Desert Perinatal ASSOCIATES

Joseph A. Adashek, M.D., FACOG
Paul T. Wilkes, M.D., FACOG
Van R. Bohman, M.D., FACOG
Donald L. Roberts, M.D., FACOG
Sean M. Keeler, M.D., FACOG

STATEMENT OF PRIVACY PRACTICES

Our office is committed to protecting the privacy rights of our patients and the confidential information entrusted to us. The dedication of each employee to ensure that your health information is never compromised is of paramount importance in our practice. We amend our privacy practices, but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Nevada. This includes issues relating to your treatment, payment and our health care procedures. Unless you object, we may share relevant information about you with family members or friends who are helping you with your perinatal care. Your personal health information will never be otherwise given to anyone without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic system are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information need to provide our standard of quality perinatal care, implement payment activities, conduct normal health practice procedures and comply with the law. This may include your name, address, telephone number(s), social security number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

PATIENT RIGHTS

You have a right to request copies of your healthcare information and to request a list of instances in which we or our business associates have disclosed your protected information. All such requests must be in writing. We may charge for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also contact the U.S. Department of Health and Human Services. We thank you for being a patient in our office. Please let us know if you have any questions concerning your privacy rights and the protection of your health information.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that I have been presented this Notice of Privacy Practices

Signature _____

Date _____

Print Name _____

ACKNOWLEDGMENT REFUSED

On this date, the undersigned patient refused or failed to acknowledge receipt of this Notice of Privacy Practices.

Date _____

Name of Patient _____

Reason for refusal/failure _____

Signature of Desert Perinatal employee _____

(File Signed Copy with Patient's Record)

PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____ Age _____
Last First MI

Address _____
Street City State Zip

Home #_____ Cell # _____ Work # _____ E-Mail _____

Preferred Method of Contact: ☐ Home # ☐ Cell # ☐ E-Mail

Social Security # _____ Marital Status _____ Employer _____ Occupation _____

Address _____
Street City State Zip

REFERRED BY_____

Name of Spouse or Responsible Party_____ Relationship _____Age_____ Date of Birth _____

Address _____
Street City State Zip

Home # _____Cell # _____ Work #_____

Social Security # _____ Employer _____ Occupation _____

Address _____
Street City State Zip

Name of relative NOT living with you _____

Relationship_____ Phone Number_____

Address _____
Street City State Zip

Name of friend NOT living with you_____

Relationship_____ Phone Number_____

Address _____
Street City State Zip

INSURANCE INFORMATION

We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Name of Primary Insurance Carrier _____ Policy Effective Date_____

Address _____
Street City State Zip

Phone _____ Insured's Name_____ Policy # _____ Group # _____

Secondary Insurance Carrier _____ Policy Effective Date_____

Address _____
Street City State Zip

Phone _____ Insured's Name_____ Policy # _____ Group # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I Hereby authorize release of any medical information necessary to process any insurance claims with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for any deductibles, co-insurance/or amounts for services not covered by the insurance carrier. All professional services rendered are charged to the patient. I further authorize release of all pertinent medical records to my physician at Desert Perinatal Associates for continuing medical treatment.

The patient is responsible for all fees regardless of insurance coverage. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the physician. A copy of signature is as valid as the original.

_____
Signature of Patient or Responsible Party (if minor)

_____
Print Patient Name Date

Southwest Location: 5761 S. Ft. Apache • Las Vegas, Nevada 89148
Summerlin Location: 10105 Banburry Cross, #430 • Las Vegas, Nevada 89144
Green Valley Location: 3001 Horizon Ridge Parkway • Henderson, Nevada 89052
Phone: (702) 341-6610 • Fax: (702) 341-6961 • www.DesertPerinatalAssociates.com

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Joel K. Schwartz, M.D., FACOG
Sean M. Keeler, M.D., FACOG

ATTENTION PARENTS AND GUARDIANS

To ensure the highest quality of care to all of our patients, children may not be left unattended in the waiting area, ultrasound rooms, or exam rooms.

