Partners in Women's Health

Patient Registration Form1

(Reason for visit) ______________________

______________________ (Last Name) ______________ (First Name) ________ (Middle)

______________________ (Primary Street Address) ______________ (City) ________ (State) ________ (Zip)

______________________ (Secondary Street Address) (City) (State) (Zip)

______________ (Home Phone) ______________ (Cell Phone) ______________ (Date Of Birth) ______________ (Mar. St.-S/M/D/W)

E-Mail Address: ______________________

______________ (Referring Physician) ______________ (Primary Care Phys. – if applic.) ______________ (Primary Language) if other than English ______________ (Race-Wh/Bl/His/As/Oth)

First Day of Last Menstrual Period: ______________________

Patient Employer: ______________________ Work Phone: ______________________

Emergency Contact: ______________________ Phone: ______________ Relationship ______________

Pharmacy: ______________________ Pharmacy Phone number: ______________________

PRIMARY INSURANCE: (1)______________________ SECONDARY INSURANCE:(2)______________________

Primary Policyholder NAME: ______________________ Primary Policyholder NAME: ______________________

Patient RELATIONSHIP to Policyholder: ______________ Patient RELATIONSHIP to Policyholder: ______________

Certificate / ID # ______________________ Certificate / ID # ______________________

GROUP # __________ Plan Type ________(PPO/HMO/Other) GROUP # __________ Plan Type ________(PPO/HMO/Other)

D.O.B of Policyholder ____________ D.O. B of Policyholder ____________

INSURANCE PHONE # on Card______________________ INSURANCE PHONE # on Card ______________________

GUARANTOR (Responsible for Bill) ( ) Self ( ) Spouse ( ) Parent Guarantor Name______________________

Guarantor Address______________________ Guarantor Phone______________________

Guarantor Employer______________________ Employer Address______________________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I hereby assign all medical and/or surgical benefits including Medicare, Medicaid, Private Insurance and other health plans to Partners in Women's Health..

I hereby also authorize assignee to release all information, including HIV test results to secure payment. I understand I am financially responsible for all charges whether or not paid by insurance and will be held responsible for all collection costs and associated legal fees should it become necessary to secure payment for services rendered. I am aware that finance charges will accrue on balances older than 30 days once they have been transferred to the patient's responsibility.

A photocopy of this assignment is considered as valid as an original and this assignment and release will remain in effect until revoked by me in writing and delivered to Partners in Women's Health.

______________________ Signature of Patient ________ Date ______________________ Signature of Guarantor/Insured ________ Date

Partners in Women's Health

Patient History & Physical Form

PATIENT ________________ (Last) ________________ (First) ________________ (Middle) AGE ________ BIRTHDATE ____________

CURRENT MEDICATIONS ____

DRUG ALLERGIES ____

CHECK IF YOU (describe usage): [ ] Smoke [ ] Drink [ ] Use Marijuana / Other Drugs ______________

SURGERIES, ILLNESS, AND/OR INJURIES ____

____

MENSTURAL PERIODS: Last Period Date was ______________. Periods come every ________ days and flow lasts ________ days.

Periods began at age ______. Periods are [ ] Regular or [ ] Irregular. Problems: ______________________

BIRTH CONTROL: ______________________ DATE OF LAST PAP SMEAR ____________ LAST MAMMOGRAM __________

LIST ALL PREVIOUS PREGNANCIES AND BIRTHS (PLEASE INCLUDE ANY MISCARRIAGES AND/OR ABORTIONS)

Infant Birthdate	Sex	Infant Birth Weight	Length of Pregnancy	Length of Labor	Complications

CHECK IF YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING:

