

CONFIDENTIAL PATIENT PROFILE

Last Name: _____
 First Name: _____ MI: _____
 Address: _____

 City: _____
 State: _____ Zip: _____
 Phone #1 (H/W/C): _____
 Phone #2 (H/W/C): _____
 Phone #3 (H/W/C): _____
 Employer: _____
 Date of Birth: _____

Marital Status: _____
 Social Security Number: _____
 Race / Ethnicity: _____
 Primary Doctor: _____
 Referring Doctor: _____

Student status: ___ Full time
 ___ Part time
 ___ Not a student

Spouse / Significant Other: Name: _____ Telephone/Cell: _____

Emergency Contact:

Name: _____ Relationship: _____
 Address: _____
 City: _____ State: _____ zip: _____
 Home Phone: _____ Work/Cell phone: _____ ext. _____

Responsible party for claims payment: ___ Self ___ Other (Name: _____)

How did you learn about our office? _____

Preferred Pharmacy: _____ Telephone: _____

Do you have a Living Will (also called an Advanced Directive)? ___ Yes ___ No

If no, would you like some information to help you create one? ___ Yes ___ No

Please list:

All surgeries (include year): _____

Medications you take: _____

Medication Allergies: _____

Medical problems not listed below: _____

Pregnancy History: Number of pregnancies: _____ Abortions: _____ Miscarriages: _____ Ectopic: _____

Deliveries: Full term: _____ Preterm: _____ Twins: _____ Living Children: _____

Patient's Medical History

Have YOU ever had:	circle	Detail Yes Remarks	Have YOU ever had:	circle	Detail Yes Remarks
Diabetes	Yes/no		Hepatitis/Liver Disease	Yes/no	
Hypertension	Yes/no		Bleeding Disorder, Hemophilia	Yes/no	
Heart Disease	Yes/no		Thyroid Disease	Yes/no	
Rheumatic Fever	Yes no		Urinary Tract Infections	Yes/no	
Mitral Valve Prolapse	Yes/no		Asthma/Respiratory Disease	Yes/no	
Kidney Disease	Yes/no		Abnormal Pap	Yes/no	
Nervous/Mental Disorders	Yes/no		Anesthesia Complications	Yes/no	
Epilepsy/Seizures	Yes/no		Breast Problems	Yes/no	
Sexually Transmitted Diseases: Chlamydia, Gonorrhea, Herpes, etc	Yes/no		Common Childhood Diseases: Chickenpox, Measles, Mumps	Yes/no	



**All About Women
Obstetrics & Gynecology**

Anthony B. Agrios, MD
Joseph Iobst, MD
Shelley Russell, CNM
Julie Rischar, CNM

INFORMED CONSENT TO ABIDE BY PRIVACY PRACTICES

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information. I have been given an opportunity to review the policies therein, and I agree to its stipulations. If I have any specific restrictions for my personal health information, I will submit them in writing.

Name of Patient or Personal Representative

Date of Birth _____

X

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (if not Patient)

PERMISSION TO RELEASE MY INFORMATION TO FAMILY AND LOVED ONES

I permit release of my personal health information to the following individuals by telephone, mail, or fax. This authorization will persist until I revoke it in writing.

Husband: _____

Parent: _____

Children: _____

Others: _____

Others: _____

X

Signature of Patient or Personal Representative

Date

PATIENT RESPONSIBILITY FOR PAYMENT FOR SERVICES RENDERED

- I. **PHYSICIAN INSURANCE ASSIGNMENT** - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described.

- II. **MEDICARE/MEDICAID - PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST.** I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for a Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

- III. **COPIES OF AUTHORIZATIONS** - I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office.

- IV. **RESPONSIBILITY FOR PAYMENT** - I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference in accordance with the agreement between All About Women and my insurance carrier. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy. I also understand that, if required, some specimens must be sent to an outside lab for testing. For example, all pap smears are sent to an outside lab for testing. I agree that I am responsible for paying all fees associated with that testing and I understand that I will be billed directly by the lab performing the testing procedure should my insurance benefits be insufficient to cover the expenses.

