

YOLANDA LAWSON, M.D., P.A.
3310 Live Oak #210
Dallas, TX. 75204
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 _____

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

OBSTETRIC HEALTH AND HISTORY

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

Month/Year	Hours in Labor	Infant Weight	Sex	Problems/Complications

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 ()	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 () Other ()	Uterine/Ovarian cancer Mother () Other ()

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?

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: None ___ Packs/day _____ How long? _____ Want to quit? _____ When did you quit? _____

Alcohol Use: None ___ Drinks per day ___ per week ___ per month _____

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?

MADEWELL OB/GYN HIPAA POLICY
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY
Effective June 1, 2008

The following is the privacy policy ("Privacy Policy") of MadeWell OB/Gyn ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include:* (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures:* to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services (“DHHS”). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to **MadeWell Ob/Gyn**.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

You have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes:* (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to **MadeWell OB/Gyn**.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer at MadeWell OB/Gyn, 3310 Live Oak #210, Dallas, TX. 75204. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to MadeWell OB/Gyn. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer at the address, telephone number listed above.

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

Patient/Guarantor Signature _____

Date _____

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

Patient/Guar. Signature _____

Date _____

Consent To Obtain Medical Records

Name: _____ SS# _____ DOB _____

I authorize: _____

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, 3310 Live Oak Ste 210, Dallas, Texas 75204

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