Legacy Women's Health
8480 S. Eastern, Suite F
Las Vegas NV 89123
702-914-6900

OBSTETRICS & GYNECOLOGY
NEW PATIENT INFORMATION

Welcome to our office! We thank you for selecting us to serve your healthcare needs. So that we may all enjoy a smooth working relationship please take a few minutes to read the following information. If you have any questions, we will be happy to answer them.

1. If you do not have insurance **payment** is required at the time of service. For patients with insurance co-pays, co-insurance and/or deductibles are required prior to office visit, delivery or surgery. Payment plans are available upon request.

2. It is necessary for you to bring your **insurance** card and Identification to all visits. If your treatment is not covered by your insurance company, all charges for treatment will be your responsibility. It will be your responsibility to notify us if your insurance changes or terminates as soon as possible. When possible learn what you can about your insurance benefits prior to making an appointment. This will keep you from being surprised later.

3. We will bill your **insurance** as a courtesy and make every effort to get payment directly from your insurance company. If your insurance has not paid 60 days after treatment, it may be necessary for us to treat your account as a cash account. If it is not possible, for us to be paid for our service after 120 days your account will be sent to a collection agency. In the event this happens your account will begin accruing interest. There may also be a collection fee or attorneys costs added to your account.

4. In most cases cultures, specimens and/or blood work are sent out to **LMC**. **Laboratories bill separately and this office cannot take responsibility for your laboratory bill.** It's your responsibly to make sure that the lab has your current insurance information. If your insurance requires you to go to another laboratory, please let the LMCL lab personnel know each time you visit our office

5. It may be necessary for this office to **release** your information to your insurance company to obtain payment and/or hospital for treatment. I authorize all payment to be made to Timothy Sauter, MD Ltd or Legacy Women's Health.

6. We will do our best to keep your **waiting** to a minimum. However, the nature of the business requires our providers to go to the hospital on short notice. If this happens we will do our best to accommodate you. This may make your wait longer, make it necessary to reschedule or see one of our other providers.

7. A parent or guardian needs to accompany a **minor** to authorize treatment and take financial responsibility.

8. All **prescription** refills require two business days to refill. We request that refill requests are faxed to our office by your pharmacy. Please understand some refills will require an office visit.

9. In the event of a **returned check** there will be a fee of $25.00 and thereafter you will be required to pay by either cash or credit.

10. Please make every effort to give us 24 hours' notice if it is necessary for you to **cancel or reschedule.** We reserve the right to charge a fee of $25.00 for missed appointments. It may be necessary for us to refuse service to you if you have a past due balance as part of your account history with us.

I have read and understand the Financial Policy and Office Procedures

Print Name of Patient Signature of Patient or Parent/ Guardian Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

My signature of this document give consent to, Timothy Sauter, M.D. Ltd DBA Legacy Women's Health to use and disclose protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Timothy Sauter, M.D. Ltd's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I understand I have the right to review the Notice of Privacy Practices prior to signing this consent. Timothy Sauter, M.D. Ltd reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Timothy Sauter, M.D. Ltd's Privacy Officer at 8480 S. Eastern, Suite F Las Vegas, NV 89123.

I give consent to Legacy Women's Health staff to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I give consent to Legacy Women's Health staff to mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I give consent to Legacy Women's Health staff to e-mail me or use any other designated form of communication to send PHI information that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Timothy Sauter, M.D. Ltd restrict how it uses or discloses my PHI to carry out TPO upon my written consent.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Legacy Women's Health use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Legacy Women's Health may decline to provide treatment to me.

I request to have the person(s) below to be able to access all my Protected Health Information (PHI) at Timothy Sauter, MD Ltd. dba Legacy Women's Health including but not limited to laboratory results. My signature will permit the exchange of my PHI with this person until I update this document in writing.

Name(s)_____Relationship_____

Name(s)_____Relationship_____

Signature of Patient or Legal Guardian_____

Patient's Name_____ Date_____

Print Name of Patient or Legal Guardian_____

Date:_____
(Fecha)

Email:_____
(Correo Electronico)

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Date:_____ **Email:**_____

Patient Name: _____ **Date of Birth:** _____
(Nombre) First MI Last (Fecha de Nacimento)

Age: _____ **Marital Status:** _____ **Social Security #:** _____
(Edad) (Estado Civil) (Numero Social)

Home Phone: _____ **Cell Phone:**_____ **Business Phone:** _____
(Telefono de Casa) (Telefono Movil) (Telefono de Trabajo)

Home Address: _____
(Direccion De Casa)

City: _____ **State:** _____ **Zip Code:**_____
(Cuidad) (Estado) (Codigo Postal)

