Patient Name: _____ **Date:** _____

■ Medical Information

Please state the reason(s) for your visit today: _____

_____

Primary Care Physician's Name _____ Phone _____

Preferred Pharmacy Name _____ City & State _____

Pharmacy Telephone Number _____ Pharmacy Fax _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
Please describe: _____		
2. Have you ever had any serious illnesses or operations?	☐	☐
Please describe: _____		
3. Are you taking any medications?	☐	☐
Please list: _____		
4. Do you smoke?	☐	☐
5. Do you drink alcohol?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Do you have religious beliefs that could impact your decision to accept blood products?	☐	☐

	Yes	No
8. Have you had any allergic reactions to the following:		
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Other Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐
Please describe: _____		
9. Women Only:		
Do you have regular periods?	☐	☐
Are you using birth control pills / patch / injection?	☐	☐
Are you pregnant now?	☐	☐
Have you ever been pregnant?	☐	☐
Number of Pregnancies: _____		

Please indicate which of the following conditions/illnesses you have or have not had:

	Yes	No
Anemia (low blood count)	☐	☐
Anorexia (no appetite)	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding Tendency	☐	☐
Blood Disease	☐	☐
Cancer	☐	☐
Chemical Dependency (drug addiction)	☐	☐
Chemotherapy	☐	☐
Chicken Pox	☐	☐
Chronic Fatigue Syndrome	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Lesions	☐	☐
Cough – persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Glaucoma	☐	☐

	Yes	No
Heart Murmur	☐	☐
Heart Disease	☐	☐
Hepatitis – Type ____	☐	☐
Hernia	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
HIV / AIDS	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Latex Sensitivity	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Measles	☐	☐
Migraine	☐	☐
Headaches	☐	☐
Mitral Valve Prolapse	☐	☐
Mumps	☐	☐
Multiple Sclerosis	☐	☐
Pacemaker	☐	☐

	Yes	No
Pneumonia	☐	☐
Polio	☐	☐
Prostate Problem	☐	☐
Psychiatric Care	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Skin Rash	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Any Other Condition	☐	☐

Please Describe: _____

_____

High Risk Pregnancy Center

PLEASE PRINT VERY CLEARLY

■ Patient Information

Name (Last, First, Middle) _____

Birthdate _____ Soc. Sec. # _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip_____ Work Phone _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Email address _____ Employer _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language Spoken: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ White ☐ Hispanic ☐ African American ☐ Indian ☐ Asian ☐ Pacific Islander ☐ Other _____

Referring Physician _____ Phone _____

■ Spouse / Legal Guardian

Name (Last, First, Middle) _____ Home Phone _____

Birthdate _____ Soc. Sec. # _____ Cell Phone _____

Address _____ Employer _____

City _____ State _____ Zip _____ Sex: ☐ M ☐ F

■ Emergency Contact

Name (Last, First) _____ Phone Number _____ Relationship _____

■ Primary Insurance

Insurance Company _____

Insurance ID # _____ Group # _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ Birthdate _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company _____

Insurance ID # _____ Group # _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ Birthdate _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

■ Assignment and Release

I hereby authorize payment directly to High Risk Pregnancy Center of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: _____ **Date:** _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ **Relationship to Patient:** _____

■ Financial Responsibility

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE. I / we do hereby acknowledge it is my/our responsibility to pay the deductible, co-insurance and any other balance not paid by my/our insurance. I / we agree to pay all collection fees, attorney's fees, service fees, court costs, and filing fees, including charges of commissions that may be assessed to me by any collection agency retained to pursue nonpayment, which may be as much as 50% of the principle owing. I further agree to pay interest at the rate of 2% per month or $5.00 per month, whichever is greater on all Invoices past due by thirty (30) days. I / We certify & I / we have read and understand all the information provided. I / we certify the information provided is true and correct to the best of my/our knowledge.

Printed Name Signature Date

Printed Name Parent I Guardian Signature Date

■ Authorization for Record Release

I do hereby agree to the request for release of all of my medical records including physician office notes, hospital documentation & reports, all laboratory and radiology reports to High Risk Pregnancy Center. I absolve all physicians and staff of any liability resulting from the release of such said records. I do hereby also agree to the release of my medical records by High Risk Pregnancy Center to any office or facility I am referred to. I absolve all physicians and staff of any liability resulting from the release of such said records.

