



WOODLANDS obgyn ASSOCIATES

Patient Name		Maiden Name	Date Of Birth	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> Sep
Street Address		City	State	Zip
Home Phone ()	Cell Phone ()	Social Security #		
Employer	Occupation	Business Phone ()		
Spouse's Full Name	Spouse's DOB	Spouse's Social Security #		
Spouse's Employer	Spouse's Occupation	Spouse's Business Phone ()		
Who Referred You To This Practice?	Preferred Method of Contact <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	E-Mail:		

INSURANCE INFORMATION

Primary Insurance Company		Primary Care Physician and IPA or Group (If Applicable)		
Name Of Policy Holder (If other than patient)	Policy ID #	Policy Group #		
Policy Holder's Date of Birth	Policy Holder's Social Security #	Policy Holder's Employer		
Secondary Insurance Company		Primary Care Physician (If Applicable)		
Name Of Policy Holder (If other than patient)	Policy ID #	Policy Group #		
Policy Holder's Date of Birth	Policy Holder's Social Security #	Policy Holder's Employer		
Medicare #	Medicaid #			

EMERGENCY CONTACT INFORMATION (Must have for everyone)

Name	Relationship	Contact's Phone ()
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In order to control billing costs payment is due at the time services are rendered.

AUTHORIZATION: I hereby authorize the physicians of Woodlands OB/GYN Associates to furnish information to insurance carriers concerning my care and I hereby irrevocably assign to the physicians all payments for medical services rendered. I attest by my signature that I have listed all insurances that I am covered by and understand I must notify the office in writing of any changes. I also understand that I am financially responsible for all charges.

Responsible Party's Signature: _____ Date: _____

Sign below only if requested. I have reviewed all the above information and found it to be accurate.

Responsible Party's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

RAJ K. SYAL, M.D. FACOG
OBGYN BOARD CERTIFIED

JENNA A. EVERSON, M.D. FACOG
OBGYN BOARD CERTIFIED

HOLLY WESTMORELAND, M.D. FACOG
OBGYN BOARD CERTIFIED

LISA M. WILKERSON PA.-C.
NCCPA CERTIFIED

9200 PINECROFT, SUITE 300 • THE WOODLANDS, TEXAS 77380 • TEL 281.364.9898 • FAX 281.292.0400

www.woodlandsobgynassociates.com

Woodlands OB/GYN Associates
Acknowledgement of Receipt of Notice of Privacy Practices,
Patient Record of Disclosures and Patient Rights & Responsibilities,
Office and Financial Policies

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I hereby give my consent for Woodlands OB Gyn Associates to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and health care operations (**TPO**).

With this consent, the staff of Woodlands OB Gyn Associates may call my home, cell or any other alternative location I have listed, leaving a voice mail or message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any other calls pertaining to my clinical care, including lab results among others. With this consent, Woodlands OB Gyn Associates may mail to my home or e-mail any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. A record will be kept of any disclosures in our Electronic Medical Record.

I give permission to the staff at Woodlands OB/GYN Associates and all of its healthcare providers to discuss issues regarding my visits, any lab or test results, my appointment or insurance with the following people.

If left blank we will not discuss with anyone, unless you are a minor, we will then follow the Texas laws.

Name _____ Relationship _____

I understand this will remain in effect until I notify the office in writing of any changes. Woodlands OB Gyn Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy officer Judy Serafini at 9200 Pinecroft Suite 300 The Woodlands, Texas 77380. By signing this I acknowledge that I have received Woodlands OB Gyn Associates Notice of Privacy Practices, Patient Rights and Responsibilities and Office and Financial Policies.

Patient Signature

Date

Printed Name of Patient

Birthdate

Signature of Patient Representative if patient is a minor

Relationship of patient representative

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for treatment, payment & healthcare operations may be permitted without prior consent in an emergency. For non-emergency request, written permission will be obtained from patient.

