My GYN Care

TopLine MD Alliance

PATIENT REGISTRATION FORM

Patient Information

Name:_____ Date of Birth:_____

First, Middle and Last name as it appears on insurance card

Sex: ❍Female ❍Male Sexual Orientation: _____

Social Security Number: _____

Marital Status: ❍Single ❍Married ❍Widow ❍Divorced ❍Other: _____

Race/Ethnicity: ❍Asian ❍Black ❍Hispanic ❍Pacific Islander ❍White ❍Other:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Primary Care Physician:_____ Phone:_____

Check One: ❍Employed ❍Retired ❍Full-Time Student ❍Other: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

If you were referred by a Doctor, who?

Doctor _____

Doctor Phone #_____

Insurance Information

Please provide your insurance card to the receptionist

Insurance Company: _____

Insured/Card Holder's Name:_____ Birthdate:_____

Relationship:_____ Phone #:_____

Policy #:_____ Group #:_____

Secondary Insurance Information

Insurance Company: _____

Insured/Card Holder's Name:_____ Birthdate:_____

Relationship:_____ Phone #:_____

Policy #:_____ Group #:_____

My GYN Care

TopLine MD Alliance

PATIENT REGISTRATION FORM *cont.*

Emergency Contact

Name:_____ Sex: ❍Female ❍Male
First, Middle and Last Name

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Social Security Number:_____

Pharmacy

Pharmacy Name:_____ Phone #:_____

Pharmacy Address:_____

Spouse/Guarantor/Responsible Party

Name:_____ Date of Birth:_____
First, Middle and Last Name

Sex: ❍ Male ❍ Female Relationship:_____

Daytime Phone:_____ Social Security Number:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Employer Name: _____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Your appointment time has been set aside for you alone; no other patients are scheduled at the same time. If you can't keep it, kindly cancel in advance. There will be a $ 75 charge for missed appointments. Initials: _____

I hereby authorize payment directly to Joyce R. Miller, MD, LLC DBA My Gyn Care for all benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work and vaccines not covered by my insurance contract as performed in the office, and for any co-payments and/or deductible amounts as specified in my insurance contract. I acknowledge that Private Health Information material (HIPAA) is posted, and available upon request.

Patient Name _____ Signature _____ Date _____

PATIENT HISTORY FORM

Name:_____ DOB:_____

Gender: ❍F ❍M Age:_____ Date of Appointment:_____

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Reason for Visit

Annual Well-Woman Exam ❍Yes ❍No

(Please be advised if you have additional problems during your annual, a copay, co-insurance and/or deductible will be charged)

Problem Visit ❍Yes ❍No

List Problem(s): _____

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access to or knowledge of this information without your express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

Current Medications

What medications are you currently taking?

Please list any prescription medications, over-the-counter medications, vitamins, herbs or nutritional supplements that you are now taking.

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following? ❍Adhesive Tape ❍Antibiotics ❍Aspirin ❍Barbiturates *(for sleep)* ❍ Codeine ❍ Iodine ❍ Latex ❍ Local Anesthetics ❍ Sulfa

Do you have any other allergies?

Name	Reaction

Past Medical History *(check all that apply)*

❍ Alcoholism
❍ Allergies
❍ Anemia
❍ Anxiety Disorder
❍ Arthritis
❍ Artrial Fibrillation
❍ Asthma
❍ AIDS/HIV
❍ Back Problems
❍ Bleeding Disorder
❍ Blood Disease
❍ Blood Transfusion
❍ Bowel Disease
❍ Cancer
❍COPD
❍Coronary Artery Disease
❍Depression
❍Diabetes
❍Ear Problems
❍Eating Disorder
❍Epilepsy
❍GERD *(reflux)*
❍Glaucoma
❍Gout
❍Heart Disease
❍Hearing Loss
❍Heart Problems
❍Hepatitis – A, B, or C
❍ High Blood Pressure
❍ High Cholesterol
❍ HIV/AIDS
❍ Hives
❍ Joint Disorder
❍ Kidney Disorder
❍ Leukemia
❍ Liver Disorder
❍ Lung Disease
❍ Lymphoma
❍ Measles
❍ Migraines
❍ Osteoporosis
❍ Pneumonia
❍ Polio
❍ Radiation Treatment
❍ Renal Disease
❍ Rheumatic Fever
❍ Stroke
❍ Seizures
❍ Skin Disorder
❍ Stomach Ulcer
❍ Substance Abuse
❍ Thyroid Disorder
❍ Tuberculosis
❍ Venereal Disease