Employer: _____ **Occupation:** _____
(Empleo) (Profesion)

Address: _____
(Direccion)

Emergency Contact: _____ **Relationship:** _____ **DOB:** _____
(Contacto de Emergencia) (Relaccion) (Fecha de Nacimento)

Telephone Number: _____ **Address:**_____
(Numero de Telefono) (Direccion)

Primary Insurance: _____ **Policy #:**_____
(Seguro Primaria) (Numero de Membresia)

Policy Holder:_____ **Group #:** _____
(Membre de Seguro) (Numero de Grupo)

Relationship : _____ **Date of Birth:** _____ **Social Security#:** _____
(Relaccion) (Fecha de Nacimento) (Numero Social)

Telephone#: _____ **Address:** _____
(Telefono) (Direccion)

Employer: _____ **Address:** _____
(Empleo) (Direccion)

Secondary Insurance: _____ **Policy#:** _____
(Seguro Secundario) (Numero de Membresia)

Policy Holder: _____ **Group#:**_____
(Membre de Seguro) (Numero de Grupo)

Relationship: _____ **Date of Birth:** _____ **Social Security#:**_____
(Relaccion) (Fecha de Nacimento) (Numero Social)

Telephone#: _____ **Address:** _____
(Telefono) (Direccion)

Employer: _____ **Address:** _____
(Empleo) (Direccion)

I hereby authorize the office of Timothy Sauter, MD, Ltd. DBA Legacy Women's Health to furnish information to insurance carriers concerning my treatments and hereby assign to the physician all payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance and lab work. (Yo autorizo la oficina de Timothy Sauter, MD, Ltd DBA Legacy Women's Health a entregar informacion a mi seguro relacionado con mi enfermedad, tratamientos y por este medio assigno el medico todos pagos servicios medicales dados a mi o mis dependes. Yo entiendo que soy responsible por cualquier cobro que no este cubierto con mi seguro.)

Patient or Guardian Signature: _____ Date:_____
(Firma de Paciente o Guardian) (Fecha)

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Medical History

Date: _____ My appointment is with: _____

Patient Name: _____ DOB: _____ Age: _____

Reason for your visit today: _____

Referred By: _____ Preferred Pharmacy _____

First day of last period: _____ Do you have regular monthly periods? Y / N

How often do your periods come? _____ Age at first period _____

Periods are: Mild Moderate Heavy Cramps are: Mild Moderate Severe

Current birth control: _____

Age at first intercourse: _____ Number of partners (lifetime): _____

Are you having any libido changes? Y / N (please explain) _____

Do you have pain with intercourse? Y / N (please explain) _____

Sexual Preference: (please circle) Heterosexual Homosexual Bisexual

Have you had a new sexual partner since last exam? Y / N

Do you desire testing for STDs? Y / N

Have you ever had a sexually transmitted disease? Y / N (circle any that apply)

Gonorrhea Chlamydia Herpes Hepatitis B HIV

Syphilis Genital Warts PID Trichomonas HPV

Current Medications: _____

Drug Allergies: _____

Do you use tobacco products? Y / N About _____ cigarettes per day

Do you drink alcohol? Y / N About _____ drinks per week

Are you experiencing any vaginal or urinary:

Discharge Odor Burning Itching Frequency Urgency Loss of Urine

Other: _____

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Last Pap Smear: ____/____ Results _____

Have you ever had an abnormal pap smear? Y / N Give year and any procedures_____

Last Mammogram ____/____ Results _____

Have you ever had an abnormal mammogram? Y / N

If yes, please give year and any procedures_____

Do you do monthly breast exams? Y / N or Occasionally

Have you had a Bone Density (Dexascan)? Y / N If so, year and results of last one_____

Have you had a Colonoscopy? Y / N If so, year and results of last one_____

Do you diet? Y / N What type?_____

Do you exercise? Y / N How often/how long?_____

Do you take calcium? Y / N How much?_____

Other Important Information:_____

Please list all surgeries / hospitalizations

Surgery / reason for hospitalization	**Date**

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Please list all pregnancies

Year	Method of delivery	Gestational age	Sex	Weight	Comments / complications

Medical Problems

Date of Diagnosis	Medical Problem

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Personal & Family History (mark all those that apply)

Disease	Self	Mother	Father	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Brother / Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma / lung problems									
Blood clots									
Bloody stools / colon polyp									
Cancer									
Diabetes									
Heart disease									
High cholesterol									
High blood pressure									
Kidney disease / UTIs									
Liver disease									
Loss of urine									
Mental illness									
Osteoporosis									
Seizures									
Stomach ulcers									
Stroke									
Thyroid disease									
Tuberculosis									
Other									

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First Trimester Screening

Welcome to our practice. We are glad you have chosen our practice for your obstetric care. We are happy to report the majority of babies are born healthy. However, if you have concerns there are screenings available to determine your baby's risk for some genetic defects. Unfortunately, these screenings can be costly and many insurance plans do not cover them. Your health care provider will explain your genetic testing options more extensively at your appointment and in most cases you will have time to determine what is right for you and your baby.