- V. **LATE FEES** - I understand that payment for professional services is due when said services are rendered. Unless other arrangements are made in advance, I agree to pay all amounts not payable by insurance immediately when billed. All amounts not paid within 30 days of the billing date may be assessed monthly late fees in the amount of \$1.00 or 1_ % of the outstanding balance, whichever is greater. If I fail to pay all amounts due in a timely manner, I agree to pay all costs incurred for collection including reasonable attorney's fees, whether a lawsuit is filed or not.

X

Signature of Patient or Personal Representative

Date

Patient Name: _____ Date: _____

Genetic Screening Questionnaire

	Yes	No	Relationship to this baby
1. Please explain if you or the baby's father or anyone in either of your families has ever had any of the following conditions:			
a. Down's syndrome			
b. Spina bifida or spinal cord defect			
c. Hemophilia or bleeding disorder			
d. Muscular dystrophy			
e. Cystic Fibrosis			
*f. Tay Sachs disease			
†g. Sickle cell disease			
‡h. Thalassemia			
i. Mental retardation. Explain cause if known:			
j. Other genetic disorder. Please describe:			
k. Other birth defect. Please describe:			
l. Three or more miscarriages			
2. Please explain if you or the baby's father have any close relatives with the following ethnic backgrounds:			
*a. Ashkenazi (Eastern European) Jews			
†b. African			
‡c. Mediterranean (Greek, Italian)			

3. How old will you be when the baby is born? _____

4. Have you used any medication or drugs during this pregnancy?

5. Are there any other medical, genetic, or family considerations about which we should know

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request

an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices, as well as disclosures made pursuant to your authorization. It also excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Making a Complaint

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact at:

Anthony B. Agrios, MD, PA
6400 W. Newberry Rd., Suite 101
Gainesville, FL, 32605, or by
Telephone: (352) 331-3332,

for further information about the complaint process. This notice becomes effective on April 14, 2003.



ANTHONY B. AGRIOS, MD, PA NOTICE OF PRIVACY PRACTICES

THIS NOTICE EXPLAINS HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Anthony B. Agrios, MD, PA is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

This Notice describes how we may use or disclose your "protected health information" for various purposes. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services.

Anthony B. Agrios, MD, PA is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. Upon your request, we will provide you with any revised Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information for Treatment, Payment and Health Care Operations

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of this practice.

Following are examples of the types of uses and disclosures of your protected health care information that the practice is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as

necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your diagnosis or treatment to your physician. Finally we may use and disclose PHI for the treatment activities of another health care entity or provider.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. We may also use and disclose PHI for the payment activities of another health care entity or provider.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or

disclose your PHI, as necessary, to contact you to remind you of your appointment. In addition, we may use or disclose your PHI to another entity in order for that entity to conduct specific health care operations, which include quality assessment activities and reviewing the competence of health care professionals.

We will share your PHI with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures That May Be Made With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke such an authorization, at any time, in writing, except to the extent that your physician or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Uses and Disclosures That May Be Made Unless You Object

We may also use and disclose your PHI in the following instances. In these instances, you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best

interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Disaster Relief: We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, as authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to public officials who are authorized by law to receive reports of abuse, neglect or domestic violence.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or

problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) requests for limited information for identification and location purposes, (3) requests pertaining to victims of a crime, and (4) alerting law enforcement officials when (a) there is suspicion that death has occurred as a result of criminal conduct, (b) in the event that a crime occurs on the Practice’s premises, or (c) a medical emergency exists (not on the Practice’s premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation:

We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may also disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has

reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Threatening Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers’ Compensation: Your PHI may be disclosed by us as authorized to comply with workers’ compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the privacy standards applicable to your PHI.