

Patricia K. Brougher, MD, PA

Our Office Policy

Welcome to our office and thank you for choosing one of our physicians for your medical care. The following are our office policies. As a patient you are expected to respect and agree to the following:

Please Initial

- _____ 1. **PAYMENTS:** All applicable fees such as: deductible, coinsurance, and co-pays must be paid at the time of service. Our office accepts cash, checks, Visa, Master Card, DV, AX, DC. If we process a returned check you will be charged a \$35.00 fee and we will no longer accept your checks as a form of payment.
- _____ 2. **HMO & PPO REFERRALS:** If your insurance policy requires a written authorization from your Primary Care Physician for an appointment, you must notify your PCP to process the request prior to your visit.
- _____ 3. **INSURANCE VERIFICATION:** As a policy holder, it is your responsibility to call your insurance and verify that the physician you selected is a provider of your plan. You must provide your insurance card (**we do not accept copies or hand written information**) at every visit to verify the insurance carrier otherwise you will be expected to pay for your visit.
_____ Any benefit verification provided to you by our office is information received from **YOUR** insurance carrier who state “the benefits or estimation given are not a guarantee of payment” which means verification or pre-authorization is not a promise of payment. Ultimately, you are responsible for your account balance.
- _____ 4. **MEDICATION REFILLS:** When requesting a refill, contact your pharmacy first, they will call our office to receive authorization. Please call for a refill when you still have at least one week’s supply of medication. Keep in mind the refill process may be delayed by insurance, a holiday, or the weekend. Refills are not considered an emergency.
- _____ 5. **APPOINTMENT TIME:** We ask you arrive on time for your scheduled appointment. If you arrive after your scheduled appointment time you may be rescheduled. At times, your physician may run late due to unscheduled deliveries, we ask for your patience.
- _____ 6. **CANCELLATIONS:** If it is necessary to cancel your appointment, we ask that you call at least 24 hours prior to your scheduled appointment. **NO SHOW NO CALL FEE \$25.00!!! NO EXCEPTIONS!!!**
- _____ 7. **AFTER HOURS CARE:** In case of an emergency, please dial the main office number (210) 698-0742. Our answering service will take your message and locate the physician on call. The physician on call will return your phone call as soon as possible.
- _____ 8. **INFORMATION CHANGES:** Please provide our office with **ANY** changes regarding your address, phone number, employment information, and medical insurance as soon as possible.
- _____ 9. **NON-COMPLIANCE:** Our office reserves the right to discontinue care due to non-compliance with your plan of treatment or any of the policies of this office.

I _____, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and responsibilities.

Patient/Guardian Signature

Date

Printed Patient/Guardian Name

Notice of Privacy Practices

Effective Date: 9/1/2013

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.

If you have any questions about this Notice, please contact:
Practice Administrator at 210-698-0742

Who Will Follow This Notice?

- Patricia K. Brougher, M.D.
 - ALL providers
 - ALL employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Dr. Brougher's office, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record.

This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

Our Responsibilities.

Dr. Brougher's office (referred herein as "the office") shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- The office will notify you, and the Department of Health and Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational, or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

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The Methods in Which We May Use and Disclose Medical Information About You.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, the office may provide a written or telephone (text message) reminder that your next appointment with Dr. Brougher is coming up.
- Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

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Special Situations.

- Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.

- Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

- Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.

- Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
 - To prevent or control disease, injury, or disability;
 - To report reactions to medications or problems with products;
 - To notify people of recalls of products they may be using;
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
 - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. 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, eligibility, or compliance, and to enforce health-related civil rights and criminal laws.

- Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.

- Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
 - In response to a court order or subpoena; or
 - If Dr. Brougher determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

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- **Coroners, Medical Examiners, and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

Your Rights Regarding Medical Information About You.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must **submit your request in writing to the Privacy Officer for Dr. Brougher**. If you request a copy of the information, the office may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records. The office may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Dr. Brougher will review your request and denial. The person conducting the review will not be the person who denied your request. The office will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Dr. Brougher to amend the information. You have the right to request an amendment for as long as the information is kept by the office. To request an amendment, your request must be made in writing and submitted to the office. In addition, you must provide a reason that supports your request. The office 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, the office may deny your request if you ask us to amend information that:
 - Was not created by Dr. Brougher 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 Dr. Brougher.
 - Is not part of the information which you would be permitted to inspect and copy; or
 - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. To request this list you must submit your request in writing to the office administrator. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. The office will

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notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the office uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information the office discloses about you to someone who is involved in your care or the payment for your care. The office is not required to agree to your request, unless the request pertains solely to a health care item or service for which the office has been paid out of pocket in full. Should the office agree to your request, the office will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing to the office. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit the office's use and/or disclosure; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that the office communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the office contact you only at work or by mail. To request that the office communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. The office will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes to This Notice.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

Complaints.

