Premier Women's Health, LLP.

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

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

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

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

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Assignment of Benefits • Financial Agreement

I herby give authorization for payment of insurance benefits to be made directly to PREMIER WOMEN'S HEALTH,LLP. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I also acknowledge that a picture will be taken and placed in my electronic chart for the purpose of identification only.

Date: _____ Your Signature: _____

Premier Women's Health, LLP

1758 Broad Park Circle South
Mansfield, Texas 76063
Office 972-780-7330 Fax 972-780-7385
Carolyn Kollar, DO, FACOOG
Magen Hutchins, WHNP

Office Hours: Monday – Thursday 8:00 am to 5:00 pm Friday - 8:00 am to 1:00 pm

Office Policies

Below you will find our office policies. Please read each one carefully. We hope this information will be helpful to you when accessing our office and making decisions about your health.

Appointments:

Office visits are by appointment only. We strive to see our patients as close to their appointment times as possible. As you know, emergencies do arise and can cause an increase in waiting time. We understand that there are times when it will be necessary for you to cancel or reschedule your appointment. In order for us to be available to as many patients as needed, we ask that you kindly provide our office with a 24-hour notice.

- **There will be a $ 50.00 fee for a no-show appointment or a cancellation the same day of your appointment or less than 24 hours before your appointment.**
- **There will be a $ 75.00 fee for a no-show or a cancellation the same day of a scheduled procedure or less than 24 hours before your appointment.**
- **There will be a $ 200.00 fee for a cancellation of a surgical procedure less than 72 hours before your surgery.**

Insurance does not cover this fee it will be billed to you and it must be paid before your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice. Reminder calls are merely a courtesy as it is still your responsibility for remembering your appointment date and time.

Telephone Calls and Medication Refills:

We ask that you make all non-emergency calls and prescription refills during our regular office hours. Calls made after 4 pm might not be returned until the next business morning. Please allow 3-5 days to process the prescription request. **Narcotics (Hydrocodone, morphine, etc.) are NOT refilled after hours or on weekends.** All prescription refill request should be done at the time of your office visit and can only be filled if up to date information is on file with our office and your pharmacy.

Referrals

Allow 5 to 7 business days to process routine referrals.

NSF/Closed Accounts

There is a $50.00 charge for all returned checks

Patient / Insurance Payments:

Payment is expected at the time services are rendered. Payment will be accepted in the form of cash, check, Mastercard or Visa. We require that you present accurate insurance information and that you complete a registration form on the initial appointment and update your information annually or as often as the information changes to assure you receive correspondence from our office as well as your prescription refills. Please be aware that most insurance plans do not cover 100% of the services provided. Account balances exceeding 90 days will be turned over to an outside collection agency and your care will be terminated with our practice.

Medical Records / FMLA:

All medical record requests require written release of information. Please allow two weeks for the processing of all medical records. There is a **$25.00** fee for patients that request medical records which must be paid prior to the records being copied and mailed.

There will also be a **$35.00** fee for forms that need to be completed by your physician. Any additional forms that need to be completed by your physician after the first set of forms is completed will be **$15.00**. This includes Family Medical Leave, disability, medical leave, etc. Please allow two weeks for completion of all forms.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

I have read and understand the office policies related to care provided by Premier Women's Health.

_____

Patient/Guardian Signature **Date**

PREMIER WOMEN'S HEALTH
CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals she deems appropriate to perform and/or order exams, test, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Premier Women's Health unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bloody fluids, such as through a needle stick; or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested if any of these situations occur during your treatment period.

_____

Patient's Printed Name Date of Birth

_____

Patient/Legal Representative Signature Date

_____

Relationship to Patient

Premier Women's Health, LLP
PATIENT PROFILE

NAME_____ DATE_____
(Last Name) (First Name) (Middle)
AGE____ MARITAL STATUS____ OCCUPATION _____Race_____
FAMILY PHYSICIAN_____ PHONE_____

HISTORY: PLEASE CIRCLE

Measles	Mumps Tuberculosis	Neurological (Nerves)
German Measles	Diphtheria	Bronchial/Asthma
Chicken Pox	Malaria Pneumonia	Sickle Cell
Whooping Cough	Tonsillitis	Cardiac (heart)
Scarlet Fever	Typhoid Fever	Mitral Valve Prolapse
Rheumatic Fever	Stomach	Joint
Smoke	How many packs per day: _____	Alcohol use and type:

Drug Allergies_____

Operations_____
_____

Medications_____
_____

- Last Pap smear: Date_____ Results_____
  Where_____
  Have you ever had an abnormal Pap: No_____Yes_____?
  If yes: When:_____ Treatment:_____
- Colonoscopy: Date:_____ Results: _____
- DEXA Scan (Bone density test:): Date:_____ Results:_____
- Mammogram: Date:_____ Results:_____

