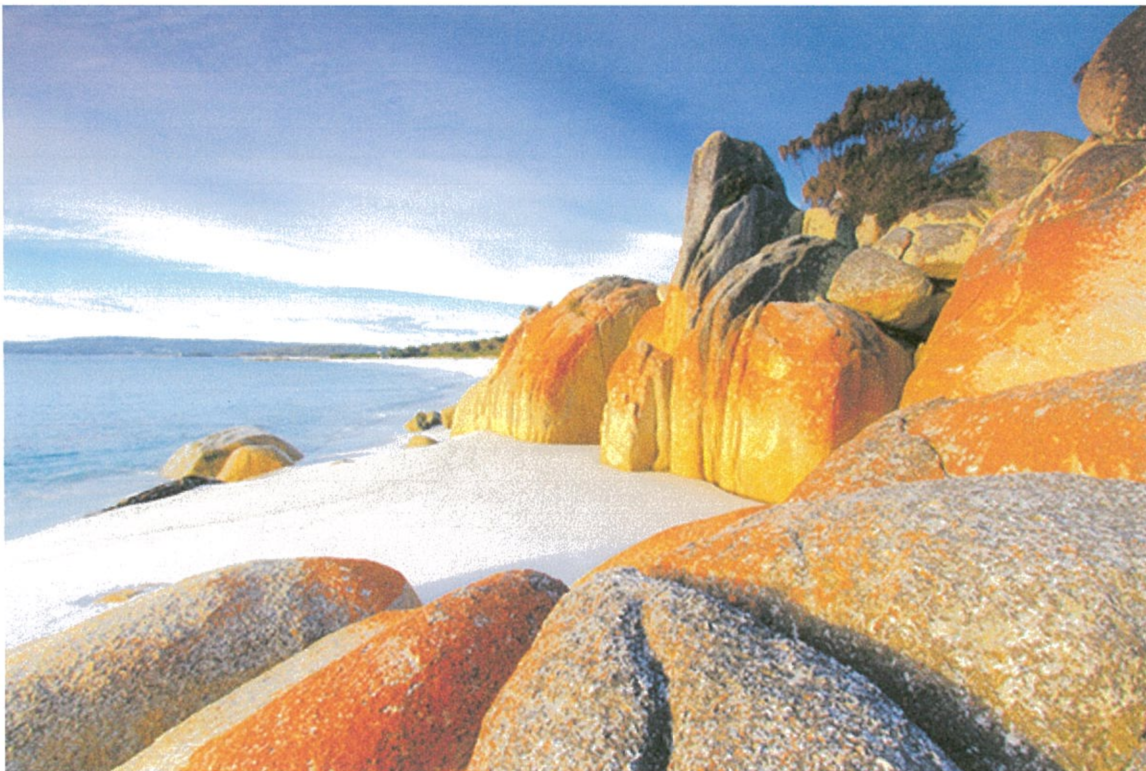
WELCOME TO RED ROCK OB GYN

For Your First Appointment:

Please no scented soaps, lotions or perfumes on the day of your appointment. Cancellations require 24 hour notice.

FOR MEDICAL PATIENTS ONLY: Please fill out the medical patient forms and bring them with you to your first appointment. Bring your actual insurance card and your driver's license. We will need a list of medications and dosages (or you can bring in actual pill bottles). We will need to know the name, location and telephone number of the Pharmacy you use.

SCULPSURE Patients **ONLY** need to complete and bring the Sculpsure Medical History Form.



PERSONAL DATA **CHART NUMBER:**

PATIENT NAME	S.S.#		MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	RACE	REL
STREET ADDRESS	APT#	CITY & STATE		ZIP CODE	HOME PHONE		
EMPLOYER		OCCUPATION		HOW LONG EMP	CELL PHONE		
EMPLOYER ADDRESS		CITY & STATE		ZIP CODE	WORK PHONE		
SPOUSE/PARENT NAME (circle one)		SPOUSE/PARENT S.S.#		DATE OF BIRTH	RELATIONSHIP		
SPOUSE/PARENT EMPLOYER		OCCUPATION		HOW LONG EMP	WORK PHONE		
EMPLOYER ADDRESS		CITY & STATE		ZIP CODE			
NOTIFY IN EMERGENCY		**RELATIONSHIP**		**PHONE #**			

INSURANCE DATA

MEDICARE #	MEDICAID #		
PRIMARY INSURANCE	PRIMARY INSURED'S NAME	RELATIONSHIP	DATE OF BIRTH
POLICY #	S.S.#	GROUP #	
SECONDARY INSURANCE	SECONDARY INSURED'S NAME	RELATIONSHIP	DATE OF BIRTH
POLICY #	S.S.#	GROUP #	
OTHER INSURANCE			
REFERRING PHYSICIAN	HOW DID YOU HEAR ABOUT US?		

