Plano Women's Healthcare, P.A.

1600 Coit Road, Suite 202
Plano, Tx 75075

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Medical Records Department

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you via bulletins and internal promotions.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence);

however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military**. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Medical Record Department in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Medical Records Department.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Medical Records Department. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Medical Records Department

PLANO WOMENS HEALTHCARE, P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

_____ _____
Patient Name Printed Date Of Birth

_____
Patient Social Security Number

I,_____, have received a copy of the Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (if patient under 18) Date

New Patient History

Patient Name_____ Date:_____

Reason for Visit: Annual Exam Problem Visit (circle one)
If Problem Visit, Please explain:_____

Social History:
Current Tobacco Use: □Yes □No Packs/day:_____ Year started:_____
Former Tobacco use Yes No Packs/day_____ Year Started:_____Year Stopped:_____
Alcohol: □Yes □No Drinks per week:_____
Exercise: □Yes □No Times/week: _____ Type of exercise:_____
Marital Status: □Single Married Divorced Widowed

Medical History:
Primary Care Physician_____

Other treating Physicians _____ For:_____
_____ For:_____
_____ For:_____

Medical Illnesses: (Check all that apply)

( ) High Blood Pressure
( ) Heart Disease
( ) Heart Attack
( ) Psychiatric Disorder
( ) Thyroid Disease
( ) High Cholesterol
( ) Stroke
( ) Depression / Anxiety
( ) Diabetes
( ) Arthritis

List any other medical issues:_____
_____

Menstrual History:
Date your last menstrual period started:_____
Menopausal: Yes or No (circle one) If Yes, age of onset:_____
Have you had a Hysterectomy: Yes or No (circle one) If Yes, please give date?_____Reason?_____
How often does your menstrual cycle start? Every _____ Days or Weeks (circle one)
How many days do you normally bleed?_____
Pad/Tampon changes per day of cycle: □4/day 6/day □8/day □other_____
Do you experience cramps? □Yes □No □Mild □Moderate □Severe
Do you take anything for cramps? □Yes □No What do you take?_____

Date of last pap smear:_____
Do you have a history of abnormal pap smears? □Yes □No Date:_____
Treatment_____
Do you have a history of Herpes ν Gonorrhea ξ Chlamydia ξ Genital Warts ξ other STD's ξ
Date of onset_____

Contraception: Are you trying to conceive? Yes No
Are you currently using a method of contraception? □ Yes □No
Please **circle** all that apply:

□Abstinence □Withdrawal □Condoms □Birth Control Pills □Patch Essure Rhythm
□Injectable □IUD □Vasectomy □Tubal Ligation Nuva Ring Nexplanon

Patient Name:_____

New Patient History

Other:

Do you perform self breast exams monthly? □Yes □No □occasionally
Have you had a mammogram? □Yes □No
Date of last mammogram_____
Have you had a tetanus or TDAP booster in the last 10 years? Yes No Do you want one today? □Yes □No
Have you ever had a bone density? □Yes □No
Date_____ Results_____
Have you ever had a colonoscopy or Cologuard?: (circle one)□Yes □No
Date of last test?_____Recommended Repeat Date: _____

Pregnancy History:

Total Pregnancies:_____ Full Term:_____ Premature:_____ Miscarriages:_____ Abortions_____

Date	Type of Delivery	Name of Child	Boy/Girl	Weight	Wks Gestation	Complications

Surgical History*:*

Please List any surgical procedures that you have had in the past:

Date	Operation	Physician	Complications

Please list any other hospitalizations or injuries and the date of each:
Surgery/Hospitalization:_____ Date:_____
Surgery/Hospitalization:_____ Date:_____

Medications:

Please list all current medications & dosages (Prescription, Non-Prescription, Vitamins or Supplements including calcium or herbal supplements) If you need additional space, please use the back of this form and check here ☐
Medication:_____Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____

Allergies:

Please list all allergies to medications, food or latex along with your reaction, or circle NONE KNOWN
Allergic to: _____ Reaction:_____
Allergic to: _____ Reaction:_____
Allergic to:_____ Reaction:_____
Allergic to:_____ Reaction:_____

Patient Name:_____

New Patient History

FAMILY MEDICAL HISTORY Other than Hereditary Cancer Syndromes, please list any family medical history that you are aware of:

Illness	Relative	Maternal Or Paternal side of family	Age at Diagnosis	Comments	Are they still living? Yes or No

Family History Questionnaire for Common Hereditary Cancer Syndromes

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.

