GYNECOLOGICAL AND OBSTETRICAL ASSOCIATES

Patient Name _____ Date of Birth ____/____/____ Age _____

Address _____Apt_____

City _____State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____

Marital Status [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Email Address _____

Social Security # _____-_____-_____ Patient Employed [ ] Yes [ ] No

Employer _____ Work Phone ( ) _____

Referred By _____

INSURANCE INFORMATION

Primary Insurance _____ [ ] PPO [ ] EPO [ ] HMO

Policy Holder _____ Date of Birth _____/_____/_____

Relation to Subscriber [ ] SELF [ ] SPOUSE [ ] PARENT [ ] OTHER_____

Member ID _____Group # _____

Secondary Insurance _____ [ ] PPO [ ] EPO [ ] HMO

Policy Holder _____ Date of Birth _____/_____/_____

Relation to Subscriber [ ] SELF [ ] SPOUSE [ ] PARENT [ ] OTHER_____

Member ID _____ Group # _____

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I authorize the release of all medical information required in the course of examination or treatment to any insurance group or carrier which I may have in support of benefits to which I may be entitled. I further direct that payment of my benefits under such insurance due me for services rendered are hereby assigned to GYN/OB Associates. I further recognize and accept personal responsibility for full payment of the charges for professional services rendered to be at my request.

I accept responsibility for any services my insurance does not cover. Requests to amend information must be made in writing. Requests to access records must be made in writing. There will be a charge for any summaries of records.

Signature (Patient/Guardian) _____ Date _____
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Gynecological & Obstetrical Associates

Rebecca Weprin, MD David Lombardi, MD Shelia Chhutani, MD
Laura Rosenfield, MD Clara Telford, MD

I, _____, hereby authorize Gynecological and Obstetrical Associates to release any information pertaining to my medical care to the following person(s): (For example: Names of parents, guardian, spouse, children, close friend, etc.)
Please list below:

_____ _____

[ ] I do not wish to have my medical information released to anyone.

Do you have a phone number where your doctor or nurse may leave a message with specific medical results and information?

[ ] No

[ ] Yes, leave messages and/or text this phone number _____

[ ] Yes, ok to send email regarding appointments. _____

Emergency Contact _____

Relationship _____ Phone ( )_____

This information will remain in effect unless you inform us of additions/deletions.

_____ _____

Patient Signature Date

_____

Witness (Office Staff ONLY)

Gynecological & Obstetrical Associates
Financial Policy

Thank you for choosing our office as your health care providers. We are committed to providing excellent health care service. As part of our professional relationship, it is important that you have an understanding of our financial policy.

ALL PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING SERVICES.

- **IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH YOUR MOST CURRENT INSURANCE INFORMATION.** If you fail to provide accurate information in a timely manner, your insurance company may deny the claim or we may not be able to file it due to filing deadlines. If the claim is denied, you **WILL BE FINANCIALLY RESPONSIBLE FOR YOUR SERVICES.**
- Failure to keep your account balance current may require us to cancel/reschedule your appointment.
- We must emphasize that as, medical providers; our relationship is with you and not your insurance company. Your insurance is a contract between you and your insurance company and possibly your employer. It is your responsibility to know and understand the level of benefits of your insurance plan
- We may accept assignment of insurance but please be aware that some or perhaps all of your services provided may not be covered in full by your insurance company. **YOU ARE FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY YOUR INSURANCE.**
- Before receiving services, you **MUST VERIFY** that we are **PARTICIPATING PROVIDERS IN YOUR PARTICULAR PLAN.**
- **Copayments, coinsurance and/or deductibles are due at the time of service.** We will estimate the amount you owe based on the information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim, regardless of our estimation.
- We will send a statement (to the billing address you provide) notifying you of any balances you owe. If you have any questions it is your responsibility to contact this office within 30 days of the statement date.
- If you submit payment by check and the bank returns the check unpaid for any reason, we will add a **$35 returned check charge** to your account.
- A **NO SHOW** fee of **$50** if you fail to cancel or reschedule your appointment at least **48 hours** prior to your appointment date.
- **There is a $25 fee for *each* set of forms being completed by our office for FMLA or other leave of absence.** (Please allow 10 business days for paperwork to be processed in our office).

