Contemporary OB/GYN of Western Kentucky

FOR OFFICE USE ONLY
☐ NEW PATIENT
☐ ESTABLISHED PATIENT
☐ CONSULTATION
☐ REPORT SENT. / /

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /
ADDRESS			
CITY:	STATE/ZIP:		
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )		
EMPLOYER:	INSURANCE:	POLICY NO.:	
NAME YOU WOULD LIKE US TO USE:	NAME OF SPOUSE/PARTNER		
NAME OF INSURED	BIRTH DATE: / /	SS #:	
EMERGENCY CONTACT	RELATIONSHIP:		
	HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
PHARMACY LOCAL:	MAIL ORDER:		
WHY HAVE YOU COME TO THE OFFICE TODAY?	REFERRED BY:		
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED			

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
AGE PERIODS BEGAN: _____ LAST MENSTRUAL PERIOD: _____	
DAYS BETWEEN PERIODS _____ LENGTH OF FLOW _____	
HAVE YOU EVER HAD SEX? _____ ARE YOU CURRENTLY SEXUALLY ACTIVE? _____	
NUMBER OF SEXUAL PARTNERS (LIFETIME): _____	
SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST? _____ WHAT WAS THE RESULT? _____	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (GONORRHEA, CHLAMYDIA, ETC)?	
WHEN WAS YOUR LAST MAMMOGRAM? _____ HAS IT EVER BEEN ABNORMAL? _____	
WHEN WAS YOUR LAST DEXA OR BONE DENSITY TEST?	
WHEN WAS YOUR LAST COLONOSCOPY?	

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

CURRENT MEDICATIONS
(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE:	FATHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE:
SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):	
NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):	

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
ALCOHOL OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS DAILY INTAKE:	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL?)	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE UNITED STATES: LOCATION(S):

PERSONAL PAST HISTORY OF ILLNESSES/DISEASES

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

REVIEW OF SYSTEMS (ROS)

1. CONSTITUTIONAL	☐ NEGATIVE ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ CHANGE IN WEIGHT ☐ FEVER ☐ FATIGUE ☐ OTHER TALLEST HEIGHT _____
2. EYES	☐ NEGATIVE ☐ VISION CHANGE ☐ GLASSES/CONTACTS ☐ OTHER
3. EAR, NOSE, AND THROAT	☐ NEGATIVE ☐ ULCERS ☐ SINUSES ☐ MOUTH SORES ☐ HEADACHE ☐ HEARING LOSS ☐ OTHER ☐ DENTAL PROBLEMS
4. CARDIOVASCULAR	☐ NEGATIVE ☐ CHEST PAIN ☐ DIFFICULTY BREATHING ON EXERTION ☐ SWELLING IN LEGS ☐ RAPID HEART BEAT ☐ OTHER
5. RESPIRATORY	☐ NEGATIVE ☐ WHEEZING ☐ COUGHING UP BLOOD ☐ SHORTNESS OF BREATH ☐ COUGH ☐ OTHER
6. GASTROINTESTINAL	☐ NEGATIVE ☐ DIARRHEA ☐ BLOODY STOOL ☐ NAUSEA/VOMITING/INDIGESTION ☐ CONSTIPATION ☐ FLATULENCE ☐ PAIN ☐ INVOLUNTARY LOSS OF GAC/STOOL ☐ OTHER
7. GENITOURINARY	☐ NEGATIVE ☐ BLOOD IN URINE ☐ PAINFUL URINATION ☐ URGENCY ☐ FREQUENCY ☐ INCOMPLETE EMPTYING ☐ INCONTINENCE ☐ PAINFUL INTERCOURSE ☐ ABNORMAL OR PAINFUL PERIODS ☐ PMS ☐ ABNORMAL VAGINAL BLEEDING ☐ ABNORMAL VAGINAL DISCHARGE ☐ OTHER
8. MUSCULOSKELETAL	☐ NEGATIVE ☐ MUSCLE WEAKNESS ☐ MUSCLE OR JOINT PAIN ☐ OTHER
9a. SKIN	☐ NEGATIVE ☐ RASH ☐ ULCERS ☐ SKIN CHANGES ☐ DRY SKIN ☐ MOLES ☐ OTHER
9b. BREAST	☐ NEGATIVE ☐ PAIN IN BREAST ☐ DISCHARGE ☐ LUMPS ☐ OTHER
10. NEUROLOGIC	☐ NEGATIVE ☐ PASSING OUT ☐ SEIZURES ☐ NUMBNESS ☐ TROUBLE WALKING ☐ SEVERE MEMORY PROBLEMS ☐ OTHER
11. PSYCHIATRIC	☐ NEGATIVE ☐ DEPRESSION ☐ CRYING ☐ SEVERE ANXIETY ☐ OTHER
12. ENDOCRINE	☐ NEGATIVE ☐ DIABETES ☐ HYPOTHYROID ☐ HYPERTHYROID ☐ HOT FLASHES ☐ HAIR LOSS ☐ HEAT/COLD INTOLERANCE ☐ OTHER
13. HEMATOLOGIC/LYMPHATIC	☐ NEGATIVE ☐ BRUISES ☐ BLEEDING ☐ ENLARGED LYMPH NODES/GLANDS ☐ OTHER
14. ALLERGIC/IMMUNOLOGIC	MEDICATIONS (PLEASE LIST) ☐ LATEX ☐ OTHER

