# 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.**



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

WHASN
Women's Health Associates of Southern Nevada

# PATIENT REGISTRATION

Preferred Pharmacy: _____ Location: _____ Pharmacy #: _____

Referring Physician: _____ Preferred Provider: _____

## Patient Information

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

Previous Name: _____ Preferred Name: _____ ☐ Female ☐ Male ☐ Transgender

DOB: _____/_____/_____ SS#: _____-_____-_____

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

Home #: _____ Work #: _____ ext._____ Cell #: _____

Email: _____

Employer: _____ Employer Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

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

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

## 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: _____

# FINANCIAL POLICY AGREEMENT

**Welcome**

Thank you for choosing Women's Health Associates of Southern Nevada (WHASN). We consider it an honor to be given the opportunity to assist you with your medical needs. Our providers are committed to being leaders and advocates in the pursuit of excellence in women's health care. We strive to provide the highest quality of care possible with integrity, honesty, compassion, and efficiency. Our healthcare providers do not discuss financial obligations or insurance coverage. This allows the providers to focus their full attention on your medical needs. Understanding our financial policy is important to a successful physician-patient relationship. We make every effort to keep our fees reasonable while at the same time covering the cost associated with the services we provide. Our financial agreement is indicative of our respect for your right to know, ahead of time, what our expectations are for the patient's financial responsibility. Payment of your bill is considered part of your overall healthcare service provided by WHASN. If you are unable to have follow-up care or testing ordered by your provider due to financial burden, please ask to speak with the office administrator. We will do our best to assist you with getting the medical care needed.

**Patient Information**

All patients must complete our Patient Registration Form prior to their visit with the physician. It is the patient's (parent/guardian) responsibility to notify this office of any information changes. This includes changes to your address, phone number and insurance information. You are required to provide updated personal demographic information, a current copy of your insurance card, a picture ID, and payment of any outstanding balance for each visit.

**Fee and Payments**

WHASN's fees are based on reasonable and customary community standards. Fees are based on the medical complexity of the service provided. There are many factors which must be taken into consideration by the provider when selecting the appropriate procedure codes to accurately reflect the services provided. We will do our best to provide you with an accurate estimate of your financial obligation. However, due to the complexity of the information which must be considered, the final amount of your financial obligation can only be determined after the physician has provided a complete accounting of the services provided and, if applicable, your insurance company has processed any claims related to those services. WHASN requires payment for the estimated patient responsibility at the time of your visit. This includes copays, coinsurance, deductibles, and non-covered services. WHASN accepts cash, credit card and debit card. Checks are not accepted at providers' offices. **Patient payments will be applied to the oldest balance, regardless of the payment date.**

**Insurance**

Women's Health Associates of Southern Nevada, as a courtesy, will file an insurance claim with your primary insurance company. In order to properly bill your insurance you are required to disclose all medical insurance coverage information. This includes any insurance coverage provided under a parent's or spouse's policy. Failure to provide complete and accurate information on all current insurance policies will result in the patient responsibility of the entire bill. Not all services are a covered benefit in all insurance policies. You are responsible for knowing and understanding the benefits, limitations and exclusions of your policy. You are responsible for verifying if the provider you are seeing is

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| contracted with your insurance plan. You are also responsible for obtaining a referral or prior-authorization prior to seeing our providers, if required by your insurance plan. Our office will only obtain authorization for services rendered by a WHASN provider. If your insurance company denies payment for services rendered by our office as; out of network, cosmetic, exhausted benefits, experimental, no referral, or as a result of inaccurate or incomplete information you provide, you will be financially responsible for the entire bill. |
| Patient/Guardian Signature: |
| Date: |

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|---|
| **Medicaid Coverage**<br>Medicaid coverage is offered through the federal government to those who qualify. The government requires the services to be billed to Medicaid as the last coverage option. This means the patient is required to provide both Medicaid and the physician with any and all medical coverage information prior to services being rendered. This includes coverage through employer, spouse, parent or private policies. You do not have the option of using Medicaid as your primary (first) insurance coverage, when you are covered under any other medical insurance policy. This rule applies even if the other insurance policy does not cover all services being provided. It is very important that you provide the physician's office with complete insurance coverage information. Failure to provide the required information, will result in you being financially responsible for the services rendered. |
| Patient/Guardian Signature: |
| Date: |

**Please note: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not on coverage by Insurance Companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance company is inappropriate and is considered insurance fraud. While a patient has the right to request an amendment to her chart, all services will be billed according to the provider's documentation.**