Printed Name Signature Date

Printed Name Parent I Guardian Signature Date

■ Appointment Cancellation Policy

I do hereby agree to notify The High Risk Pregnancy Center within 24 hours prior to any scheduled appointments if I am unable to make my appointment. I understand that if I fail to contact the office and do not show for my scheduled appointment I agree to a **$50.00** fee that will be not be covered by my insurance company and will be my sole responsibility.

Printed Name Signature Date

Printed Name Parent I Guardian Signature Date

■ Picture on File

As a medical facility, we like to offer privacy and security. High Risk Pregnancy Center asks that your picture is taken for your file so we can guarantee your own identity protection.

I have read the above and understand the reasoning. I consent to having my picture taken.

Printed Name Signature Date

Printed Name Parent I Guardian Signature Date

HIGH RISK
Pregnancy
CENTER

ULTRASOUND
CONSENT FORM

An ultrasound has been ordered on you and your unborn child by your physician. There are many reasons that this diagnostic test may have been ordered. Some of these include evaluation of your baby for birth defects, growth patterns, amniotic fluid level, Doppler flow indices, abnormal blood test results, or as adjuncts to diagnostic therapeutic testing or procedures. The quality of ultrasound examinations are extremely dependent on the equipment utilized, the sonographer doing the ultrasound, the position of your baby within your womb, your body size, previous abdominal surgery and the physician who interprets your exam.

Ultrasound examinations have never been shown to damage you or your baby. This is not an x-ray. Ultrasound uses sound waves. The ultrasound produces a small burst of high frequency sound and then listens for the "echo" of the sound in your body. A computer then integrates this information to make the picture that you see on the screen. Many things can be seen about your baby, such as birth defects and growth abnormalities. Ultrasound is also used to see where the baby is in relation to the needle when certain invasive procedures are done, such as amniocentesis.

Failure to have this ultrasound done may make it difficult, if not impossible, to care for you and your pregnancy in the best way possible. There may be abnormalities of your reproductive system that may benefit from diagnosis and treatment. You may not be able to take advantage of many options afforded to you bylaw. The birth of your baby may be compromised by not being able to have the appropriate specialists present during your pregnancy and at the time of your delivery that your baby may need. Without ultrasound, therapeutic measures would also not be possible, and this may result in a damaged baby or even the loss of the life of your baby.

The utmost care and concern is given to you and your unborn child. Even so, ultrasound is not a perfect science and things may not be seen. Factors that may limit the accuracy of the ultrasound include the gestational age of your baby, your body composition, previous abdominal surgery and the position of your baby within the womb. There are some abnormalities that are never seen with ultrasound.

I understand that ultrasound cannot see all things in my unborn child or me but that it may be a very helpful tool to help manage my pregnancy and plan the delivery.

I have read this consent, fully understand the above information, have had all my questions answered to my satisfaction.

☐ I want an ultrasound performed on me.

☐ I decline to have an ultrasound performed on me.

Signed:_____ Date: _____

Witness:_____ Date: _____

BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office at your first appointment after if changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged **$50** for each no-show occurrence. Should this occur more than twice within a 12 month period, you may be dismissed from the practice. By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, or other required documentation prior to your appointment. If our team office determines that your plan requires a referral, and you do not provide such referral, you may be required to sign a waiver in order to receive services. Additionally, even should our team fail to request such a waiver, you will nonetheless be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. By signing below, you accept these policies.

Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. By signing below, you accept these policies.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections (and subject to an additional collection fee) and/or legal action will be pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations. By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. By signing below, you accept these policies.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to High Risk Pregnancy Center for any services furnished to me or my dependents.

Signature of Patient: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(_ _ _) _ _ _ - _ _ _ _ Home / Office / Cell / Other: _____

(_ _ _) _ _ _ - _ _ _ _ Home / Office / Cell / Other: _____

(_ _ _) _ _ _ - _ _ _ _ Home / Office / Cell / Other: _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my PHI may be shared with my spouse. _____

♦ I agree that my PHI may be shared with the following other people:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to High Risk Pregnancy Center.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

HIGH RISK Pregnancy CENTER

Brian K. Iriye, MD
Stephen M. Wold, MD
Wilson H. Huang, MD
Laura A. Gorski, DO
Damon I. Masaki, MD
Bharat D. Shah, MD

NOTICE OF PRIVACY PRACTICES
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 is your Health Information Privacy Notice from the High Risk Pregnancy Center. The goal of our physicians and office is to provide the utmost in quality care for our patients in doing so we strongly believe in protecting the confidentiality and security of information we collect about you.