If you believe your privacy rights have been violated, you may file a complaint with the office administrator or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer at 210-698-0742.

Your complaint must be filed within 180 days of when you knew or should have known that the act occurred.

The address for the Office of Civil Rights is:

*Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202*

All complaints should be submitted in writing.
You will NOT be penalized for filing a complaint.

Laboratory Notice

___ I understand the laboratory test(s) or any diagnostic testing that I and/or the doctor have requested may not be covered under my insurance plan.

___ I understand it is **MY RESPONSIBILITY** to confirm coverage of these tests with my insurance carrier.

___ I also understand my physician is **NOT** responsible for handling any portion of the charges incurred by the request for blood work or pathology.

___ I understand that it is my responsibility to inform this office which laboratories are part of my health insurance network.

___ I understand that signing this notice confirms I am aware of my responsibility for any charges incurred in laboratory tests requested by me or my physician.

___ I further understand that this office does **NOT** provide any laboratory/pathology services and that I know I will receive a bill from another facility.

___ I also understand that I have the right to **REFUSE** any testing requested by my provider.

My signature below confirms I understand the above statements.

Patient Name

Date

Dr. Patricia K. Brougher

Office Policy for Annual Visits

Thank you for selecting one of our physicians as your provider for your gynecological needs.

For clarification purposes we would like for you to read the following information regarding your annual visit to establish what an “annual visit” includes.

Women in Child Bearing Years an Annual Includes:

-PAP smear, breast exam, and continuation of birth control method.

If birth control is established at annual visit this will be charged as a separate visit.

Women in Pre-menopausal Years an Annual Includes:

-If patient is 40 years and older she will receive a PAP smear, breast exam, continue Hormone Replacement Therapy (HRT) or Birth Control Method (BCM), mammogram order and rectal exam for fecal occult blood (checking for blood in stool).

-If birth control or hormone replacement is established you will be charged a separate visit.

-If patient is 50 years and older she will receive a PAP smear, breast exam, mammogram order, rectal exam for fecal occult blood (checking for blood in stool) and bone mineral density scan order as needed.

If hormone replacement is established you will be charged a separate visit.

ANY problem or concern discussed at “annual visit” that is not included in the above description **WILL** be charged as a separate visit.

~ ~ ~ MEDICARE PATIENTS ~ ~ ~

_____ Medicare **ONLY** pays for annual visits every **TWO** years. If you are seen for an annual within that two year time span **YOU** will be held responsible for payment at the time of service **UNLESS** your annual visit is covered by your secondary insurance.

By signing this form I confirm I understand the information stated above.

Patient Signature

Date

Patient Health History

Today's Date: _____

Appointment Date: _____

Name _____

DOB: __/__/__

Reason for today's visit (Please list ALL symptoms):

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

Past Medical History

Illnesses: Have you ever had any of the illnesses below? Please check all that apply.

Date/Details:

Obstetrical Yes _____

Any high-risk pregnancy Yes _____

Gynecological Yes _____

Breast Problems Yes _____

Heart Problems Yes _____

Any cancer Yes _____

Hormonal Issues Yes _____

Blood Disorders Yes _____

Any Injuries Yes _____

Bone/Joint Issues Yes _____

Psychiatric Yes _____

Respiratory Yes _____

Skin Yes _____

Neurologic Yes _____

Other Not Listed: _____

Preventative Health Maintenance

- 1) Date of last pap smear? _____ Was your last pap smear normal? Yes No
[If done elsewhere please bring copy of results]
- 2) Date of last Colonoscopy? _____ Was your last colonoscopy normal? Yes No
- 3) Date of Last Bone Density Test? _____ Was your Bone Density normal? Yes No
- 4) Date of last Pelvic Ultrasound? _____ Was your last Pelvic Ultrasound normal? Yes No
- 5) Date of last mammogram? _____ Was your mammogram normal? Yes No
- 6) Do you perform regular Self Breast Exams? Yes No
- 7) Date of last breast biopsy? _____ Was your last biopsy normal? Yes No

Past Surgical History OR Major Injuries:

Date/Details:

List ANY surgeries you have had!

- Gyn Surgery Yes _____
- Breast Surgery Yes _____
- Other surgery Yes _____
- Neurosurgery Yes _____
- Cardiac Yes _____
- Thoracic Yes _____
- Orthopedic Yes _____
- Skin Yes _____
- Endocrine Yes _____

- Digestive System Yes _____
- Urinary Yes _____
- Vascular Yes _____
- Orthopedic Yes _____
- Skin Yes _____

Other Not Listed:

Date/Details:

Medications

Please list all current medications prescribed by our doctors!

Medication Dose & Frequency

*If using Generic medication please list the name as indicated on your prescription bottle.

List any prescriptions given by ANY other doctor:

Allergies

NO KNOWN DRUG ALLERGIES

Are you allergic to any medications?