Woodlands OB Gyn Associates

PATIENT RIGHTS AND RESPONSIBILITIES

You have the right:

- To receive considerate and respectful care at Woodlands OB Gyn Associates.
- To receive an explanation of your diagnosis, treatment, and prognosis in terms you can understand.
- To receive the necessary information to participate in decisions about your care and to give your informed consent before any diagnostic or therapeutic procedure is performed.
- To expect that your personal privacy will be respected by all staff members at Woodlands OB Gyn Associates.
- To expect that your medical records will be kept confidential and will be released only with your written consent, in cases of medical emergencies, or in response to court orders. (Confidentiality can be breached if the individual poses a significant threat of harm to self or others).
- To know the names and positions of people involved in your care by official name tag or personal introduction.
- To ask and receive an explanation of any charges made by Woodlands OB Gyn Associates, even if they are covered by insurance.
- To obtain another medical opinion prior to any procedure.
- To review any medical records created and maintained by Woodlands OB Gyn Associates regarding your care and treatment.
- To effective pain management and to be informed by staff about available measures.
- To care which takes into consideration your psychosocial, spiritual, and cultural values.

You are responsible:

- For providing accurate information about your past health history.
- For asking questions if you do not understand the explanation of your diagnosis, treatment, prognosis, or any instructions.
- For providing the necessary information to complete your file.
- For any charges billed to you.
- For following the rules and regulations posted within Woodlands OB Gyn Associates.
- For providing your practitioner with at least a 24 hour notice when you or your family are in need of medications or a prescription.
- For arriving on time for appointments. If you are fifteen minutes or more late we cannot guarantee your appointment.
- For calling at least 24 hours in advance of your appointment to cancel and/or reschedule.

Woodlands Ob/Gyn Assoc. offices of Drs Syal, Everson, Westmoreland and Lisa Wilkerson PA

Notice Of Privacy Practices Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

WE ARE REQUIRED BY LAW TO HAVE YOU REVIEW THIS INFORMATION AND FILL OUT THE FORM UNDERNEATH.

PLEASE REVIEW CAREFULLY AND SIGN THE PAGE UNDERNEATH. THIS IS YOUR PERSONAL COPY.

Our promise to our patients: Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

INTRODUCTION

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords, to protect databases, compliance audits and intrusion detection software. Access to your information is limited to those who must have it to perform their jobs. At Woodlands OBGYN Associates we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003 and applies to all protected health information as directed by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit our office, a record of your visit is

OUR RESPONSIBILITIES

Our practice is required to:

- *Maintain the privacy of your health information,
- *Provide you with this notice as to 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 request restriction, and,
- *Accommodate reasonable request you may have to communicate your health information.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top right hand corner. In addition, each time you visit our office for treatment you may obtain a copy of the current notice in effect upon request.
- We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 508(b)(5), except to the extent that action has already been taken.

FOR MORE INFORMATION, or To REPORT A PROBLEM

If you have questions and would like additional information, you may contact the Woodlands OB/GYN Associates Privacy Officer at 281-364-9898.

If you believe your privacy rights have been violated, you can either file a complaint with our Privacy Officer or the Office for Civil Rights, U.S. Department of Health and Human services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record serves as an:

- *Basis for planning your care or treatment,
- *Means of communication among the many health professionals who contribute to your care,
- *Legal document describing the care you received,
- *Means by which you or a third-party payer can verify that services billed were actually provided,
- *Tool in educating health professionals,
- *Source of data for medical research,
- *Source of information for public health officials charged to improve the overall health of the nation,
- *Source of data for our planning,
- *Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understanding who, what, when, and why others may access your health information and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Woodlands OB gyn Associates, the information belongs to you. You have the right to:

- *Obtain a paper copy of this notice of privacy policies upon request,
- *Inspect and obtain a copy of your health records as provided by 45CFR 164-524 (reasonable copy fees apply in accordance with state law),
- *Amend your health record as provided by 45 CFR 164-526,
- *Obtain an accounting of disclosures of your health information as provided by 45 CFR 164-528,
- *Request confidential communications of your health information as provided by 45 CFR 164 522(b),
- *Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164-522(a) (however we are not required by law to agree to a requested restriction).

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

We will use your health information for treatment.

We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management or condition of your care.

For Example:

Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among healthcare professionals involved in your care.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.

We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:

If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.

We will use your health information for regular health operations.

We may disclose your health information for our routine operations. Those uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions. For example: This information may be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare cost.