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE SUPPLIED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE CARRIER PAYMENTS AND/OR INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize DR.____________________ to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any and all amounts not covered by insurance. **DATE:**__________________**SIGNATURE:**____________________________

CONSENT TO TREAT: I hereby give consent for appropriate diagnostic testing and treatment deemed necessary to my medical condition. **DATE:**______________**SIGNATURE**____________________________

ALL OF THE ABOVE INFORMATION IS CURRENT, UNCHANGED AND CORRECT:

DATE:______________________ **SIGNATURE:**____________________________

DATE:______________________ **SIGNATURE:**____________________________

DATE:______________________ **SIGNATURE:**____________________________

DATE:______________________ **SIGNATURE:**____________________________

RED ROCK OB GYN

Leslie L. Zak, MD & Sarah L. Newton, MD

2851 N. Tenaya Way – Suite 208 - Las Vegas, Nevada 89128

Phone: 702-228-0319 Fax: 702-477-0254

PATIENT AUTHORIZATION OF DISCLOSURE OF PHI (Personal Health Information)

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications. The privacy rule generally requires healthcare provider to take reasonable steps to limit the disclosure of PHI.

PATIENT PREFERRED METHOD OF CONTACT:

☐ **Home Telephone** ____________________ ☐ **Alternate telephone number**____________________

- ☐ **O.K. to leave detailed message**
- ☐ **Leave message with call-back number only**

E-mail address:

____

- ☐ **Written communication**
  - ☐ **O.K. to mail to my home address**
  - ☐ **O.K. to mail to work/office address**

☐ **email/portal for messages/test results**

☐ **email/portal financial statement**

If you would like to make any of your personal health information (PHI) to be released to an individual you must declare it by signing the Patient Authorization of Disclosure of PHI form.

I, ______________________, authorize the following person ___________________________ access to my personal health information as described below:

☐ **Release of the contents of my entire record**

Release limited to the following:

☐ **Communicable and sexually transmitted disease results**
☐ **Genetic test results**
☐ **Laboratory results**
☐ **Mammogram results**
☐ **Medication list**
☐ **Pap results**
☐ **Provider notes**
☐ **Ultrasound**

☐ **Billing and statement information**

I understand that I have a right to revoke this authorization at any time. I understand that if I want to revoke this authorization I must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.

Signature: ____ Date:__________

Witness:____

RED ROCK OB GYN OFFICE POLICY

It is the policy of this office that ALL VISITS be paid in full at the time of visit unless prior arrangements are made. Copayments and coinsurance as well as deductibles will be collected at the time of your visit.

APPOINTMENT CANCELLATIONS: 24 hour notice is required for cancelled appointments otherwise a $25. fee may be assessed.

FMLA/DISABILITY/LEAVE OF ABSENCE FORMS: We are happy to complete forms needed for these circumstances upon receipt of a $25. fee at the time of the request. We do not fax forms to employers or disability companies as this is the responsibility of the patient. Please make sure your authorization signature is on the form.

We ask that you not wear perfumes or scented soaps or lotions to your appointments, and that you arrive at the time indicated by the appointment scheduler. We carefully schedule our appointment types to stay on schedule because we realize your time is important, however due to the nature of our business, we may at times be called to the hospital to attend the delivery of a baby or an emergency.

We have electronic medical record system which uses a scanner. We need actual insurance cards and Nevada driver's licenses to be scanned into the system for billing and labs when they are sent out. A screenshot on your phone cannot be scanned into the record.

Nevada Medicaid is granted to residents of Nevada and therefore you should have a Nevada driver's license or ID card. Nevada law requires you to obtain a Nevada ID or driver's license within 30 days of establishing residency. You may use your passport ID if you are not a US citizen.

We deal with hundreds of insurance companies and thousands of plans. We have access to many benefits, but not all. It is NOT our responsibility to know your medical benefits. Check with your insurance carrier or go online if you are not sure. You are responsible for any charges.

Surgical/OB patients: Copays, coinsurance and deposits are due prior to procedures. You are responsible for any balances due. We will prior authorize your procedure if needed, but prior authorization is not a guarantee of payment. If your insurance doesn't pay, you are responsible for the total amount.

