DATE_____

HAVE YOU EVER BEEN A PATIENT WITH ANY WHA PHYSICIAN ? YES_____ NO _____

NAME_____NICKNAME_____
Last First MI

HOME PHONE_____CELL PHONE_____EMAIL_____

ADDRESS_____
Street Address Mailing Address(if different) City State Zip

AGE_____ DATE OF BIRTH_____ MARITAL STATUS_____

SOCIAL SECURITY #_____RELIGIOUS PREFERENCE_____

EMPLOYER_____WORK PHONE #_____

ADDRESS_____

SPOUSE/PARENT_____RELATIONSHIP_____SOCIAL SECURITY #_____

ADDRESS (if different)_____DOB_____PHONE/CELL #_____

EMPLOYER_____WORK PHONE #_____

EMERGENCY CONTACT_____RELATIONSHIP_____
(other than above listed person)

ADDRESS_____DOB_____PHONE/CELL#_____

ADDITIONAL LOCAL CONTACT_____RELATIONSHIP_____
(other than above listed person)

ADDRESS_____DOB_____PHONE/CELL#_____

HOW WERE YOU REFERRED TO WOMEN'S HEALTHCARE ASSOCIATES? _____

INSURANCE COMPANY_____

SUBSCRIBER'S NAME_____ DATE OF BIRTH_____

GROUP # OR NAME_____POLICY #_____

MEDICARE #_____ MEDICAID #_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I authorize the release of any medical information to my insurance company at their request.

Date_____ Signature_____

I hereby authorize Women's Healthcare Associates, P.L.L.C., to apply for benefits on my behalf for covered services rendered by Women's Healthcare Associates, P.L.L.C. I request that payment from my insurance company be made directly to Women's Healthcare Associates (or the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing

Date_____ Signature_____
Patient, Parent or Guardian

Name _____

Reason for this visit _____

Obstetric History: Number of Pregnancies:_____ Miscarriages:_____ Abortions:_____

	Mo/Yr	Vaginal or C/S	Weeks	Weight	Sex	Problems?
1.						
2.						
3.						
4.						
5.						

Gynecological History:

1st day of last menstrual period: __/__/__ Regular Cycles? _____

Age at first menses: _____ Cycle length (day 1 to day 1): _____ # Days: _____

Last pap smear: (date) _____ Last mammogram: (date) _____

Have you ever had? (circle)

An abnormal pap smear? Gonorrhea? Chlamydia? Syphilis?

Herpes? Genital warts? Infertility?

Number of lifetime sexual partners? _____ Number in the last year? _____

Method of contraception: _____

Medical History: List all previous hospitalizations or surgeries:

	Mo/Yr	Operation or Illness		Mo/Yr	Operation or Illness
1.			4.		
2.			5.		
3.			6.		

Have you ever had? (circle)

High blood pressure	Anemia	Diabetes
Thyroid disease	Heart Disease	Cancer
Asthma	Kidney disease	AIDS
Epilepsy	Tuberculosis	Physical abuse
Blood transfusions	Psychiatric problems	Sexual abuse
Liver disease/hepatitis		Eating disorder

Other: _____

Current/Past use: Tobacco? _____ #/day _____ years? _____

Alcohol? _____ Other drug use? _____

Medications (include dosage): _____

_____

Allergies: _____

Family History: List medical problems for these family members:

Father _____ Mother _____

Siblings _____ Children _____

Breast Cancer? _____ Colon Cancer? _____

Review of Symptoms: Do you have difficulty with: (circle)

Headaches	Shortness of breath/cough	Weight gain/loss
Hot flushes	Chest pain/palpitations	Leaking of urine
Bloody/black stools	Diarrhea/constipation	Hearing/vision loss

NOTICE OF PRIVACY PRACTICES

WOMEN'S HEALTHCARE ASSOCIATES, PLLC

Effective Date: April 14, 2003 (Revised: January 31, 2020)

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.

If you have any questions about this Notice, please contact our Privacy Officer:

Jennifer Jalomo, Office Manager, 1301 S Coulter, Suite 300, Amarillo, TX 79106, 806-355-6330

WHO WILL FOLLOW THIS NOTICE?

✓ WOMEN'S HEALTHCARE ASSOCIATES, PLLC (All Providers and Employees)

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Women's healthcare Associates, PLLC , a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

Women's Healthcare Associates, PLLC shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Women's Healthcare Associates, PLLC will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Women's Healthcare Associates, PLLC in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.

- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, Women's Healthcare Associates, PLLC may provide a written or telephone reminder that your next appointment with Women's Healthcare Associates, PLLC is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:

  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

  - In response to a court order or subpoena; or
  - If Women's Healthcare Associates, PLLC determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.*, to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for Women's Healthcare Associates, PLLC . If you request a copy of the information, Women's Healthcare Associates, PLLC may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  Women's Healthcare Associates, PLLC may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Women's Healthcare Associates, PLLC will review your request and denial. The person conducting the review will not be the person who denied your request. Women's Healthcare Associates, PLLC will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Women's Healthcare Associates, PLLC to amend the information. You have the right to request an amendment for as long as the information is kept by Women's Healthcare Associates, PLLC .

