Osceola Gynecology, PLLC

Registration Information

Referring Provider: _____
First Name: _____ MI:_____ Last Name: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ Age: _____

Mailing Address: _____

City: _____ State _____ Zip Code: _____

Marital Status: Single Married Divorced Widowed Separated

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best number to contact you: Day:
Home Cell Work Evening:
Home Cell Work

Employer: _____

Emergency Contact: _____ Relationship_____ Phone: _____

Email_____

Responsible Party Information – Please fill in ALL blanks

If you (the patient) are the responsible party (the person holding the insurance policy), mark "self" and move down to the "Insurance Information." If your spouse or parents hold the policy, mark the appropriate box and continue.

Patient relationship to responsible party: Self Spouse Dependent

First Name: _____ MI: _____ Last Name: _____
Social Security Number: _____- _____ - _____ Date of Birth: _____ Sex: M F

Street Address: _____ Phone Number: _____

City: _____ State: ____ Zip Code: _____

Employer: _____ Work Phone Number: _____

Insurance Information- Please fill in ALL blanks

Insurance Company: _____
Phone Number: _____
Subscriber Id: _____
Group # _____

CONSENT TO TREAT: I authorize Osceola Gynecology, LLC to perform the treatments or procedures approved by my physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of my treatments and/or procedures. I understand that the nature and purpose of procedure, possible alternative methods of treatment and risks involved and the possibilities of complications will be fully explained to me prior to any procedures and/or treatments.

_____ _____
Patient Signature Date

Consumer Responsibilities

Statement of Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment. Such responsibilities include:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan coverage and health plan options(when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, health care providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities

Patient Rights

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you also respect the health care provider's or facility's right to expect certain behavior from you. You may request a copy of the full text of this law from your nurse. We have provided for you a summary of your rights and responsibilities from this law, and those provided to you through additional hospital policy, regulatory and accrediting requirements.

Respect and Dignity: You have the right to participate in decisions regarding your medical care, and to be treated with courtesy and respect, with appreciation of your dignity, and protection of your need for privacy. You have the right to a prompt and reasonable response to your questions and requests. You have the right to know what rules and regulations apply to your conduct. You have the right to get information about your care in your language, and to know what patient support services are available, including whether an interpreter is available if you do not speak English. You also have a right to communication in a manner that meets your needs, including assistance with vision, speech, hearing, or cognitive impairments.

You have the right to be informed about the care you will receive, and to know when something goes wrong with your care. You have the right to ask questions and to be listened to. You may refuse at any time recordings or other images made for purposes other than your care. You have the right to be from neglect, exploitation, and any type of abuse. You also have the right to resolve conflicts that may arise regarding your care; see the section titled Conflicts Concerning Care of the Patient in this brochure.

You have the right to express grievances regarding any violation of your rights, as stated in Florida law, through the Hospital's grievance procedure and to other agencies, including the Florida Department of Health and The Joint Commission. We are committed to continually improving our services and would appreciate and request the opportunity to first hear your grievance and provide you with a resolution. Please ask to speak with the nursing director of your patient care area, or the Hospital's risk manager. Voicing a complaint does not in any way jeopardize your care.

If you prefer not to bring your concern to our attention, you may also file a grievance with the following:

1. Florida Department of Health Consumer Services Unit at 4052 Bald Cypress Way, Bin C75, Tallahassee, Florida 32399-3275, or by telephone at (888) 419-3456.
2. Joint Commission at Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181, or by telephone at (630) 792-5636.

Access to Care: You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment. You have the right to treatment for any emergency medical condition that will deteriorate if treatment is not provided. You have the right to know who is providing you medical services and who is responsible for your care. You also have the right to be given, by your physician, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis. You have a right to pain management. You may refuse any treatment, except as otherwise provided by law. If you refuse treatment or care that is the sole basis for hospitalization, or would result in care below known professional standards of care, you may be requested to leave, be transferred to another facility, or we may be required to report your refusal to other state agencies.

Access to Information: You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care. If you are eligible for Medicare, you have the right to know, upon request and in advance of treatment, whether your health care provider or the Hospital accepts the Medicare assignment rate. You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care. You are entitled to receive a copy of a reasonably clear and understandable, itemized bill and, if you request, to have the charges explained.

