Henderson WOMEN'S CARE
OBSTETRICS · GYNECOLOGY

2420 W. HORIZON RIDGE PKWY STE #130 HENDERSON, NV 89052
HendersonWomensCare.com (702) 847-6252

PATIENT REGISTRATION

Preferred Pharmacy:_____ Location: _____ Pharmacy Phone: _____

PATIENT INFORMATION

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

Preferred Name: _____ DOB:____/____/_____ SSN:_____/_____/_____

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

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Declined

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

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

Phone#:_____ Email:_____

Employer:_____

ASSOCIATED PARTIES

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

Emergency Contact:_____ Relationship: □ Spouse, □ Parent, Other:_____ Phone #:_____

INSURANCE INFORMATION

PRIMARY Insurance:_____

Policy Number:_____ Group Number:_____

Name of Insured:_____ Relationship to Insured: □ Spouse, □ Parent, Other:_____

SSN# of Insured:____/____/_____ Insured's Date of Birth:____/____/_____

SECONDARY Insurance:_____

Policy Number:_____ Group Number:_____

Name of Insured:_____ Relationship to Insured: □ Spouse, □ Parent, Other:_____

SSN# of Insured:____/____/_____ Insured's Date of Birth:____/____/_____

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FINANCIAL RESPONSIBILITY

- You are responsible for knowing if your insurance is contracted with Henderson Women's Care.
- You are responsible for knowing your coverage and benefits.
- All deductibles, co-payments and applicable charges will be due at the time of service.
- All surgery fees MUST be paid in advance of the surgical date.
- For any FMLA/Disability forms, there will be a one-time processing fee in the amount of $25.00. It is your responsibility to present these forms to our office via our front desk staff. You will receive a call once the forms are ready for pick-up. Please allow 7-10 business days for completion of the paperwork, from the date paperwork is received in the office. For URGENT requests with a 24-hour turnaround, the fee is $50.00.
- 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. After three (3) missed appointments, the practice may, at its discretion, choose to discontinue your care.
- **LATE TO APPOINTMENT POLICY:** If you are an established patient and you arrive 15 minutes late or more to your appointment, you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time, and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.
- If you are a new patient and you do not arrive 30 minutes prior to your scheduled appointment time, as instructed to complete your forms, and it takes more than 30 minutes to complete the forms and the registration process, you may also be asked to reschedule. We may, from time to time, make these forms available in advance of your initial visit to expedite this intake process and your completion of these forms.

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 your insurer directly for that information. **You will receive a separate bill from the lab for pap smear interpretation, cultures, urinalysis, and other laboratory services.**

By signing this document, you guarantee payment of all charges incurred with this office. You hereby assign and direct your insurance company or companies to pay any and all benefits for your medical services directly to this office. You authorize the release of medical information requested by your insurance company or companies to insure payment on your account. You understand that should your insurance company or companies deny any submitted charges for any reason, you are responsible for payment of those charges. In the event of collection proceedings due to lack of payment on your part, you agree to pay any and all collection fees that may be added to your account in order to recover money due to Henderson Women's Care.

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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 must 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 at the end of this consent form, you are agreeing that Henderson Women's Care can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Patient/Legal Guardian Name (Print): _____ DOB: _____/_____/_____

Patient/Legal Guardian Signature: _____ Date: _____/_____/_____

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Patient Name:_____ Age: _____ Date of Birth: _____ Date: _____

PERSONAL MEDICAL HISTORY:

□ **NONE** - (I have no diagnosed medical conditions)

□ Diabetes □ High Blood Pressure □ Stroke

□ Bleeding disorders □ Hx of Cancer □ Migraines

List any and all other medical problems:

_____ _____

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY:

□ **NONE** - (I have never had surgery)

List any and all SURGERIES & YEAR you have had (including non-GYN and cosmetic surgeries):

_____

_____

_____

_____

_____

_____

_____

PREGNANCY HISTORY: - List any and all PREGNANCIES you have had:

□ **NONE** - (I have never been pregnant)

Month/Year	Vaginal (V) Cesarean (C) Miscarriage (M) Abortion (A) Ectopic (E)	How many weeks were you pregnant when you delivered? If **≥ 37 weeks** check FT	Birth weight	**Complications** (Preterm delivery, problems with delivery, blood transfusions, High blood pressure or diabetes in pregnancy etc..)
	V C M A E	□ FT		
	V C M A E	□ FT		
	V C M A E	□ FT		
	V C M A E	□ FT		
	V C M A E	□ FT		
	V C M A E	□ FT		
	V C M A E	□ FT		
	V C M A E	□ FT		

