

Woman to Woman Gynecology, A-All Women Care

A-All Women Care

7908 W. Sahara Ave. Las Vegas, NV 89117

(702) 531-5400

Clarification of Charges for Pregnancy Termination Services

Pre Procedure Charges

\$190.00	Consultation
\$230.00	Ultrasound
\$90.00	Rh Factor Testing
\$55.00	HCG Testing
\$55.00	Syphilis Testing

Medical Termination

\$600.00	Uncomplicated Medical Termination
\$55.00	Price for follow up visit-pelvic ultrasound
\$250.00	Office D+E for Failed Medical Termination

Surgical Termination Services and Price Changes

\$600.00	≤ 12 weeks	\$110.00	Placenta Previa
\$650.00	12 ^{1/7} , 12 ^{2/7} , 12 ^{3/7} weeks	\$110.00	Prior C-Section scars
\$700.00	12 ^{4/7} , 12 ^{5/7} , 12 ^{6/7} weeks	\$110.00	Multiple fibroids, Uterine Structural Anomaly
\$710.00	13 weeks	\$110.00	Twin Gestation
\$760.00	13 ^{1/7} , 13 ^{2/7} , 13 ^{3/7} weeks	\$110.00	Psychosocial Issues - addiction, family discord, Interaction with social services.
\$800.00	13 ^{4/7} , 13 ^{5/7} , 13 ^{6/7} weeks	\$1600.00	Surgical Treatment for Blighted Ovum
\$810.00	14 weeks		
\$860.00	14 ^{1/7} , 14 ^{2/7} , 14 ^{3/7} weeks		
\$910.00	14 ^{4/7} , 14 ^{5/7} , 14 ^{6/7} weeks		

Clarification of Charges for Pregnancy of Unknown Location

\$190.00	Initial Consultation	
\$110.00	Follow-up Consultation with the doctor-	<u>Each time</u> that the patient is seen
\$230.00	Pelvic ultrasound	<u>Each time</u> that is performed
\$55.00	Pregnancy blood test	<u>Each time</u> that is performed
\$90.00	RH blood testing	\$110.00 CMP and CBC blood testing

Treatment of Ectopic Pregnancy

\$1600.00	Surgical Fees for treatment of Ectopic Pregnancy-Doctor's Surgical Fees (Hospital fees are extra)
\$1600.00	In-office Medical treatment of Ectopic Pregnancy - Medication (Methotrexate), blood testing, visits, ultrasounds, Should surgery be required- when ectopic treatment fails-then both surgical and medical fees apply.

Hospital Treatments for Pregnancy Termination Complications

Infections, abnormal clotting, prior C/S scars, placental abnormalities causing bleeding that require hospital treatments

\$300.00	Emergency room consultation and treatment plan
\$2500.00	Emergency or scheduled surgery such as Total Abdominal Hysterectomy due to sepsis, bleeding or other conditions
\$200.00	Daily hospital charges for care of patient with complications from pregnancy termination
\$1000.00	Dilation and Evacuation for Retained Products of Conception

Clarification of Charges for Additional Services and Treatments

\$130.00	Mini Rhogam	\$210.00	Full Dose Rhogam ≥ 12wk
\$160.00	IV Hydration – Each Bag of Hydration	\$50.00	Nausea Injection: Zofran or Metochlopramide
\$15.00	Oral Zofran	\$15.00	Oral Antacid Medication
\$55.00	Oral Antibiotics	\$50.00	Toradol Injection (for pain relief)
\$55.00	Additional Misoprostol for bleeding prevention	\$130.00	Intramuscular Methergine for heavy bleeding
\$45.00	Flu Shot	\$50.00	No show fee

Signature:

Date:

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PATIENT INFORMATION

Información Del Paciente

Today's Date: _____

Fecha

Name: (Last, First): _____

Nombre

Date of Birth: ____/____/____ Age: _____ Social Security # ----- _____

Fecha de Nacimiento

Edad

Seguro Social

Address: _____ Apt#: _____

Dirección

City: _____ State: _____ Zip Code: _____

Ciudad

Estado

Código Postal

Home Phone#: _____ Cell Phone#: _____

Teléfono de casa

Teléfono de celular

Email Address: _____

Correo Electrónico

Employer: _____ Occupation: _____

Empleador

Trabajo

Work Phone#: _____

Teléfono de trabajo

Marital Status (Circle one): Single Married Divorced Separated Widowed
Estado Civil *Soltera* *Casada* *Divorciada* *Separada* *Viuda*

