

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.
Established Patient History

Name: _____ DOB: _____ Today's Date: _____
 Primary Care Physician: _____ Preferred Pharmacy: _____
 Pharmacy Address: _____ Pharmacy Phone: _____

Reason for visit: _____

Date of last Menstrual Period _____

Do you ever have problems with urinating such as infections, frequency, loss of urine, blood in urine?

Have you had frequent vaginal infections? Yes No _____

Are your periods regular? Yes No Heavy? Yes No Painful? Yes No

Do you do breast self exams? Yes No

Health Maintenance

Procedure	Date	Results
Last Pap Smear	_____	_____
Last Mammogram	_____	_____
Last Bone Density (DEXAscan)	_____	_____
Last Colonoscopy	_____	_____
Last Cholesterol	_____	_____

Since your last visit have you ever been diagnosed with a new medical condition? Yes No _____

Since your last visit have you had any surgery? Yes No _____

Since your last visit have there been any changes in your family's medical history? Yes No _____

Do you currently have a partner? Yes No Partner's gender _____

How long have you been in this relationship? _____

Are you currently sexually active? Yes No

Are you currently experiencing any sexual problems? Yes No

Marital Status: Single Married Separated Divorced Widowed

Current birth control:

- None Timing Condoms Diaphragm Birth Control Pills/Patch/Ring
 Implants DepoProvera IUD Tubal Ligation Vasectomy

Occupation _____

Tobacco Yes No Quit # cigarettes/day _____ # years _____

Alcohol Yes No Quit # drinks per day/week _____ type _____

Drugs Yes No Quit type _____

Exercise Yes No # times/week _____ type _____

Have you been sexually abused, threatened, or hurt by anyone? _____

Health Care Proxy Yes No

Seat Belt Use Yes No

Medications/Strength/Directions (including over the counter medications and supplements):

List any medications or foods that you are **ALLERGIC** to (and the reaction):

Patient Signature: _____ **Date:** _____

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.

DEMOGRAPHIC & INSURANCE INFORMATION

CONFIDENTIAL

- ANNUAL UPDATE
 INFORMATION CHANGE

*****PLEASE PRINT*****

FULL NAME: _____ **DATE OF BIRTH:** _____
AGE: _____ SINGLE MARRIED DIVORCED OTHER: _____
SOCIAL SECURITY NUMBER: _____ EMAIL: _____
ADDRESS: _____ APT/SPACE/UNIT #: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: () _____ CELL: () _____ WORK: () _____
EMPLOYER: _____

PRIMARY INSURANCE: _____ **MEMBER #:** _____ **GROUP #:** _____
GUARANTOR INSURANCE INFORMATION: Self Spouse Parent
GUARANTOR NAME: _____ DOB: _____ SS#: _____
ADDRESS: _____ APT/SPACE/UNIT #: _____
CITY: _____ STATE: _____ ZIP: _____
EMPLOYER: _____ PHONE: _____

SECONDARY INSURANCE: _____ **POLICY #:** _____ **GROUP #:** _____
GUARANTOR INSURANCE INFORMATION: Self Spouse Parent
GUARANTOR NAME: _____ DOB: _____ SS#: _____
ADDRESS: _____ APT/SPACE/UNIT #: _____
CITY: _____ STATE: _____ ZIP: _____
EMPLOYER: _____ PHONE: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____
PHONE: _____ RELATIONSHIP TO PATIENT: _____

*Note: We do not give your email or personal information to any third parties.

My signature below indicates that the above information is accurate.

Signature: _____ **Date:** _____

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA

ROBI BURNS, M.D.

FINANCIAL POLICY

Welcome to Integrative Women's Healthcare of Nevada. The following outlines the patient financial responsibility policy.