GYNECOLOGIC HISTORY:

Last Menstrual Period (LMP): _____

Last Annual Exam (YEAR): _____

Last Pap Smear (YEAR): _____

Do you have monthly menstrual cycles?: □ Yes □ No

History of abnormal pap: □ No □ Yes – (YEAR):_____

Last Mammogram (YEAR): _____

Last Colonoscopy (YEAR): _____

Circle if you have had a history of the following:

Chlamydia Gonorrhea Herpes Genital Warts

Hepatitis B or C HIV Syphilis

Sexual preference (i.e. Heterosexual, Homosexual, Bisexual, etc):

_____

Are you trying to conceive?: □ No □ Yes

Are you sexually active?: □ No □ Yes

Birth Control method: □ **NONE**

□ Condoms □ Pill □ NuvaRing □ Patch □ Depo Provera

□ IUD/Nexplanon – (Type & Date placed):_____

□ Sterilization/Other:_____

SOCIAL HISTORY:

□ Married, □ Domestic Partner, □ Single, □ Widowed

Nicotine: □ No □ Yes – Amount per day:_____

Alcohol: □ No □ Yes – Drinks per day:_____

Drugs: □ No □ Yes – Specify:_____

Cannabis: □ No □ Yes – How often?:_____

ALLERGIES: - List any and all ALLERGIES

□ **NONE**

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATIONS: - List any and all MEDICATIONS you are taking

□ **NONE**

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

Breast Cancer: □ No □ Yes – Family member - Mother-side:_____, Father-side:_____

Ovarian Cancer: □ No □ Yes – Family member - Mother-side:_____, Father-side:_____

Colon Cancer: □ No □ Yes – Family member - Mother-side:_____, Father-side:_____

Other:_____

PATIENT/LEGAL GUARDIAN SIGNATURE:_____

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HIPAA NOTICE OF INFORMATION PRACTICES

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

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care of treatments. This information is often referred to as your health or medical records, referred to within HIPAA's regulations as "protected health information," and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve
- Understanding what is in you record and how your health information is used helps you to ensure its accuracy, make more informed decisions when authorizing disclosure toothers; and better understand who, what, when, where and why others may access your health information.

<u>Understanding your Health Information Rights</u>
Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your Information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

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Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations
- We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.
- If you believe your privacy rights have been violated, **you can file a complaint with the Office of Civil Rights either by calling 800-368-1019 or by writing to U.S. Dept of Health and Human Services, 90 7th Street, Suite 4-100, San Francisco CA 94103.**

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

***We will use and disclose your health information for payment*.** For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with Worker's Compensation or other similar programs established by law.

***We will use your health information for regular health operations*.** For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality and effectiveness of the healthcare and services we provide.

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Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your protected health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication. After careful judgement, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***Food and Drug Administration (FDA*).** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, if we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

By signing at the end of this consent form, you acknowledge receipt of Henderson Women's Care HIPAA Notice of Information Practices.

Patient/Legal Guardian Name (Print): _____ DOB: _____/_____/_____

Patient/Legal Guardian Signature: _____ Date: _____/_____/_____

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE WITH HIPAA

As a part of your healthcare, **Nevada Health Tanita PLLC, dba Henderson Women's Care ("HWC")**, originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. This information serves as:

- A basis for planning your care and treatment
- A means of communication among the many health professionals who contribute to your care
- A source of information for applying your diagnosis and surgical information to your bill
- A means by which a third-party payer (s) can verify that services billed were provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals

You have been provided with ***HIPAA Notice of Information Practices*** that provides a more complete description of information uses and disclosures. You have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations

HWC is not required to agree with the restrictions requested. You may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. By refusing to sign this consent or revoking this consent, this organization may refuse to treat you permitted by Section 164.520 of the Code of Federal Regulations.

As part of HWC's treatment, payment, or healthcare operations, it may become necessary to disclose your protected health information to another entity (insurance company, referring physician, consulting physician, hospital, etc.).

By signing at the end of this consent form, you are consenting to the disclosure of your protected health information (PHI) for the above permitted uses, including disclosures via fax or email.

Patient/Legal Guardian Name (Print): _____ DOB: _____/_____/_____

Patient/Legal Guardian Signature: _____ Date: _____/_____/_____

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Acknowledgement of Health Insurance Portability and Accountability Act (HIPAA) and Confidential Communications

I am aware that the Privacy Practices Notice is posted in the main lobby for my review and that I have the right to a copy at my request.

