



Nevada Health Centers, Inc.
PATIENT DEMOGRAPHICS
 (All information is strictly confidential)

Last Name	First	Middle Initial	Birth Date: / /
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Street Address	Apt #	City	State	Zip
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Mailing Address / P.O. Box	Apt #	City	State	Zip
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Student?: <input type="checkbox"/> No <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Cell Phone Number ()	Home Phone Number ()	Alternate Phone Number ()	Primary Language: _____ Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic
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E-mail Address: _____

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

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 ()
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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
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Street Address	Apt #	City	State	Zip
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Mailing Address / P.O. Box	Apt #	City	State	Zip
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Home Phone ()	Annual Income: (We need this information for statistical purposes)		
	<input type="checkbox"/> \$24,000 or less	<input type="checkbox"/> \$25,000 to \$49,999	<input type="checkbox"/> \$50,000 to \$74,999
	<input type="checkbox"/> \$75,000 to \$99,999	<input type="checkbox"/> \$100,000 or more	<input type="checkbox"/> Refused to report (Initials _____)

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

1 - Primary Insurance Company	ID #	Group #	Address
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Name of Insured	DOB	Insured's Employer	Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
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2 - Secondary Insurance Company	ID #	Group #	Address
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Name of Insured	DOB	Insured's Employer	Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
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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, Inc.
MAMMOVAN PROGRAM
MAMMOGRAPHY PATIENT QUESTIONNAIRE
PROGRAMA DE MAMMOVAN / MAMOGRAFÍA CUESTIONARIO DEL PACIENTE

 Legal Last Name /
 Apellido Legal: _____

 Legal First Name /
 Nombre Legal: _____

 Date of Birth /
 Fecha de nacimiento: _____

Physician/Clinic Name / <i>Nombre del médico/de la clínica:</i>	Physician/Clinic Phone Number / <i>Teléfono del médico/de la clínica:</i>	Physician/Clinic Fax Number / <i>Fax del médico/de la clínica:</i>
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1. Is there a chance you're pregnant? <i>¿Existe alguna posibilidad de que esté embarazada?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI	<input type="checkbox"/> POSSIBLE / ES POSIBLE			
2. Have you breastfed in the past 6 months? <i>¿Ha dado de amamantar en los últimos 6 meses?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI				
3. Are you experiencing any new breast concerns since your last screening? <i>¿Tiene alguna preocupación nueva relacionada con los senos desde su última evaluación?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI	<input type="checkbox"/> DISCHARGE / SECRECION	<input type="checkbox"/> LUMPS / BULTOS	<input type="checkbox"/> PAIN / DOLOR	
Please indicate which breast – check left (L) and/or right (R): <i>Por favor indique en qué seno – indique izquierdo (I) o derecho (D)</i>	<input type="checkbox"/> L / I	<input type="checkbox"/> R / D	<input type="checkbox"/> L / I	<input type="checkbox"/> R / D	<input type="checkbox"/> L / I	<input type="checkbox"/> R / D
4. Are you premenstrual or postmenstrual? <i>¿Está en el período antes o después de la menstruación?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI				
5. Are you currently taking hormones? <i>¿Está usted siguiendo una terapia de reemplazo hormonal?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI				
If yes, what kind? <i>Si respondió que sí, ¿De qué tipo?</i>	For how long? <i>¿Por cuánto tiempo?</i>					
6. How many full term pregnancies have you had? / <i>¿Cuántos embarazos a término ha tenido en su vida?</i>						
7. Have you had a mammogram in the past? <i>¿Se ha hecho una mamografía en el pasado?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI				
When? / <i>¿Cuándo?</i>	Where? / <i>¿Dónde?</i>					
What were the results? <i>¿Cuáles fueron los resultados?</i>	<input type="checkbox"/> NORMAL / NORMALES	<input type="checkbox"/> ABNORMAL / ANORMALES	<input type="checkbox"/> DON'T KNOW / NO SÉ			
8. Have you had breast cancer? <i>¿Ha tenido cáncer de senos?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI	When? / <i>¿Cuándo?</i>			
Did you have a breast biopsy? <i>¿Se hizo una biopsia de senos?</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI	When? / <i>¿Cuándo?</i>			
Please indicate which breast – check left (L) and/or right (R): <i>Por favor indique en qué seno – indique izquierdo (I) o derecho (D)</i>	<input type="checkbox"/> L / I		<input type="checkbox"/> R / D			

MORE QUESTIONS ON REVERSE SIDE / MÁS PREGUNTAS AL REVERSO

Nevada Health Centers, Inc.
MAMMOVAN PROGRAM
MAMMOGRAPHY PATIENT QUESTIONNAIRE
PROGRAMA DE MAMMOVAN / MAMOGRAFÍA CUESTIONARIO DEL PACIENTE

