Conroe Women's Associates
Board-Certified in Obstetrics and Gynecology

Patient Demographics

Last name: _____

First name_____Middle name _____

Date of Birth_____Age_____Sex_____Race _____

Ethnicity_____Preferred language _____

Marital status_____SS#_____

Home PH#_____Cell PH#_____

Address_____

_____

Email Address _____

Emergency Contact and phone number _____

_____

Pharmacy name & PH#_____

_____

How did you hear about us? _____

Primary insurance	Secondary insurance
Plan name: _____	Plan name: _____
Phone # _____	Phone# _____
Address to send claims: _____ _____	Address to send claims: _____ _____
Policy Holder: _____ _____DOB _____	Policy Holder: _____ _ _____DOB _____
PH#: _____	PH#: _____
SS#_____	SS# _____
Member ID_____ _____	Member ID _____ _____
Group # _____	Group# _____
Relationship to Policy Holder _____	Relationship to Policy Holder

PATIENT SIGNATURE _____
DOB_____TODAY'S DATE _____

Patient Record of Disclosures

The HIPPA Act gives individuals the right to request a restriction on users and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication, or that of a communication of their PHI is made by alternative means, such as sending correspondence to individual's work place instead of their home. The private rule generally requires Health Care Providers to take reasonable steps to limit the use or disclosure of and request for health information to the minimum to accomplish the intended purpose. Information provided below, if it is completed properly, will constitute an adequate record. Uses and Disclosures for treatment, payment and Health care operations may be permitted without prior consent in an emergency.

Patient name _____

DOB_____**Mother's maiden name**

_____**(uses as Key code to identify third parties calling to the Office)**

I wish to be contacted in the following manner:

Home telephone #_____

- o Leave message with detailed information
- o Leave message with call back number only

Work telephone# _____

- o Leave message with detailed information
- o Leave message with call back number only

Written communications:

- o Ok to mail to my work
- o Ok to mail to my home
- o Ok to email information
- o Ok to fax to _____

Spouse/ Significant other: (provide name)

_____

- o Ok to leave message with detailed information
- o Leave message with call back number only

PCP or referring Physician:

- o Ok to release my PHI
- o **Not OK** to release my PHI

Family members that can obtain my PHI (PLEASE include Phone numbers)

_____

_____

_____

Consent for Treatment and Payment Agreement

I hereby authorized **CONROE WOMEN'S ASSOCIATES** to use/or disclosure my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

A payment includes but is not limited to the authorization of payment directly to **CONROE WOMEN'S ASSOCIATES** of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to the third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accidents insurers, or for work related injury to my employer or designee understand that **I am financially responsible for charges not covered.** I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that the services are voluntary and that I have the right to refuse these services. I intend this content to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and/or percentage which the insurance is not responsible for on the day of your office visit. **It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when is required**. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment with a reasonable amount of time from the patient/guarantor, we will place your account with a Collection Agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to **CONROE WOMEN'S ASSOCIATES**, all insurance or third party payments that I received for services rendered to me immediately upon receipt. **Patient initials**_____.

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to be released to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to CONROE WOMEN'S ASSOCIATES._____(Patient initials)

I request this authorization also apply to all other insurance._____(Patient Initials)

I acknowledge that I have been given CONROE WOMEN'S ASSOCIATES Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official._____(Patient Initials)

_____ _____ _____

Patient Signature **Patient Date of Birth** **Date**

Conroe Women's Associates
Board-Certified in Obstetrics and Gynecology

Date: _____

My appointment is with:

_____

Patient Name:

_____

DOB:_____Age:_____

Reason for your visit today:

_____

_____

First day of last period: _____

Do you have regular monthly periods?

Y_____/ N_____

How many days does your menses last? ___

How often do your periods come?

