



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 **CPL**. The **laboratory** will send you a separate bill and this office cannot take responsibility for your laboratory bill. **If your insurance requires you to go to another laboratory, please remind lab personnel 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



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 Legacy Women's Health 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. Legacy Women's Health reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Legacy Women's Health Attention Privacy Officer at 8480 S. Eastern, Suite F Las Vegas, NV 89123.

I give my consent to the staff of Legacy Women's Health, they call or text 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 my consent to the staff of Legacy Women's Health, they may 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 my consent to the staff of Legacy Women's Health, they may e-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 have the right to request that Legacy Women's Health restrict how it uses or discloses my PHI to carry out TPO.

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 am requesting that the following person(s) listed below be able to access my Protected Health Information (PHI) at Legacy Women's Health including but not limited to laboratory results. My signature will permit the exchange of my PHI with this person(s) until I update this document in writing.

Name(s) _____ Relationship _____

Name(s) _____ Relationship _____

Signature of Patient or Legal Guardian _____ Date _____

Print Patient's Name _____ Legal Guardian(If Applies) _____



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

OBSTETRICS & GYNECOLOGY NEW PATIENT INFORMATION

Date: _____
(Fecha)

Email: _____
(Correo Electronico)

Patient Name: _____
(Nombre) First MI Last

Date of Birth: _____
(Fecha de Nacimiento)

Age: _____
(Edad)

Marital Status: _____
(Estado Civil)

Social Security #: _____
(Numero Social)

Home Phone: _____
(Telefono de Casa)

Cell Phone: _____
(Telefono Movil)

Business Phone: _____
(Telefono de Trabajo)

Home Address: _____
(Direccion De Casa)

City: _____
(Ciudad)

State: _____
(Estado)

Zip Code: _____
(Codigo Postal)

Employer: _____
(Empleo)

Occupation: _____
(Profesion)

Address: _____
(Direccion)

Emergency Contact: _____
(Contacto de Emergencia)

Relationship: _____
(Relacion)

DOB: _____
(Fecha de Nacimiento)

Telephone Number: _____
(Numero de Telefono)

Address: _____
(Direccion)

Primary Insurance: _____
(Seguro Primaria)

Policy #: _____
(Numero de Membresia)

Policy Holder: _____
(Membre de Seguro)

Group #: _____
(Numero de Grupo)

Relationship : _____
(Relacion)

Date of Birth: _____
(Fecha de Nacimiento)

Social Security#: _____
(Numero Social)

Telephone#: _____
(Telefono)

Address: _____
(Direccion)

Employer: _____
(Empleo)

Address: _____
(Direccion)

Secondary Insurance: _____
(Seguro Secundario)

Policy#: _____
(Numero de Membresia)

Policy Holder: _____
(Membre de Seguro)

Group#: _____
(Numero de Grupo)

Relationship: _____
(Relacion)

Date of Birth: _____
(Fecha de Nacimiento)

Social Security#: _____
(Numero Social)

Telephone#: _____
(Telefono)

Address: _____
(Direccion)

Employer: _____
(Empleo)

Address: _____
(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 asigno el medico todos pagos servicios medicales dados a mi o mis dependes. Yo entiendo que soy responsable por cualquier cobro que no este cubierto con mi seguro.)

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

Date: _____
(Fecha)



Medical History

Date: _____ My Appointment is with _____

Patient Name: _____ DOB: _____ Age: _____

Reason For Visit: _____

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 _____



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



Please list all pregnancies

Year	Method of delivery	Gestational age	Sex	Weight	Comments / complications

Medical Problems

Date of Diagnosis	Medical Problem



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									