[ ] Abnormal mammogram
[ ] Abnormal pap smear
[ ] Abnormal vaginal bleeding
[ ] Abuse – Sexual / Physical
[ ] Acne
[ ] Alcoholism
[ ] Allergies
[ ] Arthritis
[ ] Asthma
[ ] Anemia
[ ] Blood Clots
[ ] Blood Transfusion
[ ] Breast Disease ______________
[ ] Cancer ______________
[ ] Cholesterol elevation
[ ] Constipation
[ ] Depression
[ ] Diabetes / low blood sugar
[ ] Diarrhea
[ ] Diverticulosis
[ ] Drug Dependency
[ ] Emotional problems
[ ] Endometriosis
[ ] Epilepsy / seizures
[ ] Eye problems
[ ] Fainting
[ ] Gallbladder problems
[ ] Headaches
[ ] Heart problems
[ ] Hemorrhoids
[ ] Hepatitis
[ ] Hernia
[ ] High blood pressure
[ ] HIV testing
[ ] Intestinal problems
[ ] Kidney disease
[ ] Liver disease
[ ] Menstrual period pain
[ ] Neurologic problems
[ ] Ovarian tubal infections
[ ] Pain with intercourse
[ ] Pelvic / abdominal pain
[ ] Pelvic inflammatory disease
[ ] Respiratory problems
[ ] Rheumatic / scarlet fever
[ ] Sexual problems
[ ] Stroke
[ ] Sickle cell anemia
[ ] Thrombophlebitis
[ ] Thyroid disease
[ ] Tuberculosis
[ ] Ulcers
[ ] Urinary tract infections
[ ] Urinary incontinence
[ ] Varicose veins
[ ] Vaginal discharge
[ ] Vaginal infections:
  [ ] Chlamydia [ ] Trichomonas
  [ ] Gonorrhea [ ] Warts
  [ ] Herpes [ ] Yeast
  [ ] Syphilis [ ] Other ________
[ ] Vomiting
[ ] Other ______________

CHECK IF YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING:

[ ] Alcoholism
[ ] Cancer ______________
[ ] Congenital problems ______________
____
[ ] Diabetes
[ ] Epilepsy
[ ] Heart disease
[ ] High blood pressure
[ ] Kidney disease
[ ] Lung disease
[ ] Mental illness
[ ] Other ______________

PROVIDER NOTES:

Partners in Women's Health

550 Heritage Drive, Suite 203
Jupiter, FL 33458
Phone: (561) 354-1515
Facsimile: (561) 354-1516

RELEASE OF INFORMATION

In accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain authorization before releasing written or verbal information regarding any patient. Please fill out the below form accordingly. We thank you for your help and understanding.

I, ______________________________, authorize Partners in Women's Health of Jupiter, LLC and its staff to release information regarding my condition to the following people:

1) ____

2) ____

3) ____

4) ____

5) ____

(Note: Include everyone's name that you are allowing for us to release information to including, but not limited to: *yourself, spouse, child, referring/other physicians, relatives or friends*. If the name is not listed above, we are unable to speak or release information to them.)

Also, in the event that I am not home, with regards to test results such as Bloodwork, Biopsies, etc.

Please **DO** leave messages on my cell phone **Y** **N** (circle one)

Please **DO** leave messages on my home phone **Y** **N** (circle one)

Please **DO** leave messages on my work phone **Y** **N** (circle one)

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have reviewed and/or received the Privacy Notice.

____ ____________________

PATIENT (or Personal Representative) SIGNATURE DATE

If personal Representative's signature, please describe relationship to patient:

____

PARTNERS IN WOMEN'S HEALTH
Jeffrey M. Litt, M.D., FACOG
Marc A. Kaufman, M.D., FACOG
Anthony Shaya, M.D., FACOG
Laura Alsina-Sanchez, M.D., FACOG
Elise Gershman, M.D., FACOG
Erin Ethridge-Bagley, PhD, A.R.N.P
Nancy Galyon, A.R.N.P.
Ann Patrice (Pat) Casale, A.R.N.P.

550 Heritage Drive, Suite 203
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(561) 354-1515

INSURANCE WAIVER

All services that we provide for you in our office will be billed to your insurance company. Any services not paid by your insurance company will be your patient responsibility.

