

Is there a family history of: (If yes, list all members, types, and relationship to you.)

- Yes No Cancer _____
- Yes No High blood pressure, stroke, heart disease _____
- Yes No Diabetes _____ Other _____

Why do you need to see a doctor today? _____

Do you have?

- | | |
|---|--|
| Inflammatory Bowel Disease (Irritable bowel/Crohn's Disease) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A family history of bowel polyps? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any relatives with colon, breast, or gynecologic cancer (uterine, ovarian, etc.)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any first degree relatives with breast cancer under age 35? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic heart or lung problems, shortness of breath with activity or at rest? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any family members with heart problems under age 50? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Cholesterol or Triglycerides? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Close contact with or live with someone with Tuberculosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A family history of skin cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Increased sun exposure or any unusual or changing moles/skin lesions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any household or sexual contact with anyone with Hepatitis B? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A history of ever having a blood transfusion or IV drug use? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| More than one sexual partner or a partner with multiple contacts? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty or concerns with sexual relations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you have or have you ever had (Check all that applies):

- | | |
|--|--|
| <input type="checkbox"/> Colon Cancer or Polyps | <input type="checkbox"/> Diabetes in Pregnancy |
| <input type="checkbox"/> Measles, Mumps and Rubella Vaccine | <input type="checkbox"/> Bleeding disorders, easy bruising or bleeding |
| <input type="checkbox"/> Sickle Disease, Hodgkin's, Multiple Myeloma | <input type="checkbox"/> Cirrhosis or Alcoholism |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Abnormal Mammograms | <input type="checkbox"/> Recently changed sexual partners |

Do you:

- Yes No Perform MONTHLY self breast exams?
- Yes No Take a multivitamin or folic acid supplement?
- Yes No Exercise regularly?
- Yes No Wear seatbelts regularly?
- Yes No Ever feel like just giving up?
- Yes No Feel you or your children are being physically or sexually abused?
- Yes No Have a current Tetanus shot (within the last 10 years)?
- Yes No Get annual flu shots?
- Yes No Feel that perhaps you drink too much, or been told you drink too much or feel guilty about your drinking?

Any other problems or concerns you would like to discuss with the doctor today?

PATIENT INFORMATION

Name _____ Former Name _____
Last First MI

Date of Birth _____ Social Security # _____

Address _____
Street City State Zip

Primary Phone # _____ Home Cell

Secondary Phone # _____ Home Cell

Marital Status Single Married Divorced Widowed

If married, spouse's name

Financially responsible person (if under 18 years of age)

PATIENT'S EMPLOYMENT INFORMATION

Employment Status Full Time Part Time Retired Unemployed

Employer's Name _____

Employer's Phone _____ May we contact you at work? Yes No

Student Status Full Time Part Time Not a Student

RELEASE OF MEDICAL INFORMATION

With whom may we discuss your medical condition?

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

By signing this statement, you release the staff of Contemporary OB/GYN of Western Kentucky from any and all liability from disclosing confidential information to the persons listed above. This may include, but is not limited to, information regarding HIV, sexually transmitted diseases, and sexual and psychological history.

Signature _____ Date _____

Patient Name _____

Primary Care Physician _____

Referring Physician, if any _____

Emergency Contact _____
Name *Relation* *Telephone Number*

Which pharmacy do you use most often? _____

How did you hear about us (Check all that apply)?

- The Paducah Sun
- Radio
- The Yellow Pages
- The Wright Pages
- Bridal Expo
- Real Women's Expo
- Baby Fair
- Health Department
- Magazine _____
- Physician(s) (Name) _____
- Friend(s) or Family Member(s) (Please tell us so that we may thank them!) _____

Other _____

PATIENT POLICIES

We are very pleased to have you as our patient. These policies have been established so that we can give you the best care possible.

- If you are more than 15 minutes late for your scheduled appointment time, you will be asked to reschedule.
- We ask that you please give our office 24 hours notice of cancellation unless it is an emergent situation.
- After three "no show" visits in which we do not receive 24 hours notice, we will cease care.
- All co-payments are due at the time of service, unless other arrangements are made in advance.
- Self-pay patients are expected to pay in full at time of service, unless other arrangements are made in advance.
- It is ultimately the patient's responsibility to know which physicians and/or facilities are in network with their insurance company.

I have read the above patient policies. I understand that it is my responsibility to contact a staff member for assistance of if I have any questions or concerns.

Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name _____
Last First MI

Date of Birth _____ Social Security # _____

Address _____
Street City State Zip

Primary Phone # _____

I do hereby authorize _____ to release:
(Name of Facility)

My health information relating to the following treatment or condition: _____

My health information for the date(s): _____

Other: _____

I do I do not authorize the release of information related to AIDS, HIV, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Release information to: _____
Name of Company/ Agency/ Facility/ Person

Street Address

City State Zip Code

Purpose of Disclosure:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Change of Doctor | <input type="checkbox"/> Other |

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.

Signature of Individual or Guardian

Date

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 CAREFULLY.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that this is currently in effect.

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you (“Health Information”). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice’s Privacy Officer.

Treatment

We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment

We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations

We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose your medical information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.

We may use and disclose your Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care.

When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS

As Required by Law

We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety

We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates

We may disclose Health Information to our business associates that perform functions on our behalf to provide us with services if the information is necessary for such services to function. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation

If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes or tissues to facilitate organ, eye, or tissue donation and transplantation.

Military and Veterans

If you are a member of the Armed Forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers’ Compensation

We may release Health Information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks

We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and death; report child abuse or neglect; report reactions to medications or problems with products; notify people or recalls of products they may be using; informing a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

By my signature below, I acknowledge receipt and understanding of the Privacy Notice provided by Contemporary OB/GYN of Western Kentucky

Today’s Date _____

Patient Signature _____

February 2006

Dear Patient:

In light of revised Cervical Cancer Screening Guidelines/Recommendations by the American Cancer Society (ACS) in November 2002 and the American College of Obstetrics and Gynecology (ACOG) in July 2003, we are pleased to inform you that our practice will be providing patients with a test, *High-Risk HPV DNA*, designed to complement the Pap test. According to the ACS and ACOG, the incorporation of this test for *women age 30 and older* will provide extremely valuable insight in the early detection of cervical cancer and its precursors.

You are probably familiar with the Pap test, but may not be familiar with the *High-Risk HPV DNA* test and the reasons why you should have this test performed along with your Pap test.

- HPV is a very common virus.
- Approximately 20 million people are currently infected with HPV. At least 50 percent of sexually active men and women acquire genital HPV infection at some point in their lives. By age 50, at least 80 percent of women will have acquired a genital HPV infection. About 6.2 million Americans get a new genital HPV infection each year. (Centers for Disease Control and Prevention, www.cdc.gov)
- Most women will successfully clear the virus soon after infection. If the virus isn't cleared by your immune system, it may cause abnormal changes to the cells of your cervix.
- The High-Risk HPV DNA test allows us to look for these abnormal cells indicating the possible presence of HPV, a virus that can progress to cervical cancer if undiagnosed or untreated.

We are aware that certain insurance plans will be reimbursing for this test, however, we cannot be sure your particular plan has included this test in your benefits.

- It is your responsibility to ascertain your plan coverage. The Current Procedural Terminology (CPT) Code for this test is 87621.
- We will try to help you with any questions you may have regarding your discussion with your insurance provider.

HPV testing is playing a growing role in cervical cancer screenings programs and our practice is committed to providing you with the latest advancements that are available.

Thank you,

Susan K. Mueller, M.D.

Patient Signature _____

Date _____