Rafaela G. Hernandez, M.D. Chartered

Patient's Email

Last Name	First Name	Middle Initial	Maiden Name	Birthdate	S.S.#

Street Address and Apt. No.	City	State	Zip	Home Phone	Cell/Message

Mailing Address	City	State	Zip	Marital Status	Religion

Patient's Employer	City	State	Occupation	FT/PT	Business Phone	Extension

Husband's or Parent's Name (Please indicate which)	Street Address	City	State	Zip	Home Phone

Employer's Name	City	State	Occupation	Business Phone	Extension

Primary Insurance	Subscriber's Name	Relationship	Subscriber's SS#	Subscriber's Birthdate	Subscriber's Employer

Secondary Insurance	Subscriber's Name	Relationship	Subscriber's SS#	Subscriber's Birthdate	Subscriber's Employer

Friend/Relative (not living with you)	Street Address	City	State	Zip	Daytime Phone

Do you have an advanced directive (living will)? ☐ Yes ☐ No ☐ Requested ☐ Copy in File	Referred to office by:

I hereby authorize the above mentioned providers to furnish information to insurance carriers regarding my illness and treatment and I hereby assign to the provider(s) all payments for medical services rendered to myself or dependents. I understand that my assignment for insurance benefits to the provider is irrevocable, and I am financially responsible for the balance of my account. In addition, I certify I have read the information provided to me regarding office policies, and I understand and agree to those policies.
I understand that if my account becomes delinquent, collection or legal activity may be pursued, and that I am responsible for costs incurred to collect my account balance.

Signature _____ Date _____

Rafaela G. Hernandez, M.D.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT 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 Employee: _____

Please list any family members, or others, which we can communicate with involving your care or payments. Also, please specify what kind of information we can release. **This authorization will remain in effect until notifications of changes are made.**

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

NAME	RELATIONSHIP TO PATIENT	All	Scheduling/ Appointment	Medical/ Prescription	Billing/ Insurance

Patient Signature: _____ Date: _____

Print Name_____

Witness Signature: _____ Date: _____

Rafaela G. Hernandez, M. D., Chartered
GYNECOLOGY • INFERTILITY • GYNECOLOGICAL SURGERY
236 West Sixth Street, Suite 303 • Reno, Nevada 89503
Telephone 337-8400

Name: _____

Date: _____

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.
Please check each question that applies to you. Put (?) if uncertain.

Why are you seeking medical attention? _____

Yes No

- ☐ ☐ Are you now in poor health or suffering from any chronic physical or mental condition?
- ☐ ☐ Have you had any x-rays or mammograms taken in the past 5 years? Type: _____ ; Results. _____
- ☐ ☐ Have you had any laboratory tests done in the past 2 years? Type. _____ ; Results _____
- ☐ ☐ Have you ever had a blood transfusion?
- ☐ ☐ Do you have any special religious convictions which might affect your treatment?
  If yes, explain: _____
- ☐ ☐ Do you use alcohol? How much? _____
- ☐ ☐ Do you smoke? How much? _____
- ☐ ☐ Do you now or have you ever used any marijuana, cocaine, heroin, etc? Explain _____
- ☐ ☐ Do you now have or have you ever been exposed to AIDS or Hepatitis?

PERSONAL HISTORY

INFECTIOUS DISEASE: Check any of the following diseases you have had.

☐ Bladder or kidney infection	☐ Herpes	☐ Polio	☐ Tubal Infection
☐ Encephalitis	☐ Meningitis	☐ Rheumatic Fever	☐ Venereal Disease
☐ German Measles (Rubella)	☐ Mumps	☐ Scarlet Fever	☐ Genital Warts
☐ Hepatitis	☐ Pneumonia	☐ Tuberculosis	☐ Other _____

SURGERY: Have you had an operation on any of the following:

	Year		Year		Year
☐ Appendix	_____	☐ Tumor of any kind	_____	☐ Ovary	_____
☐ Gall Bladder	_____	☐ Varicose Veins	_____	☐ Tubes	_____
☐ Stones (kidney)	_____	☐ Hernia	_____	☐ Uterus (womb)	_____
☐ Tonsils	_____	☐ Hemorrhoids	_____	☐ Vagina or bladder	_____
☐ Thyroid	_____	☐ Chest	_____	☐ Cesarean section	_____
☐ Breast	_____	☐ Spine	_____	☐ D and C	_____
☐ Laparoscopy	_____	☐ Other: _____			

