

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**

**SECONDARY INSURANCE**

Insurance Name \_\_\_\_\_ Insurance Name \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Relation to Patient \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Insured's SS# \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Member ID# \_\_\_\_\_ Member ID# \_\_\_\_\_  
Group # \_\_\_\_\_ 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 45 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.*

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**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.

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**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.

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**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.

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**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.

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**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.

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**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.**

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**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.

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**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
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<hr/> <hr/> <hr/> <hr/> <hr/>	No current medications (circle if correct)
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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
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<hr/> <hr/> <hr/> <hr/>	No known allergies (circle if correct)
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PAST SURGICAL HISTORY List all surgeries including gynecological surgery (D&C, Hysterectomy, C-section, Appendix, Gallbladder, etc.)

Year	Operation	Hospital/Location
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<hr/> <hr/> <hr/>	No previous surgeries (circle if correct)
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HOSPITALIZATION List any hospital admissions that did not require surgery (Observation, Pneumonia, Hydration, etc.). Do NOT include deliveries.

Year	Problem
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<hr/> <hr/> <hr/>	Never been hospitalized (circle if correct)
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**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 Virginal** 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.	_____	<b>V / C</b>	_____
2.	_____	<b>V / C</b>	_____
3.	_____	<b>V / C</b>	_____
4.	_____	<b>V / C</b>	_____
5.	_____	<b>V / C</b>	_____

**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 \_\_\_\_\_