**Account Balances/Delinquent Balances**

Payment is expected at the time services are rendered. In some circumstances, there may be additional financial obligations not known at the time of your visit. In these circumstances we will send a statement to the address provided on your patient registration form. You are required to submit payment in-full within 15 days of the original statement date. If you are unable to pay the account balance in-full, you may request approval for an acceptable monthly payment arrangement. If you do not pay your account balance in-full within 45 days, or secure and maintain an approved monthly payment arrangement, your account will be considered delinquent. Once your account is in the delinquent status, it will be processed and assigned to a licensed collection agency. This will result in an additional fee of 50% of your account balance to cover the fee assessed by the collection agency. Once your account is assigned to a collection agency, we are unable to reduce or remove the collection fees. You are financially responsible for your entire account balance, as well as all collection fees, all attorney's fees and all legal fees incurred, in an attempt to collect your delinquent account balance.

**Account Credits**

Because we can only estimate your financial responsibility for services provided by WHASN, there is a possibility you may have a patient credit after your insurance has processed the claims submitted. It is very important for you to review the explanation of benefits (EOB) you will receive from your insurance company. It will provide detailed information on your final financial responsibility for services provided by WHASN. **If, after reviewing the EOB, you believe you have a credit due to you, please contact the billing office so we can review your account and process a refund for any credit remaining on your account.** If

you have any questions or need assistance with understanding the EOB you receive, you are welcome to contact the billing department for assistance.

**Office Visits**

You are required to pay any co-pay, co-insurance or deductible that may apply to your office visit. Additional services performed (ultrasounds, biopsies, cultures, labs, injections, etc.) during your office visit are not included in the fee for the office visit. You are responsible for payment of the additional services rendered.

**Surgical Procedures**

Surgery deposits are required and must be paid prior to your pre-operative visit. The deposit consists of your deductible (if not met) and your co-payment or co-insurance. You should contact the provider's office prior to your pre-operative visit to discuss the amount expected.

**Obstetrical Care**

Payment for obstetrical services is addressed individually. You will be provided an Obstetrical Financial Agreement. The agreement will explain the services included in the obstetrical fee and the services not included. It will also provide an estimate of your financial obligation based on your insurance benefits and when payment is required.

**Laboratory Services**

Your physician may order laboratory services to assist in diagnosing your condition or as preventative care to determine your current health status. Your insurance benefits may not cover all services provided or ordered by the provider. This includes: pap smears, testing for sexually transmitted disease, screening and diagnostic labs, genetic testing and drug screening. In some instances these services may be applied to your annual deductible or not covered. It is the patient's responsibility to know the coverage, limitations and exclusions of your insurance policy.

**Returned Checks**

WHASN's central billing office accepts checks as payment on an account. In the event a check is returned by the bank for "non-sufficient funds", "closed account", "return to maker", "check voided", "stop payment" and "un-authorized signature", a $25.00 fee will be assessed to your account. We may choose to proceed with legal action which will result in additional fees to you or the guarantor of the account. You are responsible for the additional fees.

**Cancellation / No Show Policy**

If it is necessary to cancel your scheduled appointment, we request that you notify us at least 48 hours prior to the appointment. A "no-show" is someone who misses an appointment without cancelling it at least 48 hours prior to the scheduled appointment time. A failure to present at the time of a scheduled appointment will be recorded as a "no-show". You will be charged $25 for "no-show" appointments.

**FMLA / Disability Forms**

There is a $25.00 charge for each FMLA/disability form/signature completed by this office. Payment is due at the time the form is submitted. All FMLA/disability forms are completed by the office staff. There is generally a 7-14 day waiting period for the completion of these forms. The physician's documentation in your medical chart serves as the basis of all FMLA/disability forms and cannot be enhanced by yourself or the office staff. It is important that you understand the difference between FMLA and disability forms. Disability forms can only be completed after the physician has determined the patient has a medical condition that warrants the patient to be off work. Normal symptoms during pregnancy (nausea, vomiting, headaches, swelling, pelvic pain/pressure) do not typically qualify as a medical disability.

**Embassy Letters**

WHASN understands the importance of having family support following deliveries and surgeries. We are happy to provide a letter requesting approval for a family member to travel to the United States to assist you during your recovery period. The fee to complete a letter to an Embassy is $100.00

**Minor Patients**

The parent or guardian accompanying the minor is responsible for full payment of services provided.

