Desert Sage
Obstetrics and Gynecology

☐ NEW PATIENT
☐ NEW OB
☐ NAME CHANGE
☐ ADDRESS CHANGE
☐ INS. CHANGE
☐ UPDATE

Most insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign the registration form on an annual basis. If you are mailing this form please return ALL copies. THANK YOU

PRESS FIRMLY – 2 PART FORM **PATIENT INFORMATION**

Patient's Legal Name _____ (Last / First / Middle) Birth Date _____ S.S. # _____

Address _____ (Street / City / Zip) Daytime Phone # (____) _____ (Area Code) Marital Status _____

Employer's Name _____ Occupation (Indicate if Student) _____ Business Phone # (____) _____ (Area Code)

Patient's Primary Doctor _____ (Name / Street / City/St / Zip) Drs. Phone # (____) _____ (Area Code)

Name, Address of Nearest Friend or Relative _____ Phone (____) _____ (Area Code) Relationship _____

PARENT / SPOUSE INFORMATION

Parent / Spouse Name _____ (Last / First / Middle) Birth Date _____ SS# _____

Address _____ (Street / City / Zip) Home Phone _____ Business Phone _____

Employer _____ Employer's Address _____

PRESS FIRMLY – 2 PART FORM **PRIMARY INSURANCE**

Ins. Company Name _____ Address _____ Phone # _____

ID#/Policy # _____ Group # _____ Effective Date _____

Policy Holder's Name _____ Relationship to PT. _____ Birthdate _____

Policy Holder's Address _____ Home Phone _____

SECONDARY INSURANCE

Other Insurance Co. _____ Address _____ Phone _____

Other Insured (If other than patient) _____ Address _____ Phone _____

Birth Date _____ Relationship to Patient _____ ID #/Policy # _____ Group # _____

Other Insured's Employer _____ Address _____ Phone # _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees.
I have read and understand the office policy and procedures.

* _____ _____
Responsible Party Signature Date

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Obstetrics and Gynecology

OB / GYN HISTORY FORM

Name	Date of Birth	Age	Date
Email _____ Pharmacy # _____			

Past Obstetrical History - To include miscarriages, ectopics and abortions.

Date (Mo. /Yr.)	1	2	3	4	5	6
Birth Weight						
Type of delivery (Vaginal/C-sect.)						
Complications						

Are you done having children? ☐ Yes ☐ No

Past Gynecologic History

Last Pap	Sexually Active ☐ Yes ☐ No
Last Mammogram	Your partner is ☐ Male ☐ Female ☐ Both
Last menstrual period	Contraception
Duration of flow	Partner has had Vasectomy? ☐ Yes ☐ No
Cramps? Mild / Mod / Severe / None	Age at Menopause
Time between periods	Bone Density ☐ Yes - when_____, ☐ No

Please check if you have or previously had the following	Comments
☐ Abnormal Vaginal Bleeding	
☐ Vaginal Bleeding After Intercourse	
☐ Vaginal Bleeding After Menopause	
☐ History of Abnormal Paps	☐ When ☐ Diagnosis ☐ Treatment
☐ History of Infertility	
☐ Uterine Fibroids	
☐ Endometriosis	
☐ Ovarian Cyst	
☐ Incontinence	
☐ Prolapse Bladder / Rectum / Uterus	
☐ Infections	☐ Yeast ☐ Bacterial Vaginosis ☐ PID
☐ Sexually Transmitted Disease	☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ HIV ☐ Trichamonas
☐ Cancer	☐ Breast ☐ Uterine ☐ Ovarian ☐ Vulvar ☐ Colon ☐ Other

