"From the beginning and throughout a lifetime"

Cari Graber, D.O., F.A.C.O.G., F.A.C.O.O.G.
Elana Deutsch, M.D., F.A.C.O.G.

Bethesda Health City
10301 Hagen Ranch Road Suite B-740
Boynton Beach, Florida 33437
Ph 561.734.0188 Fax 561.734.0566

Patient Information

Patient Name: ____
Maiden Name (if applicable): ______________________________________

Permanent Address: ____

City, State, Zip Code: ____

Social Security Number: ______-______-________ Date of Birth: ______/______/_______

Home Phone: (_____)______________________ Cell Phone: (_____)_________________________

E-mail: ____

Race/Ethnicity: ________________________________ Religion (optional): _______________________

Primary Language Spoken: _____________________ Secondary Language: ______________________

Marital Status (circle one): Single Married Divorced Widowed
Significant Others Name:____

Are you a Jehovah's Witness? Yes No
Do you have a living will? Yes No

- -

Occupation: ___________________________________ Employer: _______________________________
Employer's Telephone Number: (_____)_____________________________

Primary Care Physician: ____
Address:____
Telephone: (____) ___________________________ Fax: (_____) ___________________________

Specialist Physician Name: ____
Specialty Type (ex. Cardiologist, Nephrologist…): ____________________________________
Address: ____
Telephone: (____)____________________________ Fax: (_____)___________________________

Emergency Contact's Name: ____
Address: ____
Home Telephone: (_____)______________________ Cell (_____)____________________________
Relationship: _____________________________________

**Pharmacy Name: ____
Address: ____
Phone: (_____)______________________________

How did you hear about us? ____

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Notice of Privacy Practices

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help or prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your Rights Regarding your Health Information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment or healthcare operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to

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agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in an emergency, or when the information is necessary to treat you.

3. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for amendment.

4. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

5. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint. You may do so by filing it with either our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

6. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice on our health information privacy policies, please contact our office manager for further information.

I hereby acknowledge that I have been presented with or offered a copy of this Notice of Privacy Practice.

Name of Patient: ____

*Date:*_______________________

*Signature:*____

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Appointment Cancellation / No Show Policy

Our practice is committed to providing quality health care to our patients. We work diligently to maintain a high level of personalized services and make every effort to accommodate our patient's needs for office visits in a timely manner.

We understand that emergencies arise as they do for us, however when a patient cancels an appointment without adequate notice or fails to show up to an appointment without any notice, we cannot use the time to service the needs of other patients. You will receive a call the day before to confirm your appointment. We respectfully request your understanding to our policy as stated below.

Failure to give 24 hours notice of cancellation, rescheduling, or no showing to an appointment will result in a $25 charge. Insurance companies do not cover this fee and it will be billed to your account.

Please use 561-734-0188 for any calls. This is the only telephone line that is answered 24 hours a day.

Thank you for your consideration and understanding of our policy.

I have read the cancellation / no show policy.

_______________________________________ ______________
Patient Signature Date

____
Print Name

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c/o Bethesda Medical Associates

CONSENT RECORD

1. FINANCIAL AGREEMENT- I hereby guarantee payment of all charges incurred for services rendered by Bethesda Medical Associates by authorized treating physician(s). Further, I guarantee payment of all attorney fees, court costs and collection charges incurred in the event collection action is initiated by Bethesda Medical Associates.
2. MEDICARE/MEDICAID ASSIGNEMENT AND AUTHORIZATION TO REALEASE INFORMATION AND PAYMENT REQUEST- I assign benefits and request that payment be made directly to Bethesda Medical Associates. I understand that I am responsible for any deductibles and co-payments applicable.
3. USES AND DISCLOSURES OF HEALTH INFORMATION – I understand that Bethesda Associates will use and disclose my personal health information to provide treatment and process claims. This includes release of information to insurance carriers, 3rd party payers or their agents, with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV as may be necessary. Further, my information and medical records may be disclosed to members of the hospital's medical staff involved in my subsequent care and treatment. For details of uses and disclosures refer to Notice of Privacy Practices.
4. CONSENT FOR GENERAL MEDICAL TREATMENT- I hereby authorize Bethesda Medical Associates and physicians in charge of my care to administer any treatment, receive results of tests and services rendered, to administer medications deemed necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments of examinations at Bethesda Medical Associates.
5. PRIVACY PRACTICES- I have been made aware of Bethesda's privacy practices as described in the Notice of Privacy Practices.
6. I authorize the release of any medical information necessary to process my claims. I assign benefits and request payment be made to Bethesda Medical Associates. I permit a copy of these authorizations to be used in place of the original. I accept responsibility for all charges incurred and am responsible for payment. Where applicable, regulations pertaining to Medicare assignment and HMO assignment of benefits apply.