Contemporary OB/GYN of Western Kentucky

PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Former Name _____
Last *First* *MI*

Date of Birth _____ Social Security # _____

Address _____
Street *City* *State* *Zip*

E-mail address _____

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 _____

Preferred Lab Company (i.e.-Quest,Labcorp,BHP) to send your blood work/specimens to:_____

(* If you do not choose a preferred lab, we will automatically send all blood work & specimens to GenPath*)

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
☐ Hometown Phonebook
☐ Total Rejuvenation
☐ Real Women's Expo
☐ Baby Fair @ Western Baptist
☐ Health Department
☐ Magazine _____
☐ Movie Theatre
☐ Internet/ Google/Other Search Engine
☐ Facebook
__Dr. Mueller's Page
__Contemporary OB/GYN's Page
__A Friends Page
☐ 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 or labs that are in network with their insurance company. If you do not request that your blood work/pathology go to a certain lab you are responsible for any additional cost you may incur.
- I agree that Contemporary OB/GYN may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes**.**

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

Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS

Please present your insurance card(s) to the Receptionist at every visit.

Name _____

Last *First* *MI*

Primary Insurance

Primary Insurance Company Name _____

Policy Holder Name _____Policy Holder Date of Birth

Policy Holder Social Security # _____ Sex ☐Female ☐ Male

Policy Holder Employer

Relationship to You ☐Self ☐Spouse ☐Parent ☐Other _____

Copay $ _____

Secondary Insurance

Secondary Insurance Company Name _____

Policy Holder Name _____Policy Holder Date of Birth

Policy Holder Social Security # _____ Sex ☐Female ☐ Male

Policy Holder Employer

Relationship to You ☐Self ☐Spouse ☐Parent ☐Other _____

Copay $ _____

I hereby authorize and direct the above insurance company to pay benefits due in accordance with the terms of my policy as follows:

Benefits payable to:
Contemporary OB/GYN of Western Kentucky
2605 Kentucky Avenue, Suite 103
Paducah, Kentucky 42003

- I agree to pay all medical expenses not covered by the above named policy.
- I authorize Contemporary OB/GYN of Western Kentucky to release any information needed by the insurance company regarding this claim.
- I understand and agree that it is my responsibility to verify that Contemporary OB/GYN of Western Kentucky is an approved provider for my specific insurance. If preauthorization or provider verification was not obtained, I understand and acknowledge that I am fully responsible for the bill.
- I understand and agree that if it should become necessary for Contemporary OB/GYN of Western Kentucky to pursue collections of my account through a third party, I will be liable for any and all costs associated with the collection process.
- I request payment of insurance benefits be paid directly to the physician listed on the claim.

