# 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.

**Uses and Disclosures**

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan or from other sources of coverage such as an automobile insurer if such information is presented. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Women's Care, PA**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

**Additional Uses of Information**

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Fund raising. Women's Care, P.A. does not participate in fund-raising acivities, therefore, we will not use your name and address for fund raising efforts.

**Individual Rights**

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information

- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

**Women's Care, PA Duties**
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

**Requests to Inspect Protected Health Information**
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Security/Privacy Officer.

**Complaints**
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Security/Privacy Officer
Women's Care, PA
9301 W. 74th St., Suite 325
Shawnee Mission, KS 66204

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Security/Privacy Officer
Women's Care, PA
9301 W. 74th St., Suite 325
Shawnee Mission, KS 66204
(913) 384-4990, ext. 310

Effective Date
This Notice is effective on or after April 14, 2003

# Consent to Use and Disclosure of Protected Health Information

**Use and Disclosure of Your Protected Health Information**
Your protected health information will be used by **Women's Care, PA** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

**Notice of Privacy Practices**
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. I have reviewed and, if requested, received a copy of the **Women's Care, PA** Notice of Privacy Practices.

**Requesting a Restriction on the Use or Disclosure of Your Information**
You may request a restriction on the use or disclosure of your protected health information.

**Women's Care, PA** may or may not agree to restrict the use or disclosure of your protected health information.

If **Women's Care, PA** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**
**Women's Care, PA** reserves the right to modify the privacy practices outlined in the notice.

**Signature**
I have reviewed this consent form and give my permission to **Women's Care, PA** to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Date of Birth

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

WOMEN'S CARE, P.A.
CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, give my permission to disclose my health information to the following people listed below. I have the right to change, update or revoke this information at any time. This consent is effective for three years from the date signed, however, for your protection, you will be asked to complete a new consent at your first appointment more than one year after the date this consent is signed.

NAME _____ NAME _____

RELATIONSHIP _____ RELATIONSHIP _____

ADDRESS _____ ADDRESS _____

_____ _____

PHONE _____ PHONE _____

- I understand that the information disclosed as directed above may be re-disclosed to additional parties and is no longer protected for reasons beyond our control.
- You have a right to receive a copy of this consent if requested.
- Completion of this consent is not a condition for treatment.

Listed below are numbers that can be used to contact me or leave a message. Messages may include test results as well as appointment and payment information.

| NUMBERS | OK TO LM | DO NOT LM |
|---|---|---|
| HOME _____ | _____ | _____ |
| WORK _____ | _____ | _____ |
| CELL _____ | _____ | _____ |

SIGNATURE _____

DATE OF BIRTH _____ DATE _____

Rev 4/1/2010
Reviewed 04/2012

WOMEN'S CARE, PA.
9301 W. 74TH ST, SUITE 325
SHAWNEE MISSION, KS 66204
913-384-4990

# OFFICE FINANCIAL POLICY

This financial policy has been prepared for your benefit. It contains information regarding our billing and insurance procedures. If you have any questions regarding this policy, please feel free to discuss this with our billing department.

Our office operates on a fee-for-service basis. All copays are due at the time of service. We file insurance claims ONLY for the companies we are contracted with. If we are not contracted with your insurance company, all charges are due and payable in full at the time of service. We accept cash, checks, money orders, Mastercard and Visa. If other arrangements are necessary, please discuss them with our billing department BEFORE you see the doctor or midwife. We will provide you with the necessary information for you to submit to your insurance company. Please be sure to take this information with you when you leave the office.

Payment of the doctor or midwife's fee is the personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patient's charge is covered in whole or in part by insurance. It is your responsibility to know what is and what is not covered by your insurance company. Full payment is expected within 90 days. An account is considered past due if payments are not made every 30 days.

If your insurance requires you to have a referral from your primary care physician, it is YOUR responsibility to obtain this referral BEFORE your appointment and/or surgery.

Thank you for your cooperation.

I have read the above financial policy and understand my obligation.

