOWING CAREFULLY:

- You are responsible for knowing if your insurance is contracted with Women’s Health Associates of Southern Nevada.
- You are responsible for knowing your coverage and benefits.
- All deductibles, co-payments and applicable charges will be due at the time of service – **NO EXCEPTIONS.**
- All surgery fees **MUST** be paid in advance of the surgical date – **NO EXCEPTIONS.**
- There is a \$25.00 fee per signature for any FMLA/Disability forms completed. Please speak with the Care Center regarding their time frame for completion.
- Should you need to cancel or reschedule an appointment, please call at least 48 hours in advance. Failure to do so could result in a \$25.00 fee.
- All checks returned due to insufficient funds will result in a \$25.00 NSF fee being placed on the patient account.

NOTE: If your insurance requires you to utilize a particular laboratory, you will need to inform the nursing staff every time you are seen. If you are not sure whether your insurance company requires you to use a specific laboratory, please contact them directly for that information. There will be a separate bill from the lab for PAP SMEAR interpretation, cultures, urinalysis and other laboratory services.

Notice of Assignment of Benefits and Release of Medical Information

The above information is complete and correct. I hereby guarantee payment of all charges incurred with this office. I hereby assign and direct my insurance company or companies to pay any and all benefits for my medical services directly to this office. I authorize the release of medical information requested by my insurance company or companies to insure payment on this account. I understand that should my insurance company or companies deny any submitted charges for any reason, I am responsible for payment of those charges. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover money due to Women’s Health Associates of Southern Nevada. In the event my account becomes delinquent and processed for collections or if I file bankruptcy on any balance owed to Women’s Health Associates of Southern Nevada-Martin, PLLC, I understand that I will be automatically discharged from care.

Patient/Legal Guardian Name

Patient/Legal Guardian Signature

____/____/____

Date



Name: _____ DOB: ____/____/____ PCP: _____ DATE: ____/____/____

PERSONAL/MEDICAL HISTORY

- Anxiety/Depression Yes No
- Anemia Yes No
- Asthma/Lung condition Yes No
- Arthritis Yes No
- Bleeding disorder Yes No
- Bowel problems Yes No
- Cancer: _____
- Diabetes Yes No
- Elevated cholesterol Yes No
- Endometriosis/PCOS Yes No
- Heart disease Yes No
- High blood pressure Yes No
- Headaches Yes No
- Kidney disease/stones Yes No
- Liver disease/Hepatitis Yes No
- Stroke Yes No
- Thyroid disorder Yes No
- Other: _____

SOCIAL HISTORY

- Married/Single/Divorced/Widowed/Separated
- Smoke: Yes No Packs per day: _____
- Alcohol: Yes No How much? _____
- Street drugs: _____
- Marijuana: Medical Recreational
- Sexual preference: _____

ALLERGIES – INCLUDE MEDICATION REACTION

GYNECOLOGIC HISTORY

- Last pap smear: _____ Normal Abnormal
- Last mammo: _____ Normal Abnormal
- Last colonoscopy: _____ Normal Abnormal
- Last DEXA (bone) scan: _____ Normal Abnormal
- Previous treatment for abnormal pap smears?
 - Colpo Cryo LEEP Conization N/A
- Last menstrual period: _____
- Age of first period: _____
- Periods occur every _____ days and last _____ days
 - Heavy Clots Pain Cramping Irregular bleeding
- Average # of pads/tampons used per day: _____
- Menopausal: Yes No Age began: _____
- Hysterectomy: Yes No When? _____
- Complaints of: Breast pain Infertility Fibroids Ovarian cysts
 - Pain w/ intercourse Vaginal infections Leaking of urine
- Have you ever been diagnosed with any of the following:
 - Gonorrhea Yes No
 - Chlamydia Yes No
 - Herpes (Genital) Yes No
 - HPV/Genital warts Yes No
 - Hepatitis B or C Yes No
 - HIV Yes No
 - Syphilis Yes No
- Number of sexual partners (in lifetime): _____
- Current birth control method: _____
- Previous birth control method(s): _____