_____

Age at first period _____

Periods are:___Mild flow___Moderate flow or with Heavy flow ____

Clots: Y / N_____Cramps are:

Mild Moderate Severe

Taken any medication for it

_____

Drug Allergies:

_____

Current birth control:

_____

Age at first intercourse: _____

Number of partners (lifetime)_____

Are you having any libido changes? Y____/ N____(please explain)

_____

_____

Do you have pain with intercourse? Y____/ N____

Sexual Preference:___Heterosexual ___Homosexual____Bisexual

Have you had a new sexual partner since last exam? Y____/ N_____

Do you desire testing for STDs? Y____/ N_____

(STD consent form signed off: Y_____/N____)

Have you ever had a sexually transmitted disease? Y____/ N_____(mark any that apply)

Gonorrhea___Chlamydia___Herpes ___Hepatitis B_____HIV___Syphilis___HPV ___Genital Warts PID Trichomonas

Do you use tobacco products? Y / N

About how many cigarettes per day_____

Do you drink alcohol? Y____/ N_About how many drinks per week _____

Are you experiencing any vaginal or urinary problem:___Discharge___Odor____Burning __Itching___Frequency___Urgency to Urinate __Loss of urine?

Last Pap smear:_____Results_____

Have you ever had an abnormal pap smear? Y___/ N_____If yes, please give year and any procedures_____

_____

Last Mammogram_____Have you ever had an abnormal mammogram? Y / N If yes, please give year and any procedures_____

Do you do monthly breast exams? Y___/ N / ___Occasionally

Do you diet? Y /___N, What type?

_____

Do you exercise? Y /___N, How often & how long? _____

Do you take Calcium? Y / N___, If so, how much? _____

Last Colonoscopy_____Bone Dens._____

Surgeries		Hospitalizations	
Date	Reason	Date	Reason

Obstetrical History

Year	Deliv type	Weeks /Gest	Baby Weight	Anesthesia	Complications

Personal & Family History (mark all those that apply)

Disease	Self	Mother	Father	Mat/Grandmother	Mat/Grandfather	Pat/ Grandmother	Pat/ Grandfather	Brother / Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma /									
lung problems									
Blood clots									
Bloody stools /									
colon polyp									
Cancer									
Diabetes									
Heart disease									
High cholesterol									
High blood press.									
Kidney disease /									
UTIs									
Liver disease									
Loss of urine									
Mental illness									
Osteoporosis									
Psychiatric									
Seizures									
Stomach ulcers									
Stroke									
Thyroid disease									
Tuberculosis									
Others									

Medical Problems	Date of Diagnosis

Patient signature _____

DOB_____Date _____

Please indicate if you are having any <u>current problems</u> in the following areas by marking an X in the appropriate column.

General wellness Y N _____ Eyes Y N _____ Ear, nose, throat Y N _____ Heart / circulation Y___ _____N_____ Breast (pain, mass, discharge) Y___N_ Lungs / breathing Y_N_____ _____ Stomach / digestion Y_____N _____ Reproduction / urinary Y _____N_____ Muscle / joints / bones Y N_____ Skin Y_____N_____ _____ Neurological Y____ _____N_____ Psychiatric Y_____N _____ Endocrine Y___N_____ Blood / lymph Y___N_____ Allergies Y___N_____ Immunologic (Lupus, other) Y_____N_____

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CONSENT FOR STD AND HPV TESTING

Sexually transmitted diseases, called STDs or STIs for sexually transmitted infections are infections that can be transferred from one person to another through sexual contact. STD testing can be performed by either blood draw or cultures taken from vaginal secretions. There are more than 25 diseases that are transmitted through sexual activity. Other than HIV, the most common STDs in the United States are: (if you consent the testing, please mark those that you would like to be tested)

1. **( ) Chlamydia,**
2. **( ) Gonorrhea,**
3. **( ) Genital herpes**
4. **( ) HIV**
5. **( ) Hepatitis B**
6. **( ) Bacterial vaginosis**

Adolescents and young adults are the age groups at the greatest risk for acquiring an STD. Approximately 19 million new infections occur each year, almost half of them among people ages 15 to 24.

I have read the above information and I DO_____or I DO NOT_____consent to the screening listed above.

The importance of testing for high risk HPV types in specific clinical scenarios have been well established and recent data have demonstrated the importance of identification of specific HPV types. The FDA has approved a HPV 16 and 18 genotyping test, and the ASCCP (American Society for Colposcopy and Cervical Pathology has put forth a guideline, as well as additional educational information on how to appropriately use this test. On March 15, 2012, The American College of Obstetricians and Gynecologists (ACOG), the U.S. Preventive Services Task Force (USPSTF), and the American Cancer Society (ACS) published their recommendations regarding HPV testing as part of routine CERVICAL CANCER screening for women 30 to 65 years of age, along with Pap smears, every 5 years if both pap smear and HPV results were negative. A few important things to know about HPV (Human Papillomavirus) and cervical cancer screening:

1. Most women will have HPV at some point of their lives but very few will develop cervical cancer.
2. Cervical cancer develops if an HPV infection persists for many years.
3. Knowing your HPV status helps you and your provider determine how often you should be screened.
4. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
5. Your HPV status is not reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

I have read the above information regarding the HPV test performed with my pap smear (this test is automatically performed in women 30 years old and above) and I also AGREE to pay for the HPV testing should my insurance not cover the cost. **For women younger than 30 years old, please indicate if you do consent_____or don't consent_____the test.**

Patient signature _____ Witness signature _____

Date_____

Cancer Family History Questionnaire

Patient Name:_____ **Date of Birth:**_____ **Age:** _____

Please mark below if there is a **Personal or Family History** of any of the following cancers. If yes, then indicate **Family Relationship** and **Age at Diagnosis** in the appropriate column.

Consider: ***parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and cousins.***

		COLON AND Uterine/Endometrial CANCER *(Colaris^{Plus})*	**Self** *Age @ Diagnosis*	**Siblings/Children** *Age @ Diagnosis*	**Mother's Side** *Age @ Diagnosis*	**Father's Side** *Age @ Diagnosis*
Y	*N*	***Colon Cancer***				
Y	*N*	***Endometrial/Uterine Cancer***				
Y	*N*	***10 or more colorectal polyps***				
Y	*N*	***Ovarian Cancer***				
Y	*N*	***Stomach/Gastric, Brain, Kidney, ureter, renal pelvis, or small bowel***				
		BREAST AND OVARIAN CANCER *(BRACAnalysis)*	**Self** *Age @ Diagnosis*	**Siblings/Children** *Age @ Diagnosis*	**Mother's Side** *Age @ Diagnosis*	**Father's Side** *Age @ Diagnosis*
Y	*N*	***Breast Cancer***				
Y	*N*	2 cases of Breast Cancer ***at least 1 before 50*** *(in same person or on same side of the family)*				
Y	*N*	Breast Cancer in both breasts OR multiple primary breast cancers ***at any age***				
Y	*N*	***Ovarian*** Cancer ***at any age***				
Y	*N*	Male Breast Cancer ***at any age***				
Y	*N*	Are you of Ashkenazi Jewish descent?				
Y	*N*	Breast Cancer diagnosis with Triple Negative Receptors: *(ER-, PR-, and HER2-)*				
Y	*N*	Prostate Cancer				
Y	*N*	Pancreatic Cancer				
Y	*N*	A family member with a known mutation				

Has anyone in your family had genetic testing for a hereditary cancer syndrome (circle)? Yes No

Are there any other cancers in you or your family that are not listed above? _____

*Patients Signature:*_____ *Date:* _____

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Testing? ☐ *YES* ☐ *NO*

IF YES and patient offered testing, did patient: ☐ *ACCEPT* ☐ *DECLINE*

Patient Signature for declined testing:_____ ***Date:*** _____

Follow up appointment scheduled: ☐ *YES* ☐ *NO*

Provider's Signature:_____ ***Date:*** _____

Please DO NOT use Patient Portal to communicate with your Practice for urgent or emergency medical issues. If you are experiencing an urgent medical need, please contact us by phone.

For emergencies call 911.

Patient Portal User Agreement and Consent

Effective: August 10, 2012

The Patient Portal (defined below) is owned and operated by the practice to which you are seeking to online access (the "Practice"). The Practice has adopted this user agreement ("User Agreement" or "Agreement") to make you aware of the terms and conditions of your use of the Patient Portal and any derivative websites of the Patient Portal (collectively, the "Patient Portal"). In the event that you purport to be the agent of, represent, or otherwise act on behalf of any other person, references to "you," "your" or "User" shall include such entity or person in addition to such representative, and your acceptance of this Agreement shall constitute acceptance on behalf of such person.

The Practice uses reasonable efforts to maintain the Patient Portal, but the Practice is not responsible for any defects or failures associated with the Patient Portal, any part thereof or any damages (such as lost profits or other consequential damages) that may result from any such defects or failures. The Patient Portal may be inaccessible or inoperable for any reason, including, without limitation: (a) equipment malfunctions, (b) periodic maintenance procedures or repairs which the Practice may undertake from time to time or (c) causes beyond the control of the Practice or which are not foreseeable by the Practice. In addition, the Practice makes no guarantees as to the web sites and information located worldwide throughout the Internet that you may access as a result of your use of the Patient Portal, including as to the accuracy, content, or quality of any such sites and information or the privacy practices of any such site. The Practice is not a backup service for storing data you submit to the Patient Portal, and the Practice shall have no liability regarding any loss of such data. You are solely responsible for creating backups of any data you submit using the Patient Portal.