Allergies - List Reaction	**Medications & Dosage -** Include Vitamins / Herbs

CONTINUE ON BACK SIDE

_____ Reviewed by (Signature of Provider)

_____ Date

Past Medical History

Patient's Name _____

Diabetes Comments	☐ Yes ☐ No	Kidney Disease Comments	☐ Yes ☐ No	Blood Clots Leg/Lung Comments	☐ Yes ☐ No
High Blood Pressure Comments	☐ Yes ☐ No	Urinary Tract Infections Comments	☐ Yes ☐ No	Neurologic/Epilepsy Comments	☐ Yes ☐ No
Heart Disease Comments	☐ Yes ☐ No	Thyroid Dysfunction Comments	☐ Yes ☐ No	Gastrointestinal Comments	☐ Yes ☐ No
Rheumatic Fever Comments	☐ Yes ☐ No	Tuberculosis Comments	☐ Yes ☐ No	Hepatitis/Liver Disease Comments	☐ Yes ☐ No
Mitral Valve Prolapse Comments	☐ Yes ☐ No	Asthma Comments	☐ Yes ☐ No	In Utero DES Comments	☐ Yes ☐ No
Psychiatric Comments	☐ Yes ☐ No	Anesthesia Complications Comments	☐ Yes ☐ No	Other Comments	☐ Yes ☐ No

Immunization History

Have you been vaccinated against Hepatitis B?	☐ Yes ☐ No	If yes, when? _____	
Have you been vaccinated against Influenza?	☐ Yes ☐ No	If yes, when? _____	
Have you been vaccinated against Pneumonia?	☐ Yes ☐ No	If yes, when? _____	
Have you been vaccinated against Tetanus?	☐ Yes ☐ No	If yes, when? _____	
Have you had chicken pox?	☐ Yes ☐ No	If no, have you been vaccinated?	☐ Yes ☐ No
Have you had Rubella (German Measles)?	☐ Yes ☐ No	If no, have you been vaccinated?	☐ Yes ☐ No
Have you had a PPD skin test?	☐ Yes ☐ No	If yes, ☐ positive or ☐ negative.	

Surgeries (Reason & Year)		Hospitalizations (Reason & Year)
1	5	1
2	6	2
3	7	3
4	8	4

Family History

Breast Cancer Who: Dx at Age: _____	☐ Yes ☐ No	Anesthesia Complications Who:	☐ Yes ☐ No
Ovarian Cancer Who: Dx at Age: _____	☐ Yes ☐ No	Birth Defects/Hereditary Disorders Who:	☐ Yes ☐ No
Uterine Cancer Who: Dx at Age: _____	☐ Yes ☐ No	High Blood Pressure Who:	☐ Yes ☐ No
Colon Cancer Who: Dx at Age: _____	☐ Yes ☐ No	Heart Disease Who:	☐ Yes ☐ No
Osteoporosis Who: Dx at Age: _____	☐ Yes ☐ No	Diabetes Who:	☐ Yes ☐ No
Gynecological Problems Who: Dx at Age: _____	☐ Yes ☐ No	Psychiatric Disorder Who:	☐ Yes ☐ No

Social History

Occupation	Marital Status ☐ Single ☐ Married ☐ Divorced	Social Drug Use ☐ Yes ☐ No Amount:	Type: How often:
Cigarettes ☐ Yes ☐ No For how long:	Pack/day: Quit date:	Abuse/Domestic Violence ☐ Yes ☐ No Past or Present Relationship	
Alcohol ☐ Yes ☐ No Amount:	Type: How often:	Do you have a medical power of attorney? ☐ Yes ☐ No If yes, please bring copy for your chart. ☐ Yes ☐ No	

Review of Systems (Check all that apply and explain if necessary)

Constitutional ☐ Weight Loss ☐ Fever ☐ Fatigue ☐ Other	Genitourinary ☐ Burning with urination ☐ Blood in urine ☐ Voids/night ☐ Urinary frequency/urgency ☐ Caffeine/day ☐ Other
Neck ☐ Pain ☐ Difficulty swallowing ☐ Lumps ☐ Other	Skin/Breast ☐ Rash ☐ Lumps in breast ☐ Nipple discharge ☐ Pain in breast ☐ Other
Cardiovascular ☐ Palpitations (Rapid heart rate) ☐ Irregular heart beat ☐ Chest pain ☐ Shortness of breath ☐ Other	Neurological ☐ Frequent Headaches ☐ Dizziness ☐ Weakness ☐ Numbness/Tingling where? ☐ Other
Abdomen ☐ Pain ☐ Bloating ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Poor appetite ☐ Other	Psychiatric ☐ Insomnia ☐ Depression ☐ Anxiety ☐ Moodiness ☐ Other
Respiratory ☐ Cough ☐ Pain with breathing ☐ Shortness of breath ☐ Other	Lymphatic ☐ Lumps in groin, under arms, or in neck ☐ Other

Acknowledgment of Receipt of Privacy Notice

Desert Sage

By signing below, I acknowledge that I have been provided with a copy of Desert Sage Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Desert Sage and how I may obtain access and control this information.