**Assignment of Benefits**

I hereby authorize and assign all payments and/or insurance benefits for medical services rendered to me directly to Women's Health Associates of Southern Nevada. I hereby authorize Women's Health Associates of Southern Nevada to release medical information necessary to obtain payment for services rendered by providers of Women's Health Associates of Southern Nevada**. BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND FULLY UNDERSTAND IN ITS ENTIRETY, THE INFORMATION IN THIS FINANCIAL POLICY AGREEMENT. I UNDERSTAND THAT BY SIGNING THIS FINANCIAL POLICY AGREEMENT, I AM AGREEING TO THE TERMS AND CONDITIONS PROVIDED WITHIN THIS AGREEMENT.**

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Health Care Agent/Guardian/Relative Signature Date

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

**PERSONAL/MEDICAL HISTORY**

Anxiety/Depression ☐Yes ☐No

Anemia ☐Yes ☐No

Asthma/Lung conditio ☐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: _____ ☐Norma ☐Abnormal

Last mammo: _____ ☐Norma ☐Abnormal

Last colonoscopy: _____ ☐Norma ☐Abnormal

Last DEXA (bone) scan: _____ ☐Norma ☐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 |
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**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:

- Access your health record
- Book appointments online
- Pay outstanding balances
- View test results
- Request prescription refills
- Ask non-emergency questions

We still welcome your phone calls, but we offer this service to you as a convenient way to communicate with your Care Center digitally. The patient portal may also be used to contact you.

Our patient portal is powered by Healow, a trusted service specializing in health and online wellness.

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 are not filtered into your junk folder.

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: _____
(Please print clearly)

Patient name: _____

Patient DOB: _____/_____/_____

Our patient portal is also available through the free Healow app, available on iOS and Android. Visit whasn.com/patient-portal to learn more.

# 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 comer, 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

WHASN
Women's Health Associates of Southern Nevada

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

| Patient Name | Date of Birth | Medical Record Number |
|---|---|---|
| **Patient Address** | **City** | **State/Zip Code** |

I, or my authorized representative, request that health information regarding my health care and treatment as forth on this form:

In accordance with Nevada State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, **GENETIC TESTING, AND CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in item 6(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 6(a), I specifically authorize release of such information to the person(s) indicated in item 6(d).

2. If I am authorizing the release of alcohol, drug abuse treatment, mental health treatment, genetic testing, or HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without my authorization. If I experience discrimination because of the release of disclosure of HIV-related information or believe my personal health information has been disclosed without my consent, I may contact the Nevada Attorney General at 775-684-1108 or the Regional Office for Civil Rights Region IX at 800-368-1019. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I further understand that if I am authorizing the release of my health information to the care provider listed below to seek payment for health care provided to me, I cannot revoke the authorization to the extent that the records are needed to secure payment for these services.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in item 2), and this re-disclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY, GOVERNMENTAL AGENCY, PROVIDER, PERSON OR ENTITY SPECIFIED IN ITEM 6(B).**

6(a) Specific information to be released:

- ☐ Medical records (office notes, radiology studies, lab results) from: _____/_____/_____ to _____/_____/_____
- ☐ Medical records (office notes, radiology studies, lab results) for the past year only.
- ☐ Last 4 pap smear ☐ Last 4 mammogram ☐ Last 4 DEXA scan
- ☐ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other healthcare providers.
- ☐ Sensitive records requested: (Indicate by Initialing) _____ **Alcohol/Drug Treatment** _____ **Mental Health Information** _____ **HIV-Related Information** _____ **Genetic Information**

**Authorization to Discuss Health Information**

6(b) By initialing here_____ I authorize _____ to discuss my health information with my attorney, governmental agency, other care provider(s) or person(s) listed below:

_____

6(c) Authorizing release of records from (provider/facility): _____

6(d) Release records to: _____
Name of Health Care Provider/Insurance/Other

6(e) Address to mail records: _____ Fax records to: _____

7. Reason for release of information: ☐ Transferring Medical Care ☐ Primary Care Provider ☐ Consulting Provider ☐ Personal Records ☐ Insurance Eligibility/Benefits ☐ Moving Out of State ☐ Legal Investigation ☐ Other_____

| 8. If not the patient, name of person signing form: | 9. Authority to sign on behalf of patient: |
|---|---|

10. Expiration date of authorization: _____/_____/_____ Expiration event of authorization: _____
**(If no expiration date or event is selected, authorization will expire in one (1) year)**

**All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form. I further understand that there may be a copy fee of 0.60 cents per page.**

_____ _____/_____/_____

Signature of patient or representative authorized by law 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

# REVOCATION 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