CENTER OF HOPE
Gynecologic Oncology, Pelvic and Robotic Surgery

Main Office
5465 Reno Corporate Dr
Reno, NV 89511

Billing Address
PO BOX 11367
Reno, NV 89510

Peter C. Lim, M.D. FACOG
Crystal Adams, M.D. FACOG
(P) 775-327-4673 | (F) 775-327-4611

Dear Patient,

Welcome and thank you for choosing our office for your health care professional needs.

Please be advised that prior to scheduling an appointment with our office, you should confirm that we are participating providers in your network, in order to obtain the maximum benefit level of your plan. We strongly recommend patients understand their own policies by contacting their insurance and checking to make certain procedures and/or services are covered prior to receiving care.

At the time of your office visit, a copy of your updated insurance card(s) will be requested as well as a copy of your identification card and a photograph of you that is uploaded straight to your account. Please provide all insurance information. As a courtesy, we will bill your insurance for professional services provided by our office. Please note: *insurance authorization is not a guarantee of payment. Therefore, should the insurance information provided be denied for no patient eligibility, no claim payments and/or if not paid in full, the amount due will be the patient's responsibility.* It is your responsibility to notify our office of any insurance, address or phone number changes.

Co-payments are due at the time of your office visit. Co-pays must be made in the form of cash, Credit Card, or check made out to the Center of Hope or Dr. Peter C. Lim. Residual balance payments can be made in the form of cash, Credit Card or check made out to the Center of Hope or Dr. Peter C. Lim sent to our billing office address noted above. Payment is due in a timely manner. If your outstanding balance is past due, you must make a payment on your balance before you are seen and/or before a new appointment can be scheduled. Payment arrangements can be discussed if payment in full is not possible. *Finance charges will accrue on past due balances.* Each returned check will incur a fee of $25.00 for insufficient funds. Should you need to cancel or reschedule an appointment, please notify the office at least 24 hours prior to your appointment time to avoid a $25.00 cancellation/no show fee. The fee may go as high as $75.00 per appointment for repeat occurrences and may ultimately result in termination of your care.

Center of Hope requires a surgery deposit of $2000.00 from all patients that have commercial insurance. This deposit is held until insurance pays on all submitted claims. This deposit may be used towards the patients co-pays or deductibles. Once all surgery claims are processed and satisfied, the Center of Hope will disburse any remaining funds within 90 days to the patient. If there is any surgery deposit required that is also due at the time of your visit or can be collected over the phone via Credit Card. Surgery deposit must be made in the form of cash or credit card, CHECKS ARE NOT ACCEPTED FOR SURGERY DEPOSIT.

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We are happy to complete disability and FMLA paperwork for you. Please allow 10 business days for the paperwork to be completed. There is a $25.00 fee to process these papers. There is also a $25.00 fee for printing any medical records you request. This is for the time required to go through and process all the medical records as well as the cost of the paper.

If you require genetic testing via saliva and/or blood there is a $50.00 collection fee upfront prior to the collection for each time this needs to be obtained.

If you require a vaginal dilator post completing vaginal radiation the cost of the dilator is $90.00.

Prescriptions are renewed during normal office hours. Please allow 48 business hours for your requests to be processed. In some instances, we may require that the patient be seen in our office prior to medication renewal.

Should you have any questions or concerns, please contact our office at 775-327-4673.

Thank you for your cooperation,

Sincerely,

Center of Hope

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or any personal information. I understand all the additional fees should I require anything mentioned above I will make the payment noted. I also understand that my account balance will be forwarded to collections for nonpayment in a timely manner.

Patient's Name: _____ Signature: _____ Date: _____

Primary Insurance: _____ ID: _____

Secondary Insurance: _____ ID: _____

Third Insurance: _____ ID: _____

No Insurance (Circle payment option): Cash Check Money Order Visa/MasterCard/Discover

Witness Name: _____ Date:_____

Please be advised we are not contracted with the following insurances:

- United Healthcare
- Aetna
- Tricare

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- Prominence Medicare
- Silversummit Medicaid

** We will bill the services to your insurance company however authorization is required prior to the services rendered.**

I, _____ am aware that The Center of Hope will submit all claims to insurance company as a courtesy and I fully understand that should my insurance company not satisfy my claim in its entirety, that I will be fully responsible for the balance for services rendered.

_____ _____

Signed Date

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Dr. Peter Lim and Dr. Crystal Adams want to thank you for choosing our office, in order to serve you properly, we will need the following information. All information is strictly confidential and goes directly into your account.

