OBSTETRICS AND GYNECOLOGY ASSOCIATES OF DALLAS
OBSTETRICS, INFERTILITY AND GYNECOLOGY
3801 Gaston Avenue, Suite 200
Dallas, TX 75246

5575 Warren Parkway, Suite 204
Frisco, TX 75034

214.823.9630 214.821.3556 (fax)
www.obgadallas.com

Welcome!

We are so glad you have chosen our practice to manage your health care needs. We consider our patients' needs to be our highest priority and will do all we can to make your experience with us as pleasant as possible.

Enclosed is the new patient paperwork we need completed before our doctors can see you. Please arrive 15 minutes prior to your appointment time with these completed forms so we can get your information in our system prior to your appointment time.

A few office policies you should know:

- No food or drink is allowed in the office out of respect for those patients who are sensitive to smells or who are on restricted diets.
- It is the ***patient's responsibility*** to ensure our Practice has all of your insurance information. Should your claim be denied because we filed with the wrong insurance company, you will be responsible for payment.
- Services that are NOT covered by your insurance plan which you may be expected to pay include:
    - Parking at our Dallas location is available on the street, in the building, and at 3911 Gaston Avenue (next to Schlotzky's). Parking on the street and in the building costs a nominal amount. The 3911 parking lot is a free surface lot.
    - Parking at the Frisco office is a free surface lot in front of Professional Building One.
    - Appointments canceled within 24 hours of the appointment time and failure to cancel an appointment (no show) may have a fee of $25 per visit.
    - Paperwork as requested by patients (including, but not limited to, medical records, FMLA forms, attending physician statements) may have fees up to $25 per request.

If you have any questions prior to your visit, please contact our office and we will be happy to assist you.

Regards,

Linda B. Rosen
Business Manager

OBSTETRICS AND GYNECOLOGY ASSOCIATES OF DALLAS

Glen W. Heckman Steven A. Harris Dale R. Ehmer Ashwin G. Gaitonde Linden R. Collins

(please print)

Name_____ ***Date of Birth***___/___/_____
First Middle Last

Address_____
Street City State Zip

Phone_____(home) _____(cell) _____(work)

Email_____ Social Security Number_____-____-_____

Occupation_____Employer_____

Marital Status (circle one): married single divorced separated widowed partner

Ethnicity (circle one): Central American Cuban Dominican Hispanic or Latino/Spanish Spaniard

Latin American/Latin, Latino Mexican Not Hispanic or Latino Puerto Rican South American

Race (circle one): African American American Indian or Alaska Native Asian Asian Indian

Black Mexican American Indian White Other

Preferred Language (circle one): English Spanish Other_____

Preferred Pharmacy Name_____

Address_____ Phone _____

****

Spouse or Parent Name_____ Date of Birth ____/___/_____

Social Security Number_____ Phone_____(cell) _____(work)

****

Primary Insurance Company Name_____ Phone Number_____

Name of Insured_____ Date of Birth of Insured____/____/_____

Do you have a secondary insurance plan? ____ YES ____ NO Name _____

****

Referred by: _____ (doctor/friend/other)

I authorize Obstetrics and Gynecology Associates of Dallas to obtain my medication history through the Pharmacy Benefits Managers (PBM): _____ YES _____ NO _____
initials

May we leave messages about appointments and normal lab results on your:

Home phone? ____ YES ____ NO Cell phone? _____ YES _____NO

May we text you on your cellphone for appointment reminders? ___YES ____NO

I consent to the medical and/or surgical care as deemed necessary or advisable in the judgment of my physician or other provider. This may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, or other services rendered.

I authorize Obstetrics and Gynecology Associates of Dallas to furnish information to insurance carriers concerning my illness and treatments and hereby assign to physicians(s) all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

Signed _____ Date_____

(Revised Jan 15, 2018)

Name _____ Age _____ Date _____

Occupation _____ Date of last PAP Smear _____

Referred by _____ Date of last Mammogram _____

Reason you came for evaluation _____

_____

_____

_____

Menstrual History

Age of onset of periods _____

Regular periods ☐ No ☐ Yes

Usual duration of period _____ days

Cycle length _____ days (from start to start)

Flow ☐ light ☐ moderate ☐ heavy # of pads per day _____

Pains or cramps ☐ No ☐ Yes ☐ Mod ☐ Severe

Dates of last period _____

Pregnancies: # Deliveries _____ # Miscarriages _____

Year	Sex	Weight	Vag. Del./C-Sect.	Hrs. Labor	Comps.