PREGNANCY HISTORY

Number of Miscarriages: _____ Abortions: _____ Ectopic: _____ Live Births: _____

Date	Gestational Age	Birth Weight	Gender	C-section or Vaginal	Early Labor	Complications

SURGICAL HISTORY

Ablation Date: _____ Laparoscopy Date: _____
Breast surgery Date: _____ Ovaries removed Date: _____
D&C Date: _____ Tubal ligation Date: _____
Hysterectomy Date: _____

Appendectomy Back surgery Bowel Fibroid removal Gallbladder Tonsillectomy

Other: _____

FAMILY HISTORY

Breast Cancer Yes No Family Member: _____

Ovarian Cancer Yes No Family Member: _____

Colon Cancer Yes No Family Member: _____

Other: _____

CURRENT MEDICATIONS

List all medications taken daily

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____



E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions**-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**--Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Women's Health Associates of Southern Nevada can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed): _____ Date of Birth: ____ / ____ / ____

Signature of Patient (or representative): _____ Date: ____ / ____ / ____

Relationship (If other than patient): _____

Consent Denied: _____ Date: ____ / ____ / ____



PATIENT PORTAL

We provide an online Patient Portal to make managing your health care simple and convenient. Our secure portal is a helpful resource to:

- Request appointment times
- Pay statement balances and bills
- Request prescription refills
- Access patient forms before your appointment
- Ask non-emergency medical questions
- Request test results

We still welcome your phone calls, but we offer this service to you as a convenient way to communicate with your care center. The Patient Portal may also be used to contact you.

Please fill out the information below and we will send an invitation to the email you provide. Once you receive the email, click the hyperlink and follow the prompts to set up your account. Be sure to mark us as a safe sender so the emails aren't filtered into your junk folder. **If you created a Portal account before January 1, 2018, you need to create a new account with our improved system.**

Please note your first and last name must reflect exactly how they are listed in our system to activate your account. Should you have any login issues in the future, you can request your username and reset your password through the website.

Preferred Email: _____

Patient name: _____

(Please print clearly)

Patient DOB: ____/____/____



RELEASE OF PROTECTED HEALTH INFORMATION

The communication of health care information plays an essential role in ensuring that individuals receive prompt and effective health care. Due to the nature of these communications and the various environments in which individuals receive health care, the potential exists for an individual's health information to be disclosed incidentally. The HIPAA Privacy Rule permits certain incidental uses or disclosures of protected health information to occur when the provider has in place reasonable safeguards and minimum necessary policies and procedures to protect an individual's privacy.

Women's Health Associates of Southern Nevada understands there may be times when a patient will need to discuss their protected health information over the phone. As a reasonable safeguard you are personally required to select a password for your protected health information. You will be required to provide the password prior to discussing any of your protected health information with our staff over the phone. Should you require a family member or friend to contact our office to discuss any of your protected health information, they will need this password.

It is very important that you maintain the integrity of your password. In the event you become concerned that you may have shared your password inadvertently, please contact our office immediately to begin the process of changing your password.

My personally selected password to discuss any protected health information over the phone is:

(Password must be less than 20 characters)

I understand that I can only change my password in person. I further understand that it is my responsibility to maintain the integrity of my personally selected password. I authorize the disclosure of my protected health information in the above manner.

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

We may use your medical information for treatment, payment, Practice or Facility operations, research or fundraising purposes as described in this notice. All employees of Women's Health Associates of Southern Nevada, PLLC follow these privacy practices. The physicians on our medical staff will also follow this notice when they work at the Practice or Facility.

