YOLANDA LAWSON, M.D., P.A.
2509 Thomas Ave
Dallas, TX. 75201
NEW PATIENT INFORMATION

Provider you are seeing today _____Referred by _____
Patient Name _____Date of Birth _____ SSN # _____
Address _____City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Email _____ May we email you personal info? Y/N

Best number to call with test results _____ Is it OK to leave message? Y/N

Your employer _____Address_____
City _____Zip _____ Phone # _____

In case of emergency notify_____Relationship_____
Home # _____ Work # _____ Cell # _____

I do/do not give permission for my medical information to be shared with (list names):
_____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance name _____ID # _____ Group # _____
Name of Insured _____ Date of Birth _____
Insured SS # _____ Relation to patient _____
Insured Employer _____ Address _____
City _____ State _____Zip _____ Phone # _____

SECONDARY INSURANCE
Insurance name _____ID # _____ Group # _____
Name of Insured _____ Date of Birth _____
Insured SS # _____ Relation to patient _____
Insured Employer _____ Address _____
City _____ State _____Zip _____ Phone # _____

IMPORTANT INFORMATION

- All patients are required to give a 24 hour notice for any appointment cancellations. There will be a $25.00 charge for all missed appointments without this notice.
- There is a charge for copying of all medical records. Please give a written request. First 20 pages $25.00 plus .50 for every page after that. This office has 30 days to fulfill your request.
- There are miscellaneous charges for additional clerical services (i.e. disability forms, physician letters, etc.). Please ask our front desk for details.

I hereby authorize the provider indicated above to furnish information to insurance carriers and I hereby irrevocably assign all benefits for payment for medical services rendered to this provider. Verification of benefits are not a guarantee of payment by the insurance company. I understand that I am responsible for all charges whether covered by insurance or not.

Patient Signature _____Date_____

Guarantor Signature _____ Date_____

HEALTH QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. Your current health state reflects a wide range of issues vital to helping us better understand and serve your health care needs.

Date: _____ Name: _____Age:_____
How did you hear about us? _____
Occupation: _____ Intention for your visit: _____
Allergies: Medications: _____Other: _____
Preferred pharmacy, phone number or location: _____
Medications/Dosage (include prescriptions, vitamins/supplements, over-the-counter, and "alternative remedies")
_____
_____

GYNECOLOGIC HEALTH AND HISTORY

Date your last period began: _____ Date of last PAP Smear_____ Normal/Abnormal
How many days from the start of one period to the next? _____ How many days does the flow last? _____
Is the flow light_____ medium_____ heavy_____ very heavy _____
Age at first period_____
Any premenstrual symptoms? No_____ Yes_____
Age first had intercourse? _____ Are you sexually active? No___ Yes____
Do you have intercourse? No__ Yes__ With men___ with women___ Both___
Do you utilize condoms? No_____ Yes_____
Birth Control? No ___ Yes ____If yes, what type?_____
Any Menopausal Symptoms? Yes_____ No_____
Irregular cycles: _____Vaginal dryness: _____ Sleep disturbance: _____ Hot flashes: _____ Other: _____
Age at menopause: _____ Are you taking hormones? No/Yes Type/Dose: _____
Have you ever had a Mammogram? Yes__ No__ Most recent_____ Result_____Where_____
Have you ever had a Bone Mineral Density? Yes__ No__ Result_____Where_____
Have you ever had a Colonoscopy? Yes___No___Result_____Where_____

Medical Problems Have you ever had in the past or do you currently have (please check):