Signature _____ Date _____

Self Pay Only

I have no insurance and will make payment in full today by:

___Cash
___Check
___Credit Card

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), and most recent updates in 2013, I have certain rights to privacy regarding my protected health information. I ______________________ understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers and business professionals who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.
- Any and all other business practices, procedures, uses or disclosures as outlined in the policy.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

~~~~~~
~~~~~~

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

The effective date of this notice is September, 2013

Contemporary OB/GYN of Western Kentucky

Contemporary OB/GYN Guidelines and Consent for Cervical Cancer Screening & STI Testing

When to start getting Pap tests?

Your first Pap test will be at age 21.

How often to get tested?

Women ages 21 to 70 need a Pap test every year.

When to stop getting a Pap test?

Women 70 years old or older can discontinue having Pap tests if recommended by their doctors based on the results of previous tests.

Women with total hysterectomy, which were done due to causes other than cancer, can discontinue having Pap tests.

When we will test for STI's?

All women **will** be tested for STI's that think that they have had exposure.

All women 24 years and younger **will** have annual STI screenings as recommended by ACOG.

- **Both ACS and ACOG recommend yearly physical exams including breast exam, pelvic exam (with or without pap smear) and STI screening if indicated.**
- **You MUST have an annual exam including a breast and pelvic exam to receive birth control or hormonal therapy.**
- **If you have ever had an abnormal Pap smear, consult with the provider performing your exam concerning how often you will need Pap smears.**

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.

Patient Signature Date

When you will be tested for HPV:

Women Ages 21-30 will have HPV co-testing if their pap test come back abnormal.

Women Ages 30-70 will automatically be screened for HPV annually.

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

- It is your responsibility to ascertain your Insurance plan coverage.
- 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.

Screening for cervical cancer and STI's are an important part of ongoing ambulatory care for women, but it is far from the only service provided by obstetrician-gynecologists and other clinicians during a well-woman exam. When screening for cervical cancer and STI's are not indicated due to interval since last screen, hysterectomy status, or age, clinicians can instead focus on other health care concerns that will be more valuable to women—instead of spending clinician and patient time on a health care service with limited benefit. For example:

- Adolescents and young women can benefit from counseling on healthy diet, risky behaviors, family planning, and—if they are sexually active—testing for sexually transmitted diseases. The focus for cervical cancer for this age group should be on primary prevention through HPV vaccination.
- Women of reproductive age will benefit from counseling and shared decision making on family planning, including support for consistent, effective use of their chosen method.
- Women in the later reproductive years and perimenopausal women will benefit from counseling on the menopausal transition, osteoporosis prevention, and referral for mammography and colorectal cancer screening.
- Both women of reproductive age and postmenopausal women benefit from ongoing evaluation of continence and pelvic floor function, which can be essential to their health and social functioning.

Thank you,

Susan K. Mueller, M.D.

Patient Signature Date

Contemporary OB/GYN
of Western Kentucky

Depression Screening Quiz

Patient Name _____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Patient Signature _____ Date _____

Risk Assessment for Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer* (ER-, PR-, HER2-pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		POLYPOSIS SYNDROMES	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	10 or more cumulative (lifetime) colorectal adenomas (colon polyps)			

		MELANOMA	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Two or more melanomas in an individual or family			
Y	N	Melanoma and pancreatic cancer in an individual or family			

Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:	

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing:
☐ HBOC ☐ Lynch ☐ Polyposis ☐ Melanoma

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing: ☐ Accepted ☐ Declined

_____ _____

Healthcare Professional's Signature Date

*For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

MORA/12-11

MYRIAD®

Contemporary OB/GYN

Commonwealth of Kentucky-Summary of HB 1

House Bill 1, which was passed during the "Special Session" of the Kentucky General Assembly in April 2012, adds additional regulations to the prescribing of certain Controlled Substances. Please note that a complete copy of the HB 1 is available for review on the Kentucky Board of Medical Licensure's website, www.kbml.ky.gov.

Due to this regulation, if you are currently taking a Controlled Substance or if you are prescribed one during the course of your care with Contemporary OBGYN, we are required by law to query KASPER (Kentucky All Schedule Prescriptions Electronic Reporting) for all available data on you (KASPER provides a record of your prescription history).