Payment for services provided by *Robi Burns, MD*/Integrative Women's Healthcare of Nevada is required at the time of services unless prior arrangements have been made. **Co-pays, co-insurance, deductibles, and/or non-covered services are due at the time of service, no exceptions.** If we are contracted with your insurance company, we will bill your insurance company as a courtesy to you. We will NOT bill your secondary insurance. Understand that it is ultimately your responsibility as the patient to know your insurance coverage. We encourage every patient to know their medical benefits, if you need further clarification contact your insurance company directly. Although, *Robi Burns, MD*/Integrative Women's Healthcare of Nevada does contact your insurance company monthly for benefits, please be aware that benefits quoted to *Robi Burns, MD*/Integrative Women's Healthcare of Nevada is not a guarantee of benefits and/or payment. Co-Insurance and allowable information given to *Robi Burns, MD*/Integrative Women's Healthcare of Nevada is an estimate and further payment may be required after your claim has been paid. Exact payment is not determined until your claim is process by your insurance company.

Initials _____

All medications and medical supplies provided by any of the physicians should be completely paid for at the time of service. Services provided by outside laboratories such as the reading of PAP tests and/or biopsies will be **billed directly to you by the outside laboratory.** If you need to be referred to a specific laboratory or cytology lab, it is your responsibility to communicate this information to the physician.

Initials _____

If *Robi Burns, MD*/Integrative Women's Healthcare of Nevada is **not contracted** with your insurance company and you need a major medical service (such as having a baby or needing surgery), we will provide you with the opportunity to meet with our office manager. She can help you estimate the cost of your medical services. A financial agreement form will be completed which should include the cost of the surgery, any deductible due, an estimate of your insurance payment out of network rates and an estimate of the amount that you will need to pay for the service. Financial arrangements can be discussed in advance so that a specific payment plan can be arranged, if necessary. All fees are required to be paid in full prior to delivery or surgery.

Initials _____

You will receive a statement showing in detail charges incurred during the statement period and the amount due. Any uncollected fees are **payable within 15 days** of receiving the statement. You are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance. If your account becomes delinquent and is referred to a collection agency, you will be responsible for the cost of collection fees and legal fees. These fees will include a finance charge of **1.5%** per month or **18%** annually which will retro back to 30 days following the date that services were provided as well as a **35%** collection fee. All accounts that are **90 days past** due will automatically be assigned to a collection agency, regardless of current insurance coverage.

Initials _____

There will be a **\$25.00 cancellation fee** for all appointments not canceled within 48 hours of the appointment. A fee of **\$100.00** for all surgical appointments not canceled within 48 hours of appointment. A **\$100.00** fee will be charges for all re-deposited, returned checks or stop payments.

Initials _____

I authorize *Robi Burns, MD*/Integrative Women's Healthcare of Nevada to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I further authorize my insurance company and it's carriers to disclose any information requested regarding claims for medical benefits to *Robi Burns, MD*/Integrative Women's Healthcare of Nevada. A copy of this authorization may be used in place of the original.

Initials _____

I request that payment of authorized medical benefits be made on my behalf to *Robi Burns, MD*/Integrative Women's Healthcare of Nevada for services furnished to me, any physician covering for the care of her patients, or her staff unless I have paid for the services and will be billing the insurance company directly.

Initials _____

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.

Your signature below indicates that you understand and agree to this financial policy. You also are acknowledging that you have read and/or received a copy of this practices **NOTICE OF PRIVACY PRACTICES**.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____

Credit Card Signature on File Authorization

Robi Burns, MD/Integrative Women's Healthcare of Nevada will no longer take credit card payments via telephone without your signature on file. If you would like to make payments on your bill in this manner, it will be required to have the following section complete.

I authorize *Robi Burns, MD/Integrative Women's Healthcare of Nevada* to keep my signature on file and directly charge my credit card account for: **(optional)**

- Charges I personally incur
- Charges by family member(s) listed below:

Charges Monthly payments of \$_____ for _____ months

Check One:

- Visa Mastercard American Express Discover

Credit Card Number Expiration Date CVV(3digit Code)

Cardholders Name Date

Cardholders Signature

Robi Burns, MD/Integrative Women's Healthcare of Nevada

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____ Ph #: _____

Children _____ Ph #: _____

Other _____ Ph #: _____

Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call: my home my work my cell Number

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.