Signature _____ Date _____

Relationship (if other than patient) _____

Patient Name _____ Date of Birth _____
(Printed)

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of any medical or other information to my insurance company as they request. I agree that a photographic copy of this authorization is as valid as the original.

Signature _____ Date _____

# AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of medical benefits directly to Women's Care, P.A. for services rendered.

Signature _____ Date _____

Rev 1/1/10

**WOMEN'S CARE COMPREHENSIVE HISTORY (PAGE 1)**

| | |
|---|---|
| Name | Date of Visit |
| Date of birth Age | Physician/CNM |
| Social Security Number | |

**Reason for visit**

**Allergies** (Drug and Food or Latex Allergies)

| Drug or Substance | | Reaction |
|---|---|---|
| | | |
| | | |

**Medications** (Prescribed Medications, Herbs, Vitamins and Over the Counter)

| Name | Dose(i.e. mg) | Times you take this medication (i.e. Twice a day) |
|---|---|---|
| | | |
| | | |
| | | |

| **Diagnostics** | Date | Result | |
|---|---|---|---|
| Last Pap Smear | | Normal/ Abnormal | Other: List test and result |
| Mammogram | | Normal/ Abnormal | |
| Bone Density | | Normal/ Abnormal | |
| Lipid Panel | | Normal/ Abnormal | |
| Thyroid testing | | Normal/ Abnormal | |
| Colonoscopy | | Normal/ Abnormal | |

**Contraception** Current _____ Past _____

**GYN History** Date of last menstrual cycle? _____ Age of first menses _____

Have you ever taken hormone replacement therapy? YES / NO What? _____ How long? _____

Do you have a history of abnormal Pap Smears? YES/ NO When_____

If Yes, was treatment necessary? YES/ NO Type of treatment Antibiotic Cream/ Cryosurgery (freezing) Laser / Leep / Cone Biopsy / _____

Do you have a history of sexually transmitted diseases? YES/ NO

Type Chlamydia/ Genital warts/ Gonorrhea/ HPV (Human papilloma virus)/ PID (Pelvic inflammatory disease) Syphilis/ Trichimonas/ Herpes / Other _____

Have you received the Gardasil (HPV) vaccine? YES/ NO How many doses?_____

Have you ever taken fertility medications? YES/ NO Type _____

Do you have a history of endometriosis? YES/ NO Treatment _____

WC 1008

**(At Appointment)**

**Nursing Documentation** RN/MA _____

Weight _____ Height _____ Blood Pressure _____ Nurse for Exam Yes/No

Patient Name _____
DOB _____

**WOMEN'S CARE COMPREHENSIVE HISTORY (PAGE 2)**

| Pregnancies Including current | Full Term Deliveries | Premature | Elective Abortion | Miscarriage/ Spon Ab | Ectopic | Multiple Births | Living Children |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Past Pregnancies**

| Date Month/Year | Weeks of Gestation | Length of Labor | Birth Weight | Sex Male/Female | Type of Delivery | Preterm Labor Yes/No | Complications |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

If you have had an ectopic pregnancy, did you require surgery? YES / NO
Did you have an Ovary or Fallopian tube removed? YES / NO If yes, which one? _____

**WOMEN'S CARE COMPREHENSIVE HISTORY PAGE 3**
WC 1008

Patient Name _____
**DOB**

**Past Surgical History** (Throughout your entire life)

| Type of Surgery | Date | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Personal and Family Medical History** Place a check mark in the box if applicable for yourself or family member