Race: White Asian Pacific Islander Black or African American

Native American Indian Other: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Specify: _____

EMERGENCY CONTACT INFORMATION

En Caso de Emergencia Notifique

Emergency Contact: _____

Contacto de Emergencia

Phone: _____ Relationship: _____

Teléfono

Relación

Nearest Friend or Relative Not living with you: _____

La Persona o Amistad que no Vive con Usted

Phone: _____ Relationship: _____

Teléfono

Relación

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INSURANCE INFORMATION

Información de Seguranza

Primary Insurance: _____ Policy#: _____
Seguro Primario *Number de Póliza*

Claims Address: _____ City: _____
Dirección de Reclamar *Cuidad*

State: _____ Zip Code: _____ Phone#: _____
Estado *Código Postal* *Teléfono*

Policy Holder: _____ Insured D.O.B ____/____/_____
Tenedor de una Póliza *Fecha de Nacimiento*

Relationship to Patient: _____ Social Security of Insured: _____
Relación *Seguro Social del Asegurado*

Employer: _____ Occupation: _____
Empleador *Trabajo*

Date: _____

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Last name: _____ First name: _____ Date of birth: _____

Last Menstrual Period: _____ Was it normal? Yes No If No, please describe: _____

Are you menopausal or postmenopausal? Yes No I experience no more periods due to: _____

Why are you here today?

- Routine Annual Visit with **NO** problems
- Are you having any gynecologic problems you want to discuss with the doctor? _____

Are you **CURRENTLY** experiencing any of the following (please circle those that apply):

Neurological: dizziness, numbness in arms or legs, trouble walking, other: _____

Eyes: double vision, spots before eyes, vision changes, other: _____

ENT/Mouth: ear aches, ringing in ears, sinus problems, sore throat, mouth sores, other: _____

Cardiovascular: swelling of the legs, chest pain, blood clots in legs or lungs, other: _____

Respiratory: spitting up blood, shortness of breath, coughing, other: _____

Gastrointestinal: diarrhea, constipation, nausea or vomiting, bowel trouble, blood in stool, black stools, incontinence of stool, other: _____

Genitourinary: blood in urine, painful urination, frequent urination, painful intercourse, vaginal: discharge, odor, or itching, urine incontinence, other: _____

Musculoskeletal: muscle pain, joint pain, muscle weakness, joint weakness, other: _____

Constitutional: weight loss, weight gain, fatigue, fever, changes in appetite, difficulty sleeping, other: _____

Endocrine: hot flashes, abnormal thirst, other: _____

Hematologic/Lymphatic: enlarged lymph nodes, continuous bleeding, bruising easily, other: _____

Psychiatric: thoughts of suicide, frequent crying, depression, anxiety, other: _____

MEDICATION INFORMATION

Please list the **PHARMACY** you would like us to use if you needed a prescription. Name and cross streets or phone number.

<p>Do you have any ALLERGIES to medications, latex, or iodine? If so, please list them and your reactions:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>List any MEDICATIONS (prescription and over the counter), Vitamins, or supplements you are taking and the dosage.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 70%;">Name</td> <td style="width: 30%;">Dose</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Name	Dose	_____	_____	_____	_____	_____	_____
Name	Dose								
_____	_____								
_____	_____								
_____	_____								

Do you smoke tobacco (select applicable choice)?

Current every day smoker Former smoker Never smoker

Current some day smoker Date Quit: _____

Do you use any smokeless tobacco, if so how often? _____

Do you drink alcohol ever, if so how often and how many drinks average? _____

Do you use any street drugs, if so please list names and last time used? _____

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PREVENTIVE CARE

When was your last?	Date	Was it normal?	If No, explain:
Pap smear	_____	Yes No	_____
Mammogram	_____	Yes No	_____
DEXA Scan	_____	Yes No	_____
Colonoscopy	_____	Yes No	_____

Have you had the following (mark all that apply and dates):

- Gardasil vaccine (ages 9-26 for the prevention of cervical cancer and genital warts: _____)
- Flu vaccine: _____
- Pneumococcal vaccine: _____

PREGNANCY HISTORY

How many times have you been pregnant? _____

How many children do you have? _____

How many vaginal deliveries? _____

How many C-Section deliveries? _____

How many ectopic/tubal pregnancies? _____

How many miscarriages? _____

How many abortions? _____

Describe any problems you had during the prior pregnancies, include details:

- Rh Negative
- Severe bleeding requiring transfusions
- Diabetes
- High Blood Pressure
- Clots in the lungs or legs (DVT)
- Infections
- Congenital anomalies
- Any other problems or difficulties: _____

CONTRACEPTIVE HISTORY

Are you using any contraception **currently**, if so which one? _____

Have you used any of these below?

