NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
PATIENT DEMOGRAPHICS

(All information is strictly confidential)

Last Name	First	Middle Initial	Birth Date: / /
Street Address	Apt #	City	State Zip
Mailing Address / P.O. Box	Apt #	City	State Zip

Student?: ☐ No ☐ Full Time ☐ Part Time | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner | Veteran: ☐ Yes ☐ No

Home Phone ( )	Work Phone ( )	Alternate ( )	Primary Language: _____ Ethnicity: ☐ Hispanic ☐ Non Hispanic

E-mail Address:

Birth Sex:	Gender Identity:	Sexual Orientation:	Preferred Pronoun(s):
☐ Male	☐ Male	☐ Lesbian or gay	☐ He, Him, His
☐ Female	☐ Female	☐ Straight (not lesbian or gay)	☐ She, Her, Hers
Current Gender:	☐ Transgender Male / Female-to-Male	☐ Bisexual	☐ They, Them, Theirs
☐ Male	☐ Transgender Female / Male-to-Female	☐ Something else	☐ Ze, Hir
☐ Female	☐ Other	☐ Don't know	☐ Decline to Answer
☐ Undifferentiated	☐ Chose not to disclose	☐ Chose not to disclose	☐ Other

Which of the following groups do you feel you belong to? ☐ American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ Refused to report

Emergency Contact (REQUIRED)	Phone ( )

Responsible Party (Parent, or legal guardian information. If patient is 18 years or older please print the patient's information.)

Last Name	First	Middle Initial		
Street Address	Apt #	City	State	Zip
Mailing Address / P.O. Box	Apt #	City	State	Zip

Home Phone ( )	Annual Income: (We need this information for statistical purposes) ☐ $24,000 or less ☐ $25,000 to $49,999 ☐ $50,000 to $74,999 ☐ $75,000 to $99,999 ☐ $100,000 or more ☐ Refused to report (Initials _____)

Employer's Name	Employer's Address (street address, city and state)	Phone ( )

Medical Insurance

1 - Primary Insurance Company	ID #	Group #	Address	
Name of Insured	DOB	Insured's Employer		Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other
2 - Secondary Insurance Company	ID #	Group #	Address	
Name of Insured	DOB	Insured's Employer		Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

I hereby voluntarily consent to outpatient care with Nevada Health Centers, Inc., encompassing routine, minor surgical and diagnostic procedures. I furthermore consent to the performance of examination and procedures by the medical staff and their assistants, including physician assistants and advanced practice nurses. I understand that physician assistants and advanced practice nurses are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I agree to the release of medical records and information including those related to medical treatment, surgical procedures, laboratory testing, psychological services and consultations to any person or entity responsible for payment to NVHC.

_____ _____

Signature of Patient, Parent or Legal Guardian | Date

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Nevada Health Centers, Inc.
FINANCIAL AGREEMENT

I authorize the direct payment of any benefits due to me for the services provided by Nevada Health Centers, Inc. be paid directly to Nevada Health Centers, Inc. by my insurance company.

I realize that although Nevada Health Centers, Inc. may be billing my insurance company on my behalf, I am ultimately responsible for the balance on my account.

Medicare Patients: I understand that Nevada Health Centers, Inc. accepts assignment with Medicare, however, I am responsible for a 20% copay at the time of service. Nevada Health Centers, Inc. will bill my supplemental insurance, as long as I provide all information necessary to do so. I understand that Medicare only pays for services it considers to be medically necessary and that the case may arise that I request services Medicare will not pay for, I would be responsible for payment in full.

Medicaid Recipients: Federal and State statutes require utilization of all other sources before billing Medicaid for medical services. Other sources include private or employer-provided health and accident insurance coverage. I certify under penalty of fraud that I do not have private or employer provided health and accident insurance, as a primary payer, for my dependents or myself. I understand that Medicaid only pays for services that are to treat a medical condition or illness.

Private Insurance Patients: I understand that I am responsible for knowing what benefits are covered by my insurance policy. I understand that Nevada Health Centers, Inc. will verify benefits, but does not guarantee any service will be a covered benefit. I understand that if my insurance does not cover any services received, I will be responsible for payment. I understand that my copay is due and payable at the time of service.

Self Pay Patients: I understand that it is the policy of Nevada Health Centers, Inc. to collect payment for services at the time of service.