Have you ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If Yes, the results were:_____
Has any member of your family ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If yes, the results were:_____
If you answered yes to either questions above, please obtain copy of relatives test results.

Breast and Ovarian Cancer	You	Age at diagnosis	Siblings/ children	Age at diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Breast Cancer (male or female)								
Ovarian Cancer								
Breast cancer in both breasts OR Multiple primary breast cancers								
Male Breast Cancer								
Pancreatic Cancer								
Prostate Cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Colon and Uterine Cancer	You	Age at diagnosis	Siblings/ Children	Age at Diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Uterine (endometrial) Cancer								
Colorectal Cancer								
10 or more cumulative colon polyps								

Plano Women's Healthcare, P.A.

Drs. Heather Bellanger, Julie DaVolio, Marlene Diaz,
Arlene Jacobs, Amy Mos, Lisa Umholtz

PATIENT RECORD OF DISCLOSURE

The HIPAA Privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information (PHT). The individual is also granted the right to request confidential communications, or that a communication be made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: **(Number the selections below in order of your preference)**

____By my **home** telephone, My number is:_____

____It is ok to leave me a message with detailed information.

____It is NOT ok to leave me a message with detailed information.

____By my **cell phone**, my number is:_____

____It is ok to leave me a message with detailed information.

____It is NOT ok to leave me a message with detailed information.

____It is ok to contact me at **work** and my number is:_____

____It is ok to leave me a message at work with detailed information.

____It is NOT ok to leave me a message at work with detailed information.

____It is ok to leave a callback number ONLY at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

____My spouse, whose name is:_____Phone_____

____My parent, whose name is:_____Phone_____

____No one other than myself

____Fill in any other name you desire:_____Phone_____

Patient or Guardian Signature:_____Date:_____

Patient Name(please print):_____Date of Birth_____

Name of legal guardian/caretaker:_____

Plano Women's Healthcare, P.A.

Obstetrics, Gynecology & Infertility

1600 Coit Road, Suite 202
Plano, Texas 75075

Telephone:
(972) 596-2470

Thank you for choosing Plano Women's Healthcare for your obstetrical and gynecological needs.

The purpose of this form is to better acquaint you with the payment policies of this office. Please present your insurance card to the receptionist upon check-in. You must present your card every time you are seen in this office. Intentional misrepresentation of your insurance coverage is grounds for dismissal from this practice. You may also be held liable for any fines or penalties assessed to this office by or on behalf of the insurance company.

Our office participates in several PPO and HMO insurance plans. Non-PPO/HMO plan patients are responsible for all amounts deemed above the usual and customary or otherwise not paid for by their insurance carrier. If we are providers on your insurance plan, contractual adjustments will be taken. It is your responsibility to verify your insurance eligibility and deductible information prior to your appointment. You will be responsible for all co-pays, co-insurance, and deductibles along with any service that is not covered on your insurance plan. Your co-pays and any applicable deductible amounts may be collected at the close of your appointment. All non-insured patients must pay for each visit in full at the time of service. Our office accepts the following forms of payment: Cash, Check, MasterCard, Visa and Discover. All account balances not paid in full within 30 days will be sent to our collection agency.

Plano Women's Healthcare carefully reviews fees every year to ensure they are representative of the Plano area and for the quality of care which we provide to our patients. It is not the responsibility of this office to dispute these differences with your insurance carrier. Please do not hesitate to contact the insurance department if you have any questions.

Letters written and forms completed at your request may be subject to a fee depending on the context and time involved in producing such letter/form. You will be notified of the fee prior to processing.