We must tell you if medical treatment is for purposes of experimental research and you must be given the opportunity to give your consent or refusal to participate in such experimental research. You have the right to access, request amendment to, and obtain information on disclosures of your health information, in accordance with law and regulation.

Your Responsibilities: You are an integral member of the health care team. Your health and safety is enhanced by your willing participation in your recovery. You are responsible for providing your physician and our staff, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.

You are responsible for reporting unexpected changes in your condition and for communicating promptly whether or not you comprehend a contemplated course of action and/or what is expected of you. You are also responsible for following the treatment plan recommended by your doctor which includes instructions provided by nurses and other allied health providers. You are responsible for communicating any concerns you have about your treatment, care, environment, or other issues that may impact your care, hospitalization or recovery.

You are responsible for your actions if you refuse treatment or do not follow the physician's instructions. You are responsible for following the Hospital's rules and regulations affecting patient care, respecting hospital property and your conduct as well as the conduct of those who visit you. This includes, but is not limited to, following instructions related to visitors, treating your caregivers with respect, requests related to security issues, dietary restrictions, not smoking, maintaining a quiet environment for others, and refraining from consuming substances, medication and/or foods from outside sources.

You are responsible for keeping appointments and, when you are unable to do so for any reason, for notifying us or your physician. You are responsible for assuring that the financial obligations of your health care are fulfilled as promptly as possible.

Privacy and Confidentiality: You have the right, within the law, to personal and informational privacy. You have the right to:

- Refuse to talk with or see anyone not officially connected with the hospital, including visitors, or persons officially connected with the hospital but not directly involved in your care.
- Be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy. This includes the right to have a person of your same sex present during certain parts of a physical examination, treatment, or procedure performed by a health professional of the opposite sex and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which you were asked to disrobe.
- Expect that any discussion or consultation involving your case will be conducted discreetly and that individuals not directly involved in your care will not be present without your permission.

- Have your medical record read only by individuals directly involved in your treatment or in the monitoring of its quality and by other individuals only on your written authorization or that of your legally authorized representative.
- Expect all communications and other records pertaining to your care, including the source of payment for treatment, to be treated as confidential.
- Request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing you by his/her actions.
- Be placed in protective privacy when considered necessary for personal safety.

Personal Safety/Restraints: You have the right to receive care in a safe setting, and to be free from mental, physical, social, and verbal abuse, neglect and exploitation. You have the right to access protective or advocacy services. You have the right to be free of restraints (or seclusion) of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

Identity: You have the right to know the identity, function, and qualifications of individuals providing service to you and to know which physician or other practitioner is primarily responsible for your care. You may request such information from your provider or the Hospital. This includes the your right to know of the existence of any professional relationship among individuals who are treating you, as well as the relationship to any other health care or educational institution involved in your care. You have a right to refuse to allow students in clinical training programs to participate in your care.

Communication: You have the right to access communication with others outside the hospital by means of visitors and by verbal and written communication. If you need assistance with communicating with family or your health care provider(s), please let your nurse or physician know so that we can provide you with assistance.

Plan of Care: You have the right to participate in the development and implementation of your plan of care prior to and during the course of your treatment. You have the right to refuse a recommended treatment or plan of care to the extent permitted by law and to be informed of the medical consequences of this action. If you refuse treatment, you are entitled to other appropriate care and services that the hospital provides or transfer to another hospital. We will notify you of any policy that might affect patient choice within the hospital. You have the right to exclude any or all family members from participating in your health care decisions. You may at any time request additional consultation with a specialist.

Consent : You have the right to participate in informed decision-making regarding your health care. To the degree possible, this should be based on a clear, concise explanation of your condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation and probability of success. Your physician is responsible for providing you with this information. You should not be subjected to any procedure without your voluntary, competent and understanding consent. You should be informed when medically significant alternatives for care or treatment exist.

You have the right to know who is responsible for authorizing and performing the procedures or treatment. Your consent is required for recording or filming made for purposes other than the identification, diagnosis, or treatment. You may request cessation of recording or filming and you may rescind consent for use up until a reasonable time before the recording or film is used. You and others you authorize have the right to be informed about the outcomes of care, including unanticipated outcomes. Your physician is responsible for explaining the outcome of treatments or procedures you authorize whenever the outcome differs significantly from the anticipated outcome.