Kentucky Law Requirements before Prescribing/Dispensing

Before initial prescribing/ dispensing a Schedule II or Schedule II Controlled Substance with Hydrocodone, it is required by law that you:

1. Provide a complete medical history.
2. Have a physical examination prior to a Controlled Substance being prescribed.
3. Understand we are required to query KASPER about your prescription history.
4. Participate in your treatment plan and objectives of treatment and further diagnostic testing.
5. Acknowledge the risks/benefits of Controlled Substance use, including risk of tolerance and dependence.
6. Sign this written consent for treatment and ongoing evaluation.

Ongoing Evaluation

- Practitioner must review course of treatment at reasonable intervals, based upon patient's individual circumstances.
- Practitioner must provide patient with new information about treatment.
- Practitioner must obtain KASPER at least once every 3 months for all available data on patient.

Your Healthcare provider, by law, must review your KASPER report before issuing any prescriptions or refills for these substances.

As you can see, we will no longer be able to "just write" a prescription for a Controlled Substance. We are providing you this information so that you are aware that if you need to request a refill on the prescription, you must contact our office at least five (5) business days before it is needed. This will allow us time to obtain the KASPER query required by Kentucky State Law.

The Providers of Contemporary OBGYN thank you for your assistance in helping us comply with this law.

Signature_____(Circle one: Patient Parent/Guardian Surrogate)

Print Name of Patient _____ Today's Date _____

Patient Date of Birth _____

By Signing above, I am consenting to treatment and I understand this policy.

CONTEMPORARY OB/GYN OF WESTERN KENTUCKY, PSC (COB)
REVISED: 07/01/2013
Based on Final Privacy & Security Rules

Authorization to Release Health Information/Treatment Records

Last Name: _____ **First:** _____ **Middle:** _____
Other Names Used: **Date of Birth:**
Address: **City:** **State**:
Home Phone: ( ) **Work Phone:** ( )

I hereby request release of the protected health information in my health record from (date) _____to (date)_____ maintained or created by the provider named below to the recipient named below.

- ☐ Most recent Progress Notes
- ☐ Pathology/Lab Reports, HIV, STD
- ☐ Imaging Reports
- ☐ Discharge Summaries
- ☐ Billing Records
- ☐ Entire Health Record *****(Excludes Psychotherapy Notes)
- ☐ Reports of Operations/Surgeries/Procedures
- ☐ Other_____
- ☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an Individual's Health Information must be completed to obtain additional records.)

- ☐ I will pick up copies of my records
- ☐ Fax my records to: _____
- ☐ Mail copies of my records to the individual noted below
- ☐ Provide my records in electronic form: _____

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: ☐ Transfer of care ☐ legal, ☐ referral, ☐ other:_____

I understand:

I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. **Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.**

Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE.

*The information authorized for release may include protected health information and/or treatment records related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

I acknowledge that your health information contained in our electronic medical record system (EMR) contains information obtained from other healthcare entities and providers and may include information from multiple physicians, laboratories, hospitals, and other entities, including information not entered by this practice. This may include any data (sexuality, HIV, mental health, emails, etc.) that are entered, scanned, or automatically placed into the EMR both from this practice and from outside sources. This information is not redacted.

The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

I understand that if my records are released, my first copy is free if records are picked up at the office. If I choose to have the records mailed, faxed or otherwise transmitted, in accordance with the Kentucky Court of Appeals Eriksen vs Gruner regarding KRS 422.317(1) we will seek reimbursement for any charges incurred in mailing, faxing, scanning or other means to transmit the records to you or your agent. Additionally you will be charged $1.00 per page for the second copy of any paper records, **payable prior to the release** of these requested records. Records produced in digital form are free if requested via patient portal. (Make checks payable to Contemporary OB/GYN of WKY. These fees are in accordance with KRS 422.317. Records will be available within 30 days from receipt of the appropriately completed & signed request.

____ Initial

_____ _____ _____
Signature of Patient, Parent, or Legal Authorized Representative** **Relationship to Patient** **Date**

****May be requested to show proof of representative status**