  To request an amendment, your request must be made in writing and submitted to Women's Healthcare Associates, PLLC . In addition, you must provide a reason that supports your request.

  Women's Healthcare Associates, PLLC may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Women's Healthcare Associates, PLLC may deny your request if you ask us to amend information that:

  - was not created by women's healthcare associates, PLLC , unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by Women's Healthcare Associates, PLLC ;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to Jennifer Jalomo, Office Manager. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Women's Healthcare Associates, PLLC will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Women's Healthcare Associates, PLLC uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Women's Healthcare Associates, PLLC discloses about you to someone who is involved in your care or the payment for your care.

  Women's Healthcare Associates, PLLC is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Women's Healthcare Associates, PLLC has been paid out of pocket in full. Should Women's Healthcare Associates, PLLC agree to your request, Women's Healthcare Associates, PLLC will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions you must make your request in writing to Women's Healthcare Associates, PLLC . In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Women's Healthcare Associates, PLLC 's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that Women's Healthcare Associates, PLLC communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Women's Healthcare Associates, PLLC contact you only at work or by mail.

  To request that Women's Healthcare Associates, PLLC communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Women's Healthcare Associates, PLLC will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer .

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint IN WRITING with Women's Healthcare Associates, PLLC, ATTN: Jennifer Jalomo, 1301 S Coulter, Suite 300, 806-355-6330 or with the Office for Civil Rights, U.S. Department of Health and Human Services @ 1301Young Street, Suite 1169, Dallas, TX 75202. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. You will NOT be penalized for filing a complaint.

ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that WOMEN'S HEALTHCARE ASSOCIATES, PLLC provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

WOMEN'S HEALTHCARE ASSOCIATES
1301 S. COULTER, SUITE 300
AMARILLO, TX 79106
PHONE: (806)355-6330 FAX (806)351-0950

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME _____ DOB _____ SS# _____

ADDRESS _____

_____

I AUTHORIZE WOMEN'S HEALTHCARE ASSOCIATES TO DISCLOSE MY INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW, WHICH MAY INCLUDE INFORMATION CONCERNING COMMINICABLE DISEASES SUCH AS HUMAN IMMUNODEFICIENCY VIRUS ("HIV") AND ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS"), MENTAL ILLNESS (EXCEPT FOR PSYCHOTHERAPY NOTES), CHEMICAL OR ALCOHOL DEPENDENCY, LABORATORY TEST RESULTS, MEDICAL HISTORY, TREATMENT OR ANY OTHER SUCH RELATED INFORMATION. I UNDERSTAND THAT ANY DISCLOSURE OR INFORMATION CARRIES WITH IT THE POTENTIAL FOR ANY UNAUTHORIZED RE-DISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY THE FEDERAL AND STATE PRIVACY REGULATIONS. I UNDERSTAND THAT MY HEALTH CARE AND THE PAYMENT OF MY HEALTH CARE WILL NOT BE AFFECTED IF I DO NOT SIGN THIS FORM. **IF YOU ARE NOT THE INTENDED RECIPIENT AND/OR RECEIVED THIS TRANSMISSION IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE TO ARRANGE FOR THE RETURN OF THESE DOCUMENTS.**

RECORDS REQUESTED **FROM:**

_____
Physician's Name

_____
Address

_____
City/State/Zip

_____
Fax # (including area code)

SEND RECORDS **TO:**

_____
Physician's Name

_____
Address

_____
City/State/Zip

_____
Fax # (including area code)

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

___ALL RECORDS **(PERMANENT TRANSFER)**
___HISTORY/PHYSICAL EXAM NOTED DATES: _____
___LABORATORY RESULTS DATES: _____
___X-RAY REPORTS DATES: _____
___OTHER DIAGNOSTIC REPORTS DATES: _____
___OTHER (PLEASE SPECIFY) _____

**********IF YOU **DO NOT** WANT THE RECORDS FAXED DO NOT INCLUDE FAX #.**********

REASON OR PURPOSE FOR RELEASE:

___CONTINUED PATIENT CARE ___PERSONAL USE ___INSURANCE CLAIM/APPLICATION
___DISABILITY DETERMINATION/SOCIAL SECURITY ___ATTORNEY ___OTHER (SPECIFY)_____

I UNDERSTAND THAT THE INFORMATION RELEASED IS FOR SPECIFIC PURPOSE STATED ABOVE AND ANY OTHER USE OF THIS INFORMATION WITHOUT WRITTEN CONSENT IS PROHIBITED. I FURTHER UNDERSTAND THAT I MAY REVOKE THIS CONSENT (IN WRITING) AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN. THIS CONSENT WILL EXPIRE 180 DAYS AFTER THE DATE OF MY SIGNATURE UNLESS OTHERWISE SPECIFIED.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE DATE

FOR OFFICE USE ONLY: RECORDS PICKED UP _____ MAILED_____ FAXED_____ DATE _____ INITIALS_____