Transfer and Continuity of Care: You may not be transferred to another facility unless you have received a complete explanation of the need for transfer and of the alternatives to such a transfer, following all EMTALA and other applicable laws for transfers between health care facilities. You have the right to be informed by the practitioner responsible for your care, or his/her delegate, of any continuing health care requirements following discharge from the hospital.

Hospital Charges: Regardless of the source of payment for your care, you have the right to request and receive an itemized and detailed explanation of your total bill for services rendered in the hospital. You also have the right to timely notice prior to termination of your eligibility for reimbursement by any third-party payer for the cost of your care.

Pain Management : You have the right to an initial assessment and regular reassessment of your pain. You have the right to expect that all relevant care providers have been educated in pain assessment and pain management. You and those you authorize have the right, when appropriate, to receive education regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments. You have the right to know, after taking into account your cultural, spiritual, and/or ethical beliefs, that pain management is an important part of your care.

Conflicts Concerning Care of the Patient : Occasionally, a conflict will develop between the patient (and/or a parent or guardian, in the case of minors) and the hospital staff or physician concerning your care. Should this occur, it is the responsibility of the patient (or guardian, if appropriate) to inform the Department Director of the conflict. The Department Director will attempt to resolve the matter. If s/he cannot, s/he will refer the matter to the Chief Nursing Officer, or his/her designee, who will review the matter with the patient (or guardian). Presentation of a complaint does not in itself serve to compromise a patient's future access to care. An Ethics Committee consultation is always available as a non-judgmental forum for the resolution of bio-ethical issues and conflicts regarding patient care.

Osceola Gynecology, PLLC

YOUR INSURANCE COMPANY REQUESTS WE

COLLECT YOUR CO-PAYMENT AT THE

TIME OF SERVICE.

You Are Responsible for All Co-Insurance and Deductible payments after your insurance processes your claim.

WE ACCEPT CASH, CHECKS, AND CREDIT/DEBIT CARDS.

Please make checks payable to:

Osceola Gynecology

Thank you for your cooperation.

By initialing here _____, I acknowledge that I am aware and understand that uncovered services by my insurance company are my financial responsibility and I will be charged and billed [via mail] accordingly.

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

NOTICE OF PRIVACY POLICY

Effective July 14, 2010

The following is the privacy policy ("Privacy Policy") of **Osceola Gynecology,LLC** ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric

donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations. With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities. Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for

information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foresee ably rely, on such information to your detriment. All requests for amendment shall be sent to **Anthony Gyang MD 3004 17th Street, St. Cloud, Florida 34769.**

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to **Anthony Gyang, M.D., 3004 17th Street, St. Cloud, Florida 34769.**

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, **Anthony Gyang, M.D., 3004 17th Street, St. Cloud, Florida 34769.** Telephone number: **407.556.3973**. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to **Anthony Gyang M.D., 3004 17th Street, St. Cloud, Florida 34769**. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer **Anthony Gyang M.D.** at the address, telephone number, or e-mail address listed above.

Osceola Gynecology, LLC

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I have received a copy of this Office's Notice of Privacy Practices.

_____
Please Print Name

X_____
Signature

_____
Date

Please list the names of anyone who the office staff may release information to on your behalf. If they are not on this list no information will be released regarding your care or condition.

Name	**Relation to Patient and Telephone**
_____	_____
_____	_____

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to accept Notice.

_____Individual refused to sign Acknowledgement.

_____Individual was unable to sign.

_____An emergency situation prevented us from obtaining acknowledgement.

_____Other:

_____

X_____
Signature of Employee Date

Osceola Gynecology, LLC

Anthony Gyang, M.D.

St. Cloud Office
3004 17th Street
St. Cloud, FL 34769
Phone: 407-556-3973
Fax: 321-805-4718

Kissimmee Office
505 West Oak Street
Kissimmee, FL 34741
Phone: 407-483-7777
Fax: 407-483-7778

Orlando Office
2877 Delaney Ave
Orlando, FL 32806
Phone: 407-483-7777
Fax: 407-483-7778

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone: _____
Date of Birth: _____ Social Security: _____

Medical Records to be Released From:

_____

_____

Authorization For Release To:

I hereby authorize you to release a copy of my medical records to the name listed below:

_____

_____

I understand this medical record may contain information about drug abuse, alcohol abuse, venereal disease, abortions, AIDS/HIV testing and/ or mental health treatment.

