OB-GYN, P.C.
PATIENT HISTORY FORM Date _____ Dr._____/_____

Name _____ Date of Birth_____

Please choose whichever option best applies for race: ❑ Asian ❑ American Indian or Alaska Native ❑ African American ❑ Hawaiian Native
❑ Other Pacific Islander ❑ Caucasian ❑ More than one Race ❑ Unreported/Refuse to Report

Please check the box for whichever option best applies for Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported/Refuse to Report

What is your main reason for today's visit?_____

What is your main symptom? _____

Gynecologic History

❑ Frequent Bladder Infections ❑ Gonorrhea ❑ Chlamydia ❑ Condyloma/HPV/Warts ❑ Genital Herpes ❑ Syphilis ❑ HIV/AIDS ❑ DES exposure ☐
❑ HPV vaccine ❑ Trichomonas ❑ Abnormal Pap smear When: _____ Treatment: _____

Gynecologic Surgeries (Please indicate year)

❑ Hysterectomy _____ ❑ Ovaries Removed _____ ❑ Cesarean Section _____ ❑ Anterior/Posterior Repair _____ ❑ Dilation and Curettage (D&C) _____
❑ Tubal Ligation/Essure _____ ❑ Cryosurgery _____ ❑ LEEP _____ ❑ Cervical Conization _____

Pregnancy History

No.	Date (Mo./Yr.)	Weeks Gest.	Labor (Hrs.)	Spont.	Ind.	Type of Delivery	Alive/ Dead	Baby's Weight	Months Nursed	Sex	Complications (mom and baby)
1											
2											
3											
4											
5											
6											

General Health History

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Back Trouble
❑ Blood Clot
❑ Cancer
Type: _____
❑ Diabetes
❑ Drug/Alcohol Abuse
❑ Glaucoma
❑ Heart Trouble
❑ High Blood Pressure
❑ Hepatitis
❑ Liver issues
❑ Kidney Disease
❑ Migraines With aura?
❑ Yes ❑ No
❑ Osteoporosis
❑ Osteopenia
❑ Rheumatic fever
❑ Thyroid Issues
❑ Blood Transfusion
❑ Tuberculosis
❑ Pneumonia
❑ Ulcer
❑ Vein Trouble
❑ Depression
❑ Anxiety
❑ Seizures
❑ Sepsis
❑ Stroke
❑ Major Trauma

General Surgery—Type and Date: _____

(Please see reverse)

Family History

	Age (if deceased: age at death and circle)	Good Health	Fair Health	Poor Health	Alcoholism	Blood Clotting Issues	Cancer	Colon Polyps	Diabetes	Heart Disease	High Blood Pressure	Kidney Disease	Mental Illness	Osteoporosis	Stroke	Thyroid Disease	Other	Comments
Father																		
Mother																		
Siblings																		

– please indicate Brother (B) or Sister (S)

Patient Signature _____ **Date** _____

OB-GYN, P.C. Signature _____ **Date** _____

OB-GYN, P.C.
ANNUAL UPDATE FORM

Name _____ Date of Birth _____ Date _____

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed or helpless	❑	❑	❑	❑

Current Medications (please list name of medication and dosage): _____

_____

I authorize OB-GYN, P.C. to obtain my prescription history (Initial): _____

Allergies/Sensitivities to Medications, food, latex (please list): _____

Gynecological Update

First day of last menstrual period	How often do you have a period?	How long do periods last?	Periods are	Are periods painful?
_____	_____	_____	❑ Light	❑ Yes ❑ No
_____	_____	_____	❑ Average	Medication used:
			❑ Heavy	_____

Do you think of yourself as: ❑ Straight or heterosexual ❑ Gay, lesbian or homosexual ❑ Bisexual ❑ Something Else ❑ I don't know ❑ Prefer not to answer

Number of Sexual Partners in the past 12 months: _____ male(s) _____ female(s)

Sexual Practices: ❑ Vaginal ❑ Anal ❑ Oral ❑ None ❑ Prefer not to answer

Method of Contraception: _____

Condom use: ❑ Always ❑ Usually ❑ Sometimes ❑ Never

Have you had any surgeries or pregnancies since you were here last? ❑ Yes ❑ No

Have you had any new medical diagnosis/conditions since you were last here? ❑ Yes ❑ No

Social History

Relationship status: ❑ Single ❑ Engaged ❑ Married ❑ Divorced ❑ Widow ☐Length of current relationship _____

Do you feel safe in your relationships? ❑ Yes ❑ No

Are you in a relationship where you are being physically, sexually, or emotionally hurt or threatened? ❑ Yes ❑ No

Are you afraid to return to where you are living? ❑ Yes ❑ No

(Please see reverse)

Do you use Tobacco now?	❑ Yes ❑ No	Type:	Daily amount:	How long?
Have you used Tobacco in the past?	❑ Yes ❑ No	Type:	Daily amount:	How long?
Do you use alcoholic beverages?	❑ Yes ❑ No	Type:	Weekly Amount:	How long?
Do you use recreational drugs?	❑ Yes ❑ No	Type:	Weekly Amount:	How long?
Do you exercise?	❑ Yes ❑ No	Type:	How often?	How long?

