Pacific Women's Healthcare Associates

Consent Release Form for Medical Information

Patient Name: _____
(Please print patient name)

Date of Birth: _____

Doctor: _____

Internist/Family Practice Physician: _____
(First name) (Last name)

Telephone #: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Phone #: _____

Patient's Email address: _____

May we discuss your medical information with any other person or family member? Yes or No (Circle One)

Name: _____
(Please Print Name) (Relationship)

May we leave a detailed message (including abnormal results) on your voice mail? Yes or No (Circle One)

Voice Mail #: _____

_____ Date: _____
(Patient's Signature)

Pacific Women's Healthcare Associates
Financial Policy

We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you read and agree to prior to any treatment.

Insurance Billing
Your insurance policy is a contract between you and your insurance company. ***It is your responsibility to know your benefits and how they will apply to your treatment by the doctor***. We are not a party to that contract. If your insurance company has not paid your account in full within 90-days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD and AMEX.

Cash patients
All services must be paid in full at time of treatment.

Administrative Fees

- All co-pays will be collected at the time of service, prior to seeing provider. If co-payment is not made, patient may not be seen.
- ***Each Medical Record requests are subject to a preparation fee of $15.00***. The actual cost of shipping and handling will be added if applicable. Please allow 7 business days turnaround time to process and complete your request.
- ***A fee of $25 will be applied to all checks returned for non-sufficient funds.***
- ***A fee will be collected for completing all Disability, Worker's Compensation, Employer leave, of Absence and other administrative forms.*** Please allow 7 business days turnaround time to process and complete these forms. The completed forms will not be mailed or returned until the following fees are paid:

    - ***A fee of $25.00 will be collected for State Disability Forms and each Disability Private Forms;***
    - ***A fee of $5.00 will be collected for forms extending disability;***
    - ***A fee of $10.00 will be collected for DMV forms.***

OB Deposits
Before the end of your seventh month of pregnancy, our billing office will verify your OB benefits and send you a letter estimating your financial responsibility. This will allow you to make payments prior to delivery to lessen the financial burden afterwards.

Surgery Deposits
Pacific Women's Healthcare Associates charges only for professional services provided by your physician. The anesthesiologists, the facility where your procedure is performed and other assistants that your surgeon may require will be billing your insurance directly. Once a decision for surgery is made the Surgery Scheduler will provide you with your estimated financial responsibility. This process normally happens within 3-4 business days of scheduling your procedure. The estimated responsibility will be collected as a deposit at the time of your pre-op appointment.

I hereby attest that the insurance information I have provided is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.

Patient's Signature:_____ Date: _____

Patient Name: _____

Pacific Women's Healthcare Associates

HIPAA POLICY REGARDING USE AND DISCLOSURE OF PHI FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS INCLUDING SPECIAL HIPAA RULES REGARDING USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR MARKETING PURPOSES

SCOPE OF POLICY:

All offices of PWHA are covered by this policy:

What Personnel Are Covered by this Policy? This policy applies to health care providers, clinical and all employees who assist these providers in performing tasks related to health care.

PURPOSE OF POLICY: The purpose of this policy is to set forth the standards for the use of a patient's or subject's (the "Individual") Protected Health Information (PHI) for treatment, payment, and health care purposes.

DEFINITIONS:

Covered Entity: health plan; healthcare clearinghouse; or a health care provider who transmits any Health Information in electronic form in connection with a transaction covered under the HIPAA regulations.

Health Information: Any information whether oral or recorded, in any form, that is created or received by PWHA that related to an Individual's past, present, or future physical health, or to the payment of such health care.