- Birth control pills (include names)
- Nuvaring
- Ortho-Evra Patch
- IUD Mirena/Skyla/Paragard
- Implanon
- Depo-Provera shot
- Diaphragm
- Tubal Ligation

Describe any **problems** you had while taking them: _____

Please mark if you **currently have or have previously had** any of the following while taking hormonal contraception:

- Smoker
- Migraine Headaches
- High Blood Pressure
- Breast Cancer
- Liver Problems
- Varicose Veins
- Gallbladder Problems
- Blood clots of the legs or lungs
- Family member with blood clots of the legs or lungs

SEXUAL HEALTH HISTORY

Difficulties with intercourse
Pain with intercourse

Dryness with intercourse
Inability to have an orgasm

Decreased desire for intercourse
Bleeding with intercourse

BREAST HISTORY

- Fibrocystic changes
- Blocked Milk Ducts
- Cysts
- Fibroadenomas
- Intraductal Papillomas
- Mastitis
- Nipple discharge
- Biopsy
- Breast cancer

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GYNECOLOGIC HISTORY (Please mark those that apply to you, including dates where possible)

- | | | |
|--|--|--|
| <input type="checkbox"/> Pelvic Infections: Chlamydia, gonorrhea, mycoplasma, ureaplasma | <input type="checkbox"/> Pelvic scarring (adhesions) | <input type="checkbox"/> Frequency: the need to urinate frequently |
| <input type="checkbox"/> Vaginal Infections: yeast, bacterial vaginosis, beta strep | <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Loss of urine with sneezing, coughing, or laughing |
| <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Needing to wear diapers or pads to prevent being wet |
| <input type="checkbox"/> HPV Infection | <input type="checkbox"/> Inflamed blocked fallopian tubes (Salpingitis) | <input type="checkbox"/> Uterine or vaginal anomalies: double uterus, double vagina, double cervix |
| <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Uterine Cervical Ovarian Cancer | <input type="checkbox"/> Nocturia: waking up at night to use the bathroom more than once per night |
| <input type="checkbox"/> Dysplasia | <input type="checkbox"/> Ovarian Cancer | |
| <input type="checkbox"/> Molluscum contagiosum | <input type="checkbox"/> Fallopian Tube Cancer | |
| <input type="checkbox"/> Trichomonads | <input type="checkbox"/> Cervical Cancer | |
| <input type="checkbox"/> Heavy or Painful periods | <input type="checkbox"/> Urgency (the sensation to urinate all the time) | |
| <input type="checkbox"/> Endometriosis | | |

Prolapse of pelvic organs:

- | | |
|--|---|
| <input type="checkbox"/> Uterine prolapse | <input type="checkbox"/> Rectocele (prolapse of the rectum) |
| <input type="checkbox"/> Cystocele (prolapse of the bladder) | <input type="checkbox"/> Enterocele (prolapse of the bowel) |

HORMONAL HEALTH HISTORY

When was menopause for you (year and age)? _____

Hormonal Changes (select those that apply to you):

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Lack of sexual desire |
| <input type="checkbox"/> Night and day sweats | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Mood changes | |
| <input type="checkbox"/> Poor Bone Health | | |
| <input type="checkbox"/> Loss of height | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vitamin D status |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Fractures | |

FAMILY HISTORY

Has anyone in your family ever had the following, please list relation and their age of diagnosis if known.

- | | |
|---|--|
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Ovarian Cancer _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Endometrial Cancer _____ | <input type="checkbox"/> Thyroid disorder _____ |
| <input type="checkbox"/> Cervical Cancer _____ | <input type="checkbox"/> Addiction _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Seizures/Epilepsy _____ |
| <input type="checkbox"/> Other (please describe): _____ | |

SOCIAL HISTORY

Please mark appropriate sexual orientation:

Heterosexual	Bisexual	Lesbian
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Please select current relationship status:

Single	Married	Long term monogamous relationship
Separated	Divorced	Widowed

Please list current occupation: _____

Highest education level (circle one):

Some high school: _____ yrs.	Some College : _____ yrs.	Master's Degree
Graduated High School	Associates Degree	PhD
GED	Bachelor's Degree	Technical/Trade school

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GENERAL HEALTH HISTORY Do you have any of the following?