If small children accompany you to our office, please provide adult supervision (other than yourself) during your appointment.

We appreciate your efforts to make appropriate childcare arrangements before arriving at our office so that it will not be necessary to reschedule your appointment.

We offer videotaping of your ultrasound so that you may share this experience with others at a later time.

Signature of patient _____

Date_____

Print Name _____

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FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have questions or concerns about our payment policies, please do not hesitate to ask our billing manager.

All deductibles, co-payments and applicable charges are due at the time of services – NO EXCEPTIONS. All surgery fees MUST be paid in advance of the surgical date – NO EXCEPTIONS. We accept cash, checks, and for your convenience, MasterCard, Visa, Discover and American Express. If **Desert Perinatal Associates** is affiliated with your preferred provider (contracted insurance company), we will submit the claim to your insurance company. If your insurance coverage/company changes, it is your responsibility to notify our office immediately.

You must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. You are responsible for these amounts.
3. YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS. Does your insurance require a Primary Care Physician (PCP) Referral? Do our physicians participate in your plan? What facilities participate in your plan? If we can be of assistance, please let us know.
4. If the insurance company does not pay in full within 30 days, we ask that you contact the insurance carrier. If your insurance does not pay in full within 45 days, we require you to pay the balance due with cash, check, or credit card.
5. Returned checks for insufficient funds are automatically transferred to a collections agency. You are responsible for all related fees. We reserve the right to refuse payments made by check.
6. Patient balances over 60 days will be patient's responsibility and will be subjected to interest charges of 2% per month whether or not arrangement for payment has been made.
7. You are responsible for any collection fees, legal fees, or court costs.

We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Signature of patient _____

Date_____

Print Name _____

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ULTRASOUND CONSENT FORM

An ultrasound has been ordered on you and your unborn child by your physician. There are many reasons that this diagnostic test may have been ordered. Some of these include: Evaluation of your baby for birth defects, growth patterns, amniotic fluid level, Doppler flow indices, abnormal blood test results, or as adjuncts to diagnostic/therapeutic testing or procedures. The quality of ultrasound examinations are extremely dependent on the equipment utilized, the sonographer doing the ultrasound, the position of your baby within your womb, your body habitus, previous abdominal surgery and the physician who interprets your exam.

Ultrasound examinations have never been shown to damage you or your baby. This is not an x-ray. Ultrasound uses sound waves. The ultrasound produces a small burst of high frequency sound and then listens for the "echo" of the sound in your body. A computer then integrates this information to make the picture that you see on the screen. Many things can be seen about your baby, such as birth defects and growth abnormalities. Ultrasound is also used to see where the baby is in relation to the needle when certain invasive procedures are done, such as amniocentesis.

Failure to have this ultrasound done may make it difficult, if not impossible, to care for you and your pregnancy in the best way possible. There may be abnormalities of your reproductive system that may benefit from diagnosis and treatment. You may not be able to take advantage of many options afforded to you by law. The birth of your baby may be compromised by not being able to have the appropriate specialists present during your pregnancy and at the time of your delivery that your baby may need. Without ultrasound, therapeutic measures would also not be possible, and this may result in a damaged baby or even the loss of the life of your baby.

The utmost care and concern is given to you and your unborn child. Even so, ultrasound is not a perfect science and things can be missed or not seen depending on the age of the baby, your body composition, and the position of your baby within the womb. There are some abnormalities that are never seen with ultrasound.

I understand that ultrasound cannot see all things in me or my unborn child, but that it may be very helpful tool to help manage my pregnancy and plan the delivery.

I have read this consent, fully understand the above information, have had all my questions answered to my satisfaction.

◯ I ***want*** an ultrasound performed on me.

◯ I ***decline*** to have an ultrasound performed on me.

Signed _____

Date_____

Witness _____

Date_____

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CONSENT FOR OBTAINING, RETAINING, OR DISCLOSING GENETIC INFORMATION

As used in this document, "genetic information" means any information that is obtained from a genetic test.

