Gainesville Obstetrics and Gynecology

1902 Hospital Blvd., Ste. B
P.O. Box 1538
Gainesville, TX 76240
(940)665-6679 Fax (940)665-8958

Dr. Amy L. Klein, D.O. Regina Chisum, WHNP, BC Dr. Zaira Jorai-Khan, D.O.

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Communication Authorization and Release of Information To Friends or Family Members

Name of Patient _____ Date of Birth _____

DO WE HAVE PERMISSION TO:

1. Leave a message on your home answering messaging? (Laboratory, Radiology or other such diagnostic results)
   YES _____ NO _____

2. Contact you at work regarding appointments, lab results, or other health care issues?
   YES _____ NO _____

3. Discuss your health care issues with any family members?
   YES _____ NO _____

4. Do you wish to withhold medical records from insurance companies if the services were cash pay?
   YES_____ NO_____

If yes please list person(s) authorized:

Name: _____Relationship:_____

Name: _____Relationship:_____

Signature of Patient or Representative_____

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Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

This facility and its medical staff members are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and healthcare operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Uses and Disclosures

How we may use and disclose Medical Information about you.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. Different departments of the hospital also may share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine medical information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine medical information we have with that of other hospitals to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

We may also use and disclose medical information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.

Affiliated Covered Entity: Protected health information will be made available to hospital personnel at local HCA affiliated hospitals as necessary to carry out treatment, payment and healthcare operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors

- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply legal requirements. If the State privacy laws are more stringent than Federal privacy laws, the State law preempts the Federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:
Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. You may receive copies of your records if your request is approved and after payment of applicable State approved charges for copies of records has been received.

- Amend: If you feel that 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 or for the hospital.
  We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of the disclosures we make of medical information about you for purposes other than treatment, payment or healthcare operations.
- 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 healthcare operations. You also have the right to request a limit 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. For example, you could ask that we not use or disclose information about a surgery you had.
  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- 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 may ask that we contact you at work or by U.S. Mail. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- 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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the hospital and include the effective date. In addition, each time you register at or are admitted to the hospital for treatment or healthcare services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the clinic by contacting the main number and asking for the office manager or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you

Patient Medical History

Menstrual History (Complete even if post-menopausal or no longer having periods)

Date of Last Menstrual Period_____
Age of first period _____ Periods are ☐ Regular Flow is ☐ Light
Age of last period_____ ☐ Irregular ☐ Moderate
Cycle length every _____ days ☐ Painful ☐ Heavy
Lasting _____ days

Pregnancy History (Including abortions, miscarriages, & ectopic (tubal) pregnancies)

Date of Delivery	Sex	Type of Delivery	Baby's Weight	Length of Pregnancy	Length of Labor	Problems with pregnancy or delivery

Are you sexually active? ☐ Yes ☐ No ☐ Never **Age of first intercourse?**_____

What Birth Control Method do you currently use? _____

Date of Last Pap Smear_____

Have you ever had an abnormal Pap ☐ Yes ☐ No

If so, when was your abnormal Pap? _____

Have you ever needed any of the following treatment for an abnormal pap?
☐ Colposcopy ☐ LEEP ☐ Cone biopsy ☐ Laser

Have you ever had any of the following STDs?

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Pelvic Inflammatory Disease ☐ Venereal Warts ☐ Syphilis

☐ HPV ☐ Other_____ ☐ None

Date of Last Mammogram_____ ☐ Normal ☐ Abnormal ☐ Never had one

Date of Last Bone Density_____ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had one

Date of Last Colonoscopy_____ ☐ Normal ☐ Abnormal ☐ Never had one

Known Drug Allergies ☐ Yes ☐ No If yes, please list_____
_____

Latex Allergy? ☐ Yes ☐ No

Is Blood Transfusion acceptable ☐ Yes ☐ No

Have you ever had any of the following?

☐ Arthritis	☐ Kidney Disease	☐ Asthma	☐ Emphysema
☐ Diabetes	☐ Gallstones	☐ Liver Disease	☐ High Blood Pressure
☐ Heart Disease	☐ Epilepsy (seizures)	☐ Thyroid Disease	☐ HIV
☐ Blood Transfusion	☐ Anemia	☐ High Cholesterol	☐ Stroke
☐ Cancer	☐ Depression/Anxiety	☐ Bladder Infections	☐ Drug/Alcohol Problem

If you have had cancer, what type? _____ **Where?** _____

Please list ALL Medications you are currently taking (including vitamins and over the counter meds)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Other Symptoms

Have you had recent?

☐ Weight loss	☐ Weight gain	☐ Urinary Incontinence
☐ Hair Loss	☐ Vaginal discharge	☐ Painful Intercourse
☐ Bladder infection	☐ Pelvic pain	☐ Breast lumps
☐ Varicose veins	☐ Change in bowels	☐ Other_____

Past Surgical History

Please list ALL surgeries with dates

_____ _____

_____ _____

_____ _____

Social History

Do you Currently?