Third-Party Collection Agency: If you have not responded to our attempts to reach you about any unpaid balances, we may opt to send your account to a collection agency.

Patient Signature / Parent (For Minor Patient)	Date
Witness	Date

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.

MAMMOVAN PROGRAM
MAMMOGRAPHY PATIENT QUESTIONNAIRE
PROGRAMA DE MAMOGRAFÍA MAMMOVAN CUESTIONARIO DEL PACIENTE

MARTIN LUTHER KING HEALTH CENTER
1799 Mount Mariah Dr., Las Vegas, NV 89106
Phone: 877.581.6266 | Fax: 702.220.3679
nvhealthcenters.org

Legal Last Name /
Apellido Legal: _____

Legal First Name /
Nombre Legal: _____

Date of Birth /
Fecha de nacimiento: _____

Physician's Name / *Nombre de su Médico* _____

Physician's Phone / *Teléfono de su Médico* _____

Physician's Fax / *Fax de su Médico* _____

1.	Is there a chance you're pregnant? *¿Existe alguna posibilidad de que esté embarazada?*	☐ NO ☐ YES / *SI* ☐ POSSIBLE / *ES POSIBLE*
2.	Have you breastfed in the past 6 months? *¿Ha dado de amamantar en los últimos 6 meses?*	☐ NO ☐ YES / *SI*
3.	Are you experiencing any new breast problems: *¿Siente alguno de los siguientes problemas en los senos al momento?:*	☐ NO ☐ YES / *SI* ☐ DISCHARGE / *SECRECION* ☐ LUMPS / *BULTOS* ☐ PAIN / *DOLOR*
	Please indicate which breast – check left (L) and/or right (R): *Por favor indique en cual seno – indique izquierdo (I) o derecho (D)*	☐ L / *I* ☐ R / *D* ☐ L / *I* ☐ R / *D* ☐ L / *I* ☐ R / *D*
4.	Are you currently taking hormones? *¿Está usted siguiendo una terapia de reemplazo hormonal?*	☐ NO ☐ YES / *SI*
	If yes, what kind? *Si respondió que sí, ¿De qué tipo?*	For how long? *¿Por cuánto tiempo?*
5.	How many full term pregnancies have you had? / *¿Cuántos embarazos ha tenido en su vida?*	
6.	Have you had a mammogram in the past? *¿Se ha hecho una mamografía en el pasado?*	☐ NO ☐ YES / *SI*
	When? / *¿Cuándo?*	Where? / *¿Donde?*
	What were the results? *¿Cuáles fueron los resultados?*	☐ NORMAL / *NORMALES* ☐ ABNORMAL / *ANORMALES* ☐ DON'T KNOW / *NO SÉ*
7.	Have you had breast cancer? *¿Ha tenido cáncer de senos?*	☐ NO ☐ YES / *SI* When? / *¿Cuándo?*
	Did you have a breast biopsy? *¿Se hizo una biopsia de senos?*	☐ NO ☐ YES / *SI* When? / *¿Cuándo?*
	Please indicate which breast – check left (L) and/or right (R): *Por favor indique en cual seno – indique izquierdo (I) o derecho (D)*	☐ L / *I* ☐ R / *D*

MORE QUESTIONS ON REVERSE SIDE / *MÁS PREGUNTAS AL REVERSO*

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MAMMOVAN PROGRAM
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8. Do you have a family history of breast cancer? *¿Tiene usted una historia de cáncer de senos?*	☐ NO ☐ YES / *SI* ☐ DON'T KNOW / *NO SÉ*
If yes, which relative(s) and what age? *Si respondió que sí, ¿Qué familiar o familiares? ¿A qué edad se le diagnosticó?*	
9. Have you ever had breast surgery? / *¿Ha tenido usted alguna cirugía de aumento de senos?*	
☐ NO If yes, please check below / *En caso afirmativo, consultar abajo*:	
Mastectomy / *Mastectomía*:	☐ YES / *SI* When? / *¿Cuándo?*
Implants / *Implantes*:	☐ YES / *SI* When? / *¿Cuándo?*
Reduction / *Reducción*:	☐ YES / *SI* When? / *¿Cuándo?*
10. Have you ever had any form of cancer? *¿Alguna vez ha tenido alguna forma de cáncer?*	☐ NO ☐ YES / *SI*
If yes, where and/or what kind? *En caso afirmativo, ¿dónde y/o qué tipo?*	

By signing, I acknowledge that I have read and understand this form. Further, I acknowledge that I am not pregnant, have not breastfed in the past 6 months, and have not had a mammogram within the past 365 days. I give permission for the Mammovan to **obtain and/or release** any medical records and/or radiology images, including to the wellness coordinator.

