WHASN
Women's Health Associates of Southern Nevada

PATIENT REGISTRATION

Preferred Pharmacy: _____ Location: _____ Pharmacy Phone: _____

Patient Information

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

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

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

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

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

Street Address: _____ City: _____ State: _____Zip: _____

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

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

Employer: _____

Associated Parties

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

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

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

Insurance Information

Primary Insurance: _____

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

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

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

Secondary Insurance: _____

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

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

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

PLEASE READ THE FOLLOWING CAREFULLY:

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

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

Notice of Assignment of Benefits and Release of Medical Information

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

_____	_____	_____/_____/_____
Patient/Legal Guardian Name	Patient/Legal Guardian Signature	Date

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

PERSONAL/MEDICAL HISTORY

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

SOCIAL HISTORY

Married/Single/Divorced/Widowed/Separated

Smoke: Yes/No Packs per day? _____

Alcohol: Yes/No How much? _____

Street drugs: _____

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

Last Menstrual Period: _____

Age of 1st period: _____

Periods occur every _____ (days) and last _____ (days)

Heavy/clots/pain/cramping/irregular bleeding

Average # of pads/tampons used per day: _____

Are you menopausal? _____ **Age:** _____

Hysterectomy? Yes/No **When?** _____

Complaints of: breast pain/pain with intercourse/infertility/

fibroids/ovarian cysts/vaginal infections/loss of urine

SEXUALLY TRANSMITTED DISEASES

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

# of sexual partners? _____

BIRTH CONTROL HISTORY

Current method of birth control: _____

PREGNANCY HISTORY

Number of miscarriages: _____ Abortions: _____ Ectopic: _____

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

SURGICAL HISTORY

Hysterectomy Date: _____ Abdominal/vaginal

Ovaries removed Date: _____

Laparoscopy Date: _____

Tubal ligation Date: _____

D&C Date: _____

Breast surgery Date: _____

Ablation Date: _____

OTHER: appendectomy/back surgery/gallbladder/tonsillectomy/Bowel/fibroid removal

_____

FAMILY HISTORY **Family member**

Breast cancer Yes/No _____

Ovarian cancer Yes/No _____

Colon cancer Yes/No _____

Other: _____

_____

CURRENT MEDICATIONS (List all medications taken on a daily basis)

1. _____ Dose: _____ Frequency: _____
2. _____ Dose: _____ Frequency: _____
3. _____ Dose: _____ Frequency: _____
4. _____ Dose: _____ Frequency: _____
5. _____ 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

Dear Patients,

We would like to invite you to take advantage of our online Patient Portal. Our secure portal is a helpful resource to:

- Request appointment times
- Pay statement balances and bills
- Request prescription refills
- Fill out 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 more convenient way to communicate with your care center.

If you would like to sign up for the portal please visit WHASN.com and click the link to the Patient Portal.

Thank you,

WHASN

Preferred Email: _____

Patient name: _____
(Please print clearly)

Patient DOB: _____/_____/_____

HIPAA NOTICE OF PRIVACY PRACTICE

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

Women's Health Associates of Southern Nevada (WHASN) is required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to PHI. WHASN, its providers, employees, subcontracted affiliates, third party administrators (TPAs), and business associates who are involved in providing and coordinating health care are all bound to follow the terms of this Notice of Privacy. Your PHI may be shared with individuals involved in your health care and payment operations as permitted by HIPAA and this Notice. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future medical condition. We are required to provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDS, and information about alcohol and other substance abuse.

Our Commitment Regarding Protected Health Information

WHASN understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care services you receive from us. We need this record to provide you with quality health care services and comply with certain legal requirements. This notice applies to all the records of your care that we generate or receive.

