## PATIENT INFORMATION PRINT IN BLACK INK ONLY PRINT ONLY

Last Name _____ First Name _____ MI _____ DOB _____

Home Mailing Address _____ APT # _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Social Security # _____ Marital Status : ☐ SINGLE ☐ MARRIED

Employer _____ Referred By: _____

Emergency Contact _____ Phone # _____

Nearest Friend or Relative _____ Phone # _____

Email Address _____

## INSURED / PERSON RESPONSIBLE (If person responsible is the same as patient, please write "SAME")

Last Name _____ First Name _____ MI _____ DOB _____

Home Mailing Address _____ APT # _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Social Security # _____ Employer _____

## INSURANCE INFORMATION

| **Primary Insurance** | **Primary Insurance** |
|---|---|
| EFFECTIVE DATE _____ | EFFECTIVE DATE _____ |
| TERM DATE _____ | TERM DATE _____ |
| Insurance Name _____ | Insurance Name _____ |
| Phone # _____ | Phone # _____ |
| Address _____ | Address _____ |
| City _____ State ____ Zip _____ | City _____ State ____ Zip _____ |
| Policy # _____ | Policy # _____ |
| Policy holder _____ | Policy holder _____ |
| Group # _____ | Group # _____ |
| Relationship _____ DOB _____ | Relationship _____ DOB _____ |
| SSN of Insured _____ | SSN of Insured _____ |
| Employer _____ | Employer _____ |

**PATIENT SIGNATURE** _____ **DATE** _____

# PATIENT HISTORY

Referred By _____ Today's Date _____

Name _____ Age _____

Reason for Today's Visit _____ Race _____

## PAST OBSTETRICAL HISTORY

How many pregnancies (total) _____ miscarriages (total) _____ abortions (total) _____

Have you ever had an ectopic pregnancy? ☐ YES ☐ NO

If **YES**, please explain: _____

## PLEASE LIST EACH DELIVERY/MISCARRIAGE

| Date | Number of weeks at Delivery | Type of Delivery | Baby Weight | Sex M/F | Complications (if any) |
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## PAST GYNECOLOGICAL HISTORY

Last menstrual period _____ How old were you when your periods started? _____

How many days do your periods last? _____ How many days apart are your periods? _____

Last PAP smear _____

Have you ever had an abnormal PAP smear? ☐ YES ☐ NO

If **YES**, please explain _____

Have you ever had treatment for an abnormal PAP smear? ☐ YES ☐ NO

If **YES**, please explain _____

Last Mammogram _____ ☐ **Never had a mammogram**

If abnormal, please explain _____

## PLEASE MARK IF YOU'VE EVER HAD THE FOLLOWING

☐ GONORRHEA ☐ CHLAMYDIA ☐ HPV (CONDYLOMA) ☐ SYPHILLIS ☐ HERPES

Are you interested in Birth Control? ☐ YES ☐ NO

If **YES**, what type? ☐ IUD ☐ ORAL CONTRACEPTIVES ☐ PATCH ☐ DEPO-PROVERA INJECTION

Are you menopausal? ☐ YES ☐ NO If YES, at what age did you become menopausal? _____

