

SPRING-KLEIN OB/GYN

PATIENT INFORMATION FORM

PHYSICIAN'S NAME _____

PATIENT'S FULL NAME		MAIDEN NAME	
ADDRESS		APT. #	PHONE NUMBER ()
CITY	STATE	ZIP	WORK NUMBER () CELL NUMBER ()
SEX <input type="checkbox"/> F <input type="checkbox"/> M	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER	DATE OF BIRTH MM/DD/YY	PATIENT'S SOCIAL SECURITY #
PATIENT'S EMPLOYER			
EMPLOYER'S ADDRESS			
SPOUSE'S/GUARDIAN'S NAME		WORK NUMBER () CELL NUMBER ()	DATE OF BIRTH MM/DD/YY
EMPLOYER		ADDRESS	
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP	PHONE # ()
PRIMARY INSURANCE COVERAGE			
INSURANCE COMPANY		INSURED'S DOB	<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER
NAME OF INSURED		COPAY AMOUNT	
INSURED'S EMPLOYER			
INSURANCE CLAIMS ADDRESS		INSURANCE PHONE #	
CITY		STATE	ZIP
POLICY NUMBER		GROUP NUMBER	INSURED'S SOCIAL SECURITY #
SECONDARY INSURANCE COVERAGE			
INSURANCE COMPANY		INSURED'S DOB	<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER
NAME OF INSURED		COPAY AMOUNT	
INSURED'S EMPLOYER			
INSURANCE CLAIMS ADDRESS		INSURANCE PHONE #	
CITY		STATE	ZIP
POLICY NUMBER		GROUP NUMBER	INSURED'S SOCIAL SECURITY #
ANY OTHER INSURANCE COVERAGE		<input type="checkbox"/> YES <input type="checkbox"/> NO	COMPANY NAME PHONE # ()
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		PRIMARY CARE PHYSICIAN	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Spring-Klein OBGYN to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Spring-Klein OBGYN. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: _____ SIGNATURE _____ form A-04 New Patient 12321 Rev. (08/09)

Spring Klein OB/GYN

4002 Louetta Rd, Spring, TX 77388

(281)444-1770 fax (281)444-4739

Hours

Mon-Thurs 7-5:30

Fri 7-2

*Office closed 12-1 for lunch

Lab Hours

Mon-Thurs 7-5:30

Fri 7-2 pm *closed 12-1 pm for lunch

Rx Refills/Test Results

Please contact pharmacy for refill prior to prescription ending .

Refills may take 2-4 business days to process.

Test Results- Allow 1-2 weeks for test results. You will receive a phone call for all abnormal results. A letter will be sent via mail for all normal results.

Nurse Calls and Questions

Please allow 24-48 hours for the nurse to return your call for **Non-Emergency** calls (test results, medication questions, general questions, ect.)

Ultrasound and Mammogram

Ultrasounds and Mammograms are performed at Houston Northwest Medical Center or may be performed at another facility if more convenient to the patient.

FMLA/Disability paper work

Please allow 3-5 business days for completion of necessary paperwork. There is a \$25 charge.

Records Release

Please allow 7-10 business days. There is a \$25 charge.

No charge if sent physician to physician.

All records will be mailed unless otherwise indicated.

Most Medicaid programs accepted

Please call office to confirm that we accept your particular plan.

Tricare programs accepted

Insurance

All copays or deductible will be collected at the time of service.

Insurance verified for active status prior to visit.

Patient is responsible for knowledge of plan details.

Please notify office of any changes as soon as possible.

Scheduled/Missed Appointments

If you are **more than 15 minutes late** for your appointment you may be asked to reschedule.

If you need to reschedule your appointment please notify the office 24 hours in advance.

If you miss more than 3 appointments you may be charged \$25.

NOTE: If you do not know your pharmacy address or phone number please provide the name of the pharmacy and where it is located including cross streets.