Please Print your responses

Personal

Last Name_____ First & Initial_____

Mailing Address_____

City_____ State_____ Zip_____

Physical Address (if different than above)_____

City_____ State_____ Zip_____

Telephone(____)_____ Cell(____)_____

E-Mail_____

Social Security #_____-_____-_____ Birthdate_____/____/_____

Marital Status (circle one) Single Married Divorced Widowed Domestic Partner

Patient Ethnicity_____

Emergency Contact (name)_____ Phone(____)_____

Relationship to Patient_____

Insurance

Primary Insurance_____ HMO or PPO

Subscriber's Name_____ Birthdate___/___/___

Subscriber's Employer_____

Employment Status (Circle One) Full Time Part-time Unemployed Retired Student

Name of Employer_____ Phone(____)_____

Employer's Address_____

Please read and sign the following: I directly assign all medical/surgical benefits to Peter C. Lim, M.D. LTD and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Center of Hope to release all information necessary to secure the payment of my benefits. I further agree that a photocopy of this agreement shall be as valid as the original. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL.

Signature_____ Date_____/____/_____

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed or noticed before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, e-mail, or send a text to you to confirm appointments? Y or N

May we leave a message on your answering machine at home or on your cell phone? Y or N

May we discuss your medical condition with any members of your family? Y or N

If YES, please name the members allowed:

_____

_____

Printed Name of Signee_____

Signature:_____ Date:_____/_____/_____

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Medical History

By whom were you referred?_____ His/Her Specialty:_____

Referring Dr's Address:_____ Phone#:(____)_____

_____

Preferred Pharmacy: (Address, Zip code, Phone #)_____

_____

Are there any other physicians (e.g. Primary Care) with whom you would like your consultation discussed? _____

_____

_____

For what reason were you referred? _____

_____

_____

Please list and X-Rays, Ultrasounds, CT Scans, MRI's, Biopsies or blood tests you've obtained recently that's related to this condition: _____

_____

_____

Please list any other related conditions for which you have been treated in the past: _____

_____

_____

Any other medical problems or hospitalizations? _____

_____

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MEDICAL HISTORY: Please check any medical problems that you've been diagnosed with:

___Hypertension (High blood pressure)

___Diabetes

___Heart problems

- ___Angina or Coronary artery disease
- ___Heart Attack
- ___Congestive heart failure
- ___Arrhythia (Irregular heart beat)

___Liver Problems

- ___Heaptitis__A__B__C
- ___Gall bladder attacks

___Neurologic problems

- ___Stroke
- ___Seizures

___Stomach problems

- ___Ulcer
- ___Acid reflux

___ Bleeding disorder (Hemophilia, etc)

___ Blood clots/Phlebitis

___Lung-problems

- ___Asthma
- ___Tuberculosis
- ___Emphysema

___Kidney/Bladder problems:

_____

___Thyroid problems

- ___Hypothyroidism (low thyroid)
- ___Hyperthyroidism (high thyroid)

___Cancer - Type:_____

- ___Received Radiation
- ___Received Chemotherapy

Other:_____

_____

Have you ever had a colonoscopy (screening for colon cancer)? Y or N When?____/____/_____

Any allergies to medications? Y or N If so, which ones?_____

What type of reaction(s)?_____

List all medications you take and include the dose and frequency:_____

_____

_____

List all surgeries you've had and the dates they were performed:_____

_____

_____

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OBSTETRIC AND GYNECOLOGIC HISTORY

Age at first menstrual period?_____ Are they / were they regular or irregular? (Circle one)

Date of your last period:_____ How long are / were they?_____ How many days between periods?_____

Number of pregnancies:_____ Number of births:_____ Number of miscarriages / abortions:_____

Vaginal deliveries:_____ Cesarean sections:_____ Reason for C-Section?_____

Any problems with pregnancy?

(Explain)_____

When was your last pap smear?___/___/___ Obtained: Annually q3 years q5 years (Circle one)

Any abnormal pap smears previously? Y or N If yes, who performed the pap smear?_____

When was your last mammogram?___/___/___ Obtained: Annually q3 years q5 years (Circle one)

Any abnormal studies? Y or N If yes, where was the mammogram done at?_____

Did you ever take birth control pills? Y or N For how long?_____

Have you or do you use birth control? Y or N What method (e.g.condoms,pills,IUD,etc.)?_____

Ever taken hormone replacement therapy (Estrogen or Progesterone)?_____

Type of hormone therapy?_____ How long was it taken?_____

Are you currently sexually active? Y or N Any problems(e.g. pain)?_____

Have you had any gynecologic problems in the past? (check all that apply)

___Fibroids ___Ovarian cysts ___Endometriosis ___Infertillity

___Sexually transmitted disease or pelvic inflammatory disease

___Heavy bleeding requiring medication or surgery ___Pelvic prolapse or urinary problems

FAMILY HISTORY

Does anyone in your family have cancer? Y or N

Family member:	Type of Cancer:

Any other serious medical problems run in the family? _____

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SOCIAL HISTORY

___Single ___Married-How long?____ ___Partnered ___Divorced ___Widowed

Do you smoke? Y or N Did you used to smoke? Y or N How many packs / day?___ How long?___

How much alcohol do you consume typically? ___None ___Minimal ___Moderate ___Heavy

Any recreational drug use? Y or N What kind?_____ How long?_____

Living Arrangement? __With Spouse __Alone __With Child(ren) __With relatives __Care facility

Other:_____

Transfusion History: __No transfusion history __Transfused in the past - Most recent date:___/___/____

HIV Risk? Y or N If yes, what type?_____

_____

Do you currently have a living will? Y or N

Do you currently have a durable power of attorney? Y or N

Do you currently have "Do Not Resuscitate" (DNR) order in place? Y or N

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REVIEW OF SYSTEMS

Please answer each of the following questions by indication of circling positive symptoms.

