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

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:

Medicaid Coverage 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 the Past Due Accounts Department or placed with an outside licensed collection agency. This will result in late fees up to an additional 50% of your account balance. Once your account is assigned to the Past Due Accounts Department or to a collection agency, we are unable to reduce or remove the late fees. You are financially responsible for your entire account balance, as well as all late 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 provider may order laboratory services to assist in diagnosing your condition or as preventative care to determine your current health status. Your provider will choose an in-network lab to send any blood work, cultures, or other tests based on their preference. Your provider 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 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

Women's Health Associates of Southern Nevada

Las Vegas, NV

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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnoses, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided or disclose your medical information to our accountant or attorney for audit purposes. In addition, unless you object, we may use your health information

to send you appointment reminders or information about treatment alternatives or other health related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information:

State Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Electronic Patient Chart Sharing: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment Alternative: We may provide you notice of treatment options or health related services that improve your overall health.

Appointment Reminders: We may contact you as a reminder about upcoming appointments or treatment.

The following uses and disclosure of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are the notes by a mental health professional for the purposes of documenting a conversation during a private session. This session could be with an individual or a group. These notes are kept separate from the rest of the medical record and

do not include; medications and how they affect you, start and stop time of sessions, types of treatments provided, results of test, diagnosis, treatment plan, symptoms, prognosis.

Other uses and disclosures of PHI not covered by this Notice, or by the laws that apply to us, will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Medical Records Department in our office. Specifically, you have the following rights:

- **Right to Request Restrictions** - You have the right to ask that we limit how we use or disclose your medical information. We require that any requests for use or disclosure of medical information be made in writing. Written notice must be sent to the attention of the Office Manager at the practice and address indicated in the header of this Notice. We will consider your request, but in some cases, we are not legally required to agree to these requests. However, if we do agree to them, we will abide by these restrictions. We will always notify you of our decisions regarding restriction requests in writing. We will not ask you the reason for your request. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by alternative means. Your request must specify how or where you wish to be contacted. You have the right to opt out of communications for fundraising purposes.

- **Right to Access, Inspect and Copy** - With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. Consent is required prior to use or disclosure of an individual's psychotherapy notes or the use of the individuals PHI for marketing purposes.

- **Right to Amend** - If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.

- **Right to an Accounting of Disclosures** - In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- **Right to a Paper Copy of This Notice** - You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time and notify us in writing.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer.

If you have questions about this Notice or any complaints about our privacy practices, please contact:

Office of the HIPAA Privacy and Security Officer

Phone: 1.702.577.1622
8906 Spanish Ridge Avenue
Suite 202
Las Vegas, NV 89148

You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Email to OCRComplaint@hhs.gov

We will take no retaliatory action against you if you make complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

VI. Effective Date:

This Notice was effective on December 13, 2022.

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 and Security Officer, the WHASN President, 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