* _____
(Signature of Patient or Guardian)

* _____
(Print Patient name or Guardian)

* _____
(Date)

* _____
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1. _____

2. _____

3. _____

May we leave a message on an answering machine? YES ☐ NO ☐

Preferred method of contact:

Home#_____

Cell# _____

Work# _____

Deceased Persons

We may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Appointment Reminders, Marketing and Treatment Alternatives

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not disclose your health information without your written authorization.

Food and Drug Administration (FDA)

We may disclose to the FDA your health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse, Neglect & Domestic Violence

We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Sign in Sheet

We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime on our premises; to report crime in emergencies; and other appropriate situations permitted by law.

Health Oversight

We may disclose your health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, with your authorization, discovery request or other lawful process if certain specific requirements are met.

Serious Threat

To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

We may disclose your health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided in this Notice.

Website

If we maintain a website that provides information about our office, this Notice will be on the website.

Research

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

Fund Raising

We may contact you as part of a fund raising effort. If you do not want to receive these materials notify our Privacy Officer.

Original Effective Date: April 14, 2003

Effective Date of Last Revision (if any):_____

POS® Reorder # 0310005

NOTICE OF PRIVACY PRACTICES

Desert Sage
Obstetrics and Gynecology

5533 E. Bell Rd., Suite 103
Scottsdale, AZ 85254

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.

This office is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with this notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for <u>treatment</u> purposes are:

- A nurse or medical assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of use of your health information for <u>payment</u> purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and the care given, which may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.

Example of use of your health information for <u>health care operations</u>:

We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.

<u>Your Health Information Rights</u>

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your medical record and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include uses and disclosures of information for treatment, payment, or health care operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; or to family members or friends or uses relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care of your location, condition, or your death; we may charge a cost-based fee for more than one accounting in a 12-month period.
- Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our privacy officer 5533 E. Bell Rd., Suite 103, Scottsdale, AZ 85254, in person or in writing, during normal business hours. Our Privacy Officer will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the acknowledgment authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

<u>Our Responsibilities</u>

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

<u>To Request Information or File a Complaint</u>

If you have questions, would like additional information, want to report a problem regarding the handling of your information, or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact our Privacy Officer at 5533 E. Bell Rd., Suite 103, Scottsdale, AZ 85254. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

<u>Other Disclosures and Uses We Can Make Without Your Written Authorization</u>

Notification of Family/Friends

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family/Friends

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

We may use and disclose your health information to assist in disaster relief efforts.

Employers

We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.

Desert Sage
Obstetrics and Gynecology

5533 E. Bell Rd., Suite 103
Scottsdale, AZ 85254
TEL (602) 466-1111 FAX (602) 795-4706

Authorization for Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone: (Day) _____
_____ (Home) _____
Physician _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically expected: _____
_____

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information

From: _____ To: _____
Address _____ Address _____
_____ _____
Phone_____Fax_____ Phone_____Fax _____

II. Our Policy

As mandated by law we have 30 days to comply to all on-site medical record requests, for off-site requests the law mandates 90 day compliance.
Desert Sage OB/Gyn makes every attempt possible to expedite each release in a timely fashion.
Should you need records for an immediate purpose, please fill out the appropriate fields below.
If you are in need of same day or next day records a $15 charge will be applied.
We reserve the right to charge for multiple record requests.

Reason(s) for this authorization (check all that apply):

☐ at my request _____ ☐ other (specify) _____
_____
☐ transfer of care to _____ _____

Please indicate below if you need this information released prior to our 30 day allowance.

☐ Please have my records ready by (date) _____

This authorization ends: ☐ on (date) _____ ☐ when the following event occurs_____

III. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)