Neurological:

- Migraine headaches
- Seizures/Epilepsy
- Numbness
- Other: _____
- None

Eyes:

- Glaucoma
- Macular degeneration
- Cataracts
- Other: _____
- None

ENT/Mouth:

- Other: _____
- None

Cardiovascular:

- High blood pressure
- Stroke
- Heart disease
- Varicosities
- Blood clots of the legs or lungs
(Deep Vein Thrombosis)
- Circulatory problems
(describe): _____
- Other: _____
- None

Respiratory:

- Asthma
- Chronic Lung Disease
- Tuberculosis
- Seasonal allergies
- Other: _____
- None

Genitourinary:

- Kidney disease
- Urine retention
- Urine Incontinence
- Kidney stones
- Bladder cancer
- Kidney cancer
- Other: _____
- None

Psychiatric:

- Addiction (please provide information): _____

- Mental Illness (please provide information): _____

Gastrointestinal:

- Ulcerative colitis
- Crohn's disease
- Gastritis
- Esophagitis
- Bowel incontinence
- Ulcers
- GERD
- Colonic polyps
- Stomach cancer
- Bowel Cancer
- H. Pylori infection
- Hepatitis Infection
- Other: _____
- None

Musculoskeletal:

- Fractures
- Hernia (location): _____
- Osteoporosis
- Osteopenia
- Arthritis
- Other: _____
- None

Endocrine:

- Diabetes
- Thyroid disorder
- Thyroid cancer
- Multiple Endocrine Neoplasia
- Other: _____
- None

Hematologic/Lymphatic/Autoimmune:

- Lupus
- Leukemia
- Hodgkin's Lymphoma
- Sjogren's
- Other: _____
- None

Integumentary (Skin):

- Basal cell carcinoma
- Melanoma
- Psoriasis
- Other: _____
- None

- Anxiety
- Depression
- None

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SURGICAL HISTORY Please list all surgeries and the date of the procedure under appropriate body system.

Neurological (The brain, spinal cord, or nervous system)

- None
- Other: _____

Eye surgery

- Cataract removal
- Other: _____

ENT/Mouth:

- None
- Tonsillectomy
- Adenoidectomy
- Thyroidectomy
- Parathyroidectomy
- Other: _____

Cardiovascular:

- None
- Angioplasty
- Cardiac bypass surgery
- Stent placement
- Radiofrequency ablation
(For abnormal heart rhythm)
- Heart transplant
- Other: _____

Respiratory:

- None
- Thoracotomy
- Lobectomy
- Lung transplant
- Other: _____

Musculoskeletal:

- None
- Knee replacement
- Hip replacement
- Other: _____
- None

Breast:

- None
- Mastectomy for cancer
- Lumpectomy
- Breast implants
- Other: _____

Gastrointestinal:

- Cholecystectomy (Removal of gallbladder)
- Appendectomy (Removal of appendix)
- Pancreatectomy (Pancreatic surgery)
- Colectomy (Removal of part of colon)
- Hemorrhoidectomy
- Hernia repair
- Other: _____

Genitourinary:

- None
- Hysterectomy (Removal of uterus and cervix)
- Salpingo -Oophorectomy (Removal of ovaries/tubes)
- Cystectomy (Removal of ovarian cyst)
- Myomectomy (Removal of fibroids)
- Laparoscopy (Looking inside the abdomen)
- Tubal Ligation (Tie tubes for contraception)
- Pelvic prolapse (Repair of vaginal hernia)
- Mesh for prolapse
- Cystocele repair (Repair of bladder prolapse)
- Rectocele repair (Repair of rectum prolapse in vagina)
- Enterocele repair
- Nephrectomy
- Lithotripsy
- Cystoscopy
- Other: _____

Hematologic/Lymphatic:

- None
- Lymph node resection
- Other: _____

Endocrine:

- None
- Thyroid surgery
- Other: _____

I have answered all the questions truthfully and I have not withheld any information that might affect my medical care.

Patient Name (Please print): _____

Signature of Patient: _____ Date: _____

Physician's Signature: _____ Date: _____

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2022 Office Policies

Insurance Policies and Payments:

Our goal is to provide you with the best possible care. We want to be efficient, effective and diligent in our interactions with you. We cannot practice good medicine or business without timely payments.

As a result, **all payments are due at the time of service.**

Our office is NOT contracted with most insurance and does not accept insurance fee schedules.

Our fee schedules are based on 120-150% of Medicare rates.

