Thank you for choosing our office. In order to serve you properly, we will need the following information.
(Please Print). All information will be strictly confidential.

Which Doctor are you here to see: _____

Date: _____ Email Address:_____

Patient's Name: _____

Birth Date: _____Social Security # _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Partner

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone # _____ Cell Phone # _____ May we leave a message? Y/N

Name of Employer: _____ Phone # _____ Occupation _____

Address including City/State/Zip _____

Do you have medical insurance? Yes or No If no, how do you intend to pay? _____

What Doctor referred you to us? _____
(THIS MUST BE FILLED OUT PLEASE) **PHONE#** _____ **FAX #** _____

Primary insurance _____ Address _____
****If an HMO you MUST have a referral.**

Subscriber Name _____ Policy/ID # _____

Is it through your employer? Yes or No

Secondary Insurance _____Address _____

Subscriber Name _____ Policy/ID # _____

Name of Subscriber_____

Date of Birth _____ SS # _____

Name and address of Spouse Employer _____

Phone Number of Employer _____
f your spouse is the subscriber to your insurance plan all his/her information MUST be filled out.

ıergency Contact: _____

·tionship _____ Phone # _____

- **Did you sustain an injury at work?**
Yes No
- **Are your injuries accident related?**
Yes No
- **Are you currently employed**
Yes No
- **Have you ever served in the military?**
Yes No
- **Are you covered under an employer or union policy?**
Yes No
- **Is your spouse or other family member employed?**
Yes No
- **Do you have a secondary insurance policy?**
Yes No
- **Are you covered under any other health care plan?**
Yes No

•Have you made any changes to your choice of Medicare options in the last open enrollment period?
Yes No
•I am a new patient to this practice and am in a preexisting provision with my insurance carrier.
Yes No

•Who is responsible for this bill? _____

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

I directly assign all medical/surgical benefits to Women's Cancer Center and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all the necessary information to secure the payment of my benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature _____ Date _____

Today's date _____

Patient name_____ DOB_____ Age____

Referring Doctor_____Race/ethnicity_____

Reason for today's visit_____

Current Medications	Dose/Frequency

Allergies_____

Pharmacy_____ phone number _____

Address or Cross streets_____

Do you drink alcohol? Yes ( ) No ( ) How much?_____

Do you use recreational drugs? Yes ( ) No ( ) What do you use?_____

Do you smoke, chew tobacco, or vape? Yes ( ) No ( ) When did you quit?_____

How much?_____ How many years?_____

When was your last colonoscopy?_____mammogram?_____pap smear?_____

Total number of pregnancies_____Number of living children_____

Vaginal deliveries_____ C-sections_____ Largest infant weight_____

Are you currently sexually active? Yes ( ) No ( )

Have you had a sexually transmitted infection? Yes ( ) No ( )

List Surgical Procedures	Date

List medical history / illness	Date of onset/diagnosis

Have you been diagnosed with cancer? Yes ( ) No ( ) What type?_____

Did you have chemotherapy or radiation?_____

Has anyone in your family been diagnosed with cancer? Yes ( ) No ( )

Family History- Relation to you	Medical condition

What symptoms do you currently have? Please circle

Fatigue

Headaches

Visual changes

Hearing loss

Neuropathy/numbness

Anxiety

Depression

Easy bleeding/Anemia

Enlarged lymph nodes

Swelling/edema or masses

Trouble breathing/shortness of breath

Chest pain

Abdominal pain/bloating/gas

Changes to bowel habits

Painful bowel movements

Constipation

Diarrhea

Nausea

Vomiting

Rectal prolapse

Rectal bleeding

Fecal incontinence

Urinary incontinence

Painful urination

Blood in urine

Urinary frequency

Urinary urgency

Pelvic prolapse

Pelvic pain

Vaginal bleeding

Skin changes/lumps

Additional symptoms or concerns:

Women's Cancer Center Of Nevada

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Natalie M. Gould, M.D.
Aimee C. Fleury, M.D., M.P.H.
Christina L. Kushnir, M.D., M.P.H.
Geoffrey C. Hsieh, M.D, FPMRS
Leslie K. Browder, M.D., F.A.C.S., F.A.S.C.R.S.
Melissa Miles, M.D., F.A.C.S., F.A.S.C.R.S.
Richard Wasserman, MD, FPMRS

CONSENT TO DISCUSS INFORMATION

PATIENT: _____

DOB: _____

It is against Federal Law to discuss patient information without express written consent of the patient. If you would like this office to be able to discuss your medical care with someone other than yourself, please list the names of the individual(s). Include the relationship and a current phone number.

