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.

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/Unit#: _____ City: _____ State: ___ Zip: _____

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

Email: _____ Occupation: _____

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: _____

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: _____
_____ Dose: _____ Frequency: _____
_____ Dose: _____ Frequency: _____

Notice of Privacy Practices

Women's Health Associates of Southern Nevada (WHASN)

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 healthcare. 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 healthcare 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:

Substance Use Disorder (SUD) Treatment Records: If we receive or maintain any information about you from a 42 C.F.R. Part 2-covered SUD treatment program through a general consent you provide to the Part 2 Program to use and disclose your records for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 records for treatment, payment and health care operations, as described in this Notice. If we receive or maintain your Part 2 Program record through a specific consent provided to us by a Part 2 Program or another third party, we will use and disclose your records only as expressly permitted by the consent provided to us. We will never use or disclose your Part 2 Program record, or testimony that describes the information contained in that record in any civil, criminal, administrative, or legislative proceedings against you, unless authorized by your consent or by court order with the required documentation and notices.

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: Our facility participates in electronic patient chart sharing with other healthcare providers. Through this process, your health information may be made available to or received from 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.

Text messaging and Email: By providing your contact information, such as your name, phone number, and email address, you consent to receiving email and text messages from us with communications about the services we provide to you or otherwise in accordance with this Notice. You acknowledge that sending PHI in an unencrypted communication via SMS or email may be unsecure, and agree to receive such communications. These communications may include messages sent through the use of landline phone, cellular phone, and text messages (including SMS and MMS). We may use an automatic telephone dialing system (or "auto-dialer"), which may employ artificial or pre-recorded voice or "robotexts." Your carrier's standard rates and charges may apply. You may opt-out from receiving email communications at any time by contacting your provider's office. You may opt-out from text messaging by replying STOP to the text messages you receive from us. Opt-out requests will be honored promptly.

Artificial Intelligence (AI) Tools: We may utilize artificial intelligence (AI) tools to support and enhance the quality and efficiency of your care, such as for scheduling, documentation or data analysis. We have adopted safeguards to protect your medical information used in conjunction with any AI tool, and any such use will comply with applicable privacy and security standards. All decisions regarding your diagnosis and treatment will always be made by a qualified, licensed clinician using their independent clinical judgment. Any use of AI tools supports our licensed healthcare providers but does not replace their expertise and judgment.

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 Disclosure** - 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 Ave. #202
Las Vegas, NV 89148

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.

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.

V. Last Updated:

This Notice was last updated on January 28, 2026.

Notice of Privacy Practices:

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, the WHASN President, if I have any questions regarding the contents of this Notice or to file a complaint.

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Guardian Signature Date

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 provider-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 provider. **Our office requires your social security number to verify insurance billing, as well as to aid in collection proceedings. Please note this information will remain in our system and registration forms are shredded after data entry.** Should you not wish to provide your social security number our office will have to uphold policy and cancel services with our providers. It is the patient's (parent/guardian) responsibility to notify this office of any changes to your information. 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. ****Please note: A live picture will be taken at first visit for identification purposes.**

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 provider has provided a complete account 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 patient responsibility for 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 see 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 such as out of network, cosmetic, exhausted benefits, experimental, no referral, or because 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 provider 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 provider'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:

Self-pay

If the patient does not have insurance, they may be provided with a cash pay price for the office visit. Cash pay patients may be required to pay for the visit in full before being seen. Please note that the prices quoted for cash pay visits are for the ***visit only*** and based on a particular visit type, any additional services performed may increase the amount due (i.e., annual vs. annual w/problem are different rates). Any additional testing (labs, cultures, pap smears, ultrasounds, etc.) will have an additional charge.

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 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 fee of 50% of your account balance. Once your account is assigned to the Past Due Account 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. Please note that, at the discretion of the care center, delinquent account may be grounds for automatic dismissal from the practice. Other WHASN care centers may also use their discretion to provide or not provide services in the future.

Account Credits

Because we can only estimate your financial responsibility for services provided by WHASN, there is a possibility you may have 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 with an Obstetrical Financial Agreement (aka OB Contract). 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. WHASN care centers may utilize the WHASN Central Laboratory for the ordering and processing of specimens and/or cultures; however, 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. If you know that your insurance will not cover lab processing unless you go through a specific lab company, or you have a preference on the lab company you'd like to use, please notify office staff of your and/or your insurance's lab preference. Please note that if you'd like to discuss lab results, you may need to be scheduled for an appointment and that this appointment may also require additional visit costs (with self-pay or co-pay rates).