The HIPAA privacy rule allows patients the right to place a restriction on uses and disclosures of their protected health information (PHI). Additionally, patients have the right to request confidential communications or that a communication of PHI be made by alternative means.

_____

I wish to be contacted in the following manner: (Check all that apply)
Methods selected below do not apply to Appointment Reminders

HOME PHONE □ Leave message with detailed information □ Leave message with call-back number only	**WORK PHONE** □ Leave message with detailed information □ Leave message with call-back number only
MOBILE PHONE □ Leave message with detailed information □ Leave message with call-back number □ Text detailed information □ Text message with call-back number only	**WRITTEN COMMUNICATION** □ Mail to home address □ EMAIL to: _____ _____

Patient Portal Communication Notification: By registering for the Patient Portal, the patient has given Henderson Women's Care permission to communicate detailed information through secure messaging. The patient will have to log into the portal using their personal username and password to read any secure messages that are received. To learn more about the Patient Portal, please speak to the Front Office staff or visit https://hendersonwomenscare.com to register.

I authorize the release of all my protected health information (PHI) to:

NAME: _____ DOB: _____/_____/_____

Relationship to Patient: □ Spouse, □ Parent/Guardian, □ Child, Other:_____

Home Phone: _____ Mobile: _____ Work Phone: _____

By signing this consent form, you are giving consent and acknowledging receipt of this consent document in its entirety.

Patient/Legal Guardian Name (Print): _____ DOB: _____/_____/_____

Patient/Legal Guardian Signature: _____ Date: _____/_____/_____

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Consent for Initial Trial of Dangerous Controlled Medication Therapy

I understand that **Nevada Health Tanita PLLC, dba Henderson Women's Care** ("my physician") is recommending dangerous controlled medication, that is regulated by states and the Federal government, which may benefit my chronic symptoms. Medications such as, but not limited to, opioids (narcotic analgesics), benzodiazepine tranquilizers, barbiturate sedatives, amphetamines, appetite suppressants, and muscle relaxants, that may be useful in managing my chronic condition. I understand that this medication is being recommended because my complaints are moderate to severe and other treatments have not sufficiently helped. I understand that many medications can have interactions that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving – and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family. I have been informed by my physician that the initiation of a dangerous controlled medication is a fourteen (14) day trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by symptom relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage. For patients requiring Opioid (narcotic) pain medication- I have been advised by my physician that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. I understand that taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

By my initials next to each risk outlined below, I am attesting that it has been explained to me, and I fully understand, that taking such dangerous controlled medication has certain risks associated with it. These include, but are not limited to, the following:

(_____) Allergic reactions
(_____) Overdose (which could result in harm or even death)
(_____) Slowing of breathing rate
(_____) Slowing of reflexes or reaction time
(_____) Sleepiness, drowsiness, dizziness, and/or confusion
(_____) Impaired judgment and inability to operate machines or drive motor vehicles
(_____) Nausea, vomiting, and/or constipation
(_____) Anxiety, restlessness, irritability, insomnia
(_____) Itching
(_____) Physical dependence or tolerance to the relieving properties of the medication (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience withdrawal symptoms such as but not limited to: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)
(_____) Addiction
(_____) Failure to provide symptom abatement

(_____) Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.)
(_____) Changes in hormonal levels
(_____) In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby could be physically dependent upon this medication. Furthermore, I recognize that the long-term consequence on a child's development that was exposed to dangerous controlled substances is not understood.
It has been explained to me that there are other treatments that do not involve use of dangerous controlled medications.
(_____) I have been given the opportunity of ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction.
(_____) I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medications early, and early refills may not be allowed.
(_____) I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.
(_____) I will submit to initial and follow-up urine and/or blood drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further dangerous controlled medication prescriptions.
(_____) I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency only period.
(_____) I will not share, sell or otherwise permit others to have access to these medications.

Having been informed of these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the dangerous controlled medication for the initial fourteen (14) day trial period and will return to the office for follow-up directly after.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY SYMPTOMS OR DISEASE WITH DANGEROUS CONTROLLED MEDICATIONS.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

Patient/Legal Guardian Name (Print): _____

Patient/Legal Guardian Signature: _____ Date: _____

Witness Name (Print): _____ Witness Signature: _____ Date: _____