Please list medication and reaction:

Food

Indicate food and reaction:

Environmental

Indicate and reaction:

When was your last Vaccine / Immunization:

Flu Shot: _____

Pneumonia Vaccine: _____

Shingles Vaccine: _____

Gardasil: _____

Family History

Has anyone in your immediate family been diagnosed with the following disease (indicate who):

- Gynecology who? _____ At what age? _____ Maternal / Paternal
- Obstetrics who? _____ At what age? _____ Maternal / Paternal
- Cardiac who? _____ At what age? _____ Maternal / Paternal
- Endocrine who? _____ At what age? _____ Maternal / Paternal
- Neurologic who? _____ At what age? _____ Maternal / Paternal
- Respiratory who? _____ At what age? _____ Maternal / Paternal
- Hematologic who? _____ At what age? _____ Maternal / Paternal
- Psychiatric who? _____ At what age? _____ Maternal / Paternal
- GI who? _____ At what age? _____ Maternal / Paternal
- Breast who? _____ At what age? _____ Maternal / Paternal
- Neoplasm who? _____ At what age? _____ Maternal / Paternal
- Musculoskeletal who? _____ At what age? _____ Maternal / Paternal
- Renal who? _____ At what age? _____ Maternal / Paternal
- Dermatology who? _____ At what age? _____ Maternal / Paternal
- Genetic Disorder who? _____ At what age? _____ Maternal / Paternal
- Other: what? _____ At what age? _____ Maternal / Paternal

Social History

- Alcohol Use Every Day Some Days Former Never Amount Used: _____ Age Start: _____ Age Stop: _____
- Substance Drug Use Yes Describe: _____
- Tobacco Use Every Day Some Days Former Never Amount Used: _____ Age Start: _____ Age Stop: _____
- Marital Status Dating Divorced Engaged Married Not dating Remarried Single Separated Widowed
- Employment (Occupation) _____ Unemployed Homemaker Student Retired
- Exercise Regular Heavy Moderate Minimal Active Competitive Athlete Sedentary
- Daily Diet Describe: _____

Any Other Problems

Your Education Level: _____ Your Occupation: _____

Your Infection Risk/Exposure: _____ Your Hazardous Exposure: _____

Any military history? Y / N What branch? _____

Any domestic violence to report? _____

Reproductive History

Menstrual

Age Period Began: _____
 Length of periods: _____ # days
 Number of days between periods: _____
 Last Menstrual Period (Date): _____
 Menopause Status (pre/peri/post): _____
 Method of Birth Control (pills, tubal, vasectomy etc.): _____

Average Flow: heavy medium light

Certainty of LMP Date: Y or N _____

Menopause: Y / N Age: _____

Clots(Y/N)? : _____

On Hormone Replacement Therapy (Y/N)? : _____

Do you ever have bleeding in between periods? Yes/No

Pregnancies

Total Pregnancies	Full Term	Premature	Ab Induced (abortion)	Ab Spontaneous (miscarriage)	Ectopics	Multiple	Living
#	#	#	#	#	#	#	#

Please list all deliveries

D.O.B. Sex of child Birth Wt # weeks at delivery Hrs in labor Type of delivery* Anesthesia** Complications***

*Types of deliveries= Vaginal, c-section, forceps, vacuum OR v-bac

** Types of Anesthesia= Epidural, general, spinal, IV medications OR none

***Complications= List any problems or issues during pregnancy and at delivery

HEALTH SCREENING

Patient Name _____ Date of Birth: _____ Date _____

In order to accurately assess your health needs and understand your safety and well being we ask answer the following questions.

NOTE: This information will remain confidential between you and your provider.

If you do not wish to answer the following questions at this time, please initial and date below.

Initials _____ Date: _____

Smoking

When was the last time you had a cigarette? _____

How many cigarettes did you smoke yesterday? _____

How old were you when you started smoking? _____

Have you ever tried to quit smoking? _____

If you have quit before, what do you think triggered you to start again? _____

Alcohol

Have you ever consumed alcohol, including beer, wine, and/or liquor? ___ Yes ___ No

If yes:

What is the maximum number of drinks you have had on any given occasion during the past month? _____

On a typical day when you drink, how many drinks do you have? _____

On average, how many days per week do you drink alcohol? _____

Many women have experienced some form of abuse in their childhood or in their adult life. Past or current abuse can affect a women's health in many ways that concerns us, so we ask all women about this possibility.

Abuse

Has you partner ever slapped, kicked, punched, hit, stomped, shoved, sexually assaulted, or otherwise physically hurt you? _____

Has your partner ever ridiculed you called you names, or verbally harassed you? _____

Does your partner restrict your freedom of movement to leave the house to visit friends, family, or go to church? _____

Do you feel safe in your current relationship? _____

We appreciate and respect your disclosure of this information. Please initial in front of each statement.

_____ I am aware that I can discuss these questions with my provider if I so choose.

_____ I can request information of these subjects from my provider if I so choose.