Abnormal Pap Past ( ) Current ( )	**Blood Clots/DVT** Past ( ) Current ( )	**Cancer** Past ( ) Current ( )	**Eating Disorder** Past ( ) Current ( )	**Heart Murmur** Past ( ) Current ( )	**Infertility Problems** Past ( ) Current ( )	**Migraine Headaches** Past ( ) Current ( )	**Thyroid Problems** Past ( ) Current ( )
Anemia Past ( ) Current ( )	**Blood Transfusion** Past ( ) Current ( )	**Chest Pain** Past ( ) Current ( )	**Fibroids** Past ( ) Current ( )	**Hepatitis A/B/C** Past ( ) Current ( )	**Kidney Disease** Past ( ) Current ( )	**Seizures** Past ( ) Current ( )	**Tuberculosis** Past ( ) Current ( )
Asthma/Lung Disease Past ( ) Current ( )	**Bowel Disease** Past ( ) Current ( )	**Depression/Anxiety** Past ( ) Current ( )	**Gonorrhea/Chlamydia** Past ( ) Current ( )	**HIV/AIDS** Past ( ) Current ( )	**Kidney Infection** Past ( ) Current( )	**Stomach Problems/Ulcers** Past ( ) Current ( )	**Urine Leakage** Past ( ) Current ( )
Arthritis Past ( ) Current ( )	**Breast Lump** Past ( ) Current ( )	**Diabetes** Past ( ) Current ( )	**Heart Disease** Past ( ) Current ( )	**Hypertension** Past ( ) Current ( )	**Liver Disease** Past ( ) Current( )	**Syphilis** Past ( ) Current ( )	**Venereal Disease** Past ( ) Current ( )

Hospitalizations or Operations:

Year	Diagnosis/Operations	Hospital

Name_____

OBSTETRIC HEALTH AND HISTORY

Pregnancies- Total number: _____ Miscarriages: _____ Abortions: _____ #Living Children: _____

Month/Year	Hours in Labor	Infant Weight	Sex	Problems/Complications	Weeks Pregnant	Vaginal/C Section	Anesthesia	Hospital

FAMILY HISTORY

If you are adopted do you know your family history? No___ Yes___ N/A____

Please check any family problems:

Arthritis Mother ( ) Father ( ) Other ( )	**Bowel Disease** Mother ( ) Father ( ) Other ( )	**Heart Attack** Mother ( ) Father ( ) Other ( )	**Kidney Disease** Mother ( ) Father ( ) Other ( )	**Early Menopause** <40years Mother ( ) Other ( )	**Psychiatric Illness** Mother ( ) Father ( ) Other ( )
Alcohol/Drug Abuse Mother ( ) Father ( ) Other ( )	**Breast Cancer** Mother ( ) Father ( ) Other ( )	**Heart Disease** Mother ( ) Father ( ) Other ( )	**Liver Disease** Mother ( ) Father ( ) Other ( )	**Osteoporosis** Mother ( ) Father ( ) Other ( )	**Seizures** Mother ( ) Father ( ) Other ( )
Birth Defects Mother ( ) Father ( ) Other ( )	**Colon Cancer** Mother ( ) Father ( ) Other ( )	**High Cholesterol** Mother ( ) Father ( ) Other ( )	**Lung Disease** Mother ( ) Father ( ) Other ( )	**Other** Mother ( ) Father ( ) Other ( )	**Stroke** Mother ( ) Father ( ) Other ( )
Blood clots/DVT Mother ( ) Father ( ) Other ( )	**Diabetes** Mother ( ) Father ( ) Other ( )	**Hypertension** Mother ( ) Father ( ) Other ( )	**Mom used DES?** **Yes ( )** **No ( )**	**Other Cancer** Mother ( ) Father ( ) Other ( )	**Uterine/Ovarian cancer** Mother ( ) Other ( )

Any other significant family history:_____

Have you ever been tested for HIV? _____ When_____

What is your mental image of your body? (plump, thin, normal)_____ Ideal Weight? _____

Have you ever been diagnosed with an eating disorder or feel you have an eating problem? No_____ Yes_____

Are you on any diet restrictions or have any special diet preferences?_____

Do you exercise?___ Activity_____ How often_____

What is your stress level on a 1 to 10 scale? _____What do you do to relieve stress?_____

SOCIAL HISTORY

Ethnicity: _____ Religion: _____

_____ Single _____ Married _____Widowed _____Divorced _____ Life Partner_____

Tobacco Use: Ever?___Current?___None____ Packs/day____How long? ____

Want to quit?_____When did you quit?_____

Alcohol Use: None____ Drinks per day____ per week_____ per month_____Caffeine ____Amount per day_____

Street Drug Use: None____ Drug_____ How often? _____

Have you ever been in an abusive situation or relationship? No___ Yes__ Emotional___ Physical ___ Sexual ___

Do you feel safe in your current relationship? No_____ Yes_____

Can we answer any questions or provide materials about any health or gynecologic health concerns?