FAMILY HISTORY (please specify which family member, for example, Maternal Grandmother, Paternal grandfather)
_____Diabetes _____Heart Disease _____ HTN _____High cholesterol/triglycerides
_____Ovarian Cancer _____ Breast CA _____Uterine CA _____Colon CA

PLEASE LIST ALL PREVIOUS **PREGNANCIES, MISCARRIAGES AND ABORTIONS:**

Year	Month	Length of Pregnancy	Time in Labor	Weight of Baby	Anesthesia	Complications

Menstrual History
Age of first menstrual cycle_____ Are your cycles regular? _____ Cramping? _____
Clotting? ____How long does your cycle last? _____
Please Circle: Are your cycles: light, moderate, heavy
Age of 1st sexual intercourse: _____ Number of sexual partners: _____

Premier Women's Health, LLP
1758 Broad Park Circle South Mansfield, Texas 76063
Phone 972-780-7330 Fax 972-780-7385

Well Woman Exam

The American College of Obstetricians and Gynecologists explains the need for an annual assessment as a fundamental part of medical care and is valuable in promoting prevention practices, recognizing risk factors for disease, identifying medical problems, and establishing the clinician–patient relationship. The annual health assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors. The performance of a physical examination is a key part of an annual health assessment visit, and the components of that examination may vary depending on the patient's age, risk factors, and physician preference.

Every insurance plan has different stipulations and/or guidelines that must be met. ***Premier Women's Health, LLP*** leaves the responsibility to you as the patient to understand what your insurance will and will not cover for your annual well woman exam. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. As your physician, I believe that certain services are an important part of your medical care and recommend that you receive these services as part of your current treatment plan. However, in the event the services are not considered to be covered benefits under your health insurance you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services that may or may not be covered by your health insurance.

Patient Waiver for Non-Covered Services

I acknowledge that I have been informed in advance of receiving services at Premier Women's Health that may or may not be covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges.

This form must be signed by the patient or legal guardian *PRIOR* to receiving any services and will be maintained in the patient's health record.

Date _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable) _____

Signature of Parent or Legal Guardian (if applicable) _____

PREMIER WOMEN'S HEALTH, LLP
PRIVACY COMMUNICATION FORM

In complying with Health Insurance Portability and Accountability Act, HIPAA, we want to make sure that we guard your privacy according to your wishes when it comes to family, friends, and co-workers.

Please answer the following questions and indicate with a check your first choice:

- ☐ May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? **YES or NO**
- ☐ May we leave messages on your answering machine at home? **YES or NO**
- ☐ May we leave messages on your cell phone voice mail? **YES or NO**
- ☐ May we leave messages on your voice mail at work? **YES or NO**
- ☐ May we discuss your appointment schedules with your spouse/partner/parent? **(Please circle all that applies)** **YES or NO**

List any other persons other than yourself (i.e. spouse, children, or other family members, etc.) that you would wish us to discuss your medical care or financial responsibility with upon request.

Please list name, relationship, and what you wish to be discussed:

1._____

- ☐ **Medical Care**
- ☐ **Financial Responsibility**
- ☐ **Both**

2._____

- ☐ **Medical Care**
- ☐ **Financial Responsibility**
- ☐ **Both**

You must inform us, **in writing**, of any changes in your directives. This will be kept in your file along with your acknowledgement of receipt of our Notice of Privacy Practices.

Signature: _____**Date:**_____

Phone Number: _____ Email: _____

PREMIER WOMEN'S HEALTH, LLP
NOTICE OF PRIVACY PRACTICES

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.

EFFECTIVE JANURARY 1, 2018

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to **PREMIER WOMEN'S HEALTH, LLP**, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described

more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

H. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

J. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

K. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

L. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

M. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

N. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue

transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

O. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

P. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Q. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

R. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- 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.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

S. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

T. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery

request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

U. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

V. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

W. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

X. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

Y. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Z. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan)

pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Premier Women's Health, LLP
Attn: HIPAA Officer
1758 Broad Park Circle South
Mansfield, TX 76063

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

PREMIER WOMEN'S HEALTH, LLP
Acknowledgment of Receipt of Notice of Privacy Practices

These policies are to provide a description of the uses and disclosures of certain health information. I understand that Premier Women's Health, LLP reserves the right to change its Notice of Privacy Practices, Patient Financial Policy and Office Policy. Prior to implementation an updated copy will be provided at the office. A copy of the updated Policies may be requested by calling the physician's office or requesting a copy in person at an appointment.

_____

Patient's Printed Name **Date of Birth**

_____

Patient/Legal Representative Signature **Relationship to patient**

I authorize Premier Women's Health, LLP to contact me via current and any future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account(s) I owe to Premier Women's Health, LLP or to receive general information Premier Women's Health, LLP. I also authorize its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment and artificial or pre-recorded voice messages and personal calls, in their effort to contact me for purposes of collecting any portion of my account which is past due. I understand that I may withdraw my consent to call my cellular phone by submitting my request in writing to Premier Women's Health, LLP or its agents.