Operations

	Year

Other Hospitalizations

	Year

Drug Allergies _____ Present Medications _____

Hormone/Contraceptive use _____

Have you ever had:

	No	Yes
Breast discharge	☐	☐
Breast lumps	☐	☐
Endometriosis	☐	☐
Painful intercourse	☐	☐
Pelvic infection	☐	☐

	No	Yes
Herpes	☐	☐
Other sexually trans. dis.	☐	☐
Genital warts	☐	☐
Infertility	☐	☐
Abnormal PAP smear	☐	☐
Aids	☐	☐

	No	Yes
Loss of urine with cough	☐	☐
Urine urgency	☐	☐
Hot flashes	☐	☐
Vaginal infections	☐	☐
Vaginal dryness	☐	☐
Other _____		

Have you ever had:

	No	Yes
Anemia	☐	☐
High blood pressure	☐	☐
Diabetes	☐	☐
Heart disease	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
Tuberculosis	☐	☐

	No	Yes
Migraine headache	☐	☐
Hepatitis	☐	☐
Thyroid disease	☐	☐
Seizures	☐	☐
Kidney disease	☐	☐
Urinary infections	☐	☐
Transfusions	☐	☐

	No	Yes
Chest pain	☐	☐
Asthma or lung disease	☐	☐
Stomach trouble/ulcer	☐	☐
Gall bladder disease	☐	☐
Cancer	☐	☐
Hemorrhoids	☐	☐
Other _____		

Social History:

Type of work _____ Cigarettes _____ pack per day How long? _____

Caffeine use ☐ No ☐ Yes Alcohol use _____ Other drug use _____

Family History:

Has any relative had:

	No	Yes	Unsure
Diabetes	☐	☐	☐
Heart disease	☐	☐	☐
Heart attack	☐	☐	☐
Stroke	☐	☐	☐
High blood pressure	☐	☐	☐

	No	Yes	Unsure
Breast cancer	☐	☐	☐
Colon cancer	☐	☐	☐
Mother use DES	☐	☐	☐
Twins	☐	☐	☐
Early menopause	☐	☐	☐
Other cancer	☐	☐	☐

	No	Yes	Unsure
Congenital defects	☐	☐	☐
High cholesterol	☐	☐	☐
High lipids	☐	☐	☐

Type _____

Any other problem _____

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RIGHT TO ACCESS PERSONAL HEALTH INFORMATION (PHI) IN CASE OF EMERGENCY NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

NAME _____
FIRST MIDDLE LAST

ADDRESS _____
STREET CITY STATE ZIP

Date of Birth _____ Best Phone Number to Call _____

I, _____, hereby confirm I have received a copy of the Notice of Privacy Practices and authorize Obstetrics and Gynecology Associates of Dallas to provide the following people access to my PHI or in Case of Emergency:

Name: _____

Relationship: _____

Phone Number: _____

Check all that apply:

_____ Demographics

_____ Medical Record Information

_____ Financial Information

_____ In Case of Emergency

_____ Other: _____

Name: _____

Relationship: _____

Phone Number: _____

Check all that apply:

_____ Demographics

_____ Medical Record Information

_____ Financial Information

_____ In Case of Emergency

_____ Other: _____

This authorization will stay in effect until it is revoked/replaced in writing.

_____ _____
SIGNATURE DATE

(Revised 12/2017)

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Policy on Managed Care Insurers

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered, and even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care to our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service exactly what those guidelines are. It is important that you know and understand *your* contract agreement with your insurance carrier (including what services are not covered).

Unfortunately, if you do not inform us of any special requirements in your contract, and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature of Patient Date

_____ _____

Patient Name Patient Date of Birth

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PATIENT INSURANCE INFORMATION

I understand Dr. _____ is accepting me as a patient in his
(physician name)

practice for 2019.

_____ (initial) 1. I have _____ as my primary insurance
(insurance plan name)

and _____ as my secondary insurance.
(insurance plan name or N/A)

_____ (initial) 2. I am not listed as a subscriber or dependent on any other insurance plan.

_____ (initial) 3. I will notify the practice ***in writing*** within 30 days should my insurance change. I understand I may be required to complete this form again with the new insurance information.

_____ (initial) 4. Due to timely filing requirements imposed by insurance companies, the practice ***will not*** file a claim to Medicaid or any other insurance carrier for services provided to me outside of the above insurance carrier(s).

_____ Patient Name (print)

_____ Patient Date of Birth

_____ Patient Signature

_____ Date Signed

Revised 12/2018

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Ultrasound Informed Consent

My doctor has recommended an ultrasound. I understand that this ultrasound is to be performed to check fetal growth, fetal number, dating of my pregnancy, as well as other information that will be helpful in following my pregnancy. I understand that a routine ultrasound is not performed to detect congenital defects, although occasionally certain large defects may be identified. I also understand that ultrasounds are only 75% accurate in determining the sex of my baby and are not specifically performed for this purpose.

By signing this form, I acknowledge that I have been given all the information I desire concerning this procedure and have had all my questions answered. This form applies to all sonograms I have performed at this practice.

_____ _____
Patient Name (print) Patient Date of Birth

_____ _____
Patient Signature Date Signed

_____ _____
Witness (optional) Date Signed

CC: patient chart

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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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnoses, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice (such as for marketing purposes) or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we 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 you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Medical Records Department in our office. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to the Assistant Office Manager. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. You have the right to opt out of communications for fundraising purposes.

- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. Consent is required prior to use or disclosure of an individual's psychotherapy notes or the use of the individuals PHI for marketing purposes.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give you a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We will take no retaliatory action against you if you make complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Manager of Compliance Services, either by phone or in writing at:

Nadine Ludovico
Compliance Services Manager
Unified Physician Management
1501 Yamato Road, Suite 200 West
Boca Raton, FL 33431
P: (561) 300-2410, ext. 391
F: (561) 953-4152
E: Nadine.Ludovico@unifiedhc.com

V. Effective Date: This Notice was effective on **August 27, 2013**.