Gynecological
Specialty Care

Patient Information Sheet

Please complete and return at time of appointment with insurance card, photo identification and co-pay

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____ Contact Preference: _____

**E-Mail Address* _____

Date of Birth: _____ SSN: _____ Marital Status: _____

Race: ↑ Caucasian ↑ African American ↑ Hispanic/Non-White ↑ Hispanic/White ↑ Asian ↑ Other _____

****

Primary Care Physician: _____ Phone #: _____

Patient's Pharmacies: _____ Phone #: _____

Mail order: _____ Phone #: _____

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Name of Spouse/Parent: _____ Phone #: _____

Primary Insurance Company Name: _____ Policy Holders' Name: _____

Your relationship to the Policy Holder: _____ Policy Holders' Date of Birth: _____

****

Emergency Contact: _____ Relationship: _____

Primary Phone Number: _____ Secondary Phone Number _____

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_____ do hereby consent to any medical and surgical care, which is deemed advisable or necessary by my physician (s) and grant authority to Shelley C. Glover, M.D., to administer and perform all examinations, treatments, anesthetics, operations, and diagnostic procedures, needed now or in the future. I guarantee payment for all services rendered. All medical and/or surgical benefits including major medical benefits, private insurance, and any other health plan are assigned to Gynecological Specialty Care, P.C. Authorization is hereby given to release information and payment requests including information provided for payment under the Titles XVII and XIX of the Social Security Act and assurance is provided by the signature below that all the information provided herein is true and accurate. Authorization is hereby given to release confidential information, including HIV. Psychiatric and substance abuse or treatment, in regard to ordinary and necessary procedures, including issuers and other physicians, to provide for payment or collection of debts incurred or to provide for proper patient care and continuity of care. Shelley C. Glover, M.D. is hereby held harmless from any vicarious liability, including Acts of God, which may cause harm or injury to the patient or others involved in the ordinary care of business. Photocopy of this consent and assignment is to be considered as valid as the original.

_____ _____

Signature of Patient / Guardian *Date*

General *(please check all that apply)*

__Urinary leakage __Urinary urgency __Night sweats __Perform self breast exams
__Breast Tenderness __Lumps __Fluid from the nipples __Mood swings
__Abnormal Vaginal Discharge __Hot Flashes

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Gynecologic History

Menses approximate age of onset _____

Cycle is every _____ days and lasts for approximately ____ days

Bleeding amount: __Light __Moderate __Heavy __Excessive ____Menopausal _____Hysterectomy (Year _____)

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OB History

Total Number of Pregnancies ____ Live Births ____Miscarriages____ Abortions ____ Ectopic(tubal) ____

Number of living children today ____

****

Birth Control Method (Current and Previous)

__Abstinence __Condoms/Foam __Depo-Provera __Hysterectomy __Infertility __IUD __Menopausal
__Oral Contraception __Tubal Ligation __Vasectomy __Virginal ___Withdrawal/Rhythm

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Past Gynecologic History

History of Abnormal Pap Smears: Yes__ No __ If yes what were the findings_____

History of Abnormal Mammograms: Yes __ No__ If yes what were the findings_____

History of Sexually transmitted diseases Yes __No__ If yes please select type: __Chlamydia __Gonorrhea __Trich __Herpes

History of HPV: Yes__ No__ __ HIV __Hepatitis B __Hepatitis C

Date of your last Pap smear: _____ Results: Normal ___ Abnormal ___

Date of your last Mammogram: _____ Results: Normal ___ Abnormal ___

First day of your last menstrual cycle: _____

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Have you ever had a Bone density test: Yes__ No __ If yes, When _____ where was it performed_____

Have you ever had a Colonoscopy: Yes __ No__ If yes, When_____

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Please list all medications:

_____

_____

Please list all allergies: _____

Reason for your visit:_____

Gynecological Specialty Care
New Patient Medical History Form

NAME: _____ AGE: _____

Please answer all questions completely, all information is confidential

General Social History *(Please answer yes or no to all of the questions, if yes please explain)*

Illicit drug use Yes / No type _____ current use / distant past / within past year

Tobacco use Yes / No type _____ how much daily: less than 1 pack / 1-2 packs / more than 2 packs

Alcohol use Yes / No type _____ how often: daily / weekly / monthly / occasionally / holidays

Caffeine use Yes / No type: Coffee / Soda / Tea / Chocolate / other How much daily: 1 / 2 / 3 / 4 __ cups / glasses

Exercise Yes / No type: _____ How often: _____

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Your Medical History *(Please check all that apply)*