Also, please be aware that you may add or delete names to this list at any time with written notification to this office.

Name of Person	Relationship	Current #
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

New Patient Visits

Attention Patients,

During your first visit you will have an exam as well as possible further testing, depending on your diagnosis, to further evaluate you. **These tests include but are not limited to**:

-Bladder Testing

-Bladder Scanning

-Catheter Insertion

-Biopsies

-Ultrasounds

-Other Vaginal Procedures

These procedures may result in a higher copay. Unfortunately we are only able to estimate the price of this testing. Pricing for these tests can only be determined once your claim has been processed with your insurance company.

_____ _____

Patient Name Signature

_____

Date

Administrative and Research Office
3131 La Canada Str., Suite 110
Las Vegas, NV 89109
Phone 702.693.6870
Fax 702.693.6899

University of Nevada School of Medicine
Division of Gynecology and Obstetrics
2040 W. Charleston Blvd., Suite 200
Las Vegas, NV 89102
Phone 702.671.2300

CANCER CENTER

Financial Policy

Thank you for choosing WOMEN'S CANCER CENTER as your healthcare provider. We are committed to your treatment being successful. Our Billing Department will work hard to make sure your claims are filed accurately and promptly. Please understand that insurance reimbursement can be a long a difficult process. Therefore, it is important for you to understand YOUR insurance policy and coverage. **Please read and initial the following**

_____ Women's Cancer Center will submit a claim to your insurance company as a courtesy to you. If we are NOT Contracted Providers with your insurance company, your out of pocket expenses WILL be more. It is your responsibility to find out from your insurance company if we are In-Network Providers.

_____ All co-pays and/or co-insurances are due at the time services are rendered. These payments must be collected prior to you leaving our office. Our office must stay in compliance with federal law which requires us to collect all co-pays and co-insurances to the best of our knowledge.

_____ I have received and signed the **Anti-Kickback Form** and the **Assignment of Benefits Form**.

_____ Not all services are covered by your insurance company; please refer to your policy for clarification and verification of coverage and benefits. Fees for non-covered services are the responsibility of the patient or guarantor.

_____ We do NOT bill secondary insurances UNLESS Medicare is your primary or Medicare, Tricare or Medicaid is your secondary insurance.

_____ If we do bill your secondary insurance and your secondary does NOT cover the entire balance left by your *primary* insurance you are responsible for the difference between the two. We base your responsibility on your primary insurance's allowed amounts.

_____ Fees for lab work or cultures are billed separately by the appropriate lab. Women's Cancer Center is not responsible for any outside billing facilities.

_____ If your insurance company changes, it is your responsibility to notify us immediately so that we may bill correctly. If you give the NEW insurance information after services are rendered and we are denied for timely filing, you WILL be responsible for any charges.

_____ If your insurance company does not pay your claims within 90 days, we reserve the right to begin billing you directly. We recommend that you contact your insurance carrier to follow up on the payment status. Accounts become delinquent after 120 days and will be placed with a private collection agency and subject to a $25 collection fee and all costs associated with the collection process.

_____ Returned checks will be subject to a $25 fee. Payment for the returned check must be paid by cash or with a credit card. You will NOT be seen again until the fee is paid.

_____ If you do not call and cancel/reschedule your appointment within 24 hours of the appointment time, you will be charged a $25 NO SHOW FEE.

_____ I have read the financial policy, I understand and agree with this financial responsibility.

_____ _____

Patient Signature / Responsible Party Date

_____ _____

Print Patient Name / Responsible Party Date

Updated 1/2014

I, _____, understand that services rendered to me by Women's Cancer Center are my financial responsibility and that the provider will bill my insurance company, as a courtesy. I authorize my insurance company to pay my benefits directly to Women's Cancer Center and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENTOF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I have been given the estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company. I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also understand that should my insurance company send payment to me, I will forward the payment to Women's Cancer Center within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable. To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Women's Cancer Center to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness_____

_____

Signature of Patient or Guardian

Administrative and Research Office
3131 La Canada Str., Suite 110
Las Vegas, NV 89109
Phone 702.693.6870
Fax 702.693.6899

University of Nevada School of Medicine
Division of Gynecology and Obstetrics
2040 W. Charleston Blvd., Suite 200
Las Vegas, NV 89102
Phone 702.671.2300

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances. If your insurance policy has provisions such as deductibles, co-insurances or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier. If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum and we do not collect that fee, your out of pocket maximum has not been correctly calculated. Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws. We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Date_____