***Appointment Reminders**

We may disclose medical information to provide appointment reminders (e.g. contacting you at the phone numbers you have provided to us and leaving a message as an appointment reminder)

***Decedents**

Consistent with applicable law, we may disclose health

information to a coroner, medical examiner or funeral director.

***Workers Compensation**

We may disclose your health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs.

***Public Health**

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

***Research**

We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the proposal.

***Organ Procurement Organizations**

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donations and transplant.

***As Required By Law**

We may disclose health information as required by law. This may include anything required by government regulations or civil rights laws.

***Specialized Government Functions**

We may disclose health information for military and veterans affairs or national security and intelligence.

***Business Associates**

There are some services provided in our organization through contacts with business associates. Some examples are laboratory transcription services we may use. Due to the nature of their services they must receive your health information to perform the job we have asked them to do. To protect your health information however when these services are contracted we require the business associate to appropriately safeguard your information.

***Practice Marketing**

We may contact you to provide information about treatments or services that may be of interest you.

***Food and Drug Administration (FDA)**

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, surveillance information to

enable product recalls, repairs or replacement.

***Personal Representatives**

We may use or disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your healthcare).

***To Avert A Serious Threat To Health / Safety**

We may disclose your information when we believe in good faith that it is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

***Communication With Family**

Unless You Object health professionals, using their best judgment, may disclose to a family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.

***Disaster Relief**

Unless You Object, we may disclose health information about you to an organization assisting in disaster relief.

For all non-routine operations we will obtain written authorization before disclosing health information. We take great care to safeguard your information, to minimize any incidental disclosures.

Thank you for taking the time to complete this form. It will assist us in providing you with the best possible medical care during your visit today.

Name _____ Date _____

Are you here for your annual exam? Yes No Please list any other problems or concerns you would like addressed at this visit.

Gynecological History:

Last Menstrual Period _____

How many days between your periods _____ How long do they last _____

Marital Status (single, married, divorced, separated) _____

Are you sexually active _____ Any problems _____

What are you using for birth control _____

How many times have you been pregnant _____

Number of children _____ Number of miscarriages _____ Number of abortions _____

Any history of sexually transmitted diseases _____

When was your last pap smear _____

Have you ever had an abnormal pap smear _____

Any problems with your breasts _____ Last mammogram _____

Have you had a hysterectomy _____

Are you on hormone replacement therapy _____ If yes, what _____

Major Medical Problems: _____

Prior Surgeries: _____

Current Medications and dosages: _____

Drug Allergies: _____

Family History:

Cancer _____ Heart Attacks _____ Diabetes _____ High Blood Pressure _____

If yes, please explain: _____

Race/Ethnic Background _____

Habits:

Smoking _____ If yes, how much _____

Alcohol _____ If yes, how often _____

Drugs _____ If yes, what _____

Exercise _____ If yes, how often _____

Are you currently experiencing any of the following problems:

Y N	Chest Pain	Y N	Abdominal Pain	Y N	Urinary Problems
Y N	Trouble Breathing	Y N	Pelvic Pain	Y N	Constipation
Y N	Headaches	Y N	Breast Problems	Y N	Diarrhea
Y N	Dizziness	Y N	Menstrual Irregularity	Y N	Hot Flashes
Y N	Swelling	Y N	Vaginal Discharge	Y N	History of Sexual Abuse
Y N	Nausea/Vomiting	Y N	Vaginal Irritation	Y N	History of Physical Abuse
Y N	Weight Gain/Loss	Y N	Skin Problems	Y N	Problems with Sleep
Y N	Exposure to STD's	Y N	Irritability	Y N	PMS

Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

The last 2 columns on the right are for your doctor to assess your score. Please do not mark anything in these columns.

Patient's name: _____ Today's date: _____

	0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1 How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2 b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3 Are you currently sexually active? YES _____ NO _____							
4 a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5 Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6 Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7 a. If you have pain, is it usually...		Mild	Moderate	Severe			
b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8 a. If you have urgency, is it usually...		Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			

Please see full Prescribing Information on reverse.

SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) – SUBTOTAL

BOTHER SCORE (2b, 4b, 7b, 8b) – SUBTOTAL

TOTAL SCORE (Symptom Score + Bother Score) =