_____

NOTICE OF PRIVACY PRACTICES

Madewell OBGYN
2509 Thomas Ave
Dallas, Texas 75201

Privacy Officer
Office Manager
214-821-5400

Effective Date: September 23, 2013

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our office and discuss with the Privacy Officer .

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. We may also provide notification by other methods as appropriate. Email will not contain PHI or inappropriate information.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request to access your child's records or the records of an incapacitated adult you are representing if we believe allowing access would cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website www.madewellobgyn.com

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health & Human Services
Office of Civil Rights
1301 Young Street, Suite 1169
Dallas, Texas 75202

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**.
You will not be penalized in any way for filing a complaint.

I have read and received the HIPPA paperwork for this office and I understand and agree with the policy.

Patient/Guarantor Signature:_____ Date:_____

MADEWELL
OBSTETRICS & GYNECOLOGY

Consent To Obtain Medical Records

Name: _____ DOB_____

I authorize: Dr._____

_____

_____

Phone: _____ Fax:_____

to disclose my individual identifiable health information as described below, including but not limited to information concerning communicable disease such as HIV, AIDS, chemical or alcohol dependency. Laboratory results, medical history, treatment or any such related information to:

Madewell OB/GYN, 2509 Thomas Ave, Dallas, Texas 75201
Phone: 214-821-5400
Fax : 214-821-5415

Description of information to be released (check all that apply)

____Progress Notes (from _____ to _____) _____ Lab Reports _____ Prenatal Records

____Ultrasound _____Pathology _____Operative Report _____ Purpose of Disclosure

_____ Continuation of Care _____ Other

_____ I understand that this authorization will expire 180 days from the date of this authorization.

_____ I understand that I may revoke this authorization by written request if dated no later than the original date of this consent.

_____ I understand that this consent is not transferable for redisclosure of my personal health information to any other entity unless for the purposes of providing treatment, obtaining reimbursement of payment, internal operations.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____ _____

Patient's Signature Date

GENERAL CONSENT TO TREATMENT AND RIGHT TO REFUSE TREATMENT

MadeWell ObGyn respects each person's right to make choices in directing his or her healthcare. This includes the Right to Refuse Medical Treatment and any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

By signing below, I, (or my authorized representative on my behalf) authorize the Providers and staff/assistants of **MadeWell OBGYN** to conduct any diagnostic examinations, test and procedures and to provide any medications, medical treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that there will be no guarantees of outcome made or a cure, and that the practice of medicine is not an exact science and that no promises have been made as to the results of my evaluation and/or treatment.

ASSIGNMENT OF BENEFITS

I understand that I am responsible for all charges not covered by my insurance company. I understand that if any extra lab tests or procedures are requested that do not fall under my benefits then there is a possibility that I could be fully billed for these charges.

NOTICE OF PRIVACY POLICY

I have read and received the MadeWell ObGyn HIPAA Policy. I understand and acknowledge the policy.

CONSENT FOR TREAT MINOR PATIENT

The undersigned herby consents on behalf of the below name minor less than eighteen years old to the medical diagnosis or treatment described below to be performed by Dr./CNM/NP_____ and/or by any person(s) they may designate as assistants.

Name of Minor: _____

Name of parents/managing conservator/ guardian: _____

Signature: _____

Relationship of minor to the undersigned: _____

Your signature indicates full acceptance and acknowledgement of each applicable paragraph.

Patient Name Printed: _____ D.O.B.____/____/____

Patient Signature: _____ Date: _____

Guarantor Name Printed: _____

Guarantor Signature: _____ Date: _____