Returned Checks

WHASN's Central Billing Office (CBO) 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/or "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.

Credit card chargebacks

We encourage you to contact us directly with any payments concerns before initiating a credit card chargeback, as we are committed to resolving issues at the lowest level. In the event of a credit card chargeback, we reserve the right to charge a minimum fee of $35.00 per transaction, and the fee will be due after the chargeback is processed. This fee is separate from the disputed amount and is for the administrative costs associated with handling the chargeback with the card issuer.

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 failure to present at the time of a scheduled appointment will be recorded as a "no-show". *A "no-show" is someone who misses an appointment without cancelling it at least 48 hours prior to the scheduled appointment time.* In addition to being marked as a no-show, the failure to notify our office within the 48-hour period will also result in a "no-show" fee, which may **vary depending on the type of appointment** that you are scheduled for (i.e., regular visit, ultrasound, procedure, surgeries, etc.). If you have questions regarding fees that will be charged, please reach out to the care center for more information.

FMLA / Disability Forms

FMLA - There will be a charge for each FMLA/disability form/signature completed by this office. Payment is due at the time the form is submitted. Note that the charge is non-refundable, should the patient change their mind. All FMLA/disability forms are completed by the office staff. There may be the option of having

the paperwork expedited, but please note that there are additional fees due for the expedited form completion. Please note: The provider'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 provider 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. If you have questions regarding any amount(s) that will be charged or timelines to complete these forms, please reach out to the care center for these details.

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. Once the fee has been collected, the fee is non-refundable should the patient change their mind.

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/Guardian Signature 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.

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 Date of Birth: _____/_____/_____

PATIENT ELECTRONIC COMMUNICATION INFORMED CONSENT

If permitted, Women's Health Associates of Southern Nevada (WHASN) and its providers, employees, independent contractors, third party applications, and any "covered entity" or "business associate" (as defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, WHASN) may communicate with you by email, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Communication") to the telephone number(s), email address(es), or other electronic format provided documented on your account or as otherwise provided below.

Utilization of Electronic Communication: WHASN may use Electronic Communication to communicate with you regarding healthcare, scheduling, billing, and quality improvement related issues. This includes, but is not limited to:

- Test results, prescriptions, treatment options, preventative care, referrals, consultations, surgical services, and other information necessary to ensure continuity of care.
- Appointment reminders, missed appointment notifications, rescheduling notifications, cancellation requests, and appointment requests.
- Demographic information, insurance coverage, eligibility and benefits, billing, and account balances, FMLA and disability requests, and practice policies.
- Patient satisfaction surveys, and access to your patient portal.

Inherent Risks Associated with Electronic Communication: All forms of electronic communication have risks that you should consider. These risks include, but are not limited to the following:

- Emails, texts, voicemails, recordings, and other electronic communication can be circulated, forwarded, stored, and broadcast to unintended recipients.
- Senders can unintentionally misaddress an email, send text, leave a voicemail to the incorrect recipient(s).
- Backup copies of electronic communication may exist even after the sender and/or the recipient have deleted the original copy.
- Employers and on-line services have a right to inspect electronic communications sent through their company systems.
- Electronic communications can be altered, forwarded, or used without authorization or detection.
- Unauthorized individuals can intercept electronic communications and use sensitive information for fraudulent purposes.
- Electronic communications can be used as evidence in court proceedings.

Conditions For Use of Electronic Communications: Patient privacy is of utmost importance. We will use reasonable means to protect the security and confidentiality of all forms of electronic communication with a patient. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of electronic communications and will not be liable for improper disclosure of confidential information that is not caused by WHASN's intentional misconduct. The patient must consent to the use of electronic communication on the following conditions:

- **If you have a medical emergency, do not use electronic communications to contact or notify the office, dial 911 and request medical assistance.**
- Urgent matters should be relayed to us using regular telephone communication or you should seek medical care from an urgent care center or emergency room.
- It is not recommended to use electronic communications regarding sensitive information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, physical or mental abuse, substance abuse, or other matters of a sensitive nature. You will be asked to schedule an appointment to discuss all sensitive matters or review results in your patient portal.
- Employers do not observe an employee's right to privacy in their email system. You should not use your employer's email system to receive confidential email, which may include electronic personal health information (ePHI).
- WHASN will not engage in electronic communications that are illegal.
- Electronic communications from the patient concerning diagnosis or treatment may be made part of the patient's electronic medical record. Because electronic communications may be added to the patient's electronic medical record, other individuals authorized to access the patient's electronic medical record, such as support staff and billing staff may have access to the electronic communications.
- Electronic communications may include ePHI. However, the amount of ePHI shared will be limited to only necessary information.
- You are solely responsible for protecting the password(s) or other means of access to electronic communications.
- WHASN is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct.
- WHASN is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under WHASN's Patient Electronic Communications Informed Consent. You should contact your electronic service provider regarding fees and charges.
- It is your responsibility to follow up and/or schedule an appointment with your medical provider, if warranted.