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

We accept cash, checks. Master Card, Visa, Discover & American Express.

I have read and understand this financial policy.

Responsible Party Signature_____Date_____

Print Patient Name _____DOB: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have been offered a copy of Gyn/Ob Associates' Notice of Privacy Practices.

_____ _____
Patient Signature Date

8160 Walnut Hill Lane, Suite 100, Dallas, Texas 75231 Phone: 214-369-1203 Fax: 214-369-0586

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BILLING POLICIES

Office Visit:	Payment is expected at the time of your visit.
Billing:	Where indicated, insurance will be billed from this office.
Statements:	Will be sent out on a monthly basis.
Past Due Accounts:	Will be turned over to a collection agency.
Charges for Services:	If no insurance is in effect, or if not covered by insurance, payment is expected at time of the service.
Payments:	Payments can be made with cash, check, or credit card.
	There is a $35.00 charge for a returned check. If a check is returned no future checks will be accepted.
	There is a $50.00 charge for not showing for an appointment without calling to cancel
	Credit card on file may be used after speaking with patient.
	Payment plans are available if arrangements are made ahead of time.

Gynecological & Obstetrical Associates

Margot Perot Women's Center
8160 Walnut Hill Lane
Suite 100
Dallas, TX 75231
Ph. 214-369-1203
Fax 214-369-0586

Gynecological and Obstetrical Associates (Gyn/Ob) is a full service provider of women's healthcare services for more than 40 years. We are comprised of five practicing physicians and a full complement of office staff.

Our office hours are: **Monday to Thursday from 8:00 AM to 5:00 PM**

****Friday 8:00 AM to 2:00 PM****

We do have lunchtime appointments available periodically.

We are located on the first floor of the Margot Perot Center at Presbyterian Hospital of Dallas. In Suite 100.

We accept most insurance plans, including Medicare.

Gynecological & Obstetrical Associates

Leaders in Women's Healthcare

We provide a full complement of both obstetrical and gynecological care.

Our services include providing both low risk and high risk obstetrical care. This includes providing routine prenatal care, initial screening for birth defects, addressing problems during your pregnancy, providing first trimester ultrasounds, and being available 24 hours a day for questions and deliveries. All of our deliveries are at Presbyterian Hospital of Dallas.

We also provide comprehensive health services for women including well woman exams, Pap smears, contraception, STD testing, infertility, adolescent gynecology, issues related to menopause, and problems related to the genitourinary tract. We provide in office follow up for abnormal results. We can aid in scheduling mammography. We provide screening for ovarian, cervical, uterine, and breast cancer. We can also provide screening for osteoporosis via our on-site bone scanning technology.

Additionally, we provide a full range of surgical services. These include minimally invasive procedures such as laparoscopy and hysteroscopy, and new endometrial ablation techniques for treating abnormal uterine bleeding. We also offer hysterectomies by either the abdominal or vaginal approach. Our surgeons are skilled in performing incontinence procedures and also procedures related to pelvic floor reconstruction.

We look forward to assisting you in any way that we can.

You can reach us by calling 214-369-1203.

Gynecological & Obstetrical Associates

Gyn/Ob is comprised of the following physicians:

Rebecca Weprin, M.D., is a graduate of Duke University. She received her medical degree from the University of Texas Southwestern Medical Center and completed her Ob/Gyn residency at the University of Minnesota. Dr. Weprin was previously in practice in Minneapolis and has been with this practice since 1999.

David Lombardi, M.D., is a graduate of Trinity University. He received his medical degree from the University of Texas Southwestern Medical Center and completed an Ob/Gyn residency at the University of Kentucky. Special interests include high risk obstetrics as well as adolescent gynecology. Dr. Lombardi joined Gyn/Ob Associates in 2005.