Pharmacy Name: _____

Location: _____

Phone Number: _____

Spring-Klein OB/GYN Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Spring-Klein OB/GYN unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needlestick (any such test shall be conducted pursuant to Spring-Klein OB/GYN's infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Spring-Klein OB/GYN. If any of these situations occur during your treatment period.

Patient's Printed Name

Date of Birth

Patient/Legal Representative Signature

Date

Relationship to Patient

Witness

Date

SPRING-KLEIN OB/GYN
4002 LOUETTA RD.
HOUSTON, TX 77388
(P) 281-444-1770 (F) 281-444-4739

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____
SSN: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

I AUTHORIZE SPRING KLEIN OB/GYN TO RELEASE RECORDS

TO / FROM: SPRING KLEIN OB/GYN

FROM / TO: NAME: _____
PHONE: _____
FAX: _____

PLEASE SEND A COPY OF THE FOLLOWING MEDICAL RECORDS:

- | | |
|--|--|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> OBSTETRICAL RECORDS |
| <input type="checkbox"/> OPERATIVE REPORTS | <input type="checkbox"/> LAST CLINIC VISIT NOTE |
| <input type="checkbox"/> LAB REPORTS AND LAB RESULTS | <input type="checkbox"/> PAP SMEAR / PATHOLOGY RESULTS |
| <input type="checkbox"/> DIAGNOSTIC REPORTS | <input type="checkbox"/> CONSULTATION REPORT |
| <input type="checkbox"/> RADIOLOGY / XRAY REPORTS | <input type="checkbox"/> OTHER _____ |

This authorization is valid for six months from the date of signature. I understand that this authorization may be revoked by the patient (verbally or in writing) at any time prior to six months. A fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE SIGNED

RELATIONSHIP TO PATIENT

WITNESS

FOR OFFICE USE ONLY

DATE FEE COLLECTED: _____ AMOUNT: _____ BY: _____
DATE RECORDS RELEASED: _____ MAILED FAX PICKED UP BY PATIENT



Patient Name: _____
Medical Record Number: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from
(patient name)
Spring-Klein OB/GYN (SKOBGYN).

Patient Signature: _____ Date: _____

In lieu of patient signature, I, _____, a patient representative/ staff
(patient representative)
member of SKOBGYN, state that _____ has been given our current
(patient name)
Notice of Privacy Practices.

Patient Representative Signature: _____ Date: _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Spring-Klein OB/GYN (SKOBGYN) to share my protected health information with:

Name Relationship

Name Relationship

Name Relationship

If patient refuses to sign, please state the reason(s) below:

PLEASE KEEP THIS FOR YOUR RECORDS.

Spring-Klein OBGYN Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER STEPHEN EPPSTEIN, M.D. AT (817) 514-5200.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care (clinic) operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services.

We are required to maintain the privacy of protected health information and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices via our website, www.MCNT.com, or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. An updated copy will also be posted in your physician's office.

1. Uses and Disclosures of Protected Health Information

Your protected health information 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 protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office 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 protected health information 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 protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information 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 protected health information from time-to-time to another physician or health care provider (e.g., a radiologist or pathologist) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information 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 protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare (Clinic) Operations: We may use or disclose, as-needed, your protected health information in order to support the professional and business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical and nursing students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical and nursing school students that see patients at our office. In addition, 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 protected health information, as necessary, to contact you to remind you of your appointment.

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

We may use or disclose your protected health information, as necessary, to provide you with appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may send you information about products or services that we believe may be beneficial to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

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

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information,

then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. We may use and disclose your protected health information in the following instances:

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 protected health information 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 protected health information 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. Finally, we may use or disclose your protected health information 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.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object We may use or disclose your protected health information 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. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information 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 protected health information, 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 protected health information, if 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 protected health information 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 protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse.

neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information 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 protected health information 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), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information 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 protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: If you choose to participate in medical or scientific research, we may disclose your protected health information 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 protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, 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 protected health information 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 protected health information 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 protected health information 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 protected health information 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 protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information 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 requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

2. Your Rights

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

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about your health care. The request must be made in writing to the Spring-Klein OBGYN. If you request a copy of your medical record, your physician's office will provide you a copy within 30 days.