I understand that this consent is subject to revocation at any time to the extent that action has been taken in reliance thereon. I certify that I have read the foregoing, received a copy thereof, and am the patient, the patient's legal representative or duly authorized by the patient as the patient's general agent to execute the above and accept its terms. I also fully understand the consent contained in this record and voluntarily execute it.

Patient Signature: ______________________________ Date: ____________________

Witness Signature: ______________________________ Date: ____________________

Patient Contact

<u>Contact Information*</u>
The following people, other than duly designated guardian or conservator, are authorized to discuss my medical condition or billing information:

1. ____
   Name Relationship Phone Number

2. ____
   Name Relationship Phone Number

Print Name: ______________________________ Date: ____________________

Signature: ______________________________ Phone #: ____________________

**Please Note:* This Contact information will remain in effect unless change is received from you in writing.

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New Patient History

Welcome to our practice. Please provide us with the most accurate and thorough description of your history. This will help us to give you our best care. Thank you.

Name: ______________________________________ Date: _________________

Age: _________

What is your reason for coming to see your doctor today? ____________________________

____

When was your last visit to the Gynecologist? _______________________________________

Your Medical History

Do you or have you had any of the following medical conditions? If yes, please provide the year you were diagnosed.

Condition	Diagnosed Date	Condition	Diagnosed Date
___ High Blood Pressure	____________	___ History of Stroke	___________
___ High Cholesterol	____________	___ History of Heart Attack	___________
___ Diabetes	____________	___ Congestive Heart Failure	___________
___ Hypothyroidism	____________	___ Depression	___________
___ Lupus	____________	___ Anxiety	___________
___ Fibromyalgia	____________	___Migraines	___________
___ Osteoporosis	____________	___History of Deep Vein Thrombosis or pulmonary embolus	___________
___ Asthma	____________	___ Cancer If so what kind? _______________	___________

___Other: ____

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Surgical History

What surgeries have you had in your life and what year were they performed?

Surgery	Date	Surgery	Date	Surgery	Date
___ ( ) Tonsils	_______	___ ( ) Uterus removed	_______	___ ( ) Tubes Tied	_______
___ ( ) Gallbladder	_______	___ ( ) Uterus & ovaries	_______	___ ( ) Appendix	_______
___ ( ) Hernia	_______	___ ( ) Cryo/freezing of cervix	_______	___ ( ) Breast Surgery	_______
___ ( ) C-section	_______	___ ( ) Bladder lift	_______	___ ( ) Plastic Surgery	_______
___ ( ) cone biopsy/LEEP of cervix		___( ) Hip replacement	_______	___ ( ) D & C	_______

___ ( ) Other surgeries ____

Obstetrical History (If you have never been pregnant, check N/A) ◯ N/A

How many times have you been pregnant? ____
How many vaginal deliveries have you had? ____
How many preterm deliveries have you had (delivery before 37 weeks)? ___
How many cesarean sections have you had? ____
How many miscarriages have you had? ____
How many terminations of pregnancy have you had? ___
How many living children do you have? ___

Date of Delivery	Weeks pregnant at delivery	Birth Weight	Female/ Male (M or F)	Vaginal or C-Section? (V or C)	Vacuum or Forceps? (V or F)	Did you deliver before 37 weeks of pregnancy? (Y or N)	Did you have high blood pressure, diabetes, or blood clots during pregnancy? (Y or N)	Breastfed? (Y or N)
/ /								
/ /								
/ /								
/ /								

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Gynecologic History

Do you have or have you been diagnosed with any of the following?