Are you interested in Hormonal Replacement Therapy (HRT) ☐ YES ☐ NO

If menopausal, have you ever had a bone-density scan? ☐ YES ☐ NO

If **YES**, please explain _____

# PATIENT HISTORY

| Please check YES or NO | Yes | No | If YES, please specify |
|---|---|---|---|
| Heart Disease (heart attacks, chest pain, mitral valve prolapse, etc.) | | | |
| High Blood Pressure | | | |
| Lung Disease (asthma, emphysema, tuberculosis, scaroidosis, etc.) | | | |
| Breast Lump / Nipple Discharge | | | |
| Blood clots in lung, blood vessels, or legs (which require blood thinner medication) | | | |
| Hepatitis, Liver, Gallbladder or Stomach Problems | | | |
| Bladder or Kidney Infections / Stones | | | |
| Loss of Bladder Control (leakage of urine whe n coughing or sneezing) | | | |
| Pelvic Pain | | | |
| Pelvic Inflammatory Disease (PID) | | | |
| Vaginal Infections | | | |
| Cancer of the Breast / Vulva / Vagina / Cervix / Uterus / Ovaries (Please circle one) | | | |
| Other cancer - not mentioned | | | |
| Bleeding with intercourse | | | |
| Painful intercourse | | | |
| Premenstral Symptoms | | | |
| Diabetes (if so, do you take insulin) | | | |
| Thyroid Disease | | | |
| Visual Problems (if so, do you wear contacts or glasses?) | | | |
| Neurological Disorders (headaches, seizures, stroke, paralysis) | | | |
| Psychological Disorders (depression, bipolar disorder, etc.) | | | |

**PAST SURGERIES**

| Date | Type of Surgery |
|---|---|
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**PAST HOSPITALIZATIONS**

| Date | Why were you hospitalized? |
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**MEDICATIONS**

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**ALLERGIES**

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# PATIENT HISTORY

Have you ever had a **blood transfusion**? ☐ YES ☐ NO

If **YES**, please explain _____

Have you ever had a **major trauma**? ☐ YES ☐ NO

If **YES**, please explain _____

## SOCIAL HISTORY

Marital Status: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW

| Please check YES or NO | Yes | No |
|---|---|---|
| Do you smoke? If YES, how many cigarettes per day? How long? | | |
| Do you drink alcohol? If YES, how many drinks per week? | | |
| Do you use drugs? If YES, what type? | | |
| Have you ever been abused PHYSICALLY / MENTALLY / SEXUALLY (please circle one) | | |
| Do you use a seatbelt? | | |

## FAMILY HISTORY

| Please check YES or NO | Yes | No |
|---|---|---|
| Diabetes | | |
| Stroke | | |
| Thyroid Disease | | |
| High Blood Pressure | | |
| Lung or Heart Disease | | |
| Breast, Ovarian or Colon Cancer | | |

If **YES** to any of the above, please explain:

_____

_____

_____

_____

_____

_____

**IF THIS FORM IS MODIFIED IN ANY WAY, THE ENTIRE FORM WILL BE VOID.**
**OUR OFFICE RESERVES THE RIGHT TO DENY TREATMENTTO ANYONE IF THIS FORM IS NOT SIGNED.**

(If you would like a copy of this form, please feel free to ask the receptionist.)

1. Authorization to Release Information: I hereby authorize the physician to release any information required by my insurance company or another doctor or hospital, acquired in the course of my examination or treatment.
2. Authorization to pay benefits to Physician: In consideration of services rendered I the undersigned patient, do hereby irrevocably assign and transfer to my provider Dr. Alexander Norton all benefits due me whether contractual, statutory, or common law.
3. I consent to any medical treatment deemed medically necessary by the provider. I understand that prior to any treatments being rendered, the treatment will be discussed with me and all questions will be answered.
4. Patient care and confidentiality is our priority. We will not release or disclose any of your personal health information to anyone. We will not release any information to a parent, husband, friend, relative, or translator. If you would like to sign an "Authorization of Use and Disclosure of Protected Health Information" form, please ask the receptionist. This form will authorize us to release or speak to your parents, husband, family, friend, or translator regarding your personal healthcare.
5. We are contracted with most insurance companies, but please check with your insurance company to be certain that we are providers.
6. Some insurance companies do not cover pap smears, preventative, or well-women annual exams. They will cover your visit if it is a "sick visit". Or if something is wrong. Please check with your insurance prior to your visit to find out if well-woman annual exams are covered. Some insurance companies will only allow one preventative exam every 12 months. We do our best to verify your benefits before your visit, but you are ultimately responsible for anything your insurance does not cover. We ask that you notify your insurance if you are pregnant and also contact your primary care physician if your insurance requires it.
7. Please do not assume that your insurance will pay for services just because we obtained prior authorization. Your insurance can deny your claim for pre-existing conditions, benefits not covered by them, or other reasons deemed by them. You will be responsible for any claim denied by your insurance.
8. Almost all lab testing done in the office, including pap smears, will be sent out and billed by the lab.
9. I understand that Dr. Alexander Norton will bill my insurance as a courtesy to me. If payment is not received within 120 days from the date of billing, I will be made financially responsible for any and all services rendered. Should this account have to be turned over to a collection agency, I agree to pay all collection and legal fees necessary to collect the balance on my account. The outside collection agency will add a 40% collection fee to any amount we turn over to them. Legal fees may also be added.
10. Please be advised and understand that this office can only code and file a claim for your visit(s) with a diagnosis that is encountered and documented in your medical record. Thus, to ask this office to change a diagnosis for the sole purpose of securing reimbursement from an insurance carrier is inappropriate and could result in a fraudulent act. For example, once we file your claim as a preventative exam, we cannot reprocess your claim as a "sick visit" for the sole purpose of securing reimbursement by your insurance company.
11. There is a $25.00 fee for any returned checks.