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 protected health information that is subject to law that prohibits access to protected health information. 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 Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information 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 physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information 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 submitting your written request to the manager of your physician's clinic.

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 Officer at 9003 Airport Freeway, Suite 300, North Richland Hills, Texas 76180.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information for the purpose of correcting an error or misinformation. 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 that statement will become part of your medical record. Your physician may prepare a rebuttal to your statement which will also become part of your medical record. Your physician will provide you with a copy of any such rebuttal. Please contact our Privacy Officer 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 protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. 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.

3. Questions or Complaints

If you have a question or complaint about your privacy rights, please file a grievance form with the site manager of the clinic where you encountered a problem, or contact the Privacy Officer for the Spring-Klein OBGYN at (817) 514-5200. Should the Privacy Officer be unable to resolve your complaint to your satisfaction, you may contact the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

This notice became effective on April 14, 2003.

Revisions/Addenda to Notice of Privacy Practices

Family/Joint Accounts

If you or a family member receives bills with more than one person listed on the bill, you may have a joint or family account through MCNT. As a patient with this type of account, you have two options: (1) continue with a joint account or (2) request separate accounts for all members of your family. If you wish to continue to receive your bills as a joint/family account, you need take no action. If you choose to separate your joint accounts, requests must be made in writing and submitted to: Spring-Klein OBGYN Central Business Office Customer Service/ Collections Personnel 9003 Airport Freeway, Suite 300 North Richland Hills, Texas 76180 (817) 514-5200 phone (817) 514-5210 fax

PLEASE CALL YOUR INSURANCE COMPANY TODAY.

As you are probably aware, coverage under most health insurance policies HAS CHANGED. In an effort to assist our patients in understanding their insurance coverages, we have defined the following as **questions that you should ask** your insurance company. Whether you have a new insurance company (or you have had the same insurance plan for years), these questions should be asked TODAY to determine any changes in coverage. These are only a few suggestions, so please ask any other questions you may have when you make the call.

1. What is my effective date? _____

2. If I have coverage with more than one insurance, which insurance is primary?

Which is secondary?

Which company is the primary for my child if both myself and spouse have coverage?

3. Is my insurance an HMO, POS, PPO or indemnity? What does this mean?

4. Do I have out of network benefits? _____

5. Does my insurance require written referrals to specialists? _____

6. Do I have a deductible? _____ What does that mean to me, and how much has been met?

What is the deductible for?

7. Will I have co-insurance amounts due over and above my copay? _____
If yes, what are those amounts? _____

8. What is my doctor (PCP) office visit copay? _____
Specialist office visit copay? _____ Is my OBGYN treated as a specialist if I only go for my annual gynecological visit? _____

9. How often can I and/or family members have a preventive physical/well woman exam/well child visit? _____ According to your records, when did I and/or my family members last have these types of exams? _____

- Is there a copay for a preventive physical/well woman exam/well child visit? _____ How much? _____

- When I and/or family members have a preventive physical/well woman exam/well child visit, is there anything that is NOT covered?

How much do I have to pay? _____

10. Is there a cost limit, coinsurance or deductible on my preventive coverage? _____ If so, how much? _____

11. Is there a **copay, coinsurance or deductible** if I have labs or procedures done without seeing the physician or physician assistant? _____
What if the procedures or lab work occur on a day(s) before or after my appointment? _____

12. Do I have coverage for screening tests? (Colonoscopy, stress test, labs, mammograms, bone density testing, EKG, etc.) If so, what is the rate at which these tests are covered?

13. Do I have coverage for preventive immunizations? _____ Travel Immunizations? _____
Is there a co-pay when I go to the doctor for immunizations only? _____ For children, is there an annual cost limit for preventive immunizations? _____ If yes, how much? _____

14. What pre-existing conditions are NOT covered by my insurance?

NOTE: Medicare patients should find out when co-payments apply, especially when Medicare is offering a particular health service/exam.