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the termination of your physician-patient relationship. You may choose to stop participating in Electronic Communications at any time by informing WHASN in writing. You understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled. This includes continued treatment, electronic claims, electronic payments, and electronic communications with insurance companies regarding eligibility and benefits. To withdraw your consent to electronic communications, you may request an Electronic Communications Withdraw Form from a WHASN staff member.

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of electronic communications between WHASN and me, and I consent to the conditions outlined herein. In addition, I agree with the instructions outlined herein, as well as any other instructions WHASN may impose on communicating with patients by way of electronic communications.

I understand that WHASN will use the phone number(s) and email address(s) in my electronic medical record for electronic communications with me.

My signature below represents that I have read the above and consent to use electronic communications between WHASN and me.

Email Address: _____

Cell Number: _____

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Guardian Signature Date

OFFICE POLICIES

WHASN strives to provide patient centered care that is focused on exceptional, compassionate, personalized medical services for women of all ages in a warm and friendly environment. We are committed to creating provider-patient relationships built on trust, confidence, and respect for both parties. Quality healthcare requires both provider and patient to contribute to the collaborative effort of improving healthcare outcomes and improving the overall health and wellbeing of every patient.

WHASN care centers have a Zero Tolerance Policy towards aggressive behavior. This includes but is not limited to behavior such as physical assault, verbal harassment, abusive or foul language, threats (verbal or physical), and failure to respond to staff instructions. Behaviors such as these may result in removal from the office, termination from WHASN, and/or prosecution.

To respect the privacy of all patients, there will be no pictures or videotaping within any common area. The provider may limit the number of people allowed in the room for the appointment, ultrasound, or procedures. It is recommended that children do not come with you to your appointment and if children are with you, please note they are not allowed to be unattended in the waiting room.

Managing access to healthcare services requires managing and balancing of our resources. This includes providers, staff, equipment, and exam rooms. To accomplish this, it is necessary for us to make appointments to see our patients as efficiently as possible. We set aside sufficient time for you to receive the care you need from our providers. To be respectful of the medical needs of all our patients, please be courteous and notify us immediately if you are unable to show up for your scheduled appointment. Late arrivals, no shows or same day cancellations are discouraged and have consequences*. These consequences can include:

- **No-show fees (which vary depending on the type of appointment scheduled).**
- Needing to wait to see your provider. Priority will be given to patients who arrived on time. If this is not convenient for you, you may reschedule. Note: Fees may still be assessed.
- Being placed on a "Walk-In" status. Walk-In appts. are unable to be scheduled at greater than 24 hours in advance, and only if an appointment is available.
    - We are unable to guarantee that you will see your preferred provider.
- "Restricted Appointment" status. Those on Restricted Appointment status will only be allowed to make appts at the end of the day.
- Depending on the situation, **2-3 no-shows or late cancellations may cause you to be dismissed from the care center**.

***Ultrasound and procedural appointments grace periods may not be available.** This is due to the longer length and/or complexity of these appointments and their scheduling restrictions.

No Show Status Designation Types

- **Late Arrival** – Patients who arrive late for their scheduled appointment, and the provider is unable to see them may be marked as a no-show. *If the visit is for a procedure or ultrasound, additional no-show fees may apply.*

- **No-Show** – Any patient who fails to show for their scheduled appointment.
- **Same Day Cancellation** – Any patient who cancels their appointment with less than two full business days' notice. (i.e., an appointment on Monday would need to be cancelled on Wednesday of the previous week).

Patients are required to notify the office a minimum of two (2) full business days prior to your scheduled appt. If you do not arrive for your scheduled appt., and there was a failure to provide the required notification, this will result in your appointment being marked as a "No-Show".

As a courtesy, we will send appointment reminders, and in some cases, provide a reminder call, prior to your appointment; however, it is ultimately your responsibility to know of and keep your scheduled appointment.