**PATIENT SIGNATURE** _____ **DATE** _____

# HIPPA NOTICE OF PRIVACY PRACTICES

**SPRING MOUNTAIN WOMEN'S HEALTH**
**Alexander Norton Jr. M.D.**
**6140 S Fort Apache Rd #110**
**Las Vegas, Nevada 89148**
**Phone: (702) 933-6400 | Fax: (702) 933-6412**

## 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**: Your PHI may be used and disclosed by your physician, our office staff, and others outside our office that are involved in your case and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

**TREAMENT**: We will use disclosed your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example we would disclose your PHI, as necessary, to a home health agency that provides care to you. Your PHI may be provided to whom you have been referred to ensure that the physician has the necessary information diagnose or treat you.

**PAYMENT**: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

**HEALTHCARE OPERATIONS**: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHJ to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your PHI, as necessary. to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situation without your authorization. These situations include: As Required by Law; Public Health Issues as required by law; Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal. Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures, under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES**: will be made only with your consent authorization, or opportunity to object unless by law.

**YOU MAY REVOKE THIS AUTHORIZATION**: at any time, in writing, except to the extent that your physician or the physician's practice has taken and action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS**: The following is a statement of your rights with respect to your PHI.

**YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PHI**: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil criminal, oradministrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

**YOU HA VE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PHI**: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restricting to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

**YOU HA VE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AN ALTERNATIVE LOCATION. YOU ALSO HA VE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US**: upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

**YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PHI**: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURS WE HAVE MADE. IF ANY, OF YOUR PHI**: We reserve the right to change the tenns of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**COMPLAINTS**: You may complain to us or to Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone umber.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME _____

SIGNATURE _____ DATE _____

# PHARMACY AND MEDICATION INFORMATION

Patient's Name _____ Date of Birth _____

## PREFERRED PHARMACIES

**LOCAL (SHORT-TERM)**

Name of Pharmacy _____

Address or cross streets _____

Phone Number _____

**MAIL-IN (LONG-TERM)**

Name of Pharmacy _____

Address (If known) _____

Phone Number _____

## PRESCRIPTION INFORMATION RELEASE

*I hereby authorize Spring Mountain Women's Health to obtain my prescription history from an external source.*

**PATIENT SIGNATURE** _____ **DATE** _____

**PRINTED NAME** _____ **WITNESS** _____

# INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

Patient _____ Provider _____

Medications _____

In accordance with Nevada law AB 474, prior to giving me a Controlled Substance prescription, my provider is required to obtain my written informed consent.

My provider has explained to me that these medications may include opiods and/or other drugs that can be used to treat pain, anxiety, insomnia, attention deficit disorder, depression and other conditions. I understand that these medications have known risks and side effects, and can be harmful if taken without medical supervision. I further understand that taking these medications can lead to tolerance, physical dependence, and/or developing an addictive disorder. Stopping the medication abruptly may lead to withdrawl symptoms and/or psychological dependence or addiction that is an abnormal psychological craving of the medication to the point of becoming a danger to oneself or others.

