BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

LILLIAN ABBOTT, M.D.
STEPHEN FALK, M.D. F.A.C.O.G., F.A.C.S.
ERWIN KORMAN, M.D. F.A.C.O.G., F.R.C.S.

MICHAEL PETITT, M.D. F.A.C.O.G.
MARY A. POAG, M.D. F.A.C.O.G.
MARIA T. RIVERO, M.D. F.A.C.O.G.

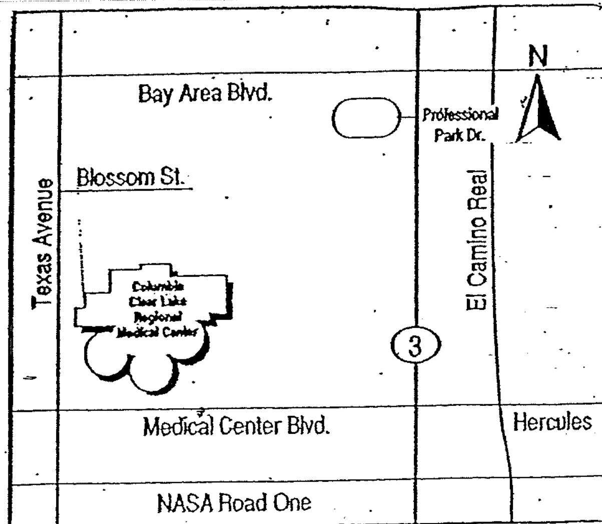
Diplomates of The American Board of Obstetrics and Gynecology
#17 PROFESSIONAL PARK
WEBSTER, TX 77598
TELEPHONE (281) 332-9511
FAX (281) 332-6685

Dear Patient:

Attached, please find several new patient information sheets that need to be completely filled out prior to your appointment on ______________. By completing these forms before you come into the office, will assist in the waiting time in seeing the physician. If the forms are not completed correctly and accurately, your time will be delayed or your appointment may be re-scheduled. Please do NOT mail these forms back to us, just bring them on your appointment.

Also, you will need to bring your current insurance card and a referral if needed or your appointment will have to be re-scheduled. Please be informed that we only accept cash, check, debit card, visa, discover and mastercard for payment. All CO-PAYS, DEDUCTIBLES AND CO-INSURANCE amounts will be PAYABLE at the time of your appointment.

File: newpt



BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

17 Professional Park • Webster, Texas 77598
281-332-9511

Date: ____________________
SS#: ____________________
TXDL#: ____________________
Email: ____________________

Pharmacy#

A. PATIENT INFORMATION

FIRST NAME ❑ MISS ❑ MRS.	MIDDLE NAME	LAST NAME	WIFE'S MAIDEN NAME
ADDRESS	CITY, STATE, ZIP CODE		HOME PHONE NO.
OCCUPATION	EMPLOYER		BUSINESS PHONE NO.
BUSINESS ADDRESS		CITY, STATE	CELL PHONE NO.

BIRTH DATE	❑ MARR. ❑ SING. ❑ DIV. ❑ SEP. ❑ WID.	BIRTHPLACE	RELIGION	REFERRED BY

IN CASE OF EMERGENCY NOTIFY: (Other than spouse)	ADDRESS	PHONE NO.