Other items to note:

Medication and Medication Refills – Please allow 72 hours (3 business days) for prescription refills. We attend to refill requests during regular business hours, and no refills will be given after hours, during the weekend, or on holidays. It is the responsibility of the patient to know when their prescription needs to be refilled. Depending on the medication (including controlled substances), an appointment may be required to get a refill, or your provider may only prescribe a limited prescription of the medication until you are seen in the office.
*If you are prescribed a controlled prescription, there may be additional paperwork required to be completed and on record.

Patient Portal – You can use the patient portal* to quickly access your WHASN medical records. WHASN can communicate with you through the portal, and this communication can go both ways. Please note:

- **Don't use the patient portal to communicate emergencies. Dial 911 or go to your local hospital.**
- Should you need to discuss the results of your lab work or diagnostic imaging, you will need to schedule an appointment with your provider.
    - The appointment will allow the provider to go over your results in more detail, answer any questions you have, and set a care plan for any next steps.
    - Note: We will always prioritize urgent or abnormal results, as quickly as possible.
- Allow up to 3 business days for your care center to respond to your portal communication.

*The Healow App can also be downloaded using Practice Code - JFFJBD

Providers – While we make every effort to schedule you with your provider of choice, occasionally we may need to schedule you with another provider within our care center. If you do have a specific provider that you see, it is normally not our policy to allow transfer to another provider unless both providers agree to the transfer. Once the transfer is completed, your new provider will be responsible for your care. This would include all care provision within your WHASN care center and providers at other WHASN care centers.

After-Hours Call Policy – We are happy to offer after-hours support when you need us; however, please note that this call may be billed as a Telehealth visit and your insurance may require a copay or apply the cost of this visit to your deductible.

Appointment clarification – Annual exams contain a physical examination and in some cases a pap smear. If your insurance doesn't cover the pap smear on an annual basis, but you'd like to have one performed, please note this will be an additional charge.

As a clarification, annual exams are known under several different names, but all annual visits have specific items covered or not covered. Please note that these types of appointments can be called routine check-ups, yearly exams, annual pap, preventative visit, wellness exams, or well-women visits. Most health care insurance plans only pay for one wellness or preventative exam per year, and this exam does not cover/include the discussion of new problems or an extensive review of chronic conditions. Any discussion or action taken on anything not covered in your wellness exam may constitute an additional charge (which may require a copay to or be applied to your deductible).

Which services are "not covered" at my Preventive Wellness Visit?

Some notable examples of services that many patients need from their primary care provider but will not be covered at a preventive wellness visit include:

- **Acute illnesses and injuries.** If you are sick or injured this will go outside of a wellness exam and could go towards an insurance benefit (deductible, co-ins or copay)
- **Problem/Complaint.** Should a condition require additional testing, referrals or medication, this is no longer considered preventative and may leave you responsible, as this might go towards your insurance benefit.
- **Surgical procedures.** There is no definition of "wellness" that would require a surgical procedure. Generally, a surgical procedure requires its own separate visit apart from anything else.
- **Medication.** Generally, apart from contraceptives for women and aspirin for certain risk groups, any discussion of prescribing new medications is not covered as a preventive service.

The list below is not all-inclusive, and you should contact your insurance company to determine your specific coverage and benefits.

Included:	**Not Included:**
• Medical, Social, Family, Surgical, and Hospitalization History • Review of medications & allergies • Preventative screenings • Vital signs and physical exam • Pap-smear, as applicable/appropriate • Mammogram, as applicable/appropriate • Ordering/review of screening labs • Health screening recommendations • Lifestyle/Behavioral recommendations	• Addressing worrisome or bothersome symptoms • New complaints or problems • Management of chronic health problems • More complex issues (i.e., Endometriosis) • Procedures or therapeutic injections • Non-screening tests • Provider identified new problems *These will require future workups & follow-ups

We appreciate your time in reviewing this information and we look forward to assisting you in your health care journey and to be your trusted OB/GYN provider, care team, and care center.

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Guardian Signature Date

PATIENT TEST RESULT COMPLIANCE AND RESULT FOLLOW-UP

Your provider may order diagnostic and/or screening laboratory, radiological, consultation, or referral services at the time of your visit or while reviewing your medical records. The more common tests we order are pap smears, mammograms, DEXA scans, cultures, biopsies, ultrasounds (pelvic/breast), and laboratory tests. It is very important that you have the test(s) that is ordered performed in the time frame requested by your physician.

Minimizing test result errors is of utmost importance to our practice. You are encouraged to utilize the patient portal or Healow app to review your testing results. Test results will be posted on the portal, as well as the mammography results will be posted and mailed. If your results are not posted on the portal, please contact us but note that not all results can be provided verbally without scheduling and meeting with a provider to go over your results.