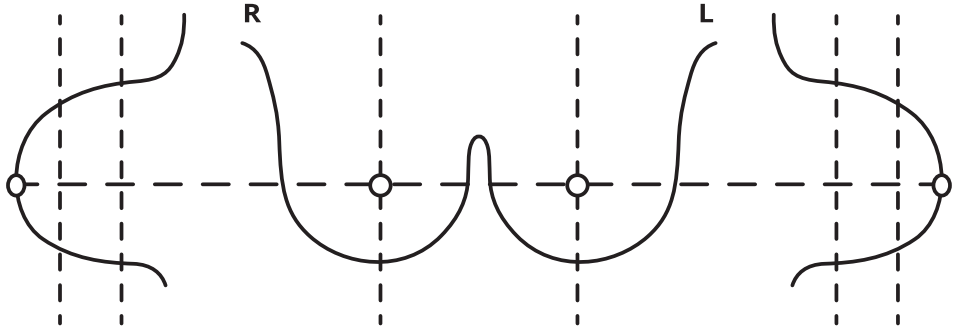
Al firmar, acepto que he leído y entendido este formulario. Además, declaro que no estoy embarazada, que no he amamantado en los últimos seis meses, y que no me he hecho una mamografía en los últimos 365 días. Doy mi consentimiento para que la Mammovan ***obtenga y/o libere*** *cualquier registro médico y/o radiografías, incluyendo al coordinador de bienestar de salud.*

Patient Signature / *Firma de la paciente*: _____ Date / *Fecha*: _____

DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY
NO ESCRIBA DEBAJO DE ESTA LÍNEA – PARA USO DE LA OFICINA SOLAMENTE

☐ Number of images _____
☐ Baseline
☐ Screening

☐ OT scanned - Proton Express
☐ Paperwork scanned - NextGen
☐ Studies pushed
☐ Priors studies pushed



_____
TECHNOLOGIST SIGNATURE

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
AUTHORIZATION TO SHARE INFORMATION

Our Notice of Privacy Practices (PE5.01Fa) provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights Section describing your right to authorize a member of your family, friend or a designated individual of your choosing to discuss your protected health information. You have the right to terminate this authorization at any time by completing this form and checking the "I want to terminate…" section below.

☐ **I authorize the following persons or entities to represent me or contact you and request information:**

☐ **I want to terminate my authorization to disclose information from the following person/entities:**

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

The persons named above can request the following information:

☐ **Medication refills** ☐ **Referrals** ☐ **All information pertaining to appointments** ☐ **All medical information**

_____	_____	_____	_____
Patient Signature	Print Name	DOB	Date

Nevada Health Centers, Inc.
AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN

Nuestro documento de Prácticas de Privacidad (PE5.01Fa) proporciona información sobre la manera en que podemos usar y revelar información de salud privada acerca de usted. La notificación contiene una sección de Derechos del Paciente que describe su derecho a autorizar a un miembro de su familia, amigo, o a un individuo a quien usted elija, para conversar sobre su información de salud privada. Usted tiene derecho a terminar esta autorización en cualquier momento completando este formulario y marcando la sección que dice "Quiero terminar..." según sigue a continuación.

☐ **Autorizo a las siguientes personas o entidades para que me representen o le contacten y soliciten información:**

☐ **Quiero terminar mi autorización de revelar información de las siguientes personas o entidades:**

Nombre: _____ Relación: _____ Fecha de nacimiento: _____

Nombre: _____ Relación: _____ Fecha de nacimiento: _____

Las personas que se nombraron anteriormente pueden solicitar la siguiente información:

☐ **Relleno de medicamentos** ☐ **Derivaciones médicas**

☐ **Toda la información relacionada con citas médicas** ☐ **Toda la información médica**

_____	_____	_____	_____
Firma del Paciente o Tutor legal	Escribir el nombre	Fecha de nacimiento	Fecha