Nicole J. Moss, M.D.

PATIENT INFORMATION

Patient Name _____ Social Security#_____/_____/_____ Date of Birth _____/_____/_____

Home Address _____ Apt#_____ City/State/Zip_____

Home# (_____)_____ Work# (_____)_____ Cell# (_____)_____

Employer _____ Referred by _____

Marital Status (circle one) S M D W

PRIMARY INSURANCE

Insurance Name _____

Insured's Name _____

Relation to Patient _____

Insured's Date of Birth _____/_____/_____

Insured's SS# _____

Member ID# _____

Group # _____

SECONDARY INSURANCE

Insurance Name _____

Insured's Name _____

Relation to Patient _____

Insured's Date of Birth _____/_____/_____

Insured's SS# _____

Member ID# _____

Group # _____

GUARANTOR IF MINOR Relationship to Patient _____

Name _____ SS#_____/_____/_____ Date of Birth _____/_____/_____

Address _____ Apt#_____ City/State/Zip_____

Home# (_____)_____ Work# (_____)_____ Cell # (_____)_____

Employer _____

EMERGENCY CONTACT (NEAREST RELATIVE NOT LIVING WITH YOU)

Name _____ Relationship _____ Phone # (_____)_____

INSURANCE ASSIGNMENT AND MEDICAL RECORDS RELEASE:

I, the undersigned, do hereby authorize my insurance carrier(s) to pay benefits directly to Nicole Moss, M.D. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-pay, deductibles and/or non-covered services. If for any reason the said insurance carrier(s) has not paid within 90 days from the initial date of submission of charges, if requested, I must pay the amount in full. Should this account become delinquent, I will be responsible for all costs and consequences of collections. I the undersigned hereby authorize the release of any medical information required by my insurance carrier(s) in order to process claims.

_____ _____

Patient / Responsible Party Signature Date

FINANCIAL & OFFICE POLICY

Nicole J. Moss, M.D.

This office's Financial Policy is strictly enforced, please read it carefully. It is ultimately your responsibility to know your insurance benefits and verify with your insurance company that Dr. Moss is a provider for your plan. ****Please initial each element below and sign at the end.*

_____ OFFICE VISITS: All co-payments, deductible amounts, coinsurance, **and full outstanding account balances** will be collected at the front desk prior to service. If there is a history of delayed prior balance remittance or a bounced check, a deposit will be collected at the front desk for the **full** estimated charges for the current visit. If we are not contracted with your primary insurance company, or if you do not have insurance coverage, our cash pay rates will apply and will be due prior to service—should you have additional services provided on top of what was estimated by the receptionist, any further balance will be billed to you. In-office payments may be made by cash, debit card, Visa, MasterCard, American Express, or Discover. Personal checks are not accepted in the office for payment.

_____ SECONDARY INSURANCES: Secondary insurances will be billed as a courtesy to you, but all pre-collected amounts will be based solely on your primary insurance, with any duplicate payments being refunded to you should they occur. If we are not a provider for your **primary** insurance company, we will **not** bill your secondary insurance, the claims will be rejected—such patients are treated as cash-pay.

_____ NURSE VISITS: If you come in for an injection or a urine check, your regular office visit co-pay will still apply and will be collected at the front desk.

_____ PROCEDURES: If you are scheduled for a non-emergent procedure or surgery, we will check your insurance benefits and advise you of your estimated financial responsibility to Dr. Moss based on your primary insurance. Secondary insurances will be billed as a courtesy to you, but all pre-collected amounts will be based solely on your primary insurance, with any duplicate payments being refunded to you should they occur. All co-pays, deductible amounts, and outstanding account balances will be required at the time of your in-office procedure, or for hospital procedures, at your pre-op appointment.

_____ PRE-COLLECTED AMOUNTS: Pre-collected co-pays, coinsurances, and deductible amounts **are estimates only.** Your final financial responsibility to the doctor will be determined by your insurance company after the visit is billed to them. As many variables play into how a visit is coded and reimbursed, this amount may be considerably different from the estimate.