Please be aware that there will be a $25.00 fee charged to your account for all No-Shows or appointments that you fail to cancel within 24 hours prior your appointment.

We realize that you have many choices for healthcare. We appreciate the opportunity to provide you with excellent care. Thank you for choosing Plano Women's Healthcare.

I have read and understand the payment policies of Plano Women's Healthcare, P.A.

_____

Print Patient Name Date of Birth

_____

Patient Signature Date of Appointment

Please sign below indicating that you have read and all of your questions have been answered.

With the new guidelines of the Affordable Care Act (ACA), preventative health care is now covered without being subject to deductible or co-insurance. However, please be aware that preventative health care does not include the management of common counseling/illnesses such as procreative counseling, depression, hormone replacement therapy, hypertension, menstrual irregularities, infections or follow-up of abnormal lab work, just to name a few. In accordance with national guidelines and our contract with your insurance company, these illnesses are coded, billed and paid separately. Management of an illness in conjunction with your preventative visit will be applied to your deductible, co-pay and co-insurance. You have the option of discussing everything with your physician at your visit today. If this is your choice, we will bill your insurance and collect your co-pay today. We will bill you for your co-insurance and deductible accordingly.

Signature: _____Date: _____

Patient's Name:_____

		Yes	No	Comments
Constitutional	Fever	☐	☐	
	Chills	☐	☐	
	Sweats	☐	☐	
	Weight loss	☐	☐	
	Weight Gain	☐	☐	
	Fatigue	☐	☐	
Respiratory	Painful breathing	☐	☐	
	Chronic cough	☐	☐	
	Productive cough	☐	☐	
	Dry cough	☐	☐	
	Shortness of breath	☐	☐	
	Wheezing	☐	☐	
Gastrointestinal	Abdominal Pain	☐	☐	
	Change in bowel habits	☐	☐	
	Dark or bloody stool	☐	☐	
	Frequent constipation or diarrhea	☐	☐	
	Indigestion	☐	☐	
	Change in appetite	☐	☐	
	Nausea/vomiting	☐	☐	
Genitourinary	Incomplete emptying	☐	☐	
	Painful urination	☐	☐	
	Frequent urination	☐	☐	
	Urinary urgency	☐	☐	
	Blood in urine	☐	☐	
	Urinary Incontinence	☐	☐	
	Getting up at night to urinate	☐	☐	
	Bleeding or pain with intercourse	☐	☐	
	Unusual discharge or odor	☐	☐	
	Vulvar or vaginal itching or burning	☐	☐	
	Pelvic Pain	☐	☐	
Allergy/Immuno	Sneezing	☐	☐	
	Itching eyes or nose	☐	☐	
	Hives	☐	☐	
Musculoskeletal	Back Pain	☐	☐	
	Weakness	☐	☐	
	Joint pain, stiffness	☐	☐	
	Swelling of legs	☐	☐	
Eyes	Spots before eyes	☐	☐	
	Double vision	☐	☐	
Ears, Nose, Throat	Ear aches	☐	☐	
	Nose bleeds	☐	☐	
	Sore throat	☐	☐	
	Dry mouth	☐	☐	
Cardiac	Dizziness	☐	☐	
	Shortness of breath at rest	☐	☐	
	Shortness of breath w/mild exertion	☐	☐	
	Chest pain	☐	☐	
	Loss of consciousness	☐	☐	
	Palpitation	☐	☐	
Neurologic	Numbness or tingling	☐	☐	
Skin	Nodules	☐	☐	
	Change in moles, freckles	☐	☐	
	Change in hair growth, loss, texture	☐	☐	
	Breast lumps	☐	☐	
	Breast nipple discharge	☐	☐	
	Breast pain	☐	☐	
Heme/Lymph	Swollen lymph glands	☐	☐	
	Easy bruisability	☐	☐	
Endocrine	Excessive thirst	☐	☐	
	Tremor	☐	☐	
	Cold or heat intolerance	☐	☐	
	Excessive urination	☐	☐	
Psych	Depression	☐	☐	
	Anxiety	☐	☐	
	Mood Swings	☐	☐	