| Disease/ Medical Condition | Yourself | Family member | PLEASE EXPLAIN OR GIVE DETAILS HERE |
|---|---|---|---|
| Migraines | | | |
| Seasonal Allergies | | | |
| Asthma | | | |
| Respiratory problems | | | |
| Pulmonary Embolism | | | |
| High blood pressure | | | |
| Coronary Artery Disease | | | |
| Stroke | | | |
| Deep Venous Thrombosis (Blood clots) | | | |
| Elevated Cholesterol | | | |
| Seizures/Epilepsy | | | |
| Neurological Diseases | | | |
| Thyroid Disease | | | |
| Hepatitis | | | |
| Diabetes | | | Gestational Diabetes, Type 2, |
| Kidney problems | | | |
| Recurrent Urinary Tract Infections | | | |
| Blood transfusions | | | |
| Osteoporosis | | | |
| Osteopenia | | | |
| Breast disease | | | |
| Breast Cancer | | | |
| Ovarian Cancer | | | |
| Cervical Cancer | | | |
| Uterine Cancer | | | |
| Colon Cancer | | | |
| Anxiety/Panic attacks | | | |
| Psychiatric Treatment | | | |
| Postpartum Depression | | | Treatment: |
| HIV/AIDS | | | |
| Other, explain | | | |

**Social History**

Occupation _____ Marital Status Single/ Married/ Divorced/Separated

RACE (Medically Required CIRCLE ONE) AfricanAmerican Asian American Indian Caucasian Hispanic Indian Jewish/Eastern European Middle Eastern Pakistani Other _____

Do you currently smoke? YES/ NO Amount?_____ Did you smoke in the past? YES/ NO

When did you quit? _____ Ever tried to quit? YES / NO

Passive smoke exposure at home or work? YES / NO

Do you drink alcohol? YES / NO Type of alcohol_____ How often _____

Do you feel you drink too much alcohol? YES / NO

Do you eat/drink caffeine? YES/NO Type _____ Frequency _____

In a medical emergency, would you accept blood products? YES / NO

Have you ever sought treatment for alcohol or drug use? YES / NO / N/A

Do you currently use recreation drugs? YES/ NO What substances do you use?_____

Have you used recreational drugs in the past? YES / NO

Have you ever been abused ? YES / NO

Are you being abused at this time? YES / NO Are you concerned about your safety? YES/ NO

What is your sexual preference? Heterosexual/ Bisexual/ Lesbian

# Women's Care

DATE _____

## PATIENT REGISTRATION INFORMATION

**Please complete all sections and provide us with a copy of your medical coverage card.**

### PATIENT INFORMATION

Name _____
(LAST) (FIRST) (INITIAL) (MAIDEN NAME)

Home Address _____
(STREET/APT NO.) (NO P.O. BOX PLEASE) (CITY) (STATE) (ZIP)

Mailing Address _____

Phone# (Home) ( ) _____ (Work) ( ) _____ (Cell) ( ) _____

Birthdate _____ Age _____ SS# _____ Marital Status _____

May we call to confirm your appointment? ❑ Yes ❑ No May we call your home with medical/billing information? ❑ Yes ❑ No

Your Employer _____ Work Address _____

Spouse/Other Name: _____ (Work) ( ) _____ (Cell) ( ) _____

Do you have a Living Will? ❑ Yes ❑ No

### NAME AND ADDRESS OF PERSON NOT LIVING WITH YOU

Name _____

Address _____

Phone# (Home) ( ) _____ (Work) ( ) _____ (Cell) ( ) _____

### PRIMARY POLICY HOLDER INFORMATION

Name _____ Circle One: Self / Spouse / Parent / Other

Birthdate _____ SS#/ Required _____

Employer _____ Work Phone ( ) _____

Work Address _____

**Insurance Carrier** _____ Policy # _____

Claims Mailing Address _____ Group # _____

### SECONDARY INSURANCE INFORMATION

Name _____ Circle One: Self / Spouse / Parent / Other

Birthdate _____ SS#/ Required _____

Employer _____ Work Phone# ( ) _____

Work Address _____

**Insurance Carrier** _____ Policy # _____

Claims Mailing Address _____ Group # _____

### Assignment of Benefits · Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Women's Care, and any assisting physicians, for services rendered. I understand that copays are due at the time of service and that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall serve as valid as the original.

Your Signature: _____ Date: _____


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Angela L. Piquard, M.D.
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SHAWNEE MISSION, KS 66204
(913) 384-4990
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SOUTHRIDGE MEDICAL BUILDING
12541 FOSTER ST. #240
OVERLAND PARK, KS 66213

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SHAWNEE, KS 66226