Smoke ☐ Yes ☐ No If yes, _____packs a day **Illicit drug use** ☐ Yes ☐ No If yes type_____

Alcohol use ☐ Yes ☐ No If yes, _____drink(s) per day/week/month

Caffeine use ☐ Yes ☐ No If yes, _____drink(s) per day

Do you exercise? ☐ Yes ☐ No If yes, type and frequency_____

Family History

Please list any relatives with a history of the following

☐ Diabetes _____ ☐ Heart Disease_____

☐ Breast Cancer_____ ☐ Ovarian Cancer_____

☐ Colon Cancer_____ ☐ High Blood Pressure_____

☐ High Cholesterol_____ ☐ Thyroid Disease_____

☐ Other_____

********NOTE: Fill out the following section ONLY IF YOU CURRENTLY ARE PREGNANT*********

Prenatal Genetic Screening

Have you, baby's father, or anyone in your families ever had any of the following:

Down Syndrome ☐ Yes ☐ No

Cystic Fibrosis ☐ Yes ☐ No

Congenital Heart Defect ☐ Yes ☐ No

Sickle Cell Disease ☐ Yes ☐ No

Bleeding Disorder ☐ Yes ☐ No

Neurofibromatosis ☐ Yes ☐ No

Polycystic kidney disease ☐ Yes ☐ No

Neural Tube Defect ☐ Yes ☐ No

Mental Retardation ☐ Yes ☐ No

Cleft Lip/Palate ☐ Yes ☐ No

Thalassemia ☐ Yes ☐ No

Muscular Dystrophy ☐ Yes ☐ No

Tay Sachs-Canavan Disease ☐ Yes ☐ No

Bone or skeletal disorder ☐ Yes ☐ No

Any other genetic condition, chromosomal abnormality, or birth defect not listed above_____

Have you, or baby's father had a baby who died shortly after birth, or within the first year, or had a stillborn or two or more spontaneous pregnancy losses? ☐ Yes ☐ No

Have you had an ultrasound in this pregnancy ☐ Yes ☐ No If so where?_____

Have you or the baby's father ever been treated for infertility? ☐ Yes ☐ No

Patient Signature _____ **Date** _____

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Patient Registration

Full Name_____ Today's Date_____

Date of Birth_____ SSN#_____

Mailing Address_____ City_____

Marital Status: Single Married Other_____

State_____ Zip Code_____ Email address_____

Home phone_____ Cell phone_____ Work phone_____

Employer_____ Occupation_____

Spouse/Partner Full Name_____

Date of Birth_____ SSN#_____

Mailing Address_____ City_____

State_____ Zip Code_____ Phone number_____

Employer_____ Occupation_____

Emergency Contact (Other than partner/spouse)

Full Name_____ Relationship_____

Phone Number_____

Primary Care Physician

Name_____ Phone number_____

Address_____ City_____

State_____ Zip Code_____

Pharmacy

Name_____ Phone number_____

How did you hear about our office_____

Patient Signature _____ **Date** _____

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FINANCIAL POLICY/PATIENT RESPONSIBILITIES

Thank you for choosing Gainesville OB/Gyn as your healthcare provider. This office is committed to your health and treatment. We ask that you please read the following FINANCIAL POLICY/PATIENT RESPONSIBILITIES and sign this form prior to any treatment.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME THE SERVICE IS RENDERED. IF OTHER ARRANGEMENTS NEED TO BE MADE, PLEASE SPEAK WITH THE RECEPTIONIST PRIOR TO YOUR VISIT.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER.

We do accept assignment on most major insurance companies. We must have your current insurance information to do any billing. In the event your insurance does not pay, we reserve the right to transfer balances to your responsibility. We will be happy to assist you by providing an explanation of benefits from your primary insurance after your balance with us is satisfied.

All copays and deductibles are due at the time of treatment unless prior billing arrangements have been made. If your insurance requires a referral, we request you bring that with you at the time of your visit.

I understand that I am financially responsible for all charges.

MISSED APPOINTMENTS

If you are unable to keep your scheduled appointment we ask that you please give us 24 hour notice in canceling your appointments. You will be charges a $30.00 no show fee for all appointments that are not canceled or rescheduled before your allotted appointment time. Also due to the high volume of patients we see if you are 15 minutes late for your appointment time we may have reschedule your appointment. If you miss more than 3 appointments without calling to cancel or reschedule we may be forced to discharge you from our care. We understand that emergencies arise, so please speak with us when that happens so that your account can be handled properly.

FORMS COMPLETION

There will be a $10.00 charge for items which the physician are required to complete including but not limited to the following items:

A. Letter of Medical Necessity
B. Family Medical Leave Act Forms (FMLA)
C. Short Term Disability Forms

CONSENT TO TREAT A MINOR

Minor patients must accompanied by a parent or legal guardian who is responsible for the minor.

Thank you for understanding our Financial Policy/Patient Responsibilities. Please let us know if you have any questions or concerns.

I have read the FINANCIAL POLICY/PATIENT RESPONSIBILITIES. I understand and agree to this policy.

Patient Signature/Legal Guardian:_____ **Date:**_____