_____

Patient or Guardian Signature

_____

Name Please Print

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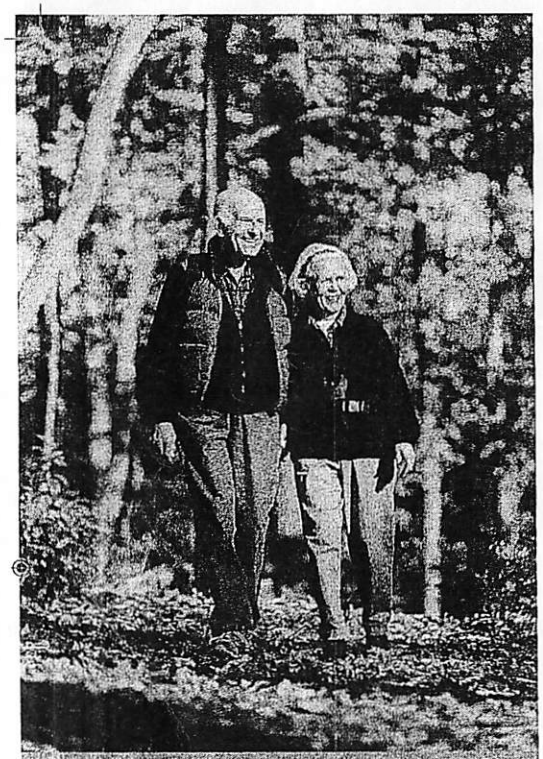


"We feel stronger when we walk frequently. And we have a more positive outlook."

Patient Name:_____ Date:_____

Signature:_____

What YOU Can Do

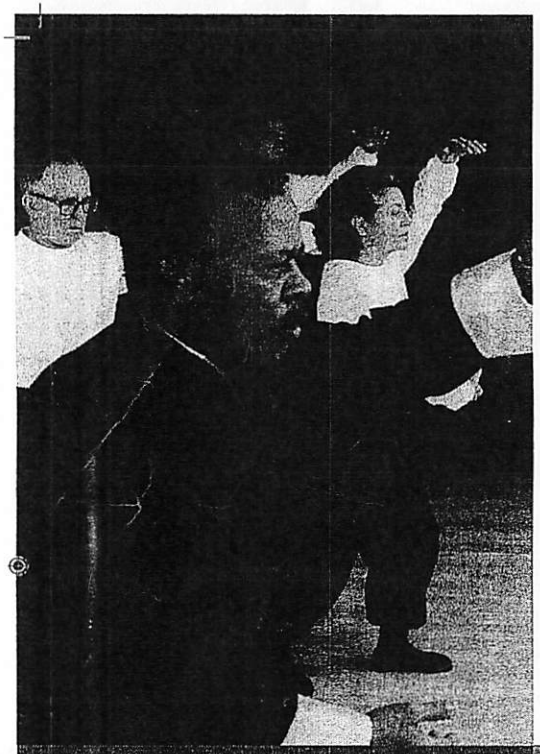
To Prevent Falls

CDC FOUNDATION
MetLife Foundation

Department of Health and Human Services
Centers for Disease Control and Prevention

For more information, contact:
Centers for Disease Control and Prevention
770-488-1506
www.cdc.gov/injury

CDC FOUNDATION
MetLife Foundation



"I thought I was too old to learn Tai Chi. But I enjoy the classes and my balance is much better."

Four things YOU can do to prevent falls:

❶ Begin a regular exercise program

Exercise is one of the most important ways to lower your chances of falling. It makes you stronger and helps you feel better. Exercises that improve balance and coordination (like Tai Chi) are the most helpful.

Lack of exercise leads to weakness and increases your chances of falling.

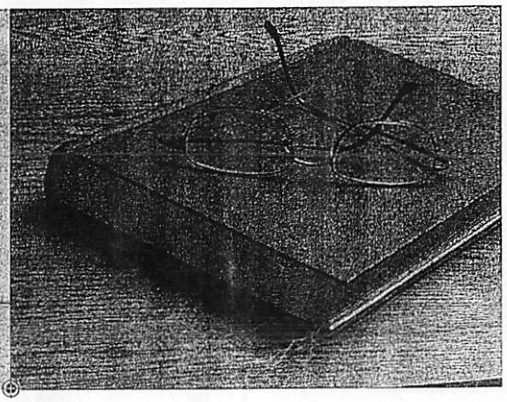
Ask your doctor or health care provider about the best type of exercise program for you.

❷ Have your health care provider review your medicines

Have your doctor or pharmacist review all the medicines you take, even over-the-counter medicines. As you get older, the way medicines work in your body can change. Some medicines, or combinations of medicines, can make you sleepy or dizzy and can cause you to fall.