Have you ever been advised to have any surgical operation which has not been done? yes ☐ no ☐

ILLNESSES: Have you ever had:

☐ Anemia	☐ Blood clots or phlebitis	☐ Hernia	☐ Hayfever
☐ Bleeding disorder	☐ Heart murmur	☐ Hemorrhoids	☐ Asthma
☐ Jaundice	☐ High blood pressure	☐ Colitis	☐ Convulsion
☐ Diabetes	☐ Ulcer	☐ Arthritis	☐ Kidney stone
☐ Cancer	☐ Gall bladder trouble	☐ Bone disease	☐ Nervous breakdown
☐ Migraine	☐ Chronic diarrhea	☐ Back trouble	☐ Varicose veins
☐ Abnormal pap smear	☐ Other: _____		

Have you ever been hospitalized for any illness: yes ☐ no ☐

Diagnosis and year: _____

GYNECOLOGIC HISTORY

Menstrual History:

	Yes	No
Age at first period? ___ ____ Menstrual flow usually lasts for a total of _____ days.		
Have you missed periods without being pregnant?	☐	☐
When NOT on birth control pills, are your periods: regular ☐, somewhat regular ☐, completely irregular ☐?		
The interval between first day of one period to first day of next period ranges from ___ to ___ days.		
Menstrual flow usually is: scant ☐, moderate ☐, heavy ☐, excessive with clots ☐.		
Are your periods usually painful?	☐	☐
If painful: mild ☐, moderate ☐, severe ☐, incapacitating ☐.		
Do you ever have bleeding or spotting between periods or following intercourse?	☐	☐
Do you now or have you ever had a problem with infertility?	☐	☐
If not menstruating, stopped at age _____. Any bleeding or spotting since?	☐	☐

	Yes	No
Do you have any abdominal or pelvic pain unrelated to menstruation?	☐	☐
Do you ever have any pain with sexual intercourse?	☐	☐
Do you have any other complaint, concern or question regarding sex?	☐	☐
Do you have any vaginal or vulva irritation, heavy discharge or dryness?	☐	☐
Do you frequently have loss of urine with sneezing and coughing?	☐	☐
Do you have frequent night urination, dribbling of urine or bed wetting?	☐	☐
Do you have a protrusion or bulging sensation from your vagina?	☐	☐

	Yes	No
Have you ever had an ABNORMAL pap smear?	☐	☐

OBSTETRIC HISTORY

How many babies born alive? _____.
How many stillbirths? _____
How many prematures (less than 5 pounds born alive)? _____.
What was largest baby's weight? _____.
How many cesarean sections? _____.
How many miscarriages or abortions? _____.
Have all of your children been normal? yes ☐ no ☐.
My blood is: Rh positive ☐, negative ☐, uncertain ☐.
Any serious complications with any pregnancy? Explain: _____.
How many living children do you have? _____. Year oldest born: _____. Date of last delivery: _____.

MEDICATIONS	Never	Not in past year	Occasionally	Frequently	Daily	Name of Medication
Cortisone or steroid	☐	☐	☐	☐	☐	
Blood Pressure Pills	☐	☐	☐	☐	☐	
Thyroid	☐	☐	☐	☐	☐	
Heart Medicine	☐	☐	☐	☐	☐	
Diuretic (water) pills	☐	☐	☐	☐	☐	
Tranquilizer or nerve pills	☐	☐	☐	☐	☐	
Appetite suppressant or pep pills	☐	☐	☐	☐	☐	
Herbs or vitamins	☐	☐	☐	☐	☐	
Sleeping Pills	☐	☐	☐	☐	☐	
Asthma medicine	☐	☐	☐	☐	☐	
Arthritis medicine	☐	☐	☐	☐	☐	
Birth Control Pills/Hormones	☐	☐	☐	☐	☐	

FAMILY HISTORY		Age	Health	IF DECEASED: Age at Death	IF DECEASED: Cause
Father					
Mother					
Brother or Sister	1.				
	2.				
	3.				
	4.				
	5.				
Son or Daughter	1.				
	2.				
	3.				
	4.				
	5.				