Sheila Chhutani, M.D., is a graduate of Truman State University. She received her medical degree from St. Louis University and completed an Ob/Gyn residency at Rush University. She completed an Advanced Pelvic Surgery Fellowship in 2005.

Laura Rosenfield, M.D., was born and raised in Dallas, TX and is a graduate of both JJ Pearce High School and Southern Methodist University. Dr. Rosenfield completed her undergraduate studies with a Bachelor of Arts in Psychology and Distinction and membership in Phi Beta Kappa honor society. Dr. Rosenfield earned her medical degree from Texas Tech University School of Medicine and completed her residency in Ob/Gyn at The University of Nevada School of Medicine in Las Vegas.

Clara Telford M.D., is originally from Euless, Texas. She received her Bachelor of Science in physiology from Oklahoma State University where she was a member of the varsity women's track team. She moved back to North Texas after college and attended medical school at the UT Southwestern Medical School where she graduated with Alpha Omega Alpha honors. She completed her residency in obstetrics and gynecology at Baylor University Medical Center in Dallas.

Gynecological & Obstetrical Associates

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

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

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Susan Carrillo
8160 Walnut Hill Lane Suite 100
Dallas, TX 75231
214-369-1203

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **TREATMENT.**
   Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your IIHI in order health care providers for purposes related to your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **PAYMENT.**
   Our practice may use and disclose you IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collections efforts.

3. **HEALTH CARE OPERATIONS.**
   Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use you IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose you IIHI to other health care providers and entities to assist in their health care operations.

4. **APPOINTMENT REMINDERS.**
   Our practice may use and disclose you IIHI to contact you and remind you of an appointment.

5. **TREATMENT OPTIONS.**
   Our practice may use and disclose you IIHI to inform you of potential treatment options or alternatives.

6. **HEALTH-RELATED BENEFITS AND SERVICES.**
   Our practice may use and disclose you IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **RELEASE OF INFORMATION TO FAMILY/FRIENDS.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **DISCLOSURES REQUIRED BY LAW.**

Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. PUBLIC HEALTH RISKS.

Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. HEALTH OVERSIGHT ACTIVITIES.

Our practice may disclosure your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor governmental programs, compliance with civil rights laws and the health care system in general.

3. LAWSUITS AND SIMILAR PROCEEDINGS.

Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. LAW ENFORCEMENT.

We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person

- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. DECEASED PATIENTS.

Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. ORGAN AND TISSUE DONATION.

Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. RESEARCH.

Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when and Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) and adequate plan to protect the identifiers from improper use and disclosure; (B) and adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. SERIOUS THREATS TO HEALTH OR SAFETY.

Our practice may use and disclose your IIHI 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. Under these circumstances we will only make disclosures to a person or organization able to help prevent the threat.

9. MILITARY.

Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. NATIONAL SECURITY.

Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order protect the President, other officials or foreign heads of state, or to conduct investigations.

11. INMATES.

Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you , (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. WORKERS' COMPENSATION.
Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI
You have the following rights regarding the IIHI that we maintain about you:

1. CONFIDENTIAL COMMUNICATIONS.
You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Susan Carrillo,** specify in the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. REQUESTING RESTRICITONS.
You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI 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 agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make you request in writing to **Susan Carrillo, 214-369-1203.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. INSPECTION AND COPIES.
You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Susan Carrillo, 214-369-1203 in** order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. AMENDMENT.
You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for 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 **Susan Carrillo, 214-369-1203.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **ACCOUNTING OF DISCLOSURES.**
   All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of you IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Susan Carrillo, 214-369-1203.** All requests for and "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **RIGHT TO A PAPER COPY OF THIS NOTICE.**
   You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Susan Carrillo, 214-369-1203.**

7. **RIGHT TO FILE A COMPLAINT.**
   If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Susan Carrillo, 214-369-1203.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DICLOSURES.**
   Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Susan Carrillo, 214-369-1203.**