ABOUT THIS NOTICE

This notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to your medical information;
- follow the terms of the notice that is currently in effect; and
- notify individuals, either known or reasonably believed to be affected, following a breach of unsecured protected health information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and give examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one or more of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other Practice or Facility personnel who are involved in your care. Different departments of the Practice or Facility also may share medical information about you in order to coordinate the different services you may need, such as prescriptions, lab work and imaging services. We also may disclose medical information about you to people outside the Practice or Facility who may be involved in your medical care.

For Payment. We may use and disclose medical information about you so that we may bill for treatment and services you receive at the Practice or Facility and collect payment from you, an insurance company or another party. For example, we may need to give information about the medical care you received at the Practice or Facility to your health plan so that the plan will pay us or reimburse you for the applicable treatment. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose information about you to other healthcare facilities for purposes of payment as permitted by law.

For Healthcare Operations. We may use and disclose medical information about you for operations of the Practice or Facility. These uses and disclosures are necessary to run the Practice or Facility and make sure that all of our patients receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you. We may also

combine medical information about many patients to decide what additional services the Practice or Facility should offer, what services are not needed and whether certain new treatments are effective. We may also combine medical information we have with medical information from other Practices or Facilities to compare our performance and to make improvements in the care and services we offer. We may also disclose information to doctors, nurses, technicians, medical students and other Practice or Facility personnel for educational purposes. We may also disclose information about you to other healthcare facilities as permitted by law.

Appointment Reminders. We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care.

Treatment Alternatives. We may use and disclose medical information to tell you about possible treatment options that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information to balance research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will be approved through this process. However, we may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Practice or Facility. When required by law, we will ask for your specific written authorization if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at the Practice or Facility.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

SPECIAL SITUATIONS

Nevada State Law. Special privacy protections apply to genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided an explanation of how the information will be protected. For further information, please contact the Privacy Officer. This contact information is listed on the last page of this Notice.

Organ and Tissue Donation. If you are an organ or tissue donor, we may release medical information about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.

Military and Veterans. If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose to authorized public health or government officials medical information about you for public health activities. These activities generally include the following:

- to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA- regulated product or service;
- to prevent or control disease, injury or disability;
- to report disease or injury;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications and food or problems with products;
- to notify people of recalls or replacements of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other legal demand by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information about you if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the Practice or Facility or by healthcare providers affiliated with the Practice or Facility;
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; and
- to authorized federal officials so they may provide protection for the President and other authorized persons or conduct special investigations.

Coroners, Medical Examiners and Funeral Directors. We may release medical information about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information to funeral directors so they can carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

To a School. We may disclose information to a school, about an individual who is a student or prospective student of the school, if:

- The protected health information that is disclosed is limited to proof of immunization;
- The school is required by State or other law to have such proof of immunization prior to admitting the individual; and
- The covered entity obtains and documents the agreement to the disclosure from either:
 - A parent, guardian, or other person acting in loco parentis of the individual, if the individual is an un-emancipated minor; or

- The individual, if the individual is an adult or emancipated minor.

Other Uses and Disclosures. Other uses and disclosures not described in this Notice will be made only with your written authorization, and you may revoke such authorization provided under this section at any time, provided that the revocation is in writing, except to the extent that we have taken action(s) in reliance upon your authorization; or if the authorization was obtained as a condition of obtaining insurance coverage.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. This right does not include psychotherapy notes, information compiled for use in a legal proceeding or certain information maintained by laboratories. In order to inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer listed on the last page of this Notice for the location at which you were treated. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed. To request a review, contact the Privacy Office. This contact information is listed on the last page of this Notice. A licensed healthcare professional will conduct the review. We will comply with the outcome of the review.

Right to Amend. If you think that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice or Facility. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, listed on the last page of this Notice, for the location at which you were treated. In addition, you must give a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for the Practice or Facility
- is not part of the information that you would be permitted to inspect and copy; or
- is accurate and complete.