Health Care Operations: Any of the following activities of the PWHA Covered Component to the extent that the activities are related to the functions of the PWHA Covered component that make it a health plan, health care provider or a health care clearinghouse:

(a) health care protocol development (excluding research protocol development)
(b) case management and health care coordination;
(c) contacting health care providers and patients with information about treatment alternatives;
(d) accreditation, certification, licensing or credentialing activities;
(e) conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

Individually Identifiable Information: Health Information, including demographic information, that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

Marketing: Marketing is:

(1) An arrangement between a Covered Entity and any other entity pursuant to which the Covered Entity discloses PHI to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own services that encourages the recipient of the communication to use;
(2) Making a communication about a service that encourages the recipient of the communication to use the service unless the communication is made:
    (a) to describe a health related service (or payment for such service) that is provided by, or included in a plan of benefits provides by the Covered Entity that is making the communication (including communications about entities that are participating in a health care provider network or health plan network, or about replacement of or enhancement to a health plan; and health related services available only to a health plan enrollee that add value to, but are not part of a plan of benefits);
    (b) for treatment of the Individual;
    (c) for case management or care coordination for the Individual;
    (d) to direct or recommend alternative treatments, therapies, health care providers or setting of care to the Individual

Protected Health Information (PHI): Individually Identifiable Health Information that is transmitted by electronic media or transmitted or maintained in any other form or medium.

POLICY:

General Rule: The PWHA Covered Component may use and disclose PHI for Treatment, Payment and Health Care Operations purposes without first obtaining a written authorization (that contains all HIPAA-required elements) from the Individual who is the subject of the PHI, provided that the use or disclosure falls within one of the following categories:

(a) the PWHA Covered Component may use or disclose an Individual's PHI for it own Treatment, Payment or Health Care Operations;
(b) the PWHA Covered Component may disclose an Individual's PHI for the treatment activities of a health care provider;
(c) the PWHA Covered Component may disclose an Individual's PHI to another Covered Entity or a health care provider for the payment activities of the entity that receives the PHI;
(d) the PWHA Covered Component may disclose an Individual's PHI to another covered entity for the Health Care Operations of the entity that receives the PHI if each entity either has, or had, a relationship with the Individual; the PHI pertains to the relationship; and the disclosure is for quality assessment, quality control or peer review purposes or for the purpose of health care fraud, and about detection or compliance.

Consent: Although the PWHA Covered Component is not required to obtain an Individual's authorization for the use of PHI for the treatment, payment and health care operations purposes in order to comply with HIPAA, it is permitted under HIPAA to obtain an individual's consent to such uses/disclosures.

PROCESS/PROCEDURE:

Consent for Treatment: The PWHA Covered Component should continue to obtain a signed consent for treatment for each Individual who receives health care services. This consent for treatment may contain a consent to the use and disclosure of the Individual's PHI for treatment, payment and health care operations purposes; however, for uses and disclosures of PHI for the HIPAA purposes outlined above under the General Rule, a HIPAA authorization is not required.

APPLICABILITY OF MINIMUM NECESSARY AND ACCOUNTING RULES:

Minimum Necessary Rule: The Minimum Necessary Rule does not apply to disclosures made for treatment purposes. The Minimum Necessary Rule does apply to any other uses and disclosures permitted under this policy that are not made to the Individual or made pursuant to the written authorization of the Individual.

Accounting Rule: The PWHA Covered Component is not required to keep records accounting for the disclosure of PHI used for Treatment, Payment and Health Care Operations purposes permitted under the policy, or for disclosures made to the Individual or pursuant to the written authorization of the Individual. Records of all other disclosures permitted hereunder must be maintained in order to provide an Individual with an accounting of such disclosures upon her request. These records must be maintained for a period of six years following the date of the disclosure.

HEALTH INFORMATION EXCHANGE:

This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

I acknowledge receipt of HIPAA privacy policy:

_____ _____

Signature Date

Pacific Women's Healthcare Associates

Rhonda M. Flora, M.D., F.A.C.O.G.
Brooke A. Hargrove, M.D., F.A.C.O.G.
Lisa M. Karamardian, M.D., F.A.C.O.G.
Anne M. Kent, M.D., F.A.C.O.G.
Jody W. Lai, M.D., F.A.C.O.G.

