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

New Patient History

I. Identifying Information

Name: _____ DOB: _____ Date: _____

Reason for visit: _____

_____

Age: _____ Marital Status: _____ Occupation: _____

Who referred you? _____

Name of internist or family doctor: _____ Preferred Pharmacy: _____

Pharmacy Address: _____ Pharmacy Phone: _____

Spouse/Partner's name: _____ Occupation: _____

List any other physicians or health care providers you see:

_____

II. Medical History ☐ None

Please list any medical problems that you have.

_____

_____

_____

_____

_____

Have you had any hospitalization, injuries, fractures or motor vehicle accidents? ☐ None

_____

_____

Check if you have or have you ever had:

☐ Alcohol abuse	☐ Anesthetic reaction	☐ Bleeding disorder
☐ Asthma	☐ Anemia	☐ Chronic lung condition
☐ Blood clots	☐ Drug and substance abuse	☐ Depression/anxiety
☐ Diabetes	☐ Heart disease	☐ High blood pressure
☐ High cholesterol	☐ Hepatitis/Jaundice	☐ Cancer
☐ Irritable bowel syndrome	☐ Kidney stones	☐ Hypothyroidism
☐ Seizure disorder	☐ Stroke	☐ Tuberculosis
☐ Stomach ulcers	☐ Mitral valve prolapse	☐ Rheumatic fever
☐ Transfusion reaction	☐ Eating disorder	☐ Lupus/autoimmune disorder

List all medications that you take with the dose and timing (including birth control pills): ☐ None

Drug **Dose** **Frequency** **Reason for medication**

_____

_____

_____

_____

_____

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing: ☐ None

_____

_____

Allergies: List all adverse reactions or allergies you have to medications and what happened. ☐ None

_____

_____

_____

III. Surgical History ☐ None

List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, LEEP.

Date **Operation** **Diagnosis**

_____

_____

_____

_____

IV. General Health

How much alcohol do you drink/week? ☐ None ☐ Avg. less than 1/day ☐ Avg. 1/day ☐Avg. more ____

Do you smoke? ☐ Yes ☐ No Amount/day _____ How many years_____

If you quit smoking, when did you stop? _____

Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type: _____

Do you perform self breast examinations monthly? ☐ Yes ☐ No

V. Gynecologic History

Date of last pap smear: ☐ None _____

Date/place of last mammogram: ☐ None_____

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe

When was the FIRST day of your last menstrual period? _____ ☐ Menopausal ☐ Hysterectomy

Length of cycle from first day to first day each month: _____ days ☐ Regular ☐ Irregular

Average length of each period: _____ ☐ Heavy ☐ Moderate ☐ Light

What do you use to keep from getting pregnant? ☐ Nothing ☐ Vasectomy ☐ Condoms ☐ Rhythm

☐Tubal ligation ☐ IUD ☐ Diaphragm ☐ Birth Control Pills/Patch ☐ Abstinence ☐ Withdrawal

Please check if you have or have had any of the following:

☐ Menstrual Cramps	☐ PMS	☐Recent change in periods
☐ Endometriosis	☐ Fibroids	☐Laser/Freezing of Cervix
☐ Ovarian cysts	☐ Pelvic adhesions	☐Herpes
☐ Gonorrhea	☐ Syphilis	☐Chlamydia
☐ Condyloma (warts)	☐ Abnormal pap smear	☐Recurrent vaginitis
☐ Mycoplasma/Ureoplasma	☐ Trichomonas	☐HPV

STD Screening: Would you like to have testing today? Please check any of the following test(s) that you are interested in having performed today: ☐ **Chlamydia & Gonorrhea Screening** ☐ **HIV Testing**

☐ **Herpes Screen** ☐ **Syphilis Screen**

Infertility History: (Complete if indicated) ☐ None

How long have you been trying unsuccessfully to become pregnant? _____

Please describe any tests/diagnosis/treatments you have had performed _____

_____

_____

Urologic History: (Complete if indicated) ☐ None

Do you lose urine against your will? ☐Yes ☐No

Does your incontinence occur after coughing, exercising, sneezing, or lifting? ☐ Yes ☐ No

Do you have a strong sense of urgency to void just prior to losing your urine? ☐ Yes ☐ No

Do you wear a pad to protect against urine loss? ☐ Yes ☐ No

Pregnancy history: ☐ No pregnancies

Number of times pregnant _____Full term births _____Premature births _____ Elective termination _____
Miscarriages _____ Ectopic pregnancies _____ Adopted children _____ Step children _____Twins _____

Pregnancies lasting more than 20 weeks:

Date	Length of preg. in weeks	Vaginal or C-section	Sex and weight	Hospital/Doctor	Complications

VI. FAMILY HISTORY: ☐ Adopted

Which of your 1st degree family members have the following:

Breast cancer: _____ Asthma: _____
Ovarian cancer: _____ Stroke: _____
Colon cancer: _____ High cholesterol: _____
Other cancers: _____ Bleeding disorders: _____
Diabetes: _____ Drug abuse: _____
Heart disease: _____ Drinking problem: _____
High Blood Pressure: _____ Anesthesia Problems _____

Patient Signature: _____ **Date:** _____

INTEGRATIVE WOMEN'S HEALTHCARE HAS A "NO RECORDING" POLICY. WE ASK THAT YOU POWER DOWN ALL RECORDING DEVICES, CAMERAS, AND CAMERA PHONES PRIOR TO BEING CALLED BACK BY THE NURSE.

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

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

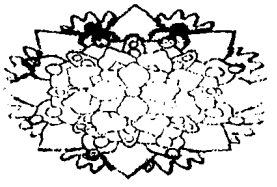
Which laboratory is contracted with your Insurance Company? **Please circle only one below.**

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 your 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 HIPPAA 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.