We will provide you with written notice of action we take in response to your request for an amendment.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. We are not required to account for any disclosures you specifically requested or for disclosures related to treatment, payment or healthcare operations or made pursuant to an authorization signed by you. To request an accounting of disclosures, you must submit your request in writing to the Privacy Office. This contact information is listed on the last page of this Notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We will attempt to honor your request. If you request more than one accounting in any 12-month period, we may charge you for our reasonable retrieval, list preparation and mailing costs for the second and subsequent requests. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. Additionally, you can request restrictions on medical information disclosed to a health plan if the disclosure

is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which you, or person other than the health plan on your behalf, has paid us in full. To request a restriction, you must contact the Privacy Office. This contact information is listed on the last page of this Notice.

We are not required to agree to your request. If we agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. You may terminate the restriction at any time. If we terminate the restriction, we will notify you of the termination. We are not able to terminate or refuse your request for restrictions to disclosures to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which you, or person other than the health plan on your behalf, has paid us in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the Privacy Office. This contact information is listed on the last page of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will attempt to accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at your first treatment encounter at the Practice or Facility. You may get an additional copy of this Notice at any time by contacting the Privacy Office. This contact information is listed on the last page of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you we already have as well as any information we receive in the future. We will post copies of the current Notice at the Practice or Facility. The Notice will contain on the first page, in the bottom right-hand corner, the effective date. In addition, each time you register at the Practice or Facility for treatment or healthcare services, we will provide available copies of the current Notice. Any revisions to our Notice will also be posted on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or Facility or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with the Practice or Facility, please call or write to the Privacy Office. This contact information is listed on the last page of this Notice. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not described in this Notice or the laws that apply to us will be made only with your written authorization on a Practice or Facility authorization form. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we may continue to use or disclose that information to the extent we have relied on your authorization. You also understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.



ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received from WHASN a copy of the Notice of Privacy Practices of WHASN. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how WHASN can use and disclose my personal health information both with and without my authorization. I further understand that I may contact WHASN's Privacy Officer, Michael Oliphant if I have any questions regarding the contents of this Notice or to file a complaint.

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

____/____/_____
Date



PATIENT NOTIFICATION OF ADVANCE DIRECTIVE AVAILABILITY

It is the policy of Women's Health Associates of Southern Nevada to inform patients of the availability of an Advance Directive form. Patients are encouraged to make informed decisions about end-of-life care and services. Women's Health Associates of Southern Nevada encourages patients to learn about options for end-of-life care and services. Implement plans to ensure your wishes are honored. You are encouraged to discuss your decisions with family, friends and healthcare providers.

- Yes, I have an advance health care directive/living will.
- No, I do not have an advance health directive/living will.
- I would like additional information on advance health directives.

Patient Name

Patient Chart #

Patient/Health Care Agent/Guardian/Relative Signature

____/____/____
Date

The following forms are not part of our new patient packet. You **do not** need to fill them out unless they become pertinent to your care.



AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I, _____, hereby authorize Women's Health Associates of Southern Nevada, PLLC to use and/or disclose a copy of my medical records containing individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that this disclosure may include HIV-related, mental health, or substance abuse information. I also understand that, if the organization authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by state or Federal privacy laws or this authorization.

Person/Organization Providing the Information:

Name of Patient or Representative:

Person/Organization Authorized to Receive the Information:

Specific and meaningful description of the information to be used and/or disclosed (such as dates of service or treatment, type of service or treatment, level of detail to be released or origin of information):

This medical information is being used and/or disclosed for the following purpose(s):

("At the Request of the Individual" is sufficient if the request is made by the patient and the patient does not want to state a specific purpose.)

This Authorization shall remain valid and in effect until:

A) (MM/DD/YR): ____/____/____ OR

B) The event that relates to the use and/or disclosure occurs and this Authorization is no longer necessary.
This expiration event is:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I also understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is released to research or (2) if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

____/____/____
Date

Description of Personal Representative's Authority

A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PATIENT.