I understand that the most common side effects that can occur with the use of these medications include but are not limited to:

- Constipation
- Nausea/Vomiting
- Excessive drowsiness or sleepiness
- Itching
- Urinary retention (inability to urinate)
- Low Blood Pressure
- Irregular heart rate
- Inability to sleep
- Depression
- Impaired judgement and/or reasoning
- Respiratory depression (slow or no breathing)
- Impotence
- Tolerance to medications
- Physical or psychological dependence
- Addiction
- Death

I further understand that it may be dangerous for me to operate a motor vehicle or other machinery while taking these medications.

The risks, benefits and alternative treatments, including their risks and benefits have been explained to me. I understand that not every possible risk and benefit is listed on this form and that this consent includes the most common side effects or reactions. I acknowledge that I have been warned about the dangers of overdose and/or combining the prescribed medications with other drugs or alcohol may cause serious illness or death.

**For Female patients in child bearing age**

I understand that there are unknown side effects of the prescribed medications that could harm an unborn child. If I am not pregnant, I will use appropriate contraception (birth control) during the course of my treatment. If I become pregnant or am uncertain, I will notify my provider immediately.

**For Minors**

I have been informed of the risks that my child may abuse, misuse or divert these controlled substance medications. I have been informed of the ways to detect such misuse.

In addition I have been informed of

- Proper use storage and disposal of these medications
- How refills will be addressed
- If the medication is an opioid, I understand that I can get the medication to counteract its effects (an opioid antagonist) without a prescription.

The goal of this treatment is for management of my current medical condition, I understand that my treatment plan will be tailored for me. I further understand that I may withdraw from this treatment plan and discontinue medication use at any time. I understand that prior to doing so I need to inform my provider since there may be a medical risk associated with abrupt termination of these medications.

I have been given an opportunity to ask questions about my condition and treatment and the risks and benefits of the prescribed controlled substance(s).

***I authorize and direct my provider to prescribe controlled substance(s). I understand in order to initiate or continue treatment with controlled substances I must agree to the condition set forth above.***

| SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE | DATE | TIME |
|---|---|---|

***I certify that I have explained the nature, purpose, anticipated beliefs, material risks, complications and alternatives to the prescribed medications to the patient or patient's legal representative. I have answered all questions fully and I believe the patient/ legal representative fully understands what I have explained.***

| PROVIDER SIGNATURE | DATE | TIME |
|---|---|---|

If cancellation of my appointment becomes necessary, I shall cancel my appointment no later than twenty-four (24) hours prior to my scheduled appointment time.

I understand that if I fail to cancel in advance, I will personally be billed $50.00 and such charge will not be payable through my insurance.

I am aware that there is a $25.00 charge for any returned checks.

There is a $25.00 charge for any family medical leave act papers that need to be filled out by the provider.

Patients requesting copies of their medical records will be billed $0.60 per printed page.

| PRINT NAME | PATIENT SIGNATURE | DATE |
| --- | --- | --- |

## AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ hereby, authorize Spring Mountain Women's Health to leave a message regarding my test results:

On my cell phone: _____ On my home phone: _____

May leave a message with my spouse or significant other:

_____

**PATIENT SIGNATURE** _____ **DATE** _____

***I do NOT authorize Spring Mountain Women's Health to release any information regarding my medical care or condition to anyone other than myself.***

**PATIENT SIGNATURE** _____ **DATE** _____

## PRESCRIPTIONS

We require 24-72 hours to process your prescription refills. This 24-72 hours excludes weekends and holidays. If you are running low on your medications please call ahead of time to allow us the proper amount of time to refill your prescriptions.

## TELEPHONE MESSAGES

Any urgent messages that we receive will be answered as soon as possible. All other messages received we will try to address by the end of the day or else it will be first thing in the morning.

| PRINT NAME | SIGNATURE | DATE |
| --- | --- | --- |