_____ LAB CHARGES: Any specimens sent to a laboratory will incur separate charges billed directly by the lab company. **Estimated amounts due are for Dr. Moss only—any lab charges not fully covered by your insurance company (or if you are cash-pay) will be additional.**

_____ PREVENTATIVE CARE VISITS: As preventative care, or "well care", commonly has limited or different co-pays charged by insurance companies, it is important to know specifically what is included in a "Well-Woman Exam". Please refer to our form "What exactly is a Well-Woman Exam" available in the office.

_____ TREATMENT VIA PHONE: Any problem that may require a new prescription for treatment will require you to be seen in the office, including suspected urinary tract infections or yeast infections. Treatment for such will not be given out over the phone.

_____ PAYMENT RESPONSIBILITY: Payments for any patient responsibility balances are due within 15 days of statement date. You are financially responsible for any charges not covered by your insurance carrier(s), including co-pays, deductibles, coinsurance, and/or non-covered services. If for **any** reason your insurance carrier(s) has not paid within 45 days from the initial date of submission of charges to them, if requested, you must pay the amount in full at that time, with any duplicate payments being refunded to you should they occur. If your account becomes delinquent, we may refer your account to a collection agency and you will be responsible for all costs and consequences of collections.

_____ FMLA & DISABILITY FORMS: There is a $20 charge for the completion of each FMLA and disability form, payable when forms are dropped off at the office.

_____ RETURNED CHECKS: There will be a $25 charge added to your account for any check returned for insufficient funds.

_____ MISSED APPOINTMENTS: Repeated missed appointments not cancelled prior to 24 hours before the appointment will result in discharge from the practice.

_____ OBSTETRICS: Dr. Moss is no longer seeing new OB patients. If you are pregnant, or become pregnant, you will be referred to another physician for your pregnancy care.

_____ MEDICARE: Dr. Moss has opted-out of Medicare. If you are 65 or older you will be required to sign a Medicare beneficiary private contract.

_____ CHANGE OF ADDRESS: It is your responsibility to promptly notify us of any address changes. If your account becomes delinquent because we do not have a current address, you will be responsible for all costs and consequences of collections.

Failure to comply with this financial policy will result in discharge from the practice.

Please sign below to acknowledge that you have fully read and understand this 2 page financial and office policy.

_____ _____

Patient / Responsible Party Signature Date

HEALTH QUESTIONNAIRE

(please print legibly in BLACK or BLUE ink)

DATE_____/_____/_____ NAME_____ DATE OF BIRTH_____/_____/_____

CURRENT MEDICATIONS (Prescription or over-the-counter)

Name Dose Amount Frequency

_____ No current medications (circle if correct)

_____

_____

_____

_____

PAST MEDICAL HISTORY (circle any of the following that you have ever had)

Bleeding tendencies/unusual bruising	Asthma	Depression	Diabetes
Epilepsy (fits, seizures, convulsions)	Emphysema	Anxiety	Cancer
Ever received a blood transfusion	Chronic Bronchitis	Pneumonia	Tumors
High Blood Pressure disease	Bowel disorders	Pleurisy	Arthritis
Elevated cholesterol	Colitis	Heartburn	Gout
Kidney or bladder trouble	Rheumatic fever	Stomach ulcer	Stroke
Gallbladder problems	Heart murmur	Jaundice	Thyroid
Blood clot (DVT)	Heart disease	Hepatitis	Goiter
Pulmonary embolism (PE)	Varicose veins	Tuberculosis	Hay fever

Explain any circled item or other medical problems_____

_____

ALLERGIES TO MEDICATIONS

Name Reaction

_____ No known allergies (circle if correct)

_____

_____

_____

PAST SURGICAL HISTORY List all surgeries including gynecological surgery (D&C, Hysterectomy, C-section, Appendix, Gallbladder, etc.)

Year Operation Hospital/Location

_____ No previous surgeries (circle if correct)

_____

_____

HOSPITALIZATION List any hospital admissions that did not require surgery (Observation, Pneumonia, Hydration, etc.). Do NOT include deliveries.