However, the **Nuchal Translucency Screening** is a **First Trimester Screening** only. Because this screening is **time sensitive** it is necessary for us to help you understand a little about what this is before your first visit to our office, for this pregnancy. The **First Trimester Screening** specifically determines your baby's risk factor for **Down syndrome**. This screening must be done between **11 and 13 ½ weeks**. Through the use of this **First Trimester Screening** approximately 90% of Down syndrome cases are detected. This is a two part test which includes a blood test and an ultrasound. If you are interested in having the **First Trimester Screening** done, you will need to make the appointment for the ultrasound and have this done prior to 13 weeks gestational age. If you are interested in this screening and your first office visit for this pregnancy will be after this time, please contact us.

I understand that the Nuchal Translucency Screening is time sensitive and is optional. I also understand it may not be covered by insurance and that this office is unable to provide the cost of the lab portion of this screening. All billing inquiries regarding the lab work performed in conjunction with the ultrasound should be directed to the appropriate laboratory. If you need more information regarding your financial obligation, please contact your insurance company.

Quest Diagnostics (702) 733-7866
Lab Corp (800) 845-6167
CPL (702) 795-4900

_____I wish to have the Nuchal Translucency Screening done. Please send my lab work to the following lab.
_____Quest ____Lab Corp ____CLP

_____I do not wish to have the Nuchal Translucency Screening done.

_____I understand that my gestational age is too far advanced to receive the Nuchal Translucency Ultrasound and Lab work.

PATIENT NAME **PATIENT SIGNATURE** **DATE**

If you are not sure or still have questions, please print this form and bring it with you to your appointment, in most cases, it can be sign after you have received more information.

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New OB History /Genetics Screening

Please answer the following questions the best as you can. This information will help us in the care of you during your pregnancy.

Patient Name_____Date of Birth_____

Date of last period_____Since last period what symptoms have you experienced:

_____nausea _____vomiting (how often) _____ _____Bleeding (how much) _____

Have you gained or lost any weight since becoming pregnant? ____Yes_____No

Have you taken any medications since last menstrual period other than prenatal vitamins (include vitamins, supplements and over the counter medications)? ____Yes____No

Do you use alcohol, tobacco or street drugs? ____Yes____No

Do you have cats at home? ___Yes____No

Do you have close contact with children on a regular basis? ____Yes ____No

Have you had recurrent pregnancy loss (miscarriages or stillbirths)? _____Yes____No

Have you had chicken pox?____Yes____No

Family History

Are you or your baby's father from any of the following ancestry?

Jewish?____Yes____No African American/Black?_____Yes_____No

Are you or your baby's father from any of the following areas?

Southeast Asia, Taiwan, China or the Philippines? _____Yes____No

Italy, Greece, or the Middle East? _____Yes____No

Genetic Screening: Includes patient, baby's father, or blood relative
Where your ancestor came from may give us important information about the health of your baby.

Do you or the father of your baby or family members have any of the following?

Thalassemia?_____Yes_____No

Sickle cell disease or trait?____Yes____No

Tay-Sach disease?____Yes____No

Down Syndrome?____Yes____No

Genetic Screening Continued:

Canavan's disease?_____Yes____No

Neural tube defect (Meningomyelocele, Spina Bifida, Anencephaly)? ____Yes_____No

Congenital heart defect? ____Yes____No

Hempohilia, Von Willebrand or other blood disorders? _____Yes_____No

Muscular Dystrophy? _____Yes____No

Cystic Fibrosis? _____Yes_____No

Huntington's Chorea? ____Yes____No

Mental Retardation/Autism? ____Yes____No (If Yes was person tested for Fragile X)? _____

Maternal Metabolic Disorder (Diabetes or PKU)? ____Yes____No

Do you or the father of your baby have a child with a birth defect not listed above? ____Yes____No

Do you or the father of your baby have any birth defects not listed above? ____Yes____No

Infection History:

Has anyone in your household been exposed to or have TB? _____Yes_____No

Do you or your partner have a history of genital herpes? _____Yes_____No

Do you have a history of any sexually transmitted disease (Gonorrhea, Chlamydia, HIV, HPV, Syphilis)? ____Yes____No

Have you had a rash or STD since becoming pregnant? ____Yes_____No

Are there any other problems or concerns we should know about?_____

_____