Desert Inn Women's Clinic
1771 E. Flamingo rd 220B
LAS VEGAS NV 89119
(702) 735-1960
DrSilvermedical@outlook.com

(PLEASE COMPLETE ALL INFORMATION)

PATIENT INFORMATION

Today's Date:			
Name:	Home Phone:	Cell Phone:	
Address:			Apt#:
City:	State:	Zip:	
Date of Birth:	Age:	Sex: ☐Male ☐Female	Marital Status: S M W D SEP
Social Security Number:	Email:		
Race: ☐ Declined	Sexual Orientation: ☐ Declined	☐ Hispanic ☐ Not Hispanic ☐Other ☐ Middle Eastern ☐Northern African	
Name of Employer:	Work Phone:		

PATIENT PHARMACY INFORMATION

Pharmacy Name:	Pharmacy Phone:
Pharmacy Address:	CROSS STREETS:

EMERGENCY CONTACT

Name:		Phone:	
Address:	City:	State:	Zip:
Relationship:			

INSURANCE INFORMATION

Primary:	Secondary:
Group or Claim #:	Group or Claim #:
Policy #:	Policy #:
Name of Policy Holder:	Name of Policy Holder:
Dob:	Dob:
SSN of Policyholder:	SSN of Policyholder:
Insurance Company Phone:	Insurance Company Phone:

If this is for treatment at a SILMO Medical Center, I hereby give my consent to treatment by physicians and staff of the above named clinic. This includes all necessary examinations, treatment, medicines, surgery, anesthetic agents, and any other related procedures to provide professional medical care.
If this is a Disability Evaluation I hereby authorize Disability Evaluation Services to perform a disibility evaluation on myself, and request release of all records and findings to a requesting entity or attorney. I authorize SILMO Medical Center to receive my pharmaceutical history.

Patient (Parent or Guardian if patient is a minor): _____ Date: _____

Authorization to Pay Benefits: I hereby authorize payment directly to the above clinic, otherwise payable to me, for medical services received, but not to exceed the usual and customary charges. If needed, I also authorize the above clinic to sign my name in the event a check is made out to both parties and I cannot be reached. I understand that I am fully responsible for allowable charges not covered by insurance.

Patient (Parent or Guardian if patient is a minor): _____ Date: _____

Please call within 24 hours if you must cancel your appointment, and avoid unnecessary personal expense.

Notifier(s):

Patient Name: Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (MEDICARE)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	Alpha-fetoprotein, Serum Amylase CA 15-3/CA 27.29 CA 125 CA 19.9 CBC CEA Cholesterol Collagen Cross Link Cytogenic Studies Digoxin Fecal Occult Blood Ferritin Fructosamine (Glycated Protein) Genetic Testing GGT (Gamma Glutamyl Tranferase) Glucose, Serum or Plasma Lipoprotein A2 (PLAC) Apolipoprotein	Lipoprotein Glycated Hemoglobin A/C FSH LH Gonadotropin HCG, Serum Quant. HDL, Cholesterol Hematocrit Hemoglobin Hepatic Function Panel, AMA Hepatitis Panel (Acute), AMA Hepatitis C, RNA HIV 1 Ab/Reflex Western Blot HIV 1 RNA Iron Binding Capacity LDL, Cholesterol, Direct Lipid Panel Lipoprotein Electrophoresis Magnesium Partial Thromboplastin Time (PTT)	Platelet Count Prothombin Time (PT) with INR PSA Total PSA Free RPR/VDRL Sedimentation Rate T3 Uptake T4, Free T4, Total Transferrin Triglycerides Troponin TSH Urine Culture/Reflex Sensitivity **Medicare Screens:** Fecal Occult Blood Pap Smear Liquid Based PapTest PSA, Total
Reason Medicare May Not Pay:			
Estimated Cost:			

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above. **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the_____listed above. I understand with this notice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (INSURANCE)

NOTE: If your insurance doesn't pay for items checked or listed in the box below, you may have to pay. Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	SEE ABOVE CHART FOR TEST ITEMS		
Reason Medicare May Not Pay:			
Estimated Cost:			

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above. **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the_____listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation Benefits(EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions on the EOB. If my insurance does pay, you will refund any payments I made, less co-pays or deductibles.

☐ **OPTION 2.** I want the_____listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment **I cannot appeal if my insurance is not billed.**

☐ **OPTION 3.** I don't want the_____listed above. I understand with this notice I am **not responsible for payment,** and I cannot appeal to see if my insurance would pay.

Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call the member services number on your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

SILMO

SILMO MANAGEMENT CORPORATION
Quality Health Care Management Services

REQUEST FOR RELEASE OF MEDICAL RECORDS

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ Date of Birth:_____

The information you may release subject to this signed form is as follows:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other (please specify) _____

Records for dates of treatment from 20_____ through 20_____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:_____

Address:_____

City, State, Zip:_____

This authorization will remain in effect from the date signed below until _____.
I understand that under HIPAA regulations that I may revoke this authorization in writing by contacting your office.

Signature:_____ Date: _____

SILMO

SILMO Form HIPAAconsent

☐ Desert Inn Medical Center
1900 E. Desert Inn Rd.
Las Vegas, Nevada 89169
(702) 735-1960

☐ Desert Inn Women's Clinic
1900 E. Desert Inn Road
Las Vegas, Nevada 89169
(702) 735-1960

DESERT INN MEDICAL CENTER

PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN THE RIGHT TO REVIEW SUCH NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS BELOW TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF DESERT INN MEDICAL CENTER 'NOTICE OF PRIVACY PRACTICES'. THIS NOTICE DESCRIBES HOW DESERT INN MEDICAL CENTER MAY USE AND DISCLOSURE OF MY HEALTHCARE INFORMATION, CERTAIN RESTRICTIONS ON THE USE AND DISCLOSURE OF MY HEALTHCARE INFORMATION, AND RIGHTS I MAY HAVE REGARDING MY PROTECTED HEALTH INFORMATION.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE SIGNED: _____

RELATIONSHIP TO PATIENT (IF PATIENT IS A MINOR): _____

PATIENT HISTORY:

Todays Date:_____

Name: _____ **Birth Date:** _____

Reason for today's visit:

_____

Last Menstrual Period: _____

Last PAP Smear: _____

Last Mammogram: _____

Allergic to Any Medication: _____

Currently taking Birth Control: YES / NO which kind if so: _____

Sexually Active? YES / NO New Partner recently? YES / NO Male or Female

Are you experiencing any:

Itching or Burning	Pain during intercourse	
Vaginal Odor	Abnormal Bleeding	Currently STD
Vaginal Discharge	Missing Menstrual	Other

Do you smoke? YES / NO Drink Alcohol? YES / NO Street Drugs? YES / NO

How many Pregnancies in your lifetime? _____ Living Children? _____

Vaginal Deliveries? _____ C- Section Deliveries? _____

Any Gynecological Surgeries? If so, which?

_____