The Patient Portal is a secure website that allows you to use a computer to interact with medical information via the internet. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

Responsibilities, Risks and Benefits:

- The Patient Portal is provided as a convenience to you at no cost and is only available in English at this time. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the Patient Portal access at any time and for any reason.
- All messages sent to you will be electronically secure. Messages and emails from you to any staff member must be sent through the Patient Portal for security and confidentiality reasons.
- The Patient Portal messages will be handled by our staff in a manner similar to how phone communication is handled.
- Although we strive to reply to Patient Portal messages within one business day, we cannot guarantee that we will be able to address your messages in that timeframe. We encourage you to use the Patient Portal at any time but understand that we can only reply to messages during our office hours, excluding holidays recognized by the Practice. If you do not receive a response within two business days, please feel free to call our office.
- You are responsible to provide us with your correct email address and inform us immediately of any change. You are also responsible for the protection of your login information and password.
- Please understand that all electronic communications carry some degree of risk, even in a secured environment. Even with all due precautions, online communications may be intercepted, forwarded or changed without a patient's or the healthcare provider's knowledge. By using or accessing the Patient Portal, you expressly accept these risks.
- Note that it is easier for a patient's identity to be stolen or for someone to try to impersonate a patient via online communication.
- Online communications are admissible as evidence in court just as medical records are in the event the physician-patient privilege is waived or if a court orders disclosure.
- Online communications may disrupt or damage a computer if a computer virus is transmitted via an attached file, hyperlink or other method. You assume liability for such disruptions or damages caused by such transmissions.
- Responses to online communications are limited by the information provided and your question may necessitate a follow-up phone call or a request to meet with you in person to gain further information.

OVER PLEASE

- Electronic communications will be viewed by not only the physician, but the staff members assigned to handle such communications and any other provider covering for the patient's physician if the patient's physician is unavailable to respond.
- Applicable law may allow a health care professional to determine that a minor patient is "mature" to keep a portion of the minor's medical information confidential. If the minor patient is determined "mature" by his or her physician, all Patient Portal communication will be with the minor directly and a new consent form with the minor's email address will be required.
- Applicable law may also permit confidential communication with a minor patient in regards to treatment and reporting of sexually transmitted diseases to the minor and communications with pregnant minors in regards to questions about the health of her fetus. In these situations, all Patient Portal communications will be directly with the minor and a new consent form with the minor's email address will be required.
- The Practice will keep a copy of all medically important online communications in your medical record secure pursuant to applicable federal and state laws and regulations. Print or store in a secure place (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.
- The Practice will not forward online communications with you to third parties except as authorized or required by law.
- Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools as noted above.
- Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an online communication did not receive a response.
- You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. The Practice is not responsible for breaches of confidentiality caused by you or an independent third-party.

Guidelines for Safe Online Communications

Take steps to keep your online communications to and from the Practice confidential, including:

- Do not store messages on your employer-provided devices (e.g. computer, cell phone, tablet, etc.); otherwise personal information could be accessible or owned by your employer.
- Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.
- Do not allow other individuals or third parties access to the devices(s) upon which you store medical communications.
- Keep your login and password information secure and confidential.
- Do not use email for medical communications. Standard email lacks the necessary security and privacy features and may expose medical communications to employers or other unintended third-parties.

Access to Online Communications

The following pertains to access to and use of online communications:

- Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement.
- The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

PLEASE READ AND FILL OUT THE FOLLOWING:

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information

Print Patient Name:_____ Date of Birth _____

_____ _____ _____

Signature Relationship Date

☐ I am over the age of 18 and have sole responsibility of my medical care

□ Yes

□ No (We do not offer the Patient Portal to minors or those patients which do not make their own medical decisions at this time. We apologize for the inconvenience).

☐ I choose not to participate in Patient Portal at this time because:

□ I do not have an E-mail address

□ I do not wish to share my E-mail address

□ English is not my preferred language

□ Other

EMAIL _____