Year Problem

_____ Never been hospitalized (circle if correct)

_____

_____

FAMILY HISTORY List any diseases that run in your family (Breast cancer, ovarian cancer, diabetes, heart disease, etc.)
Relationship (and side of family) Disease Age at diagnosis

_____

_____

_____

SOCIAL HISTORY

Do you smoke? **NO YES** Packs per day_____

Do you drink alcohol? **NO SOCIALLY FREQUENTLY**

Do you use any narcotic, addicting, or recreational drugs? **NO YES** Details_____

Present Occupation:_____ Highest grade level:_____

Marital Status: **S M D W** Place of Birth:_____

GYNECOLOGICAL HISTORY

Last menstrual period_____/_____/_____ Last Pap smear_____

Age period began_____ Frequency of periods_____ Length of period _____

Currently sexually active? **Yes No** Any history of STD's? **Yes No** Details_____

Current birth control method _____ Past methods _____

Problems with any birth control methods you have used_____

Have you had the Gardasil (HPV) vaccine? **NO YES** Year given_____ Number of doses received? **1 2 3**

Have you ever had a bone density test? **NO YES** If so, when_____

Have you ever had a mammogram? **NO YES** If so, when_____ and where_____

Please circle any of the following you have ever had

Full feeling or falling out sensation in the vagina	Current vaginal discharge or odor	Hot flashes/flushes
Exposure to DES	Pain associated with period	Leak or lose urine
Diagnosed with venereal disease	Diagnosed with cervical dysplasia	Difficulty reaching orgasm
Diagnosed with warts or condyloma	Spotting/bleeding between periods	Pain/bleeding with intercourse
Diagnosed with any other female infection	Greater than 5 sexual partners	Abnormal pap smears

Explain any circled items or add other female problems you have had that are not listed_____

_____

REVIEW OF SYMPTOMS (circle if you have recently had)

Unexpected weight change/more than 10 lbs.	Frequent vaginal discharge	Frequent/severe headaches
Increased frequency or amount of urination	Serious problems with eyes or ears	Frequent cough or wheezing
Unusual/severe shortness of breath	Frequent/severe back pain	Pain or burning with urination
Frequent racing of skipping heart beats	Frequent constipation/diarrhea	Blood/mucus in bowel movement
Frequent/severe stomach/abdominal pain	Bowel movement looking like black tar	Difficulty swallowing
Pain or tightness in chest with exertion	Frequent swelling of ankles or legs	Redness or pain/swelling in joints
Unusual skin problems/persistent sores	Problems (stress) at home/work	Breast lumps/nipple discharge

Any additional information not listed previously, please list here _____

_____

OBSTETRICAL HISTORY

Pregnancies

No.	Year	Vaginal / Cesarean	Complications
1.	_____	**V / C**	_____
2.	_____	**V / C**	_____
3.	_____	**V / C**	_____
4.	_____	**V / C**	_____
5.	_____	**V / C**	_____

Miscarriages

Year	Weeks at time of miscarriage	Surgery required	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Elective Termination of Pregnancy

Year	Weeks at time of termination	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nicole Moss, M.D.
Nicole J. Moss, M.D., Ltd.
2931 N. Tenaya Way, Ste. 204
Las Vegas, NV 89128
(702) 233-2123

Consent for Purposes of Treatment, Payment and Healthcare Operations

Privacy Officer: Nicole Moss, M.D.
Telephone: 702-233-2123

I consent to the use or disclosure of my protected health information by Dr. Nicole Moss and her staff ("The Office") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations at this office. I understand that diagnosis or treatment of me by Dr. Moss may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of this office. The Office is not required to agree to the restrictions that I may request, however, if The Office agrees to a restriction that I request, the restriction is binding on The Office and the care provided by Dr. Moss.

I have the right to revoke this consent in writing at any time, except to the extent that Dr. Moss has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. The protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have a right to review the office's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for the office is also provided by request. The Notice of Privacy Practices also describes my rights and the office's duties with respect to my protected health information.

The office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting Dr. Moss (privacy officer) and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative_____

Name of Patient or Personal Representative_____

Description of Personal Representative's Authority_____

Date_____