B. SPOUSE OR PARENTS

NAME	RELATION	OCCUPATION	BUSINESS PHONE NO.
EMPLOYER	ADDRESS, CITY, STATE		

C. INSURANCE

INSURANCE NAME	CLAIMS ADDRESS	
INSURED NAME	INSURED'S DOB	ID#
GROUP#	INSURED'S EMPLOYER	

REASON FOR THIS VISIT ____________________

DATE OF YOUR LAST PERIOD ____________________ DATE OF LAST PAP SMEAR ____________________

HOW ARE YOUR PERIODS? REGULAR ____________________ IRREGULAR ____________________

LIGHT ____________________ MODERATE ____________________ HEAVY ____________________

NO PAIN ____________________ SLIGHT PAIN ____________________ MUCH PAIN ____________________

LIST SPECIAL PROBLEMS WITH YOUR PERIODS ____________________

CHECK THE TYPE OF CONTRACEPTIVE BEING USED NONE __________ RHYTHM __________ CONDOM __________ WITHDRAWAL __________

FOAM __________ DIAPHRAM __________ IUD __________ PILL __________ TUBAL LIGATION __________ VASECTOMY __________

LIST NUMBER OF PREGNANCIES __________ MISCARRIAGES __________ ABORTIONS __________ CHILDREN __________

LIST ANY SURGERY DONE ____________________

LIST MAJOR MEDICAL PROBLEMS ____________________

LIST PRESENT MEDICATION ____________________

LIST KNOWN ALLERGIES ____________________ SMOKER __________ NON SMOKER __________

NAME:____

1. **How old are you?____________**
2. **Are you single________ married_________ widow________ divorced________ or separated________?**
3. **What is your occupation?____________________________**
4. **When did you have your last pap (cancer) test?____________________**
5. **How many pregnancies have you had?______________**
6. **How many abortions (spontaneous or induced) have you had?____________**
7. **How many living children do you have?___________**
8. **How old were you at the time of your first period?____________**
9. **Are you regular with your periods (between 25-35 days)?__________**
10. **How long do your periods last?______________**
11. **When was your last normal period?__________________**
12. **What do you use for contraception?____________________How long?___________ What kind?________________**
13. **Have you ever had problems using birth control?__________**
14. **Have your periods been excessively heavy recently?________________**
15. **Have you spotted between periods recently?______________**
16. **What is the longest interval between periods? (past year)________________**
17. **Do you have pain with your period?________________**
18. **Do you have pain with intercourse?________________**
19. **Have you had pain when you urinate recently?_______________**
20. **Do you ever lose your urine when you cough or sneeze?_____________**
21. **Have you ever been seriously ill or hospitalized?___________________ When?_____________ What for?____**
22. **Have you ever had major surgery?________________ When?___________________ What for?____**
23. **Have you ever had professional help for emotional problems?___________________ If so, when?____**
24. **What drugs, if any, are you allergic to?_______________________________________**
25. **What medications do you take regularly? If so, how long?_____________________**
    ____
26. **Do you smoke?_______ If so, how much?____________________**
27. **Do you drink?________ If so, how much?____________________**
28. **Does any of your family members have high blood pressure, diabetes, birth defects, cancer or any other diseases that you know of?________________________________**
    ____
29. **What is your main problem now?____**
30. **I understand should Dr. _______________ not be available as a result of illness, vacation or attendance at a medical conference, there will be a qualified physician on call.**

______________________________________ ________________________
Signature **Date**

File: newptquestions

BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

LILLIAN ABBOTT, M.D.
STEPHEN FALK, M.D. F.A.C.O.G., F.A.C.S.
ERWIN KORMAN, M.D. F.A.C.O.G., F.R.C.S.

MICHAEL PETITT, M.D. F.A.C.O.G.
MARY A. POAG, M.D. F.A.C.O.G.
MARIA T. RIVERO, M.D. F.A.C.O.G.

Diplomates of The American Board of Obstetrics and Gynecology
#17 PROFESSIONAL PARK
WEBSTER, TX 77598
TELEPHONE (281) 332-9511
FAX (281) 332-6685

MEDICAL TREATMENT CONSENT FORM

This will verify that I hereby authorize any and all doctors from Bay Area Obstetrics & Gynecology, P.A. or those designated by them including ancillary personnel to evaluate, diagnose, treat, and otherwise care for including all necessary tests or procedures, whether in our office or elsewhere.

This permission is valid until revoked by notice to Bay Area Obstetrics & Gynecology, P.A. in writing.

Signed________________________________ **Date**__________________

File: medconsent

BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

LILLIAN ABBOTT, M.D.
STEPHEN FALK, M.D. F.A.C.O.G., F.A.C.S.
ERWIN KORMAN, M.D. F.A.C.O.G., F.R.C.S.

MICHAEL PETITT, M.D. F.A.C.O.G.
MARY A. POAG, M.D. F.A.C.O.G.
MARIA T. RIVERO, M.D. F.A.C.O.G.

Diplomates of The American Board of Obstetrics and Gynecology
#17 PROFESSIONAL PARK
WEBSTER, TX 77598
TELEPHONE (281) 332-9511
FAX (281) 332-6685

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am personally obligated to pay all physician bills from Bay Area Obstetrics & Gynecology for services rendered to me. I understand that the physician bills are separate from and do not include charges made by the hospital, outside laboratories and other physicians. The fact that I may be covered by insurance does not relieve my personal obligation to pay all my physician bills; including bills for non-covered services and any amounts applied to co-pays, deductibles and co-insurance.

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the provider of any services for Bay Area Obstetrics & Gynecology.

I agree to pay at Webster, Harris County, Texas the charges of Bay Area Obstetrics & Gynecology.

______________________________ ______________________

Patient **Date**

______________________________ ______________________

Witness **Date**

File: finanrespon

Bay Area Obstetrics & Gynecology, PA
17 Professional Park
Webster, Texas 77598
281-332-9511

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMNT FORM

I,__________________________, have received a copy of Bay Area Obstetrics & Gynecology, P.A.'s
(Print patient name)
Notice of Privacy Practices for review; which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communication of personal health information be made by alternate means, such as sending correspondence to the individual's home, or calling an individual at their office.

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

__________________________ __________________________
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________

What is the best way for us to contact you? __________________________

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. (Such as diagnosis and medication).

I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

Home Telephone ------ Is it OK to leave a <u>detailed</u> message? YES NO

Work Number: ------ Is it OK to leave a <u>detailed</u> message? YES NO

Cell Phone Number: ----- Is it OK to leave a <u>detailed</u> message? YES NO

Written Communication: ------ Is it OK to mail <u>detailed</u> information to my home address? YES NO

I understand that I have the right to revoke/change this authorization, by coming to the office at anytime to update this in person. Otherwise, this authorization will be in force permanently.

Cindy Flynn/Reata Baker, Privacy Officers
#17 Professional Park
Webster, Texas 77598 FAX 281-332-6685

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used of disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

__________________________	__________________________
Signature of Patient or Personal Representative	**Print Name of Patient or Personal Representative**
__________________________	__________________________
Date	**Description of Personal Representative's Authority**

Notice of Privacy Practices

Bay Area Obstetrics and Gynecology

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence

activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge

for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Cindy Flynn / Reata Baker
17 Professional Park
Webster, Tx 77598
281-332-9511 (phone)
281-332-6685 (fax)

This notice is effective April 14, 2003.