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

Cell Phone Number ( )	Home Phone Number ( )	Alternate Phone Number ( )	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

NEVADA HEALTH CENTERS

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 MAMMOVAN / MAMOGRAFÍA CUESTIONARIO DEL PACIENTE

Legal Last Name /
Apellido Legal: _____

Legal First Name /
Nombre Legal: _____

Date of Birth /
Fecha de nacimiento: _____

Physician/Clinic Name / *Nombre del médico/de la clínica:*	Physician/Clinic Phone Number / *Teléfono del médico/de la clínica:*	Physician/Clinic Fax Number / *Fax del médico/de la clínica:*

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 concerns since your last screening? *¿Tiene alguna preocupación **nueva** relacionada con los senos desde su última evaluación?*	☐ NO ☐ YES / *SI* ☐ DISCHARGE / *SECRECION* ☐ LUMPS / *BULTOS* ☐ PAIN / *DOLOR*
	Please indicate which breast – check left (L) and/or right (R): *Por favor indique en qué seno – indique izquierdo (I) o derecho (D)*	☐ L / *I* ☐ R / *D* ☐ L / *I* ☐ R / *D* ☐ L / *I* ☐ R / *D*
4.	Are you premenstrual or postmenstrual? *¿Está en el período antes o después de la menstruación?*	☐ NO ☐ YES / *SI*
5.	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?*
6.	How many full term pregnancies have you had? / *¿Cuántos embarazos a término ha tenido en su vida?*	
7.	Have you had a mammogram in the past? *¿Se ha hecho una mamografía en el pasado?*	☐ NO ☐ YES / *SI*
	When? / *¿Cuándo?*	Where? / *¿Dónde?*
	What were the results? *¿Cuáles fueron los resultados?*	☐ NORMAL / *NORMALES* ☐ ABNORMAL / *ANORMALES* ☐ DON'T KNOW / *NO SÉ*
8.	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 qué 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
MAMMOGRAPHY PATIENT QUESTIONNAIRE
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9. Do you have a family history of breast cancer? *¿Tiene usted una antecedentes familiares 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?*	
10. Have you ever had breast surgery? / *¿Ha tenido usted alguna cirugía de senos?*	☐ NO
If yes, please check below / *En caso afirmativo, marque abajo*:	
Mastectomy / *Mastectomía*:	☐ YES / *SI* When? / *¿Cuándo?*
Lumpectomy / *Lumpectomía*:	☐ YES / *SI* When? / *¿Cuándo?*
Implants / *Implantes*:	☐ YES / *SI* When? / *¿Cuándo?*
Reduction / *Reducción*:	☐ YES / *SI* When? / *¿Cuándo?*
11. 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 records or radiology images related to screening mammography to include a referral to a specialist.

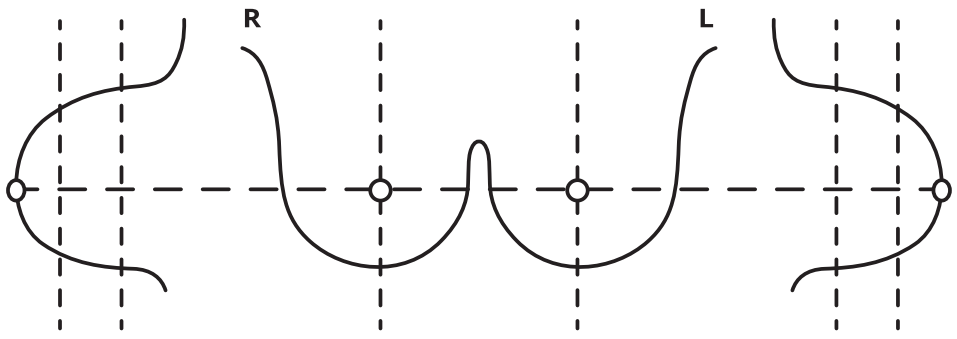
*Al firmar, acepto que he leído y entendido este formulario. Además, declaro que no estoy embarazada, no he amamantado en los últimos seis meses y no me he hecho ninguna mamografía en los últimos 365 días. Autorizo a la Mammovan a que **obtenga o revele** cualquier expediente o imagen de radiología que 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. I understand that NVHC is a teaching facility and that residents and students (under the direct guidance of my healthcare provider or clinical staff) may observe and /or participate in my care, during the course of my visit.

Telemedicine: I understand that NVHC may provide certain services by remote telehealth technology. 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. 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. Furthermore, 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

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Nevada Health Centers, Inc.
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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.

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 and 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 _____

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
AUTHORIZATION TO SHARE INFORMATION

Our Notice of Privacy Practices (FD-ALL.014e) 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: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

If you are signing for a minor child, please enter your name above, as well as any other parent or guardian who has your authorization for us to share information with them.

The persons named above can request the following information:

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

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature *(Parent/legal guardian signature if patient is under 18 years old)* Date

_____

Print Signature Name *(if parent/legal guardian)*