What type of diet do you follow: ❑ Standard American ❑ Healthy ❑ Vegetarian ❑ Gluten free ❑ Other

Review of Systems:

Indicate if you have experienced any of the following symptoms in the past 2 weeks:

		No	Yes
Constitutional	Fever		
	Weight loss/weight gain		
	Night Sweats		
	Fatigue		
Head/Ears/Nose/Throat	Headaches		
	Decreased hearing		
	Hoarseness		
Breasts	Lumps		
	Tenderness		
	Nipple Discharge		
	Breast skin change		
	Swelling		
	Redness		
Heart	Chest pain		
	Irregular heart beats		
	Rapid heart rate		
	Fainting		
Lungs	Shortness of breath		
	Cough		
Gastrointestinal	Abdominal pain		
	Nausea		
	Vomiting		
	Diarrhea		
	Constipation		
	Heartburn		
	Blood in stools		

		No	Yes
Kidney, Bladder	Painful urination		
	Urgency		
	Frequency		
	Incontinence		
	Blood in urine		
Genitals	Pelvic pain		
	Vaginal discharge		
	Painful periods		
	Painful intercourse		
Skin	Rash		
	New skin lesions		
Neurologic	Muscular weakness		
	Tingling		
	Numbness		
Musculoskeletal	Muscle pain		
	Joint pain		
	Back pain		
Endocrine	Hot flashes		
	Loss of hair		
	Abnormal body hair		
Psychiatric	Anxiety		
	Depression		
	Memory loss		
	Mood changes		
Heme-Lymph	Easy bleeding		
	Easy bruising		

Patient Signature _____ **Date** _____

OB-GYN, P. C. Signature _____ **Date** _____

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with OB-GYN, P.C. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

OB-GYN, P.C. is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on OB-GYN, P.C.'s web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or OB-GYN, P.C. has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by OB-GYN, P.C., how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of OB-GYN, P.C. except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the OB-GYN, P.C. discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

How We May Use or Disclose Protected Health Information
Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of OB-GYN, P.C. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - OB-GYN, P.C. may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

OB-GYN, P.C.
2854 S. 11th Street
Kalamazoo, MI 49009-2129

Effective Date 4/1/2019 Publication Date 4/1/19

OB-GYN, P.C.
Financial Policy/Consent to Treat

We pledge to earn your trust in taking the best possible care of you, if you have special needs, we are here to work with you. The following information is provided to avoid hard feelings or misunderstandings, concerning payment for professional services. Please let us know if you have any questions.

Our office participates with many insurance plans including Medicare. If you are insured under one of these plans, we will submit your bill directly to your insurance carrier.

If you have insurance that we do not participate with, payment in full is expected at the time of service, unless prior financial arrangements have been made. Payment for services can be made with cash, check or credit card.

Pre-Authorizations: It is your responsibility to obtain any required pre-authorizations for treatment prior to your visit at OB-GYN, P.C. If you do not provide the authorization at the time of your appointment, your visit may be rescheduled, or you will be held financially responsible.

IT IS YOUR RESPONSIBILITY TO: **(PLEASE INITIAL WHERE INDICATED BELOW)**

- Provide us with any copy of your insurance coverage, address and phone number.
- Know what your insurance policy coverage is for your visit.
- Pay your co-pay, deductible and any non-covered services at each visit. Pay any balance not covered by your insurance plan. Unpaid balances will go to collections after 60 days.
- If you have more than one insurance carrier it is your responsibility to know which one is the Primary and Secondary coverage and communicate that to us. If incorrect information is given and claims are denied you will be held responsible for the entire balance. We will not refile to your insurance.
- **_____Provide us with current insurance information-failure to provide this information will result in you being held responsible for the entire balance.**
- **_____Provide us with a copy of your insurance card, we may scan your card at each visit. If a current card is not given, a $25 charge will be applied to your account to reprocess your visit/services. Your insurance company will not pay for this fee.**

If the patient is a minor (17 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, as well as bringing the necessary insurance cards.

Some services may not be a covered benefit under your insurance plan or under Medicare guidelines. It is your responsibility to pay any balance not covered by your insurance plan.

If you have any questions about your insurance, we are happy to help you. Specific coverage information, however, should be directed to your insurance company's Members/Customer Service Department. (Phone number should be on the insurance card)

We want your visit with our office to be a positive one. Our practice believes a good provider/patient relationship is based on understanding and good communication. Questions regarding our financial policies can be directed to our Patient Account Representatives.

PLEASE SIGN THAT YOU HAVE READ AND AGREE TO THIS FINANCIAL POLICY.

Consent to Treat: I hereby authorize treatment and authorize my insurance benefits to be paid directly to OB-GYN, P.C. for service rendered by OB-GYN, P.C. provider and to release pertinent medical information to the insurance carrier.

_____ _____

Signature of Responsible Party Date

This agreement expires one year from the date of your signature.

Chart #_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a Notice of Privacy Practices from OB-GYN, P.C.

Patient Signature_____

Date_____