Due to the magnitude of changes within the insurance companies we are unable to pre-verify benefits for all gynecological and/or diagnostic services. Patients need to be aware of their own insurance benefits and what will be covered by their plans.

In addition, it is the patient's responsibility to be sure that we are participating with their insurance plan.

I hereby accept and understand the above waiver.

______________________________ ______________

Patient Name Date

____

Signature of Patient

Jeffrey M. Litt, M.D., FACOG
Marc A. Kaufman, M.D., FACOG
Anthony Shaya, M.D., FACOG
Laura Alsina- Sanchez, M.D., FACOG
Elise Gershman, M.D., FACOG
Erin Ethridge-Bagley, PhD, A.R.N.P
Nancy C. Galyon, A.R.N.P.
Ann Patrice Casale, A.R.N.P.

Obstetrics and Gynecology

MALPRACTICE Acknowledgment

Emergency Care. Delivering a baby. Having a mammogram. These are medical services that all of us take for granted. We assume that if we need these medical services, there will be doctors and hospitals available to provide them at a cost we can afford. Unfortunately, we can no longer take those things for granted because of the growing medical liability insurance crisis in Florida. Here in our area, the symptoms of this crisis are already appearing. Over the last 12 months we have witnessed a number of fine physicians close their medical practices and relocate to other areas of the country where practice conditions are more favorable. We have likewise seen a number of physicians specializing in obstetrics and gynecology elect to cease delivering babies in an effort to limit their liability. We cannot afford to ignore these symptoms any longer. The continuing rising costs of even the lowest level of malpractice coverage, the decreasing reimbursements of medical services, and the ever increasing costs to run a medical practice have forced us to make a hard decision.

The choice we have made for now is to become one of the ever-increasing numbers of self-insured practices. This choice is difficult because it affects our patients, our practice, and our families as well. Your choice to remain a part of this practice will require you to understand certain realities and to commit to a compromise for the future of our relationship. We cannot in all good conscience risk the economic future of our practice without this commitment from you.

What we ask from you is to accept the following: (1) our clinicians and staff will always strive to provide you with the best possible care we can, being always committed to what is best for you, always trying to be as accurate and available to answer any of your questions whenever you need us, (2) even medical care provided according to acceptable medical practice standards, and in a timely manner, will not always produce perfect outcomes, (3) present testing and procedures are designed to screen for most problems but are still not 100% accurate in predicting all potential problems, (4) individuals need to accept responsibility for their own vices and behavior which can contribute to future bad outcomes or complications, <u>(5) unexpected outcomes which do occur will be addressed by discussion and arbitration between physician and patient as well as family members when necessary, rather than through litigation as a first means of solving problems.</u>

Now that you understand the impact the current medical liability crisis has on the relationship between patient and physician, we ask that you sign your name to the required commitment. For those of you who do not wish to sign, it will be understood that you are unwilling to accept these terms and we will forward your clinical records to your next physician. Those of you who do sign, we appreciate your understanding of the changing face of medicine and your willingness to continue our professional relationship as allies and advocates rather than adversaries.

We promise to keep you informed of developments and welcome your feedback. With your help, we can address this crisis now so patients can continue to benefit from the range of healthcare services they need, expect, and deserve. Thank you for your support.

Acknowledged:

______________________________ ____________
Patient Signature Date

____
Print Name

550 Heritage Drive, Suite 203, Jupiter, Florida 33458
Telephone: (561) 354-1515 • Facsimile: (561) 354-1516

Notice of Privacy Practice Acknowledgement

Partners in Women's Health of Jupiter, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____ ________________

Patient Name or Legal Guardian (print) Date

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: ____________ Attempt: ________________________________

Staff Name: __________________________

Notice of Privacy Practices
Partners in Women's Health of Jupiter, LLC

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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

550 Heritage Drive, Suite 203
Jupiter, Florida 33458

Office: (561) 354 - 1515
Fax: (561) 354-1516

Attn: Compliance Contact/Gillian Perkins

Please sign the accompanying "Acknowledgement" form

2013