<p>9. Do you have a family history of breast cancer? <i>¿Tiene usted una antecedentes familiares de cáncer de senos?</i></p>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI	<input type="checkbox"/> DON'T KNOW / NO SÉ
<p>If yes, which relative(s) and what age? <i>Si respondió que sí, ¿qué familiar o familiares? ¿A qué edad se le diagnosticó?</i></p>			
<p>10. Have you ever had breast surgery? / <i>¿Ha tenido usted alguna cirugía de senos?</i></p>	<input type="checkbox"/> NO		
<p>If yes, please check below / <i>En caso afirmativo, marque abajo:</i></p>			
<p>Mastectomy / <i>Mastectomía:</i></p>	<input type="checkbox"/> YES / SI	When? / <i>¿Cuándo?</i>	
<p>Lumpectomy / <i>Lumpectomía:</i></p>	<input type="checkbox"/> YES / SI	When? / <i>¿Cuándo?</i>	
<p>Implants / <i>Implantes:</i></p>	<input type="checkbox"/> YES / SI	When? / <i>¿Cuándo?</i>	
<p>Reduction / <i>Reducción:</i></p>	<input type="checkbox"/> YES / SI	When? / <i>¿Cuándo?</i>	
<p>11. Have you ever had any form of cancer? <i>¿Alguna vez ha tenido alguna forma de cáncer?</i></p>	<input type="checkbox"/> NO	<input type="checkbox"/> YES / SI	
<p>If yes, where and/or what kind? <i>En caso afirmativo, ¿dónde y/o qué tipo?</i></p>			

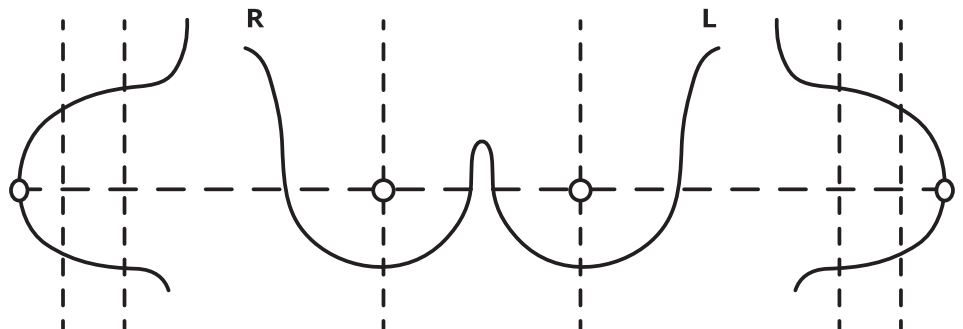
By signing, I acknowledge that I have read and understand this form. Further, I acknowledge that I am not pregnant, have not breastfed in the past 6 months, and have not had a mammogram within the past 365 days. I give permission for the Mammovan to **obtain and/or release** any records or radiology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

*Al firmar, acepto que he leído y entendido este formulario. Además, declaro que no estoy embarazada, no he amamantado en los últimos seis meses y no me he hecho ninguna mamografía en los últimos 365 días. Autorizo a la Mammovan a que **obtenga o revele** cualquier expediente o imagen de radiología que tenga relación con la mamografía de evaluación para incluirla en una remisión con un especialista.*

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, Inc.
PATIENT ACKNOWLEDGEMENT AND
CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Nevada Health Centers and/or its affiliated facilities (each and all of them referred to as “NVHC” in this form).

Consent to Healthcare Services: I am requesting that healthcare services be provided to me (or my minor child or the patient named below) at NVHC. I voluntarily consent to all medical treatment, dental treatment, behavioral health treatment, and healthcare-related services that the caregivers at NVHC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my NVHC caregiver. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

Telemedicine: I understand that NVHC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine and, as always, my insurance carrier will have access to my medical records for quality review / audit. I understand that I will be responsible for any copayments or coinsurances that may apply to my telemedicine visit.

Clinical Pharmacy Services: I understand that NVHC may provide certain clinical pharmacy services. Such clinical pharmacy services involve a clinical pharmacist working in collaboration with my Primary Care Provider. During these appointments, the clinical pharmacist may initiate, modify or discontinue medications pursuant to a collaborative practice agreement. I understand that the clinical pharmacist is not a physician, advanced practice registered nurse or physician assistant and may not diagnose. Further, I understand the clinical pharmacist has the right not to answer questions or perform services outside the pharmacist’s scope of practice.

Uses and Disclosures of Health Information: I have received Nevada Health Centers’ Notice of Privacy Practices. The Notice of Privacy Practices explains how Nevada Health Centers may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let Nevada Health Centers use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient’s) health information and financial account information to all third-party payers and/or their agents that are identified by NVHC, its or billing agents, collection agents, attorneys, consultants and/or other agents that represent NVHC or provide assistance to NVHC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient’s) healthcare, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that NVHC has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to NVHC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from NVHC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from NVHC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

Nevada Health Centers, Inc.
PATIENT ACKNOWLEDGEMENT AND
CONSENT FORM

I hereby consent and grant to NVHC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by NVHC. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge NVHC, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

Valuables/Limitation of Liability: I understand that I should not bring valuables (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to NVHC. If I choose to bring valuables to NVHC, I AGREE THAT NVHC SHALL NOT BE RESPONSIBLE FOR VALUABLES.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

In Person Consent

Signature of Patient or Responsible Party

Date/Time

Printed Name of Patient (or Responsible Party if not the Patient)

Responsible Party's Relationship to Patient

Phone Number(s)

Home _____

Cellular _____

OR

Telephone Consent

Printed Name of Individual Providing Telephone Consent

Date/Time

Printed Name of Patient (or Responsible Party if not the Patient)

Responsible Party's Relationship to Patient

Phone Number(s)

Home _____

Cellular _____

