HIPPA NOTICE OF PRIVACY PRACTICES

University Obstetrics and Gynecology
4915 E Baseline Rd, Ste. 126
Gilbert, AZ 85234
(480)969-3096

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

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

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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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. For example, we would disclose you protected health information, as necessary, to a home health agency that provides care to 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 teat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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 Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in 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 may use or disclose your protected health information in the following situations without your authorization: these situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Requires Uses and Disclosures: Under the law, we must make disclosures known to you and when required by the Secretary of the Department of Health and Human Services Investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

You make revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has to take an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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.

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 purpose of treating, payment, of health care operations. You may also request that any part of your protected health information not be disclose 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 the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request, to receive, confidential communication from us by alternative means or at an alternative location. 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 alternatively. (i.e. electronically)

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you, by mail, of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on/or before April 14, 2003.

We are required, by law, to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. . If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

University Obstetrics & Gynecology
Eric G. Huish, D.O., FACOOG
Melissa A. Craig., P.A.-C.
Erika L. Biggs., P.A.-C.

As a courtesy to our patients, we are glad to bill your insurance for the services rendered in our office. We realize that during your care, changes can occur in your insurance policy or you may have additional information, such as a **secondary** insurance that may also need to be billed.

In order for us to do our job effectively and meet your needs, please make sure to provide our office with **all of the information and changes**. Please understand that if you do have multiple insurances, you **MUST** inform us of all policies. This will ensure that your file has the most up-to-date information possible.

***Please be aware that if you have an AHCCCS plan, it is **ALWAYS** the last insurance to pay. This means that if you do not provide our office with your primary insurance, AHCCCS will not pay and you will be solely responsible for all charges.

I understand that I need to provide University OB/GYN with any and all insurance policies that I have. If I fail to do so, I am aware that I will be held financially responsible for all services that are rendered in the office.

I understand that I am responsible for checking my insurance benefits, and that if a service provided to me is not a covered benefit, I will be financially responsible and agree to pay the usual and customary fees charged.

I understand that University OB/GYN will contact my insurance company to comply with all prior authorization procedures for the services provided.

Print Name:_____ DOB:_____

Signature:_____ Date:_____

4915 E Baseline Rd, Ste 126
Gilbert, AZ 85234

Phone 480.969.3096 Fax 480.969.0963

PATIENT INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to Receptionist.

IMPORTANT OFFICE POLICIES
Please Read and Sign this Form:

PATIENT NAME _____ DATE OF BIRTH _____

RELEASE OF MEDICAL INFORMATION
I authorize University OB-GYN to release and receive the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

RELEASE OF ELECTRONIC MEDICAL INFORMATION
I authorize University OB-GYN to release and receive, through the CCHIT software that meets or exceeds the Federal standard for encrypted electronic medical records concerning my son/daughter/self to/from any pharmacy, physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS
I authorize my insurance carrier to assign all surgical and or medical benefits, applicable, to University OB-GYN. I also authorize release of medical information necessary to process all medical insurance claims.

HIPAA POLICY
I acknowledge that I have received a copy of the University Obstetrics and Gynecology's "Notice of Privacy Practices". This notice describes how University Obstetrics and Gynecology may use and disclose my protected health information, certain restrictions on the use and disclosures of my healthcare information, and rights I may have regarding my protected health information.

PAYMENT POLICY
Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and MasterCard. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

REFERRAL POLICY
I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____

UNIVERSITY OBSTETRICS AND GYNECOLOGY
Eric G. Huish, D.O., FACOOG
Melissa A. Craig, P.A.-C.
Erika L. Biggs, P.A.-C

Authorization to Release Medical Information
From: University OB-GYN
To: Designated Person(s)

Patient Name:_____ DOB:_____

Address:_____

Home phone #:_____ Cell phone #:_____

I, _____, authorize University OB-GYN, my doctor, or his staff to discuss my medical care information as noted below, with the following person(s):

_____ Specific information to be discussed (ie ANY; PREGNANCY ONLY; Appt Times & Date) _____ Name of Designated person to receive information Relationship to patient

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_____ Specific information to be discussed (ie ANY; PREGNANCY ONLY; Appt Times & Date) _____ Name of Designated person to receive information Relationship to patient

_____ _____
Patient Signature Date

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UNIVERSITY OBSTETRICS AND GYNECOLOGY
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Melissa A. Craig, P.A.-C.
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Congratulations on your pregnancy! Below is a list of over the counter medications that are ok to take during your pregnancy. This is a guideline only. If you are unsure about how to deal with something or the advice below isn't working, please call our office.