In the past 2 weeks, have you experienced any of the following symptoms:

SKIN:
Rash
Skin Ulcers
Other Skin Problems

PSYCHIATRIC:
Depression
Other Problems

GENITOURINARY:
Blood in Urine
Pain with Urination
Vaginal Discharge
Vaginal Bleeding
Painful intercourse
Loss of Urine when Coughing or Sneezing

ENT/MOUTH:
Ulcers Inside your Mouth
Cold Symptoms

RESPIRATION:
Shortness of Breath
Wheezing (difficulty breathing)

MUSKULOSKELETAL
Muscle Weakness
Arthritis/Painful Joints
If so, which joints?_____

GASTROINTESTINAL:
Nausea
Vomiting
Diarrhea
Bloody Stool

NEUROLOGIC:
Fainting
Seizures
Numbness of Finger or Toes

ENDOCRINE:
Diabetes
Thyroid Problems
Hot Flashes

LYMPHATIC:
Bruise Easily
Bleeding Gums

CARDIOVASCULAR:
Chest Pain
Shortness of breath at rest
Shortness of breath w/ walking or climbing stairs

ADDITIONAL:
Weight Change
Fatigue
Recent Change in Vision

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WRITTEN INFORMED CONSENT CONTROLLED SUBSTANCE THERAPY FOR PAIN

Please review the information listed here and put your initials next to each item when you have reviewed it with your prescriber and feel you understand and accept what each statement says.

___My prescriber is prescribing pain medications, including controlled substances, I have discussed with my prescribing physician the important provisions of the treatment plan established for me in clear and simple manner.

___Every pain medication, including controlled substances, has different benefits and risks in the treatment of my symptoms.

___Before I was prescribed these pain medications, we discussed non-opioid, alternative means of treatment for my symptoms including Tylenol, and nonsteroidal anti-inflammatory drugs, relaxation, hot and cold therapy.

___I have discussed with my prescriber and I understand the potential risks and benefits of treatment using controlled substances, including if a form of the controlled substance that is designed to deter abuse is available, the risks and benefits of using that form.

___When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness and sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

___When I take these medications, it will not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise imparied by these medications, I should not do things that would put other people at risk for being injured

___When I take these medications regularly, I will become physically dependent on them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

___I may become addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications. I have discussed with my prescriber the proper use of the controlled substance.

___Anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.

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___I have discussed with my prescriber the methods to safely store and legally dispose of the controlled substance. I understand that prescriptions should always be stored in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I can return my medications in the bottle to a local pharmacy, a local drug-take back day, a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera bag, which may be available for purchase at my local pharmacy.

___I have discussed with my prescriber the manner in which the prescriber will address requests for refills of the prescription and I understand that my prescriber has seven days to refill, if refill is warranted.

___I understand that, due to the risk of possible overdose resulting from use of controlled substances, the opioid overdose antidote naloxone (Narcan) is now available without a prescription. I may obtain naloxone (Narcan) from a pharmacist.

___**For Women:** It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome.

I have reviewed this form with my prescriber and have had the chance to ask any questions. I understand each of the statements written here and by signing I give my consent for treatment of my pain condition with medication, including controlled substances.

Patient Name:_____Date:_____

Patient Signature:_____

If the patient is an unemancipated minor, as the Parent/Guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

Parent/Guardian Name:_____Date:_____

Parent/Guardian Signature:_____

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The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Answer the following using a scale of 0-4, 0= Never 1= Seldom 2= Sometimes 3= Often 4= Very Often

	0	1	2	3	4
How often do you have mood swings?					
How often have you felt a need for higher doses of medication to treat your pain?					
How often have you felt impatient with your doctors?					
How often have you felt that things are just too overwhelming that you can't handle them?					
How often is there tension in your home?					
How often have you counted pain pills to see how many are remaining?					
How often have you been concerned that people will judge you for taking pain medication?					
How often do you feel bored?					
How often have you taken more pain medication that you were supposed to?					
How often have you worried about being left alone?					
How often have you felt a craving for medication?					

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How often have others expressed concern over your use of medication?					
How often have any of your close friends had a problem with alcohol or drugs?					
How often have others told you that you had a bad temper?					
How often have you felt consumed by the need to get pain medication?					
How often have you run out of pain medication early?					
How often have others kept you from getting what you deserve?					
How often, in your lifetime, have you had legal problems or been arrested?					
How often have you attended an AA or NA meeting?					
How often have you been in an argument that was so out of control that someone got hurt?					
How often have you been sexually abused?					
How often have others suggested that you have a drug or alcohol problem?					
How often have you had to borrow pain medication from your family or friends?					
How often have you been treated for an alcohol or drug problem?					