In some cases, in the event your results are abnormal, or the provider would like additional services performed, our office will attempt to contact you by phone to schedule an appointment for follow-up. It is very important that you provide up-to-date contact information. If we are unable to reach you by phone, we will mail a request for you to contact our office to discuss results.

If your provider orders diagnostic services to assist in diagnosing and/or treating an illness, injury or disease, you should schedule an appointment to see the provider within two weeks of the service being performed, or as directed by the provider. The provider will review the test results with you and discuss any additional medical services that need to be performed. Early diagnosis and treatment are extremely important and can reduce the morbidity/mortality rate for many conditions.

I understand that should I have any questions regarding my lab, or if my provider requests that we discuss my labs/imaging, I must schedule a follow-up appointment with my provider. I further understand I am required to schedule and be seen by my provider in a timely fashion for any diagnostic services ordered by my physician.

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Guardian Signature Date

WHASN LAB

Your physician may order laboratory services to assist in diagnosing a condition or as preventative care to determine your current health status. Our practice is pleased to announce that it has developed a laboratory dedicated solely to women's healthcare, which we believe will provide our patients with a high level of specialized care for laboratory testing.

WHASN care centers may utilize the WHASN Central Laboratory for the ordering and processing of blood, specimens and/or cultures. This includes HPV testing, testing for sexually transmitted infections, screening and diagnostic labs, and drug screening. In addition, our physicians will have a direct line of communication with a pathologist to discuss your care. We believe these factors will contribute to our ability to provide our patients with increased continuity of care and more timely results.

As with any laboratory and its services, we cannot guarantee that all services will be covered at 100% under each patient's insurance. 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 plan. **If you know that your insurance will not cover lab processing unless you go through a specific lab company, or you have a preference on the lab company you'd like to use, please notify office staff of your and/or your insurance's lab preference and we will honor this choice.**

When your insurance company is billed for our laboratory's services, you will receive an Explanation of Benefits ("EOB") from your insurer that will indicate the patient responsibility (your responsibility), if any. Please note that the provider's name listed on your EOB or patient statement will be Dr. Jamie Shutter (our lab pathologist) or Dr. Rebecca Herrero (the WHASN Medical Director).

Should you have any questions relating to your EOB or your bill, please call 702.529.1821.

*Please note that if you'd like to discuss lab results, you will need to schedule an appointment with your provider and that this appointment may also require additional costs associated with the visit.

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Guardian Signature Date

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 or through a secure link sent to my phone. 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/Guardian Signature Date

HIPAA/PRIVACY AUTHORIZATION

Please read the policy below and complete the applicable sections.

This privacy policy is to protect your privacy and to protect the providers and staff at our care centers from violating your patient confidentiality. If there is not a signed consent on file, providers and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing our providers and staff to leave a message on an answering machine, voicemail, or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results requested by you, to your primary care physician or another physician involved in your care with a signed medical record request.

I give my consent to the provider and/or staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary. (Check all that apply)

Primary cell number: _____ - _____-_____

____ Leave detailed voicemails on this phone number
____ Leave nondetailed voicemails on this phone number (call back number only)
____ Approved to send text message to this phone number
____ Do not leave voicemails or send texts on this phone number

Secondary home number (as applicable): _____ - _____-_____

____ Leave detailed voicemails on this phone number
____ Leave nondetailed voicemails on this phone number (call back number only)
____ Approved to send text message to this phone number
____ Do not leave voicemails or send texts on this phone number

I also give consent to the provider and/or staff to discuss scheduling, treatment, surgery, labs or radiology results and other information to anyone listed below:

_____

_____

Name: _____

Relationship: _____

Number: _____

Name: _____

Relationship: _____

Number: _____

I may refuse to complete this Authorization. I understand that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may cancel this authorization at any time. Cancellation of my authorization must be in writing and signed by the patient in office.

These permissions will remain in effect throughout your time in our practice and should you need to make any revisions to these contacts or permissions, please reach out to your care center.

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Guardian Signature Date

NOTICE OF ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

The above information is complete and correct. I hereby guarantee payment of all charges incurred with this office. I hereby assign and direct my insurance company(s) to pay any and all benefits for my medical services directly to this office. I authorize the release of medical information requested by my insurance company(s) to insure payment on this account. I understand that should my insurance company(s) deny any submitted charges for any reason, I am responsible for payment of those charges. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover money due to Women's Health Associates of Southern Nevada.

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Guardian Signature Date