Cold, flu or allergy symptoms:

- OK to take Tylenol cold, flu, allergy or sinus products or the generics for cold or flu symptoms, sinus headache
- Sudafed or generic for congestion
- Benedryl for allergies or itching
- Robitussin DM for cough-be sure to drink plenty of water with this (sugar-free if you are diabetic)
- Any over the counter cough drops
- Cloraseptic throat spray for sore throat

Constipation:

- OK to Surfak, Konsyl Easy-Mix, Colace or generic stool softener
- Increase water, fiber, fresh fruit & vegetable intake
- DO NOT TAKE stimulant laxatives, saline laxatives or Castor Oil

Diarrhea:

- OK to take Kaopectate, Immodium
- BRATT diet: bananas, rice, applesauce, tea & toast
- Call the office if you have a fever or if not improved in 5-7 days or if weak or dizzy

Nausea/Vomiting:

- OK to take Dramamine (also non-drowsy), Vitamin B6 (not more than 50mg per day), Ginger tea or Emetrol or generic
- Call the office if you are unable to keep liquid down for more than 24 hours or if weak or dizzy (signs of dehydration)

Heartburn/Gas:

- OK to take Tums, Mylanta, Maalox, Pepcid, Zantac, Gaviscon
- Call the office if bad abdominal pain

Headache:

- OK to take Tylenol or Extra Strength Tylenol (or generic) as directed on the bottle
- DO NOT TAKE ASPIRIN, ADVIL OR ALEVE UNLESS DIRECTED BY YOUR DOCTOR
- Call the office if you experience dizziness or blurred vision that doesn't resolve

Hemorrhoids:

- SEE CONSTIPATION
- Preparation H, Anusol. Tucks pads

Leg cramps:

- OK to take Tums, Oscal500 or similar over the counter calcium, twice daily
- Call the office if only one leg is painful all the time

Dental:

- OK to see the Dentist, have dental x-rays with **abdominal shield**, may use Novacaine, antibiotics & some pain medications, if needed
- **HAVE THE DENTIST'S OFFICE CALL OUR OFFICE TO DISCUSS TREATMENT OR TO HAVE A LETTER FAXED TO THEM**

Other reasons to call the office:

- LABOR PAINS
- IF YOU THINK YOUR WATER BROKE, LEAKING FLUID
- VAGINAL BLEEDING, SPOTTING
- DECREASED BABY MOVEMENT

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PATIENTS – COMPLETE THIS TOP SECTION ONLY PLEASE

Patient Name _____ ALLERGIES _____

Address _____ Insurance _____ Pre Cert. _____

City/State/Zip _____ Delivery Hospital _____ Pediatrician _____

Home Phone _____ Work Ph. _____ Obstetrician _____ Breast ____ Bottle ____

Occupation _____ Baby's Father's Name _____ Age ____

Date of Birth _____ Age _____ Occupation _____ Wk Phone _____

Marital Status _____ Social Security _____ Racial Background: Patient _____ Father _____

PREGNANCY HISTORY Grav ____ Para ____ SAB ____ T/EAB ____ Stillborn ____ Neonatal Death ____ Other Loss ____ Premature ____

No.	Date	Weeks	Sex	Wt.	Delivery Mode (if c-section, reason)	Length of Labor	Obstetrical Problems	Neonatal Problems

LABORATORY STUDIES

BASIC PRENATAL SCREEN

Date _____

WBC _____

HGB _____ HCT _____

MCV (90±9µµ3)_____

BLOOD TYPE & RH _____

Atypical Antibodies _____

Serology _____

Rubella Screen _____

	DATE	RESULT
Urinalysis		
HBSAg		
Triple/Quad Screen		

PAP SMEAR _____

GLUCOSE SCREEN

Date _____ Fasting _____ 1 hr. _____

REPEAT ANTIBODY SCREEN 24 wks ±, if Rh-Neg.

Date _____ Results _____

OPTIONAL LAB STUDIES

	DATE	RESULT
CF Screen		
GC Screen		
Chlamydia		
HIV Screen		
Sickle Cell		
Herpes		
Drug Screen		
Group B Strep		
Fetal Fibronectin		
NT/1st Trimester Screen		
Varicella Screen		
Repeat Urinalysis		
Glucose Tolerance ____ Hr ____ Result		
IgG/IgM antibodies		

REPEAT HGB/HCT

Date _____ Results _____

Other:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DETERMINATION OF GESTATIONAL AGE

LMP _____

Cycle length _____

Menstrual EDC _____

Date of Conception (if known) _____

Ultrasound EDC _____

Date Performed _____

ADDITIONAL ULTRASOUND DATA (OPTIONAL)

Date _____ Findings _____

Date _____ Findings _____

Date _____ Findings _____

Date _____ Findings _____

CLINICAL EDC _____ AS OF _____

The CLINICAL EDC is the physician's best estimate of the due date and is the date used for clinical management.