___ Fibroids
___ Endometriosis
___ Infertility
___ Irregular periods
___ Gonorrhea
___ Chronic pelvic pain
___ Hot flashes
___ Insomnia
___ Vaginal dryness
___ Postmenopausal bleeding
___ Urinary incontinence
___ Pelvic organ prolapsed
___ Chronic yeast infections
___ Chlamydia
___ Breast cysts or masses
___ HIV
___ Pelvic inflammation
___ Chronic urinary infections
___ Chronic bacterial vaginosis
___ Decreased sex drive
___ Ovarian cysts
___ Heavy bleeding
___ Abnormal pap smears
___ Syphilis
___ Hepatitis
___ Trichomonas
___ Genital Warts

- Do you use birth control now? Yes or No
  If yes, what kind? ____________________
- Are you on hormone therapy now for menopausal symptoms? Yes or No
  If yes, what kind? ____________________
- Have you ever been on Hormone therapy (ex. Pills, creams, patch)? Yes or No
  If yes, for how many years? _________________

Bleeding History

- What was the first day of your last menstrual period? _____________
- What age was your first period? ___________ If postmenopausal, at what age was your last period? _____________
- On average, how many days do/did your periods last? ______________
- Do you get your period monthly? _________________
- Have you ever had severe pain or heavy bleeding with your periods? ____________
- Do you have bleeding or spotting after intercourse? _____________
- Do you ever get more than one period in a month? _____________
- Have you ever had a blood transfusion? _____________
- Have you ever had any spotting or bleeding after menopause? ____________

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Medications

Please list medications with dosages (including birth control, hormones, and vitamins)

◯ *Check here if you brought a list/copy of your medications*

1. ______________________________ 5. __________________________ 9. ____________________

2. ______________________________ 6. __________________________ 10. ____________________

3. ______________________________ 7. __________________________ 11. ____________________

4. ______________________________ 8. __________________________ 12. ____________________

Allergies

- Do you have any allergies to ***medications***? Yes or No
  If so, what medication? ____
- Do you have any allergies to ***food***? Yes or No
  If so, what food? ____
- Do you have any allergies to ***latex*** (gloves)? Yes or No
  If so what reaction? ____

Social History

- Marital Status: Single Married Divorced Widowed
- Do you smoke? Yes or No
  If you have quit smoking, when was your quit date? ________________
- Have you ever had a problem with drugs or alcohol? Yes or No
- Do you exercise? Yes or No
  How many times a week? __________
- Are you sexually active? Yes or No
  If yes, with men, women, or both? _________________
- Have you been in a relationship where you were verbally or physically abused? Yes or No
- Do you have a significant concern regarding food, body image or weight? Yes or No

Family History

- Has anyone in your immediate family had breast ***cancer, colon cancer, uterine cancer*** or ***ovarian cancer***? Yes or No If yes, who? ________________________________
- Has anyone in your immediate family had a ***blood clot*** in their legs or lungs? Yes or No
- Any family member with ***diabetes, strokes, heart attacks, thyroid disease***? Yes or No

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Medical Record Release

Women for Women – Obstetrics & Gynecology
10301 Hagen Ranch Road, Ste B740
Boynton Beach, FL
Ph: 561-734-0188 Fx: 561-734-0566
www.womenforwomenfl.com

Patient Name (First, Last, Middle Initial): ____

Date of Birth: _________________________________

Type of information requesting:

- ○ Entire Medical Record
- ○ Operative Report
- ○ Pathology Report
- ○ Discharge Summary
- ○ Laboratory Reports
- ○ Radiology Reports
- ○ PAP
- ○ Mammogram

Please obtain my medical records from:

Name of Doctor: ____

Address: ____

Phone Number: ____________________________________

Fax Number: _______________________________________

- *I understand that I have a right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing.*
- *I understand that authorizing the disclosures of this health information is voluntary, I can refuse to sign, and the facility will not base my statement, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure.*
- *I understand that the recipient may be prohibited from disclosing substance abuse information.*
- *I understand that I may inspect or copy the information to be disclosed.*
- *I understand that the information used of disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and is not longer protected by federal confidentiality laws.*
- *I understand that Women for Women will release only the minimum amount of information necessary to fulfill a request.*
- *This authorization will expire six months form the date of signature.*

Patient Signature: _____________________________________ **Date:** ____________________