be. Women's Health & Wellness

PATIENT HISTORY QUESTIONNAIRE

A Patient's Name: _____ Date: _____

1. Referring Physician: _____ 2. Occupation: _____
3. Preferred Phone Number: _____ Cell Phone Number: _____
4. Text/Voice Mails OK: ☐ Yes ☐ No

B **CURRENT MEDICATIONS (Include dose (amount) per day)**

Medication	Dose	Frequency

Name of pharmacy and location:_____

C **PAST MEDICAL HISTORY** Check any that apply:

Please list ALL conditions you have been diagnosed with

☐ Arthritis
☐ Diabetes: Controlled?
☐ Diet ☐ Pill ☐ Insulin
☐ High blood pressure
☐ Heart disease
☐ Other:_____
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including Hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder

Any drug allergies? ☐ No ☐ Yes : _____

D **PAST SURGICAL HISTORY (NOT OB/GYN)**

5. List all surgeries and their year:

Surgeries	Year

E **PAST OBSTETRICAL/ GYNECOLOGICAL SURGERIES** Check any that apply:

Surgery	Year	**Surgery**	Year
☐ D&C		☐ Myomectomy	
☐ Hysteroscopy		☐ Cyst(s) removed ovarian L / R	
☐ Infertility surgery		☐ Ovary removed L / R	
☐ Tubal Ligation		☐ Vaginal or bladder repair	
☐ Laparoscopy		☐ Other (specify) _____	
☐ Hysterectomy (Vaginal)/ (Abdominal)			

F **FAMILY HISTORY** **List who Maternal(M) or Paternal(P) & what disease or cancer**

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other:_____
☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer

List :_____

G DO YOU CURRENTLY?

6. Smoke? ☐No ☐Yes ____ Packs/day
7. Alcohol? ☐ No ☐ Yes: wine (glasses/day) ____ Beer(Bottles/day)____ Hard Liquid (oz/day) ____
8. Exercise _____ How often:_____

H PAST GYNECOLOGICAL HISTORY Check any that apply:

☐ Venereal Warts ☐Herpes-genital ☐ Syphilis ☐Pelvic Inflammatory Disease ☐ Chlamydia ☐Gonorrhea
☐ Endometriosis ☐ Fibroids ☐ Cysts

I MENSTRUAL HISTORY (<u>Complete even if post-menopausal or no longer having periods</u>)

1. First day of last menstrual period _____
2. If your menstrual periods are regular; periods start every: _____ days.
3. If you menstrual periods are irregular; periods start every: ____ to ____ days (e.g. 12 to 60).
4. Duration of bleeding: _____ days
5. Age at first period _____Years Menopause _____ Age

J BIRTH CONTROL /SEXUAL HISTORY

1. What birth control method(s) do you currently use? _____
2. Do you have a sexual partner? ☐ Yes ☐ No ☐ Male ☐Female

K PAP SMEAR/MAMMOGRAM HISTORY

3. Date of last pap smear: _____/_____/_____
4. Have you had abnormal pap smears? ☐Yes ☐No
5. Have you had treatment for abnormal smears?☐Yes ☐No
6. Date of last mammogram: _____
   Month Year
7. Facility Name: _____
8. Have you had an abnormal mammogram? ☐Yes ☐No
9. Have you had a bone density?☐ No☐ Yes When _____ Where _____
10. Have you had a colonoscopy? ☐ No☐ Yes When_____ Where_____

If Yes what type(s)	Year
Cryotherapy	
Laser	
Cone Biopsy	
Loop Excision (LEEP)	

L PREGNANCY HISTORY (ALL PREGNANCIES)

<u>OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES</u>						Child		
Year	Location	Duration of Pregnancy	Hours of Labor	Type of Delivery	Complications Mother/Infant	Sex	Birth Weight	Present Health

_____ _____

Patient Signature Date

be. Women's Health & Wellness

Patient Demographic Sheet

Last Name: _____ First Name: _____ Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

E-Mail: _____ SSN: _____ Date of Birth: ___/___/___

Race: _____ Religion: _____ Marital Status: (M / S / D / W)

Employer: _____ Address: _____ Occupation: _____

Spouse: _____ Date of Birth: _____ Phone #: _____

Emergency Contact: _____ Telephone #: _____

Primary Insurance:

Insurance Carrier: _____ Insurance #: _____
Claims Address: _____
Member ID: _____ Group #: _____ Effective Date: _____
Policy Holder Last Name: _____ Policy Holder First Name: _____
Date of Birth: ___/___/___ SSN: _____ Relationship to Patient: _____
Policy Holder Employer: _____ Employer Phone #: _____

Secondary Insurance:

Insurance Carrier: _____ Insurance #: _____
Claims Address: _____
Member ID: _____ Group #: _____ Effective Date: _____
Policy Holder Last Name: _____ Policy Holder First Name: _____
Date of Birth: ___/___/___ SSN: _____ Relationship to Patient: _____
Policy Holder Employer: _____ Employer Phone #: _____

Acknowledgment:

I certify that the above information is true and correct to the best of my knowledge. I understand the importance of current information and know it is my responsibility to keep this office informed of any changes in my insurance or personal information. I realize any claims that are denied or delayed for due to this information not being updated are my responsibility. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

By signing below, I verity the information above is correct and true.

_____ _____
(Patient or Legal Representative's Signature) (Date)

8700 US Hwy 380, Ste. 300, Crossroads, TX 76227
Office: (940) 365-9001 Email: beagreatwoman@gmail.com

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of *Be. Women's Health and Wellness* Notice of Privacy Practices with the effective date of ___/___/20____.

I give *Be. Women's Health and Wellness* permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services. *If you decline to give such permission, leave the following blank.*

Spouse: _____

Children: _____

Other: _____

I give *Be. Women's Health and Wellness* permission to leave a message with the person who answers the telephone or a voice-mail message at the most current telephone number on file concerning appointment reminders or requesting that I contact my health care provider. *If you decline such permission, do not list any telephone number below.*

Telephone Number(s): _____

I give *Be. Women's Health and Wellness* permission to contact me at the following telephone number or send a message to the most current e-mail address on file to notify me of any breach of my protected health information. *If you decline such permission, do not list any telephone number or e-mail address below:*

Telephone Numbers(s): _____

E-mail Address: _____

_____ _____

Signature of Patient/Patient Representative (Expires at the end of the calendar year)

Date

_____

Relationship to Patient

(ORIGINAL TO BE MAINTAINED IN PATIENT'S PERMANENT MEDICAL RECORD)

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:

Privacy Officer – Be. Women's Health and Wellness 8700 US Hwy 380 Crossroads, TX 76227 940-365-9001

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.

OPTIONAL:

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 of potential treatment options or alternatives.

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. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. 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)

OPTIONAL:
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.

OPTIONAL:
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.

OPTIONAL:
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 to

Privacy Officer: Be. Women's Health and Wellness 940-365-9001 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 to Privacy Officer: Be. Women's Health and Wellness 940-365-9001. 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 Privacy Officer: Be. Women's Health and Wellness 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. Another licensed health care professional chosen by us will conduct reviews.

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 and submitted to Privacy Officer: Be. Women's Health and Wellness. 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 Privacy Officer: Be. Women's Health and Wellness 940-365-9001.

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 Privacy Officer: Be. Women's Health and Wellness 940-365-9001. 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.