Uses and Disclosures of Protected Health Information Not Requiring Your Prior Authorization

Except where prohibited by federal or state laws that require special privacy protections, we may use and disclose your PHI for treatment, payment and health care operations without your prior authorization as follows:

Treatment. We may use and disclose your PHI to provide and coordinate the treatment, medications and services you receive. For example, we may disclose PHI to physicians, physician assistants, nurse practitioners, nurses, ultrasound techs and other personnel involved in your health care. We may also disclose your PHI with other third parties, such as hospitals, pharmacies and other health care facilities and agencies to facilitate the provision of health care services, medications, consultations, referrals and equipment/supplies you may need. This allows for continuity of care and helps to make sure everyone involved in your care has the information necessary to provide the highest quality of care possible.

Payment. We may use and disclose your PHI in order to obtain payment for health care services and supplies that we provide to you and for other payment activities related to the services we provide. For example, we may need to give your health plan information about your treatment so they can authorize or pay for your health care services. The information on or accompanying a claim may include information that identifies you, as well as information about the services that were provided to you. We may also disclose your PHI to other health care providers or HIPAA covered entities who may need it for their payment of services.

Health Care Operations. We may use and disclose your PHI in order to facilitate business operations. These activities include, but are not limited to, quality assessment and improvement, analyzing health care delivery effectiveness and efficiency, employee reviews and training and conducting other business activities.

Other Uses and Disclosures. We may also use and disclose your PHI without your prior authorization for the billing services, copy service, consulting services, appointment reminder services, and communication of medical results. We may also disclose to a family member, other relative, close personal friend, or any other person you identify, PHI directly relevant to that persons involvement in your care which, based on the providers judgement, will improve the delivery or outcome of health care services provided. In addition, we may disclose of PHI to any person(s) having authority by law to make health care decisions for you or has authority according to federal or state law to obtain your PHI. Additionally, we may provide PHI for purposes of; worker's compensation, public health authorities, law enforcement, health oversight, judicial proceedings, research, coroner's office, national security purposes, military and veterans services, victims of abuse and neglect agencies, and to avert a serious threat to health and safety.

Uses and Disclosures of PHI that Require Your Prior Authorization

Specific Uses or Disclosures Requiring Authorization. We will obtain your written authorization for the use or disclosure of PHI for marketing and advertising purposes. We will also require your written authorization for release of your PHI to health care providers and facilities not involved in your current or ongoing health care.

Patient Rights Regarding Protected Health Information

You have the right to receive a copy of WHASN's Privacy Practice Notice when you receive medical care. Even if you have agreed to receive an electronic copy of the Notice, you are still entitled to a paper copy.

You have the right to inspect or obtain a copy of your PHI by submitting a written request for the information.

You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Office. We are not required to agree to the restrictions, except in the case of where the disclosure is to a health plan for purposes of carrying out payment or health care operations, is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you, or a person on your behalf, has paid in full for the item or service.

You have the right to request an amendment to your PHI if you feel the information is incomplete or incorrect. You must submit your request for amendment in writing explaining your reason for the amendment. If your request is denied, you will receive a written explanation of why your request was denied.

With the exception of certain disclosures, you have the right to receive a list of the disclosures we have made of your PHI, in the six years prior to the date of your request to entities or individuals other than yourself.

You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For instance, you may request that we contact you at your residence, via fax, e-mail or phone. Please note that communication through e-mails or other electronic formats is not secure and if you elect to receive PHI from WHASN via e-mail or other electronic means, that there is a risk that PHI contained in the e-mails may be intercepted and read by unauthorized third parties. To receive confidential information regarding your PHI you must submit a request in writing. Your request must state the information requested, as well as, how and where the information is to be sent.

You have the right to be notified following a breach of your unsecured PHI. WHASN will notify you in accordance with the applicable law.

You may submit a written request for confidential PHI to your physician's office directly or direct the request to:

Women's Health Associates of Southern Nevada
Privacy Office
9580 W. Sahara Avenue, Suite 180
Las Vegas, Nevada 89117

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____/_____/_____

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, Carla Turner, M.D., if I have any questions regarding the contents of this Notice or to file a complaint.

_____ _____

Signature of Patient or Patient's Representative 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