500 Superior Ave., Suite 310
Newport Beach, CA 92663
(949) 650-7100 / (949) 644-2722

4870 Barranca Pkwy., Suite 200
Irvine, CA 92604
(949) 559-4870

Vinita J. Speir, M.D., F.A.C.O.G.
Patricia Strachan, M.D., F.A.C.O.G.
Nicolle S. Underwood, M.D., F.A.C.O.G.
Lisa M.T. Worsch, M.D., F.A.C.O.G.

INSURANCE WAIVER

I have chosen to receive medical services from Dr. _____. I understand that my insurance benefits cannot be verified at this time.

I understand I am responsibile for all deductibles, copayments and non-covered expenses, and other out -of-network expenses incurred by seeking serices by a non-preferred/out-of-network provider. I am also aware that any outside services (labs, ultrasounds, mammograms, hospital care, etc.) ordered by the physician are also subject to out-of-network reimbursement depending on my individual plan according to my insurance carrier.

_____ _____

Patient Signature Date

_____

Print Name

Pacific Women's Healthcare Associates

Rhonda M. Flora, M.D., F.A.C.O.G.
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NAME	SSN	AGE
ADDRESS	PHONE	

I OB-GYN HISTORY

A. NUMBER OF PREGNANCIES _____

NUMBER OF FULL-TERM DELIVERIES _____

NUMBER OF PREMATURE DELIVERIES _____

NUMBER OF ABORTIONS (Miscarriages) _____

NUMBER OF LIVING CHILDREN _____

DATE	Type of Delivery	M/F	Complications	Days in Hospital

B. AGE ONSET OF PERIODS _____

REGULARITY-EVERY _____ DAYS

C. LENGTH IN DAYS OF PERIOD _____

CLOTS: (write yes or no) _____

CRAMPS: (write yes or no) _____

D. DATE OF FIRST DAY OF LAST MENSTRUAL PERIOD _____

WAS IT A NORMAL PERIOD (write yes or no) _____

E. DATE OF LAST PAP SMEAR _____ Normal? Yes ☐ No ☐

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? Yes ☐ No ☐

F. DATE OF LAST MAMMOGRAM _____

NORMAL? Yes ☐ No ☐

II SURG & MEDICAL HISTORY

HAVE YOU EVER HAD (if Yes, explain)

A. SURGICAL OPERATIONS

B. SERIOUS OR CHRONIC MEDICAL ILLNESSES

C.

YES	NO	
☐	☐	GONORRHEA
☐	☐	SYPHILLUS
☐	☐	INFECTION IN YOUR TUBES
☐	☐	VAGINAL INFECTION
☐	☐	GENITAL HERPES
☐	☐	CHLAMYDIA
☐	☐	GENITAL WARTS

SEXUAL HISTORY

SEXUALLY ACTIVE Yes ☐ No ☐

PAINFUL INTERCOURSE Yes ☐ No ☐

DISCHARGE/BLEEDING AFTER INTERCOURSE Yes ☐ No ☐

D. CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS WHICH YOU (OR YOUR FAMILY) HAVE HAD

Patient	Family		Patient	Family	
☐	☐	TUMOR OR MASSES OF THE BREASTS	☐	☐	VARICOSE VEINS
☐	☐	DIABETES	☐	☐	PHLEBITIS (Blood Clots in Veins)
☐	☐	EPILEPSY OR CONVULSIONS	☐	☐	PULMONARY EMBOLUS (Clots in Lungs)
☐	☐	HIGH BLOOD PRESSURE	☐	☐	ASTHMA
☐	☐	MIGRAINE HEADACHES	☐	☐	THYROID DISEASE
☐	☐	BLURRED OR ABNORMAL VISION	☐	☐	FIBROIDS (Tumors in Uterus)
☐	☐	LEG CRAMPS	☐	☐	CANCER (Specify) _____
☐	☐	FLUID RETENTION	☐	☐	HEART ATTACK
☐	☐	DEPRESSION (required treatment)	☐	☐	HEART DISEASE
☐	☐	GASTROINTESTINAL DISEASE	☐	☐	STROKE
☐	☐	KIDNEY DISEASE OR BLADDER INFECTION	☐	☐	OTHER (Specify) _____
☐	☐	HEPATITIS (Liver Disease)			

