SHOLES CENTER
FOR WOMEN'S HEALTH

HIPAA PRIVACY AUTHORIZATION FORM

*****Please Read and Sign This Form*****

The Sholes Center for Women's Health

Patient's Name: _____ Date of Birth: _____

I understand that my health information is private and confidential. I understand that *The Sholes Center for Women's Health* works very hard to protect my privacy and preserve the confidentiality of the personal health information. Some information can be relayed by telephone. In this instance, we will call your telephone number we have on file that you have provided. For more information it is necessary to send a letter. In this case we will send a letter addressed only to you at the address you have provided.

I understand that *The Sholes Center for Women's Health* may use and disclose my personal health information (PHI) to help provide health care to me, to handle billing and payment, and to take care of the other health care operations. In general, there will be no other uses and disclosures of this information unless I authorized it in writing. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

The Sholes Center for Women's Health has detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting our patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. *The Sholes Center for Women's Health* may update this "Notice of Privacy Practices" at any time. If I ask, *The Sholes Center for Women's Health* will provide me with the most current "Notice of Privacy Practices". I have been provided a copy of this at my first visit.

Our Notice of Privacy Practices states that we may disclose your Personal Health Information (PHI) to others who may assist in your care, such as your spouse, children, parents or caregiver. Please list any family members and caregivers with whom we are authorized to <u>discuss your medical care</u> or to whom we may <u>release medical records.</u>

NAME: _____ PHONE: _____RELATION:_____

NAME: _____ PHONE: _____RELATION: _____

NAME: _____ PHONE: _____RELATION:_____

☐ **Only disclose my health information to the following person(s) in my presence.**

☐ **Only disclose my health information to the following person(s) at any time.**

☐ **ONLY disclose my health information to myself.**

Under the terms of this consent, I can ask *The Sholes Center for Women's Health* to limit how my personal health information is used or disclosed to carry our treatment, payment or health care options. I understand that *The Sholes Center for Women's Health* does not have to agree to my request. If *The Sholes Center for Women's Health* does agree to my request, I understand that they would follow the agreed limits. I may cancel this consent in writing at any time by writing, signing, and dating a letter to *The Sholes Center for Women's Health*. The letter must say that I want to revoke my consent to authorize the use and disclose of my personal health information for treatment, payment and health care operations. If I revoke this consent, *The Sholes Center for Women's Health* does not have to provide my further health care services to me. My signature below indicates that I have been given the chance to review a current copy of *The Sholes Center for Women's Health's* "Notice of Privacy Practices". My signature means that I agree to allow *The Sholes Center for Women's Health* to use and disclosure my patient's personal health information to carry out treatment, payment and health care operations.

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient

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Patient Information

Preferred Language: _____

Preferred Pharmacy: (Name and Address): _____

Primary Care Provider: _____

Referring Provider: _____

Employer: _____

Employer Phone Number: _____

Preferred Contact:
- ○ Mail
- ○ Home Phone
- ○ Work Phone
- ○ Cell Phone
- ○ Email

Ethnicity:
- ○ Hispanic/Latino
- ○ Non-Hispanic
- ○ Unknown

Race:
- ○ Asian
- ○ Black or African American
- ○ White
- ○ Other

Responsible Party: _____SELF ____OTHER

If **OTHER please provide the following information*

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____

Relationship to Patient: _____

If *The Sholes Center for Women's Health* has signed a contract with my insurance company, provisions of the contract will be followed. Otherwise, charges for office visits are due at the date of service. Other procedures covered by insurance will be filed as courtesy. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure or portions of my medical records, I also hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and other health plans to *The Sholes Center for Women's Health* for unpaid charges. I understand I am responsible for seeing that all charges are paid in a timely manner. Deductible, co-insurance, co-pays, non-covered services and all other balances not covered by insurance are my responsibility. I understand that if I am unable to keep any scheduled appointments I will call with 24 hours of the appointment or be charged $25 per missed appointment.

Signature: _____ Date: _____

SHOLES CENTER
FOR WOMEN'S HEALTH

T. Taylor Sholes, MD
Obstetrics and Gynecology

Last Name: _____ **First Name**: _____ **MI**: _____

DOB: _____ **Sex**: _____ **Age**: _____

Physical Address: _____

Mailing Address (if different from physical) _____

City: _____**State**: _____**Zip**: _____ **County:** _____

Home Phone: _____**Cell Phone**: _____

SSN: _____ **Marital Status**: Single Married Divorced Widowed

Email: _____

How did you hear about us? ☐ **Facebook** ☐ **Google** ☐ **Dr.** ☐ **Family/Friend** ☐ **Radio**

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Address: _____

Relationship: _____ Home Phone: _____

Insurance: Please present your insurance card upon arrival. You will be considered as self-pay patient until we have a copy of your card. THANK YOU.

Authorizations, Medical Records Release, Assignment of Benefits

1. **Treatment Authorization:** I authorize you to give me reasonable and proper medical care by today's standards.
2. **Release of Information:** I authorize release of my records to *The Sholes Center for Women's Health* including Human Immunodeficiency Virus, Psychiatric, Drug/alcohol records, Venereal Disease and any other statutory protected disease, as necessary for continued medical care, to obtain insurance reimbursement, or to comply with utilization review. I authorize this office to obtain previous medical records from other physicians and/or medical facilities.
3. **Medical Lifetime Signature on File:** (if applicable) I request that payment of authorized Medicare Benefits be made to *The Sholes Center for Women's Health* for any services furnished me by a member of this group. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or benefits payable for related services.
4. **Assignment of Benefits:** I request that payment of authorized insurance benefits be made on my behalf to *The Sholes Center for Women's Health.*
5. **Financial Responsibility:** I understand that *The Sholes Center for Women's Health* will file my insurance as a courtesy to me, and that I remain responsible for payment of co-pays, coinsurance, deductibles, non-covered services and any other charges not paid by insurance within 45 days.
6. **Patient Rights:** I have received a letter pf patient rights from *The Sholes Center for Women's Health.*

Signature: _____ Date: _____

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THE SHOLES CENTER FOR WOMEN'S HEALTH

Name: _____ Date: _____

Ht: _____ Wt: _____ BP: _____ P: _____

Chief Complaint: _____

Date of Last Menstrual Period: _____
Number of Pregnancies: ____
Term: ____ # Preterm: ____ # Abortion/Miscarriage: ____ # Living: ____ Delivery Method: _____

Date of Last Pap Smear: _____ Date of Last Mammogram: _____

Allergies: _____

Past Medical History: _____
_____

Past Surgical History (Major/Minor):
_____
_____

Gynecological History: regular or abnormal periods, if *abnormal* describe how often: _____; Rate pain (1-10): ____, Duration: _____
Birth Control Method: _____

Social history: Tobacco: _____ Alcohol: _____ Drugs: _____

Family History: Breast Cancer _____, Cervical Cancer _____, Uterine Cancer _____, Colon Cancer _____

Medications: _____
_____