Sign below that you have read the above information regarding Red Rock OB/GYN office policy.

SIGNATURE____ **DATE:** _______________

WITNESS ____ **DATE:** _______________

PATIENT PROCEDURES/LABORATORY CHARGES AND PRIOR AUTHORIZATION

You may have a procedure or lab test done at some point during your care at Red Rock OB GYN. Procedures include, but are not limited to: ultrasounds, non-stress tests, colposcopies, biopsies, treatment for genital warts, LEEP procedure, cone biopsy, breast aspirations, diaphragms, catheterization, pessary insertion, polypectomy, IUD insertion or removal, injections, laboratory tests, excisional procedures, cryosurgery or implantable contraceptive devices.

Our office will check for prior authorizations prior to proceeding with office or hospital procedures. We must provide as much information as we have regarding your medical condition to your insurance. Your insurance company reviews this information and makes their determination as to medical necessity. Pre authorization means only that a procedure is medical indicated or necessary to be performed but it DOES NOT MEAN THAT THEY WILL PAY, or that the procedure is a covered benefit under your plan.

We make every effort to get benefits and estimate payments and copayments before your procedure however, we are NOT responsible for your plan's benefits or what is paid by them at the time your claim is presented. There may be exclusions or restrictions by your insurer. It is important that you know what your benefits are and we suggest you check with your insurance to know your entire coverage. Many insurance plans have deductibles that need to be met before benefits can be paid out as well as copays and coinsurance. Check your individual policy for coverages. Red Rock OB GYN is not responsible for non-payment of insurance claims. If your insurance does not pay, you are ultimately responsible for payment of services given.

Also, it is important to note that many insurance companies use only contracted laboratories. It is important for you to know which lab your insurance company utilizes. LAB CHARGES ARE SEPARATE FROM THE PHYSICIAN and will be billed by the laboratory. We make every effort to ensure that specimens are sent to the correct labs, however if there is an error payment to the incorrect lab is the patient's responsibility. You will be billed accordingly including deductibles that may be owed. Even though your annual exam may be a covered benefit, payment of your pap may be subject to deductibles or copays to the lab. Again- Red Rock is not responsible for your coverages for laboratory work. Some portions of your lab or pathology may need to be referred to a specialized pathologist or lab. Again, you may receive a bill for those charges as well, but any questions regarding lab coverages need to be directed to the laboratory and not our office.

Sign below that you have read the above information regarding labs/procedures/prior authorizations and understand Red Rock OB/GYN is not responsible for conditions not covered by your insurance

SIGNATURE: ____ **DATE:** ________________

WITNESS: ____ **DATE:** _________________

The doctors and staff of Red Rock OB/Gyn do not Discriminate against age, race or ethnicity. Information Regarding age, race and ethnicity is used to determine disease related risk factors and is used for assessment and treatment purposes only

Patient Name: ______________________
Age: ______________________
Date: ______________________

HEALTH HISTORY

Please Circle All That Apply

Pregnancy History:

Number of Pregnancies __________
Full Term Deliveries __________
Pre-Term Deliveries __________
Abortions__________
Miscarriages __________
*Pregnancy Complications:
Pre-Term Labor, Toxemia, High Blood Pressure, Diabetes, Hemorrhage, Cesarean section (Reason ______________________)

Gynecologic:

Irregular periods, Endometriosis, Fibroids, Infertility, Breast Problems, Breast Surgery-(including augmentation or reduction), Sexually Transmitted Diseases (Gonorrhea, Chlamydia, Herpes), Abnormal Pap Smear, Warts, Vaginal Discharge, Hot Flashes, Vaginal Dryness
Age at first period: ________Days between periods _____ Length of periods ________

Eyes/Ears/Nose/Throat

Wear Glasses or Contacts, Cataracts, Glaucoma, Hearing Loss, Hearing Aids, Ear Infections, Allergies, Sinus Infections, Sore Throat, Voice Problems
Other: ______________________

Respiratory

Asthma, Bronchitis, Emphysema, Pneumonia, Tuberculosis or Positive Test, Cough, Other

Cardiovascular:

High Blood Pressure, Chest Pain, Mitral Valve Prolapse, Rapid/Irregular Heart Rate, Stroke, Anemia, Sickle Cell, Abnormal Bleeding or Bruising, High Cholesterol, Other

Gastrointestinal:

Ulcers, Irritable Bowel Syndrome, Constipation, Diarrhea, Blood in Stool, Hiatal Hernia/Reflux, Abdominal Pain, Change in Weight or Appetite, Lactose Intolerance, Vegetarian Diet, Other

