

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 \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ DOB \_\_\_\_\_ PHONE/CELL # \_\_\_\_\_

ADDITIONAL LOCAL CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ DOB \_\_\_\_\_ PHONE/CELL # \_\_\_\_\_

**HOW WERE YOU REFERRED TO WOMEN'S HEALTHCARE ASSOCIATES?** \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

POLICY # OR NAME \_\_\_\_\_ GROUP # \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ 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 the 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) \_\_\_\_\_

Facility/Location \_\_\_\_\_

Abnormal (circle) Yes No (If yes, please fill out attached Ancillary Release.)

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 (including 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

Bloody/black stools

Leaking of urine

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 the 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 a 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 the 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 for 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 the 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 or 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 officer;
  - 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 100, 806-355-6330 or with the Office for Civil Rights, U.S. Department of Health and Human Services (Region 6) 1301 Young 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.

# 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 COMMUNICABLE 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 FOR 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:

### SEND RECORDS TO:

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

Fax # (including area code) \_\_\_\_\_

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 \_\_\_\_\_

WOMEN'S HEALTHCARE ASSOCIATES P.L.L.C.  
ANCILLARY DEPARTMENT  
1301 S. COULTER, SUITE 300 AMARILLO, TX 79106  
PHONE: (806) 457-2258 FAX: (806) 457-2262  
Janessa Hernandez

PATIENT NAME (please print) \_\_\_\_\_

PATIENT DATE OF BIRTH \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

To Whom It May Concern:

The above-named patient has recently been to our facility for a mammogram examination. Previous mammogram images on **CD** or shared via *Powershare* and **REPORTS** are needed for comparison study. Please fax the last three most recent exams to our facility as soon as possible, along with mailing a CD or forwarding images through *Powershare*. If you do not have images on file, please notify us.

Powershare to: Women's HealthCare Associates PLLC  
1301 S. Coulter Suite 300, Amarillo, TX 79106  
Facility/ Obstetrics & Gynecology

Thank you,  
WOMEN'S HEALTHCARE ASSOCIATES P.L.L.C.  
Ancillary Department

**CONFIDENTIALITY NOTICE**

Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being sent to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without the additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal or state law.

**IMPORTANT WARNING:**

This correspondence is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, copying, distribution, or unauthorized use of this information is **STRICTLY PROHIBITED**. If you have received this correspondence in error, please notify the sender immediately by telephone and arrange for the return or destruction of these documents.

Facility: \_\_\_\_\_ Fax# \_\_\_\_\_ Phone# \_\_\_\_\_