Has any blood relative ever had: (please check)		
Diabetes		
Tuberculosis		
High Blood Pressure		
Epilepsy		
Hemophilia		
Cystic Kidneys		
Muscular Distrophy		
Glaucoma		
Mongolism		
Birth Defects		
Twins		
Cancer		
What type?		
and location?		

Are you currently under the care of any other physician: Yes ☐ No ☐ If yes, whom? _____

What type of treatment? _____

Were you referred to this office? Yes ☐ No ☐ If yes, by whom? _____
If you have not done so already, describe in *detail* why you are here _____
(i e., onset of symptoms, current problem, previous treatment, current treatment).

Are you allergic or have you had any reaction or side effects from drugs or other agent? Yes ☐ No ☐

Aspirin or pain medicine _____ Other _____: _____

Penicillin _____ _____

Sulta _____

Novocaine _____

Birth control pills _____

THIS IS A COMPLETE MEDICAL HISTORY AND NOTHING IS LEFT OUT.

_____
PATIENT SIGNATURE ***DATE***

Do not write below this line

Date of last pap smear: **LMP:** **PMP:**

Result										Current Medications									
Occupation:																			
Age:		G	P	AB	RA		W	N	O	I	S		M	S	W	D			
PE:	Gen				EENT				Lungs			BP					Wt.		
	Breast								Heart			P					Ht.		
	Abd.																		
Pelvic	Ext.										Wet Mount -	Trich.							
	Vag.											Yeast							
	Cx											Bacteria							
	Uterus															Prot	Sug	Nit	
	Adnexa											Urine				☐	☐	☐	
	Rect.																		
Extrem:																			
Other:																			

STUDIES	LAB	RADIOLOGY	TOPICS	Wt. Loss	SCHEDULE
Pap	FSH	Mammo	HRT	Nutrition	Colposcopy
GC/Chl	E2	Sono./Saline	BCPs	WHI	Bone Density
	TSH	HSG	Smoking		Surgery

Impression:

Rafaela G. Hernandez, M.D.

NOTICE OF PRIVACY PRACTICES

Mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Effective Date: 4/1/03

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law, or permitted by law without your authorization.

If the practices described in this notice meet your expectations, there is nothing you need to do. If you prefer additional limitations on the use of your medical information, you may request them following the procedures below.

If you have any questions about this notice, please contact our Privacy Officer at the address listed below.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Provider and his/her employees, whether made by health care professionals or other personnel. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

OUR OBLIGATIONS

Law requires us to:

- Maintain the privacy of medical information that concerns your condition or treatment, how your care is paid for, and demographic information, if such information can be used to identify you
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health insurance so they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have, or should schedule, an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to:

- prevent or control disease, injury or disability
- report births and deaths

- report child abuse or neglect
- report reactions to medications or problems with products
- notify people of recalls of products they may be using
- notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Protective Services for the President. National Security and Intelligence Activities. We may release Health Information to authorized federal officials for providing protection to the President, other authorized persons for foreign heads of state or conduct special investigations or for intelligence, counter-intelligence, and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request

with a reason supporting your request, in writing, to our Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- is not part of the medical information kept by the provider
- is not part of the information which you would be permitted to inspect and copy
- is accurate and complete

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use ,or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. If complying with your request entails additional expense over our usual means of communication, we may ask that you reimburse us for those expenses.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice please write to our Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer as listed below. All complaints must be made in writing. You will not be penalized for filing a complaint.

PRIVACY OFFICER

Privacy Officer
236 West Sixth St., #303
Reno, NV 89503
Phone 775-337-8400
Fax 775-337-8407

RAFAELA G. HERNANDEZ, M.D.

HOLLY T. ASHLEY, M.D.

236 WEST 6TH ST. SUITE #303

RENO, NV 89503

PRESCRIPTION DRUG CONSENT FORM

I, _____ give my consent to Dr. Hernandez / Ashley to have access to all of my Prescription Drug/Medication history.

Signature _____ Date: _____

Witness: _____ Date: _____

Please list name and address of preferred pharmacy:

_____

_____