__Anemia
__Asthma
__Arthritis
__Diabetes
__Endometriosis
__Fibrocystic Breasts
__Fibromyalgia
__Gastrointestinal Problem
__Cancer (please specify type) _____

__Heart Attack
__Heart Murmur
__High Cholesterol
__High Blood Pressure
__Infertility
__Migraines
__Mitral Valve Prolapse

__Osteopenia
__Osteoporosis
__Seizures
__Stroke
__Thyroid Problems
__Other: _____
_____

Surgical History - Pelvic *(Please check all that apply)*

__C-Section
__Tubal Ligation
__Dilation & Curettage
__Abdominal Hysterectomy

__Vaginal Hysterectomy
__Ovary(s) removed LT/RT/Both
__Ovarian Cysts removed
__Laparoscopy

__Bladder Suspension
__Uterine Ablation
__Other_____
_____

General Surgical *(Please check all that apply)*

__Appendectomy __Gallbladder __Tonsillectomy __Hernia __Breast Biopsy __Breast Implants __Mastectomy
__Cosmetic Other (please specify) _____

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Family History *(as applies to PARENTS, SIBLINGS, GRANDPARENTS only, please check all that apply)*
Please mark which family member each applies to

__Asthma ___
__Diabetes ___
__Heart Disease ___
__Hypertension (High blood pressure) ___
__Osteoporosis ___
__Thyroid Disease___

__Arthritis___
__High Cholesterol___
__Heart Attack___
__Stroke___

__Unknown __ Adopted

Cancer (check all that apply)
__Breast___ __Lung___
__Ovarian___ __Other
__Uterine___
__Cervix___
__Colon/Rectal___

NOTICE OF PRIVACY PRACTICES

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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnoses, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Medical Records Department in our office. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to the Assistant Office Manager. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. You have the right to opt out of communications for fundraising purposes.
- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. Consent is required prior to use or disclosure of an individual's psychotherapy notes or the use of the individuals PHI for marketing purposes.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give you a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice (such as for marketing purposes) or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

IV. Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We will take no retaliatory action against you if you make complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Director of Compliance, either by phone or in writing at:

Valerie Williams
Director of Compliance
Unified Physician Management
1501 Yamato Road, Suite 200 West
Boca Raton, FL 33431
P: (561) 300-2410, ext. 336
F: (561) 953-4152
E: valerie.williams@unifiedhc.com

V. Effective Date: This Notice was effective on **August 27, 2013.**

Gynecological
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Acknowledgement of receipt of Privacy Practices

Signature below verifies that you have received a copy of our privacy practices. Please sign and date below to confirm acknowledgement of our privacy practices.

Printed Name: _____

Signature: _____

Date: _____

Please return the signed acknowledgement to the receptionist.

Thank you!

Gynecological
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FINANCIAL POLICY

Welcome to Gynecological Specialty Care. The following outlines our patient financial policy.

Payment for services provided is required at time of service. We accept cash, check, money orders, Visa and MasterCard. As a courtesy, we will file your insurance claim. **Please understand that ultimately it is your responsibility as a patient to know your insurance coverage and we encourage every patient to know their medical benefits.** Please contact your insurance carrier for clarification of your individual insurance policy should any questions arise. **Benefits quoted to Gynecological Specialty Care are not a guarantee of payment.** Exact payment is not determined until your claim is processed. Bring your insurance card and photo identification at the time of service. Co-pays, co-insurance, deductibles, and/or non-covered services are due at time of service**, no exceptions.**

Any and all services provided by an outside laboratory, such as PAP SMEAR,,biopsies, and cultures **will be billed directly to you by the outside lab.** ***If you have any questions regarding this billing, please contact them directly.***

You will receive a statement reflecting any outstanding balance incurred for services rendered during the billing cycle. This balance is due upon receipt. All accounts that are 90 days past due regardless of insurance coverage will be assigned to our collection agency. Any and all fees related to collection efforts will be your responsibility.

Additional Charges:

- **NO DO NOT ACCEPT CHECKS..**
- **$100** No Show/Cancellation fee for appointments not canceled 24 hours prior to scheduled appointment. After 3 no show/cancellation charges you will discharged from practice.
- **$35** processing fee for all forms needing completion for social security, disability, insurance, etc.

Your signature below indicates that you understand and agree to this financial policy.

Patient Signature:_____

Print Name:_____Date:_____

We DO NOT accept any MEDICARE, MEDICARE ADVANTAGE or MEDICAID