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: ______________ Sex: ____________ Gender: ________________

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.

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

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____

Check if you have or have you ever had:

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

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____

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

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____

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 other illicit 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

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: ______________________________
Ovarian cancer: ______________________________
Colon cancer: ______________________________
Other cancers: ______________________________
Diabetes: ______________________________
Heart disease: ______________________________
High Blood Pressure: ______________________________

Asthma: ______________________________
Stroke: ______________________________
High cholesterol: ______________________________
Bleeding disorders: ______________________________
Drug abuse: ______________________________
Drinking problem: ______________________________
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 ***PLEASE PRINT***
□ INFORMATION CHANGE

FULL NAME: ______________________________ **DATE OF BIRTH:** ________________

AGE: _______ □ SINGLE □ MARRIED □ DIVORCED □ OTHER: ______________________

SOCIAL SECURITY #: ______________________ EMAIL: _________________________

ADDRESS: ______________________________________ APT/SPACE/UNIT #: ________

CITY: _____________________________ STATE: ____________ ZIP: ______________

PHONE: (____) _______________ ALT PHONE: (____) ________________

EMPLOYER: ____

PRIMARY INSURANCE: ____________ MEMBER #: _____________ GROUP #: ________

GUARANTOR INSURANCE INFORMATION: □Self □ Spouse □ Parent/Guardian

GUARANTOR NAME: ____________________ DOB: ___________SS#: _______________

ADDRESS: __________________________________ APT/SPACE/UNIT #: _____________

CITY: ______________________________ STATE: ___________ ZIP: ________________

EMPLOYER: _____________________________ PHONE: _______________________

SECONDARY INSURANCE: ____________ MEMBER #: _____________ GROUP #: ______

GUARANTOR INSURANCE INFORMATION: □Self □ Spouse □ Parent/Guardian

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: ____

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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.

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.

LABORATORY CONSENT

We ask that **you, the patient or parent/guardian,** call your insurance company to verify the lab contracted with your insurance plan so that we can send out any collected specimens from your visit. This will help to insure that you do not receive any unexpected bills from the laboratory. We at Integrative Women's Healthcare will not handle any prior authorizations, billing disputes, or payments for any lab work. The lab work you may receive has been coded appropriately by your physician in accordance to your visit. We at Integrative Women's Healthcare do not know what testing your insurance may or may not cover. It is your responsibility to be aware of deductibles, co-payments, and co-insurances prior to having any lab work drawn. You have the right to decline testing at any time but please know that if you are being evaluated for any presence of pelvic pain, vaginal pain, discharge, odor, irritation, itching, or burning the physician may collect a vaginal culture and will no longer be able to be stopped once the specimen has left our facility.

Reference Laboratory

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

QUEST **LAB CORP**

GENPATH/LMC (For Un-Insured Patients)

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

Printed Name: ______________________________ DOB: ____________________

Signature: ______________________________ Date: ____________________

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.