❸ Have your vision checked

Have your eyes checked by an eye doctor at least once a year. You may be wearing the wrong glasses or have a condition like glaucoma or cataracts that limits your vision. Poor vision can increase your chances of falling.



❹ Make your home safer

About half of all falls happen at home. To make your home safer:

- ☐ Remove things you can trip over (like papers, books, clothes, and shoes) from stairs and places where you walk.
- ☐ Remove small throw rugs or use double-sided tape to keep the rugs from slipping.
- ☐ Keep items you use often in cabinets you can reach easily without using a step stool.
- ☐ Have grab bars put in next to your toilet and in the tub or shower.
- ☐ Use non-slip mats in the bathtub and on shower floors.
- ☐ Improve the lighting in your home. As you get older, you need brighter lights to see well. Hang light-weight curtains or shades to reduce glare.
- ☐ Have handrails and lights put in on all staircases.
- ☐ Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.

Women's Cancer Center Of Nevada

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John A. Ellerton, M.D.
Richard Wasserman, MD, FPMRS

TO ALL PATIENTS:

Unless you are critically ill, please go to Valley Hospital, UMC Hospital, or Sunrise Hospital emergency rooms ONLY. This is the only way the doctors at Women's Cancer Center can provide continuous care to you.

We are asking that you sign this acknowledgment as your receipt of this information.

Thank you from WCC.

Patient Signature **Date**

Administrative and Research Office
3131 La Canada St., Suite 241
Las Vegas, NV 89169
Phone 702-693-6870
Fax 702-693-6899

www.wccenter.com

Women's Cancer Center of Nevada

Pain Medication Contract

This is an agreement between _____(the patient) and

Dr. Natalie Gould	Dr. Geoffrey Hsieh	Dr Leslie Browder
Dr Aimee Fleury	Dr. Melissa Miles	Dr. Richard Wasserman
Dr Christina Kushnir	Dr. Nick Spirtos	Barbara Caldwell APRN
Tessa Semlek PA	_____	_____

Concerning the use of opioid analgesics (narcotic painkillers) for the treatment of chronic pain. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence.
3. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose.
4. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.
5. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child could be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
6. Overdose on this medication may cause death by stopping my breathing; this overdose may be reversed by emergency medical personnel if they know I have taken narcotic painkillers.
7. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
8. I understand it is my responsibility to inform the provider of any and all side effects I have from this medication.
9. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing provider.
10. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the provider to discontinue prescribing to me.
11. I agree that the opioids will be prescribed by only one provider and I agree to fill my prescriptions at only one pharmacy.

12. I agree not to take any pain medication or mind-altering medication prescribed by any other provider without first discussing it with the above-named provider.
13. I give permission for the provider to verify that I am not seeing other providers for opioid medication or going to other pharmacies.
14. I agree that, consistent with Nevada Law and Medical Best Practices, I will acquire my opioid analgesic medications from a single provider and will not ask for this type of medication from more than one provider or provider's representative.
15. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced under any circumstances.
16. I agree not to sell, lend, or in any way give my medication to any other person.
17. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication.
18. I agree that I will attend all required follow-up visits with the provider to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment.
19. I also agree to participate in other chronic pain treatment modalities if recommended by my provider.
20. I understand that my provider my cancel my treatment if they feel that I am not following though with the treatment plan, or that I am not responding positively.
21. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the provider may discontinue this form of treatment.

_____ Print and sign name

_____Witness _____ Date

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.myriadtests.com

FHQ/09-11

MYRIAD

Colon and Rectal Questionnaire

Are you 50 years or older without a colonoscopy?	YES	NO
Do you experience rectal pain?	YES	NO
Do you experience rectal bleeding?	YES	NO
Do you experience any leakage of gas or stool?	YES	NO
Do you experience constipation?	YES	NO
Do you experience diarrhea?	YES	NO
Do you experience anal itching?	YES	NO
Have you noticed any changes in bowel habits?	YES	NO

Comment:

Urogynecology Questions

Do you experience any urinary leakage?	Yes	No
Do you experience any leakage of stool or gas?	Yes	No
Do you have trouble getting to the bathroom on time?	Yes	No
Do you urinate more frequently than normal?	Yes	No
Do you get out of bed at night to urinate?	Yes	No
Do you have trouble completely emptying your bladder	Yes	No
Do you have the sudden uncontrollable urge to void?	Yes	No
Do you have pain in your bladder?	Yes	No
Do you experience looseness with intercourse	Yes	No
Do you have constipation	Yes	No

Comment:

Name: _____

Phone Number: _____

Email: _____