Urinary:

Frequent Bladder Infections, Kidney Infections, Kidney Stones, Blood in Urine, Other

Musculoskeletal:

Arthritis, Painful Joints, Broken Bones, Scoliosis, Rashes, Large or Changing Moles, Other

Endocrine:
Thyroid Problems, Diabetes, Excessive Thirst, Loss of Energy

Mental Status/Neurologic:
Headaches, Seizures/Epilepsy, Heat Trauma, Depression, Other Mental Illness, Suicide Attempt, Postpartum Depression, Eating Disorder-Anorexia/Bulimia, Abusive Relationship, Other

Other: Hepatitis, Cancer, HIV

Childhood Illnesses/Vaccines:
Chicken Pox, Measles, Mumps, Whooping Cough(Pertussis), German Measles
When was your last tetanus booster? ____________________

Have you ever had a blood transfusion? ☐YES ☐NO If Yes When? ____________________

Surgeries:
Please list all surgeries you have had: ____
____
____
____

Allergies:
Are you allergic to any medications? ☐YES ☐NO If YES, please list medication and reaction: ____
____
____

Habits:

Tobacco	☐YES	☐NO	☐QUIT	Amount: ____________________
Alcohol	☐YES	☐NO	☐QUIT	Amount: ____________________
Drugs	☐YES	☐NO	☐QUIT	What Kind: ____________________
Caffeine	☐YES	☐NO		Number of cups coffee/tea/caffeinated soda__________

Family History:
Please list any health problems/chronic diseases of family members ____________________
____
____
____

*******************for office use only*************************

vs	neck	abd	gu8
gen	resp	back	
h	cv	ext	
ent	breast	neuro	

RED ROCK OB/GYN

SCULPSURE® MEDICAL HISTORY FORM

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________ State: __________ Zip Code: __________

Telephone: Home: __________ Work: __________ Cell: __________

Date of Birth: ______________ Sex: Female _____ Male _____

Family Doctor: ______________________ Phone: ______________

Pharmacy: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________

Which body area/areas would you like treated? ______________________

____

____

Please answer all of the following questions **YES NO**

1. Do you have **ANY** current or chronic medical illnesses? ☐ ☐

   Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

   Please List: ____

   ____

2. Do you have **ANY** current or chronic skin conditions? ☐ ☐

   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

   Please List: ____

   ____

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

   ____

4. Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ☐ ☐

   Please List: ____

   ____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? ☐ ☐

   Please List: ____

RED ROCK OB GYN

2851 N. Tenaya Way – Suite 208 - Las Vegas, Nevada 89128
Phone: 702-228-0319 Fax: 702-477-0254

CONSENT FOR RELEASE OF PHI

Red Rock OB/GYN is committed to safeguarding our patient's privacy. Red Rock OB/GYN will assure that all medical data is restricted to only those individuals directly involved in treatment, payment and healthcare operations (TPO).

Private healthcare information (PHI) may be used and disclosed to other providers of care including hospitals, physicians, radiologists, anesthesiologists, insurance companies, and laboratories to carry out treatment, payment and health care operations. This means we may use or release necessary demographic information in order to bill insurance companies, call in prescriptions, order laboratory tests, radiology tests or to refer you to other physicians.

Demographic information may contain your name, birthdate, address, a portion of your social security number, phone number, fax number, names of relatives, names of employers, email address, medical records, health plan account identification number or other unique identifying number, characteristic or code which entity has reason to believe may be available to an anticipated recipient of the information. This may be transported via telephone, fax, mail, email or electronically.

Before signing this consent form, you have the right to review the complete description of those uses and disclosures in the Notice of Privacy and Disclosures by asking the privacy officer of this practice. You have the right to revoke consent in writing after you have reviewed our privacy notice. If you specifically do not want ANY of the above PHI disclosed you will need to pay for your office visit, treatment, surgery or procedure IN CASH IN ADVANCE and be personally responsible for reimbursement by your insurance company.

ADVANCE DIRECTIVES/LIVING WILL/ DURABLE POWER OF ATTORNEY:

Advance directives can limit life-prolonging measures or limit care provided by medical practitioners in life-threatening situations. A living will explains your wishes if you have a terminal disease. If you have a living will, durable power of attorney or advance medical directive, does this office have a copy of this document?

YES **NO** If yes, date given: ________________

Signature: ____ **Date:** ____________

Witness: ____