LABORATORY CONSENT

We ask that **you, the patient or parent/guardian**, call your insurance company to verify the lab contracted with your plan or agree to which lab we will send any collected specimens. This will help to insure that you do not receive any unexpected bills from the laboratory.

Reference Laboratory

Which laboratory is contracted with your Insurance Company? **Please circle only one below.**

QUEST

CPL

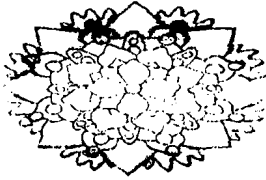
LAB CORP

GENPATH (CASH PAY)

GENPATH has agreed to charge the lesser contracted cash rates for our office for those without insurance.

Printed Name: _____ DOB: _____

Signature: _____ Date: _____



2633 W. Horizon Ridge Pkwy STE 100 Henderson, NV 89052
Phone: 702-853-1400 Fax: 702-851-6720

****ALL BLOOD TEST RESULTS WILL NEED TO BE DISCUSSED IN PERSON****

STD PANEL 1 WEEK FOLLOW UP

OB PANEL 2 WEEK FOLLOW UP

IIRT PANEL 2 WEEK FOLLOW UP

HML PANEL 2 WEEK FOLLOW UP

TO AVOID EXTRA FEES, PLEASE READ BEFORE HAVING YOUR LABS PERFORMED IN OUR OFFICE OR AN OUTSIDE LABORATORY FACILITY

The lab work you may receive has been coded appropriately by your physician in accordance with your visit. It is the responsibility of the patient (You) to verify with your insurance company which laboratory facilities are contracted with your specific plan. It is also your responsibility to be aware of deductibles, co-payments, and co-insurances prior to having any lab work drawn. Unfortunately, Integrative Women's Healthcare of Nevada does not know in advance what testing your insurance company may or may not cover. It is your responsibility to check with your insurance as to whether or not they cover specific testing. The name of each test and their correlating codes will be listed on your attached lab requisition.

You have the right to decline testing at any time.

Lab facilities such as Quest, Labcorp, CPL, and GenPath are outside companies and are not affiliated with Integrative Women's Healthcare of Nevada. **Integrative Women's Healthcare of Nevada does not handle prior authorizations, billing disputes, or payments for any lab work.**

Please be advised that if you are being evaluated for the presence of pelvic pain, vaginal pain, discharge, odor, irritation, itching, or burning the physician may collect a vaginal culture. The culture will be sent out to the laboratory that you have selected.

Thank You,

Integrative Women's Healthcare of Nevada

Signature _____ Date _____

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.

Reiki Master and Nutritionist/Personal Trainer appointment policy

I _____ understand that there will be a **\$50.00 no show/cancellation fee** for all missed appointments. If you need to cancel or reschedule make sure you call at least 48 hours in advance of the appointment time.

**Your signature below indicates that you understand and agree to this financial policy.
This is not indicative of participation in said offered programs.**

If declined please check and sign: Declined

Printed name of patient: _____ DOB: _____

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA

ROBI BURNS, M.D.

CONSENT FOR BIRTH CONTROL PILLS (OR PATCH)

Birth control pills (BCPs) are potent synthetic steroid hormones used to stop ovulation. As a form of birth control, they offer 99% effectiveness. This means 1 in 100 women using oral contraceptives as prescribed for one year will become pregnant. The benefits of BCPs include decreased menstrual flow and cramps and a decreased incidence of uterine and ovarian cancer. There is also a decreased incidence of benign (non-cancerous) tumors and anemia in women on BCPs. Unlike barrier methods (condoms, foam, sponge, diaphragm), the pill offers no protection against sexually transmitted diseases. There are, however, potential side effects from taking these pills and some of them include:

1. Blood clots or thrombosis can occur anywhere in the body. These clots may arise in the extremities (i.e. the legs) and move to the lungs which can cause pulmonary embolism (a blood clot in the lung). Some cases of pulmonary embolism can cause prolonged hospitalization and death. Other complications of blood clots may be liver damage, blindness, stroke or heart attack. The risk of thrombosis and embolism increase with age and smoking.
2. May cause temporary infertility due to delayed ovulation.
3. May cause or elevate existing high blood pressure.
4. May cause jaundice or abnormal liver function tests resulting in the possibility of serious liver disease. These effects are usually reversible when the pills are stopped. Benign liver tumors may occur rarely in women taking BCPs.
5. May cause breast tenderness.
6. May cause mental depression or nervousness.
7. May aggravate migraine headaches or diabetes.
8. Other medications taken with BCPs may alter the effectiveness of the BCP. Conversely, the BCP may alter the effectiveness of other medications. Certain antibiotics (Ampicillin, Tetracycline, Griseofulvin, and Rifampin) and antiepileptics (barbiturates, phenytoin) and Butazolidin can decrease the effectiveness of the pill. You should notify your doctor of all medications taken and/or being considered prior to beginning therapy.
9. The BCP is not as effective the first month of use, and therefore additional forms of birth control (specifically barrier methods) should be used in addition to taking BCPs during the first month of use.
10. The pill must be taken daily and if one or more pills are missed in a cycle, a barrier form of birth control must be used until the cycle ends. It is recommended that you take them at the same time of day. Many women prefer to take them at night to avoid the side effect of nausea.
11. BCPs may make your periods lighter than normal.
12. If you fail to have a menstrual period while on the pill, you should notify your physician.
13. Taking BCPs while pregnant may cause birth defects.
14. There may be an increased risk of gallbladder disease with prolonged use of BCPs.

Minor side effects may include irregular bleeding, nausea, vomiting, abdominal cramping, bloating weight gain (either increase or decrease), swelling of the hands or legs, increased skin pigmentation, rashes and/or changes in sex drive.

I have read and understand the above side effects and complications of taking the BCP. The alternative forms of birth control were discussed along with the risks and benefits of each. I feel the contraceptive benefits of the pill will out weigh the risks and wish to take oral contraceptive pills. I agree to inform my doctor promptly of any side effects of this medication.

If declined please check and sign: Declined

Patient Name: _____ Date: _____

Patient Signature: _____

INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Your Confidential Healthcare Information may be released to other healthcare professionals within this practice for the purpose of providing you quality healthcare.

Your Confidential Healthcare Information may be released to your insurance provider to obtain payment for services provided to you.

Your Confidential Healthcare Information can only be disclosed to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but **only** if you give us a written authorization.

Your Confidential Healthcare Information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence

Your Confidential Healthcare Information may be released to other healthcare providers in the event you need emergency care.

Your Confidential Healthcare Information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication) .

Your Confidential Healthcare Information may not be released for any other purpose that which is identified in this notice.

Your Confidential Healthcare Information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

You may be contacted by the practice to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

You may be contacted by the practice for the purposes of raising funds to support the practice's operations.

You have the right to restrict the use of your confidential healthcare information. However, the practice may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

You have the right to receive confidential communication about your health status.

You have the right to review and photocopy any/all portions of your confidential healthcare information.

If you request copies of your health information we will charge you \$0.60 for each page, a \$16.00 administration fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you.

If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

If you prefer, we will prepare a summary or an explanation of your health information for a fee. For more information, contact our HIPPA Compliance Officer listed below.

You have the right to make changes to your confidential healthcare information.

You have the right to know who has accessed your confidential healthcare information and for what.

****** Please be aware that we use EHR, Electronic Medical Record, in our office**

This practice is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

- You have the right to complain to this practice if you believe that your rights to privacy have been violated. If you feel that your privacy rights have been violated, please mail your complaint to our HIPAA Compliance Officer: ATTN: HIPPA Compliance Officer
Robi Burns, MD/Integrative Women's Healthcare of Nevada
2633 W. Horizon Ridge Pkwy, Suite 100
Henderson, NV 89052
- All complaints will be investigated. No personal issue will be raised for filing a complaint with this practice.
- For further information about this Notice of Privacy Practices, please contact the privacy officer.

This practice will abide by the terms of this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our Privacy Practices, we will change this Notice. You may request a copy of our Notice at any time.