Check-In By:_____

PATIENT HISTORY FORM *cont.*

Name:_____ DOB:_____

Gender: ❍F ❍M Age:_____ Date of Appointment:_____

My GYN Care

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Hospitalizations & Surgeries

Reason	Date

Family History *(check all that apply)*

❍ Alcoholism
❍ Allergies
❍ Alzheimer's
❍ Anemia
❍ Anxiety
❍ Arthritis
❍ Asthma
❍ AIDS/HIV
❍ Bleeding Disorder
❍ Blood Disease
❍ Cancer _____
❍ Diabetes
❍ Depression
❍ Epilepsy
❍ Genetic Disorder
❍ Glaucoma
❍ Heart Disease
❍ Hepatitis – A, B, or C
❍ High Blood Pressure
❍ High Cholesterol
❍ Joint Disorder
❍ Kidney Disease
❍ Liver Disorder
❍ Lung Disease
❍ Migraines
❍ Psychiatric Disorders
❍ Osteoporosis
❍ Stroke
❍ Substance Abuse
❍ Thyroid Disorder

Lifestyle Factors

Are you sexually active? ❍Yes ❍No # of partners in past year: _____

Has anyone in your home ever physically or verbally hurt you? ❍Yes ❍No

Have you ever smoked? ❍Yes ❍No # of years: _____ # packs/day: _____

Do you smoke now? ❍Yes ❍No # packs/day: _____

Do you use recreational drugs? ❍Yes ❍No Types? _____ # times/week:_____

How much alcohol do you drink per week? ❍Yes ❍No # drinks/week: _____

How much caffeine do you drink per day? ❍Yes ❍No # drinks/day: _____

How often do you exercise? ❍Yes ❍No # times/week: _____

OB/GYN History

Have you ever had, or do you currently have any of the following? *(check all that apply)*

❍Abnormal Vaginal Bleeding
❍Abnormal Pap Smear
❍Bleeding between Periods
❍Breast Lump
❍Breast Cancer
❍Breast Surgery
❍Cervical Cancer
❍Chlamydia
❍Cryosurgery
❍ DES Exposure
❍ Extreme Menstrual Pain
❍ Fibroids
❍ Genital Warts
❍ Gonorrhea
❍ Herpes
❍ Hot Flashes
❍ HPV
❍ Infertility
❍ Irregular Periods/Discharge
❍ Ovarian Cancer
❍ Ovarian Cysts
❍ Painful Intercourse
❍ Pelvic Inflammatory Disease
❍ Uterine Cancer
❍ Urinary Incontinence
❍ Yeast Infections - Frequent

Check-In By:_____

PATIENT HISTORY FORM *cont.*

Name:_____ DOB:_____

Gender: ❍F ❍M Age:_____ Date of Appointment:_____

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Pregnancy History

Please describe any pregnancies you have had:_____

# of Pregnancies:_____ # of Full Term:_____ # of Miscarriages:_____ # of Abortions:_____

Are you currently pregnant? ❍Yes ❍No

Are you trying to become pregnant? ❍Yes ❍No

Do you need birth control or contraceptive advice? ❍Yes ❍No

Menstrual History

When was the first day of your last period? _____

How often does your period occur? _____

How long do your periods last? _____

Is your period regular? ❍Yes ❍No

What age were you when you had you first period? _____

What age were you at menopause? _____

Health Exams & Procedures *(Please check and date all immunizations you have had)*