1. I understand that no insurer or corporation that provides health insurance, carrier serving small employers or health maintenance organization may:

(a) Require me or any member of my family to take a genetic test;

(b) Require me to disclose whether I or any member of my family has taken a genetic test;

(c) Request my genetic information or the genetic information of a family member of my family; or

(d) Determine the rates of any other aspect of the coverage or benefits for health care for me or my family based on whether I or any other member of my family has taken a genetic test or based on my genetic information or the genetic information of any member of my family.

2. I also understand that:

(a) I have the right to receive the results of a genetic test, after the person conducting the test has received the results. The written results must indicate that, except as otherwise provided in chapter 629 of NRS, my genetic information may not be obtained, retained or disclosed without first obtaining my informed consent.

(b) It is unlawful for a person or entity to obtain genetic information without my informed consent, unless the information is obtained;

(i) By a federal, state, county or city law enforcement agency to establish the identity of a person or a dead human body;

(ii) To determine the parentage or identity of a person in certain circumstances;

(iii) To determine the paternity of a person in certain circumstances;

(iv) For use in a study where the identities of the persons from whom the genetic information is obtained are not disclosed to the person conducting the study;

(v) To determine the presence of certain inheritable disorders in an infant in certain circumstances; or

(vi) Pursuant to an order of a court or competent jurisdiction.

(c) It is unlawful for a person to retain genetic information that identifies me first obtaining my informed consent, unless retention of the genetic information is:

(i) Necessary to conduct a criminal investigation concerning the death of a person or a criminal or juvenile proceeding;

(ii) Authorized pursuant to an order of a court of competent jurisdiction; or

(iii) Necessary for certain medical facilities to maintain my medical records.

(d) If I have authorized a person to retain my genetic information, I may request that the person destroys the genetic information. Such a person shall destroy the information, unless retention of the information is:

(i) Necessary to conduct a criminal investigation, an investigation concerning the death of a person or a criminal or a juvenile proceeding;

(ii) Authorized by an order of a court of competent jurisdiction;

(iii) Necessary for certain medical facilities to maintain my medical records; or

(iv) Authorized or required by law.

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CONSENT FOR OBTAINING, RETAINING, OR DISCLOSING GENETIC INFORMATION

(e) Except as otherwise provided by federal law or regulation, a person who obtains my genetic information for use in a study shall destroy the information upon completion of the study or my withdraw from the study whichever occurs first, unless I authorize the person conducting the study to retain my genetic information after the study is completed or upon my withdraw from the study.

(f) it is unlawful for a person to disclose my identity if I was the subject of a genetic test or to disclose to another person genetic information that allows the other person to identify me without first obtaining my informed consent, unless the information is disclosed:

(i) To conduct a criminal investigation, an investigation concerning the death of a person or a criminal or juvenile proceeding;

(ii) To determine the parentage or identity of a person in certain circumstances;

(iii) To determine the paternity of a person in certain circumstances.

(iv) Pursuant to an order of a court of competent jurisdiction;

(v) By a physician after I am deceased and my genetic information will assist in the medical diagnoses of persons related to my blood;

(vi) To a federal, state, county, or city law enforcement agency to establish the identity of a person dead body;

(vii) To determine the presence of certain inheritable preventable disorders in an infant in certain circumstances; or

(viii) By an agency of criminal justice in certain circumstances.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

I, *(Patient Name, please print)* _____, herby give my consent to Desert Perinatal Associates to disclose my genetic information, lab results, ultrasound results and diagnostic testing results, and/or billing information to the following:

- Referring Physician _____
- Spouse/ Significant Other _____
- Other _____

I give permission to leave NORMAL RESULTS on my voicemail/ answering machine / e-mail. Yes_____ No_____

If the person tested is unable to sign, please indicate the reason here:_____

_____

_____ _____

Patient Signature or Legal Representative Date