This notice describes how we protect the personal Health Information of our patients and your rights as a patient with respect to your Personal Health Information (PHI) and how you may exercise those rights.

The Health Insurance Portability & *Accountability* Act of 1996 (HIPAA) requires our office to maintain the privacy of protected health information and to provide you notice of our legal duties to abide by those privacy practices with respect to IHI.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information that it maintains. You may access a revised notice upon request or by contacting one of our HIPAA point persons or by referring to the most updated notice posted in our waiting areas.

For any additional information regarding our HIPAA Medical Information Privacy Policy please ask for or write to one of our HIPAA point persons (HHP's) Privacy officers listed below, request for any restrictions or to revoke any restrictions must b done in person with either person feed below or in written form signed, dated and received via pre-paid certified return receipt mail to.

Angelina Cruz 870 Seven Hills Dr. Ste 103 Henderson, NV 89052 – Nubia Sandhu 2011 Pinto Ln. Ste 200 Las Vegas, NV 89106 - Cecilia Camacho 9090 W Post Rd, Ste 100 Las Vegas, NV 89148 Phone: (702)382-3200 Fax (702)382-3575

Under applicable laws our office may use or disclose your PHI for the purpose of carrying out treatment, payment or health care operations. This may be done orally, electronically or by means of paper form.

Treatment - Means use and disclosure will take place in providing, coordinating, or managing healthcare and its related services by one or more of your health care providers, such as when our physician consult with your primary care physician regarding your condition.

Payment - Means activities such as obtaining or provide benefits, authorization or reimbursement for providing healthcare, Collection activities, and utilization review. Example: obtaining authorization required by your insurance to provide services.

Health Care Operations - Include the business aspects of running our practice, such as quality assessment and improvement, providing review and training, auditing functions, cost-management analysis, management and administration purposes and providing quality customer care. An example of this would be to assist in an audit of the quality of care provided by our staff.

We may use and disclose your PHI, without your consent or authorization as required and permitted under Nevada State Law. These laws relate to public health activities and safety issues. An example of this would be someone coming into contact with a communicable disease that could possible become a public health risk. We may also create and distribute de identified health information by references to individually identifiable information.

We may contact you to provide appointment reminders or information alternatives or other health-related benefits and services that may be of removing all about treatment interest to you.

You have the right to request the following with respect to your PHI, which you can exercise by presenting a written request to the HHP or Privacy Officer at the above listed address.

The right to request restrictions on certain uses and disclosures of PHI to carry out treatment, payment or healthcare operations, However our office is not required to agree to your requested restriction.

The right to receive and our office is required to accommodate reasonable request to receive confidential communication of your PHI.

The right to inspect and copy your PHI

The right to amend your PHI

The right to receive a copy of the disclosures of your PHI

The tight to obtain a copy of this notice from our office upon request

Unless you object, we may disclose to family members, relatives, friends, or other persons identified by you, PHI that is directly relevant to the persons involvement with your care. In addition, unless you object, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for your cam, or certain disaster relief agencies of your location, general condition, or death. Objection to this may be communicated to one of the above listed HPP.

If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this notice, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick-up medical supplies, x-rays or similar forms of Protected Health Information.

Any other uses and disclosures will be made only with your written consent and authonzation. You have the right to revoke your consent at any time, except to the extent that the Center for Maternal-Fetal Medicine has taken action in reliance of a prior consent or authorization.

"Notice to Patients Regarding the Destniction of Health Records"

NRS 629 -

a.) Pursuant to the provisions of subsection 7 of the NSR 629.051:

1.) The health care records of a person who is less than 23 years of age may not be destroyed; and

2.) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have *been* retained for at least 5 years or for any longer period provided by federal law: and

b.) Except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

If you believe that your privacy rights have been violated, you may complain to one of our Privacy Officers at the Address and Numbers fisted above or by contacting the Secretary Department of Health and Human Services, Hubert H. Humphrey Building 200 Independence Ave. SW, Washington DC 20201. You wtil not be retaliated against for filing a complaint

Revised: January 18, 2010