	Mo/Yr	Result		Mo/Yr	Result
❍Colonoscopy	___/___	_____	❍Breast MRI	___/___	_____
❍CT/CAT Scan	___/___	_____	❍Pap Smear	___/___	_____
❍Dexascan *(Bone Density)*	___/___	_____	❍Pelvic Ultrasound	___/___	_____
❍Fecal Occult Blood Test	___/___	_____	❍Gardasil	___/___	_____
❍Mammogram	___/___	_____			
❍Breast Ultrasound	___/___	_____			

Check-In By:_____

PATIENT HISTORY FORM *cont.*

Name:_____ DOB:_____

Gender: ❍F ❍M Age:_____ Date of Appointment:_____

My GYN Care

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Review of Symptoms *(check all that apply)*

ENT
❍Bleeding Gums
❍Blurred Vision
❍Crossed Eyes
❍Difficulty Swallowing
❍Double Vision
❍Earaches
❍Ear Discharge
❍Hay Fever
❍Hoarseness
❍Hearing Loss
❍Nosebleeds
❍Persistent Runny Nose
❍Recurring Sore Throat
❍Ringing in Ears
❍Sinus Problems
❍Vision Halos

Mental Health
❍Anxiety
❍Depression
❍Loss of Interest
❍Feeling Hopeless
❍Hearing Voices
❍Marital Problems
❍Panic Attacks
❍Trouble Concentrating
❍Suicide *(Thoughts/Attempts)*

Gastrointestinal
❍Appetite Gain
❍Appetite Loss
❍Bloating
❍Bowel Changes
❍Constipation
❍Diarrhea
❍Gas
❍Hemorrhoids
❍Indigestion
❍Intestinal Disorder
❍Lactose Intolerance
❍Rectal Bleeding
❍Stomach Pain
❍Vomiting
❍Vomiting Blood

Skin
❍Acne
❍Bruise Easily
❍Changes in Moles
❍Dry/Sensitive Skin
❍Eczema
❍Hives
❍Itching
❍Rash
❍Scars
❍Sores That Won't Heal

General
❍ Chills
❍ Dizziness
❍ Fainting
❍ Fever
❍ Hair Loss
❍ Hair Growth *(Excessive)*
❍ Night Sweats
❍ Sleeping Problems
❍ Thirst *(Excessive)*
❍ Weight Gain
❍ Weight Loss

Neurological
❍ Coordination Problems
❍ Convulsions
❍ Difficulty Walking
❍ Learning Disabilities
❍ Light-Headedness
❍ Memory Loss
❍ Numbness/Tingling
❍ Paralysis
❍ Seizures
❍ Speech Problems
❍ Tremors
❍ Other Symptoms:_____
_____
_____

Cardiovascular
❍ Chest Pains
❍ Irregular Heart Beat
❍ Circulation Problems
❍ Heart Palpitations
❍ Rapid Heartbeat
❍ Swelling of Ankles
❍ Varicose Veins

Respiratory
❍ Coughing
❍Coughing Up Blood
❍Shortness of Breath
❍Wheezing

Genitourinary
❍Blood in Urine
❍Lack of Bladder Control
❍Frequent Urination
❍Painful Urination

Race *(This information is needed for prenatal testing. Please feel free to ask your doctor any questions you may have regarding information gathered.)*

❍ American Indian or Alaska Native ❍ Native Hawaiian or Other Pacific Islander
❍ Black or African American ❍ White ❍ Asian ❍ Hispanic or Latino

Check-In By:_____

My GYN Care

TopLine MD Alliance

FINANCIAL POLICY

Thank you for choosing Joyce R. Miller, MD, LLC DBA My Gyn Care as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT
WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, there is a $75.00 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $50.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

FORMS: There is a flat fee of $15.00 for each set of forms the office completes on your behalf.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name:_____ **DOB:**_____

Patient/Responsible Party Signature:_____ **Date:**_____

My GYN Care

TopLine MD Alliance

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT MEDICAL RECORDS

Patient Information

Patient's Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Day Phone #:_____ Social Security #:_____

Practice Information

Practice Name:_____ Physician:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

Where do you want the records to be sent?