I understand that I may revoke this consent at any time, except where information is already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

Signed _____ Date _____

Witness _____ Date _____

Osceola Gynecology, LLC

Anthony Gyang, M.D., FACOG

APPOINTMENT CANCELLATION/NO SHOW POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an Appointment Cancellation/No Show Policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Please be courteous and call our office if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary for you to cancel your scheduled appointment, please contact our offices no later than twenty four (24) hours in advance. Your early cancellation will give another person the possibility to have access to timely medical care.

Each time a patient misses an appointment without providing notification (no-shows), another patient is prevented from receiving care. A failure to be present at the time of your scheduled appointment will be recorded in the medical record, and an administrative fee of $25.00 will be accessed to the account. A letter will be generated and mailed to the address on file to alert the patient that they have failed to show up for an appointment. If an individual has three (3) no-shows within a one year period, they may be discharged from the practice.

While we understand that situations may arise preventing patients from arriving to their scheduled appointment on time, if a patient is more than fifteen (15) minutes late for their appointment without notifying the office, the appointment may be canceled or rescheduled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. We thank you in advance for your cooperation and understanding.

By signing below you acknowledge that you have been presented with the above policy.

Printed Name _____ Patient Signature_____ Date _____

Osceola Gynecology, LLC

Name: _____ DOB: _____

Date: _____

Reason for today's visit: (Circle One) Annual Exam Pelvic Pain Postmenopausal Bleeding Abnormal Pap Abnormal Bleeding Abnormal Imaging Birth Control Consult about Surgery Other:_____

ALLERGIES:

_____

OB History:

Total number of pregnancies: _____ Total Living: _____ Miscarriages: _____ Abortions: _____

Number of Vaginal Deliveries: _____ Number of C-Sections: _____

GYN History:

Last Menstrual Cycle: _____ Sexually Active: Yes No Total Lifetime Partners: _____

Age at Coitarche: _____ Age at Menarch: _____ HPV Test: Positive Negative HPV Vaccination: Yes No

Birth Control Method: Tubal Ligation Condoms Oral Contraceptives Depo-Provera IUD Nexplanon/Implanon Nuva Ring Other:

_____

Last Pap: _____ Abnormal: Yes No If Yes, describe:

_____

Last Mammo: _____ Abnormal: Yes No If Yes, describe:

_____

Last Colonoscopy: _____ Abnormal: Yes No If Yes, describe:

_____

Last Dexa Scan: _____ Abnormal: Yes No If Yes, describe:

_____

Last Pelvic US: _____ Abnormal: Yes No If Yes, describe:

_____

History of STD: Yes No If Yes, describe:

_____

History of Endometriosis: Yes No

History of Fibroids: Yes No

History of Infertility: Yes No

History of PCOS: Yes No

History of Cervical Dysplasia: Yes No

History of Ovarian Problems: Yes No

Surgical History:

List surgeries	Year
1.	
2.	
3.	
4.	
5.	

Medical Conditions:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10

Family History Breast Cancer Ovarian Cancer Uterine Cancer Cervical Cancer Colon Cancer Melanoma

Social History: : Yes No Drink Alcohol: Yes No Ever been Sexually Abused: Yes No

Medication List:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10

Pharmacy Name: _____Location/Phone#: _____

Print name_____

Signature_____ Date_____

Osceola Gynecology, PLLC
Yearly Well-Woman Exam

The Yearly woman exam includes:

- Pap Smear
- Breast Exam

Any other exams and/or procedures such as Ultrasounds, Lab work, etc. are NOT PART of the Yearly Woman Exam and will NOT be covered by your insurance company. You may incur or be liable for some fees/costs if other exams are perform.

For additional information, please speak to one of our staff before seeing the Dr. Gyang.

Signature_____ Date_____

Osceola Gynecology, PLLC
Self-Pay Specimen Agreement

At the time of your visit, Dr. Gyang might require or recommend laboratory work. As a self-pay patient, it will be your responsibility to pay or be billed by the provider testing the samples collected at the office or at their location.

For additional information, please speak to one of our staff before seeing the Dr. Gyang.

Signature_____ Date_____