I have read this disclosure and agree to the terms described above.

_____ _____

NAME DATE

Premier Women's Health, LLP
Notice of Patient Rights and Responsibilities

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient: a) has been adjudicated incompetent in accordance with the law, b) is found to be medically incapable of understanding the proposed treatment or procedure, c) is unable to communicate his or her wishes regarding treatment, or d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. **Access to Care.** You will be provided with impartial access to treatment and services within this practice's capacity and availability and in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, disability or handicap, or source of payment for care or services.

2. **Respect and Dignity.** You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

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

    - Be interviewed and examined in surroundings that ensure reasonable privacy
    - Have a person of your own sex present during a physical examination or treatment
    - Not remain disrobed any longer than is required for accomplishing treatment or services
    - Request transfer to another treatment room if a visitor is unreasonably disturbing
    - Expect that any discussion or consultation regarding care will be conducted discreetly
    - Expect all written communications pertaining to care to be treated as confidential
    - Expect medical records to be read only by individuals directly involved in care, quality-assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

4. **Personal Safety.** You have the right to expect reasonable safety regarding the practice's procedures and environment.

5. **Identity.** You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.

6. **Information.** You have the right to obtain complete and current information concerning your diagnosis (to the degree known), your treatment, and any known prognosis. This information should be communicated in terms that you understand.

7. **Communication.** If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

8. **Consent.** You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.
    - Consent discussions will include an explanation of the condition, the risks and benefits of treatment, as well as the consequences of no treatment.
    - Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.
    - You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. **Consultation.** You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

10. **Charges.** Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

11. **Rules and Regulations**. You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

1. **Keep Us Accurately Informed.** You have the responsibility to provide, 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, including unexpected changes in your condition.

2. **Follow Your Treatment Plan.** You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care, implement the physician's orders, and enforce the applicable practice rules and regulations.

3. **Keep Your Appointments.** You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.

4. **Take Responsibility for Noncompliance.** You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

5. **Be Responsible for Your Financial Obligations.** You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information.

6. **Be Considerate of Others.** You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.

7. **Be Responsible for Lifestyle Choices.** Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____ Date of Birth: _____

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU Age at Diagnosis	SIBLINGS/ CHILDREN Age at Diagnosis	MOTHER'S SIDE Age at Diagnosis	FATHER'S SIDE Age at Diagnosis
For example: Colorectal cancer	none —	Brother 36 yrs	Aunt 44 yrs Cousin 58 yrs	Grandfather 65 yrs
BREAST AND OVARIAN CANCER				
Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No				
COLON AND UTERINE CANCER				
Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more cumulative colon polyps				
MELANOMA				
Melanoma				
Pancreatic cancer				
OTHER CANCER				
_____				

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

FOR OFFICE USE ONLY	
☐ Patient appropriate for further risk assessment and/or genetic testing ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer Syndrome ☐ COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) ☐ COLARIS *AP*® – A test for Adenomatous Polyposis Syndromes ☐ MELARIS® – A test for Hereditary Melanoma	☐ Discussed hereditary cancer risk with patient ☐ Patient offered genetic testing ☐ ACCEPTED ☐ DECLINED ☐ Follow up appointment scheduled Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way • Salt Lake City, UT 84108-1214 • 1-800-469-7423 • www.myriadtests.com

Premier Women's Health

Carolyn Kollar, DO FACOOG
1758 Broad Park Circle South
Mansfield, TX 76063
(972) 780-7330
Fax: (972) 780-7385

Authorization for Release of Information

Patient Name: _____
Previous Name: _____
Date of Birth: _____ Social Security #: _____

I understand and authorize my medical information to be released to Premier Women's Health from:

_____

_____

This information is to be released to:

Premier Women's Health
Dr. Carolyn Kollar
1758 Broad Park Circle South
Mansfield, TX 76063
Fax (972) 780-7385

I understand that the information is to be released for the following purposes:

_____ Treatment _____ Referral _____ Co-management

_____ Continuity of care _____ Record Review _____ Patient Request

_____ Other, please specify: _____

Information to be requested from following time period:

From: _____ (month/year) To: _____ (month/year)

I hereby authorize Premier Women's Health to use/disclose my protected health information in accordance with the current Health Insurance Portability and Accountability Act (HIPAA) guidelines. I understand that I may be responsible for any processing fee that may be required for the requested information. Identification will be required for patient privacy and confidentiality.
I understand that my medical information may include sensitive health information. I understand that I a may revoke this authorization in writing at any time. I understand that the authorization expires 180 days from the date of my signature. A photocopy of this authorization is considered as valid as the original. I understand that if the recipient authorized to receive the health information is not a health plan or health care provider the released information may no longer be protected by federal and state privacy regulations.

_____

Signature of Patient or Legal Representative Date/Time

_____

If Representative, specify relationship to patient Date/Time

If more than 10 pages please mail the records to our office