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

What records do you want sent or released?

(Please specify the years of records you wish to be sent or released)

Record Name	Years	Record Name	Years	Record Name	Years

How do you want the information delivered? *(Requests take 7-10 business days for processing)*

❍Mail ❍Patient will pick up *(fees apply)* ❍Fax ❍Pick up by: _____*(fees apply)*

Purpose of Release *(Why is it needed?)*

❍Transfer of care to new physician ❍Continuing care/Second opinion ❍Other: _____

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Joyce R. Miller, LLC DBA My Gyn Care from all liability arising from this disclosure of my health information. I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. For patients and governmental entities: 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. For other entities: up to $1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Name:_____ DOB:_____

Patient/Responsible Party Signature:_____ Date:_____

(Patient, Parent, Guardian or Legal Representative)

Joyce R. Miller, M.D. · Karen Seetal Kihei, APRN
9700 South Dixie Highway, Suite 1060
Miami, FL 33156
786.453.0332 Fax 786.453.0394

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

Name _____ DOB _____

Please select all that apply:

☐ You have my permission to leave a detailed voice message:

Telephone _____

☐ I authorize the office of My Gyn Care to discuss my medical care with the following:

Name _____ Relationship _____

Telephone _____

Name _____ Relationship _____

Telephone _____

☐ Please DO NOT release ANY medical information to anyone other than myself.

Patient Signature _____ Date _____

Witness _____

CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to Joyce R. Miller, MD, LLC DBA My Gyn Care to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name)_____ , age (if minor) _____ . Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by Joyce R. Miller, MD, LLC DBA My Gyn Care and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing. I acknowledge that Joyce R. Miller, MD, LLC DBA My Gyn Care is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released. Joyce R. Miller, MD, LLC DBA My Gyn Care has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold Joyce R. Miller, MD, LLC DBA My Gyn Care , its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production. I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ **Email:** _____

Signature: _____ **Date:** _____

Name of Parent/Legal Custodian *(under age 18):* _____

Signature of Parent/Legal Custodian *(under age 18):* _____

Witness Name: _____

Witness Signature: _____ **Date:** _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold Joyce R. Miller, MD, LLC DBA My Gyn Care responsible for instances of these violations.

Signature: _____ **Date:** _____

Notice of Privacy Practices

JOYCE R. MILLER, MD, LLC DBA MY GYN CARE

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.

JOYCE R. MILLER, MD LLC
9700 SOUTH DIXIE HIGHWAY, #1060
MIAMI, FL 33156
(786)453-0332

Please sign the accompanying "Acknowledgement" form

Notice of Privacy Practice Acknowledgement

JOYCE R. MILLER, MD, 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: _____

My GYN Care
TopLine MD Alliance
9700 South Dixie Highway, Suite 1060
Miami, FL 33156
786.453.0332 Fax 786.453.0394
Joyce R. Miller, M.D. • Karen Seetal Kihei, APRN

FLU, COVID, RSV QUESTIONNAIRE

Patient Name: _____ DOB: _____

1. Have you experienced any of the following symptoms in the last 7 days?
   - Fever Yes No
   - Cough Yes No
   - Shortness of breath or difficulty breathing Yes No
   - Sore Throat Yes No
   - Chills or body aches Yes No
   - Loss of smell or taste Yes No
   - Headache Yes No
   - Muscle aches or pain Yes No
   - Fatigue Yes No
   - Congestion or runny nose Yes No
   - Nausea, vomiting or diarrhea Yes No

2. Have you been in close contact with anyone who has been diagnosed with Flu, COVID, RSV or cold symptoms in the last 7 days? Yes No

3. Have you traveled in the last 14 days? Yes No

4. Are you currently taking antibiotics? Yes No

I hereby certify that the above statements are true and correct and understand that a false statement may disqualify me from further services.

_____ _____
Patient Signature Date