REQUEST FOR AMENDMENT OF MY MEDICAL RECORD

Patient Name: _____ Date of Birth: ____ / ____ / ____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

After a review of my medical record, I do not believe that the original documentation made by Women's Health Associates of Southern Nevada, PLLC accurately and correctly reflects my treatment, condition or diagnosis on the following date ____ / ____ / ____ and therefore, my medical record should be supplemented and corrected with clarifying information.

I understand that my physician or health care provider may or may not supplement or correct my record with an addendum to my medical record based upon this request. I understand that my physician or health care provider is not allowed to alter the original medical record. I understand that my request for an amendment will be made a permanent part of my medical record and will be sent with any future authorized request for my medical record.

I understand that, if WHASN denies my request for an amendment to my medical record, I have the opportunity to provide a statement of disagreement to contest the denial of my request.

The reason I request an amendment is as follows:

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

____ / ____ / ____
Date

Description of Personal Representative's Authority



REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF MY MEDICAL RECORD

Patient Name: _____ Date of Birth: ____ / ____ / ____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

I understand that I have a right to request an accounting of certain disclosures of my medical record made by Women's Health Associates of Southern Nevada, PLLC.

To the extent applicable, I request an accounting of disclosures of my medical records made by WHASN for the following time period:

____ / ____ / ____ to ____ / ____ / ____
MM/DD/YY MM/DD/YY

I understand that I am not permitted to request an accounting of disclosures of my medical record made by WHASN prior to April 14, 2003.

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

____ / ____ / ____
Date

Description of Personal Representative's Authority



REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF MY MEDICAL RECORD

Patient Name: _____ Date of Birth: ____ / ____ / ____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

I request that I receive communications regarding information contained in my medical record according to the following means:

(Check and complete the appropriate option.)

- I request that when reasonable, information pertaining to my treatment at WHASN be sent by regular mail to the following address:

Street Address: _____

City: _____ State: _____ Zip: _____

- I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me using the following telephone number:

Phone Number: _____

- I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me using the following facsimile number:

Phone Number: _____

- I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me according to the following method:

I understand that not every request for confidential communications may be accommodated by the practice due to limitations on the practice's capabilities.

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

Date

Description of Personal Representative's Authority



REQUEST FOR RESTRICTIONS ON USES AND/OR DISCLOSURES OF MY MEDICAL RECORD

Patient Name: _____ Date of Birth: ____ / ____ / ____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

I understand that I have a right to request restrictions on certain uses and/or disclosures of my medical record made by Women's Health Associates of Southern Nevada, PLLC.

I request that the use and/or disclosure of my medical record be restricted in the following manner:

I understand that WHASN may deny this request in whole or in part based upon the professional judgment of WHASN.

If this request for restrictions on certain uses and/or disclosures of my medical record is granted, in whole or in part, I understand that I may cancel this restriction at any time by notifying WHASN. I also understand that WHASN may terminate this restriction at any time after WHASN notifies me of the termination.

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

____ / ____ / ____
Date

Description of Personal Representative's Authority



**REVOCAION OF MY AUTHORIZATION FOR THE USE AND DISCLOSURE OF
MEDICAL INFORMATION**

I, _____ (patient's name), hereby revoke my earlier authorization of ____/____/____ (date of authorization) which previously allowed Women's Health Associates of Southern Nevada, PLLC to use and/or disclose a copy of my medical records containing individually identifiable health information.

Patient Name

Patient/Health Care Agent/Guardian/Relative Signature

_____/_____/_____
Date

Description of Personal Representative's Authority



CONSENT FOR OBTAINING, RETAINING, OR DISCLOSING GENETIC INFORMATION IN NEVADA

As used in this document, “genetic information” means any information that is obtained from a genetic test.