- _____ *Patient Initials*

Labs and Testing:

We are not contracted with Insurances for Office Visits or Procedures done in office. We **are able** to use insurances toward labs or testing done in office. If we send out your specimen (s) to a lab for processing though your insurance we are not responsible for any bills you receive from the lab.

If you do not have insurance, or would prefer not to use your insurance, you are responsible for paying the lab fee in our office. You are also responsible for calling the lab within 24 hours for Pap smear collections for the discounted price.

We are not responsible for any bills you have received from the lab.

- _____ *Patient Initials*

Communications with Patient:

By supplying my telephone number, I understand that I may receive calls or text message reminders from our office. Phone calls may be made in regard to office visits, test results, or medications. We will not discuss any information over the phone until we have confirmed we are speaking directly to you. If you are unable to answer the phone, we will leave a general message that does not disclose any Personal Health Information.

Text Messages are for appointment reminders. Receiving them is completely optional. You may opt out of them at any time.

- _____ *Patient Initials*

Balances on Accounts:

Your balance will be due at your follow up visit, unless, there are special circumstances, such as, payment arrangements scheduled in collaboration with the office manager.

- _____ *Patient Initials*

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Credit Card Payments

A 3.99% fee will be applied when services are paid by credit and debit. There are no fees when paying with cash.

- _____ ***Patient Initials***

Cardholder Policy:

It is our policy that the cardholder be present at the time of the appointment. Any charges that are refunded if the cardholder is not present will become the patient's responsibility.

- _____ ***Patient Initials***

Contested Credit & Debit Card Policy

After our services are provided should the patient or cardholder contest the charges and we fight the claim for those contested charges and win the patient will be responsible for a fee of \$250. If this \$250 fee is not paid it will be sent to collections.

- _____ ***Patient Initials***

Prescription refills:

No prescriptions will be refilled unless the account is paid in full or is up-to-date with the payment schedules. All prescriptions must first be approved by Dr. Anna Contomitros.

We are unable to fill prescriptions for Birth Control over 3 months unless an Annual Exam has been completed.

- _____ ***Patient Initials***

Acknowledgement of the Notice of Privacy Practices

I hereby acknowledge that I have reviewed the "Notice of Privacy Practices" from Woman to Woman Gynecology. I understand that the "Notice of Privacy Practices" sets forth my rights relating to the use and disclosure of my personal health information and explains how Woman to Woman Gynecology use and disclose my personal health information, both with and without my authorization. I further understand that I may contact Woman to Woman Gynecology if I have any questions regarding the contents of this notice, or to file a complaint.

- _____ ***Patient Initials***

No "Insurance Assignment" For Abortion Services

Any and all abortion services provided by Dr. Contomitros in office, or at the Hospital, are paid for by Cash, Debit, or Credit Card only.

Woman to Woman Gynecology does NOT bill insurances for any abortion services.

Woman to Woman Gynecology does NOT accept insurance assignments for abortion services.

- _____ ***Patient Initials***

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Missed Appointment Policy

Should you cancel your appointment in less than 24- 48 hours, or not show up for your appointment without giving us a courtesy call, there will be a \$50.00 charge applied to your account for the missed appointment date. This amount is payable prior to the provision of any other future services.

We contact via SMS/Email/Phone call in advance with a reminder of their visit time.

Attestation by patient:

I am aware of the policies and I understand that I will be charged for late cancellations of appointment or for not showing up for my scheduled services.

- _____ *Patient Initials*

Collaboration between Patients and Office Providers:

We desire to help you at all times. Getting better, feeling well and being satisfied requires our mutual collaboration. So, we absolutely need your help in taking care of you! Failure to follow up with our instructions to do testing, to get your mammograms, biopsies, consultations, failure to show up for your appointments, repeatedly canceling your appointment, all will be considered as an indication that our collaboration in your best interest is not working. We will dismiss patients from our practice that are not civil to our staff and who are inconsistent with their health commitments or their payments to our practice.

We have zero tolerance for obscenities or any form of verbal or physical violence. We do not allow weapons in our office. We do not allow unauthorized photos of our staff and doctor.

Name _____ Date _____

Signature _____ Date: _____

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Release of Records:

If anyone were to call on your behalf, we are unable to disclose any information about you, your office visit, or your test results unless they are listed below. You do have the option of marking "No one".

I, _____, give Anna Contomitros, M.D. of A-All Women Care and Woman to Woman Gynecology, the authorization to release and discuss any information about myself and the following people.

No one

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

I understand that is my full responsibility to notify the office of any changes.

Signature: _____ Date: _____