E. DO YOU SMOKE? Yes ☐ No ☐

DO YOU DRINK? Yes ☐ No ☐

SOCIAL DRUGS? Yes ☐ No ☐

Patients Name: _____ Date: _____

III ALLERGIES - MEDICATIONS

A. CHECK ANY OF THE FOLLOWING TO WHICH YOU ARE ALLERGIC.

- ☐ PENICILLIN
- ☐ TETRACYCLINE
- ☐ SULFA
- ☐ ASPIRIN
- ☐ CODEINE
- ☐ CONTRACEPTIVE CREAM
- ☐ OTHER MEDICATIONS *(Give Names)*
- ☐ _____

B. LIST ALL MEDICATIONS *(Including Birth Control Pills)* WHICH YOU ARE PRESENTLY TAKING:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

IV BIRTH CONTROL METHODS

A. WHAT FORM OF BIRTH CONTROL ARE YOU PRESENTLY USING?

- ☐ PILL
- ☐ IUD
- ☐ DIAPHRAGM
- ☐ CONDOM
- ☐ FOAM OR CREAM
- ☐ WITHDRAWAL
- ☐ RHYTHM
- ☐ VASECTOMY
- ☐ TUBAL LIGATION
- ☐ HYSTERECTOMY
- ☐ NONE

B. DO YOU PLAN TO CONTINUE PRESENT FORM OF BIRTH CONTROL? ☐ Yes ☐ No

C. THE NEW METHOD YOU WISH TO USE IS:_____

Pacific Women's Healthcare Associates

PATIENT INFORMATION (Print Clearly Please) DATE:_____

MARITAL STATUS: ❑ Married ❑ Single ❑ Widow ❑ Divorced ❑ Domestic Partner

EMPLOYMENT STATUS: ❑ Employed F/T ❑ Employed P/T ❑ Student ❑ Home Maker

Social Security # _____ Driver's License # _____ Date of Birth _____

Patient's Name _____
Last First MI

Home Phone ( ) _____ Cell phone ( ) _____

Home Address _____
City State Zip

Mailing Address _____
(If Different) City State Zip

Patient's Employer _____ Work Phone # ( ) _____ Ext.

Address _____
City State Zip

Occupation _____

PCP/REFERRED BY: _____ Phone # ( ) _____
Last First

Subscriber information ❑ Self ❑ Spouse ❑ Parent ❑ Guardian

Name of Subscriber _____ Date of Birth _____
Last First MI

Subscriber Employer _____ Work Phone # _____ Ext.

Address _____
City State Zip

EMERGENCY CONTACT: _____ Relationship _____

Phone # ( )_____

MEDICAL INSURANCE INFORMATION

Insured's Name _____ Relationship _____

Name of Insurance Company _____ Effective Date _____

ID # _____ Group # _____

Secondary (if any):

Insured's Name _____ Relationship _____

Name of Insurance Company _____ Effective Date _____

ID # _____ Group # _____

ASSIGNMENT & RELEASE

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO PAID DIRECTLY TO **PACIFIC WOMEN'S HEALTHCARE ASSOCIATES**. I AM FINANCIALLY RESPONSIBLE FOR NONCOVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS.

Patient Signature: _____ Date: _____

I hereby authorize treatment of: _____ FOR MY MINOR CHILD BY **PACIFIC WOMEN'S HEALTHCARE ASSOCIATES**.

Parent/Guardian Signature: _____ Date: _____