1. I understand that no insurer or corporation that provides health insurance, carrier serving small employers or health maintenance organization may:
 - (a) Require me or any member of my family to take a genetic test;
 - (b) Require me to disclose whether I or any member of my family has taken a genetic test;
 - (c) Request my genetic information or the genetic information of a member of my family; or
 - (d) Determine the rates or any other aspect of the coverage or benefits for health care for me or my family based on whether I or any member of my family has taken a genetic test or based on my genetic information or the genetic information of any member of my family.
2. I also understand that:
 - (a) I have the right to receive the results of a genetic test, in writing, within 10 working days after the person conducting the test has received the results. The written results must indicate that, except as otherwise provided in chapter 629 of NRS, my genetic information may not be obtained, retained or disclosed without first obtaining my informed consent.
 - (b) It is unlawful for a person or entity to obtain my genetic information without my informed consent, unless the information is obtained:
 - (1) By a federal, state, county or city law enforcement agency to establish the identity of a person or a dead human body;
 - (2) To determine the parentage or identity of a person in certain circumstances;
 - (3) To determine the paternity of a person in certain circumstances;
 - (4) For use in a study where the identities of the persons from whom the genetic information is obtained are not disclosed to the person conducting the study;
 - (5) To determine the presence of certain inheritable disorders in an infant in certain circumstances; or
 - (6) Pursuant to an order of a court of competent jurisdiction.
 - (c) It is unlawful for a person to retain genetic information that identifies me without first obtaining my informed consent, unless retention of the genetic information is:
 - (1) Necessary to conduct a criminal investigation, an investigation concerning the death of a person or a criminal or juvenile proceeding;
 - (2) Authorized pursuant to an order of a court of competent jurisdiction; or
 - (3) Necessary for certain medical facilities to maintain my medical records.
 - (d) If I have authorized a person to retain my genetic information, I may request that the person destroy the genetic information. Such a person shall destroy the information, unless retention of the information is:
 - (1) Necessary to conduct a criminal investigation, an investigation concerning the death of a person or a criminal or juvenile proceeding;
 - (2) Authorized by an order of a court of competent jurisdiction;
 - (3) Necessary for certain medical facilities to maintain my medical records; or
 - (4) Authorized or required by state or federal law.

(e) Except as otherwise provided by federal law or regulation, a person who obtains my genetic information for use in a study shall destroy the information upon completion of the study or my withdrawal from the study, whichever occurs first, unless I authorize the person conducting the study to retain my genetic information after the study is completed or upon my withdrawal from the study.

(f) It is unlawful for a person to disclose or to compel another person to disclose my identity if I was the subject of a genetic test or to disclose to another person genetic information that allows the other person to identify me without first obtaining my informed consent, unless the information is disclosed:

- (1) To conduct a criminal investigation, an investigation concerning the death of a person or a criminal or juvenile proceeding;
- (2) To determine the parentage or identity of a person in certain circumstances; (3) To determine the paternity of a person in certain circumstances;
- (4) Pursuant to an order of a court of competent jurisdiction;
- (5) By a physician after I am deceased and my genetic information will assist in the medical diagnosis of persons related to me by blood;
- (6) To a federal, state, county or city law enforcement agency to establish the identity of a person or dead human body;
- (7) To determine the presence of certain inheritable preventable disorders in an infant in certain circumstances; or
- (8) By an agency of criminal justice in certain circumstances.

I, _____ (name of person giving consent), hereby give my consent to
_____ (name of person or agency obtaining genetic information)
to obtain my genetic information; or

I, _____ (name of person giving consent), hereby give my consent to
_____ (name of person or agency retaining genetic information)
to retain my genetic information; or

I, _____ (name of person giving consent), hereby give my consent to
_____ (name of person or agency disclosing genetic information)
to disclose my genetic information to _____
(name and address of person or agency to receive genetic information).

This consent document is valid until ____ / ____ / ____ (date of expiration).

If the person tested is unable to sign, please indicate the reason here: _____

Signature of consenting person or his or her legal representative ____/____/____
Date

Witness ____/____/____
Date