INITIAL PHYSICAL EXAMINATION

Wt _____ Pre-OB Wt _____ Height _____

BP_____ Pulse _____ HEENT _____

Thyroid _____

Breasts _____

Heart _____

Lungs _____

Abdomen _____

Back _____

Extremities _____

Vulva _____

Vagina _____

Cervix _____

Uterus _____ est. wks.

Adnexa _____

Pelvis _____

REMARKS

_____

_____

_____

_____

_____

Exam by _____

Date _____

Check here if Physical Exam was dictated ☐

OBSTETRICAL MEDICAL HISTORY

Patient Name _____ Date Form Completed _____

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? ..... ☐ Yes ☐ No
   If yes, please list: _____
2. Please mark any condition that you have or have had in the past:

☐ Arthritis or Lupus	☐ Cancer	☐ Fibromyalgia	☐ HIV
☐ Asthma	☐ Chicken Pox	☐ Group B Strep	☐ Hyperactivity/ADD
☐ Bladder or Kidney Infections	☐ Depression	☐ Headaches	☐ Kidney Disease
☐ Bleeding Disorder	☐ Diabetes	☐ Heart Problems	☐ Migraine Headaches
☐ Blood Disease	☐ Emotional Disorders	☐ Hepatitis	☐ Skin Disorders
☐ Bowel Disease	☐ Epilepsy	☐ Herpes	☐ Thyroid Disorder
		☐ High Blood Pressure	☐ Other

   Describe, if needed: _____
3. Please indicate any operations or surgery you have had: _____
4. Please describe any health problems or symptoms you are having at this time:

EXPOSURES AFFECTING HEALTH

1. Do you use tobacco? ☐ Yes ☐ No If yes, how much per day? _____
2. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? _____
   What type of drink(s)? _____
3. Please list any medications taken since your last period, including over-the-counter medications: _____
4. Have you had an influenza (flu) vaccine? ☐ Yes ☐ No If yes, when? _____
5. Please list any drugs used in the past (i.e. cocaine, marijuana, pain medication, meth, etc.):
   Dates last used: _____
6. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?
7. Do you work with, or have you been exposed to chemicals or radiation (i.e. x-rays)? ..... ☐ Yes ☐ No
   If yes, please describe: _____
8. Are you on a special diet? ..... ☐ Yes ☐ No
   If yes, please describe: _____
9. Do you have cats? ..... ☐ Yes ☐ No

GYNECOLOGIC HEALTH HISTORY

1. When was your last menstrual cycle (period)? _____
2. When was your last Pap Smear? _____ Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No If yes, when? _____
   What was the diagnosis? _____
   What was done? _____
3. Have you ever had gonorrhea, chlamydia or pelvic inflammatory disease? ☐ Yes ☐ No
   If yes, when and where were you treated? _____
4. Have you ever had herpes? ..... ☐ Yes ☐ No
5. Did you receive the HPV vaccine (Gardasil)? ..... ☐ Yes ☐ No
6. Do you use contraceptives? ☐ Yes ☐ No If yes, what type: _____
7. Have you had bladder or kidney infections? ..... ☐ Yes ☐ No
   If yes, what was done? _____
8. Do you have a history of infertility? ☐ Yes ☐ No If yes, please describe when and treatment received: _____
9. Please list any other concerns you have related to your past health history:

PHYSICIAN NOTES

_____ _____ _____
Patient Signature Print Name Date

Patient Name _____ ALLERGIES _____

OBSTETRICAL MEDICAL HISTORY, PAGE 2

10. Do you have any religious or other objections to any form of medical treatment you would like to make us aware of (i.e. refusal of blood transfusion)? _____

11. Do you have any special needs for: Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Language: ☐ Yes ☐ No

FAMILY HISTORY & GENETIC HISTORY

1. Have either you or the baby's father had a child born with a birth defect? ..... ☐ Yes ☐ No
   If yes, please describe: _____

2. Did either you or the baby's father have a birth defect yourselves? ..... ☐ Yes ☐ No
   If yes, please describe: _____

3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). _____
   _____
   How is the affected child/person related to you? _____

4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? ..... ☐ Yes ☐ No
   If yes, have either of you had genetic counselling? ..... ☐ Yes ☐ No
   If yes, have either of you had chromosomal studies? ..... ☐ Yes ☐ No
   Where and results: _____

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is of one of these backgrounds:

   Jewish ancestry? ☐ Yes ☐ No If yes, have you had Tay-Sachs screening tests? ..... ☐ Yes ☐ No
   Date: _____ Result: _____

   African-American? ☐ Yes ☐ No If yes, have you had Sickle Cell screening? ..... ☐ Yes ☐ No
   Date: _____ Result: _____

6. Please mark if anyone in your family or the baby's father's family has:

Diabetes	☐ Yes ☐ No	If yes, how is that person related to you? _____
Bleeding Disorder	☐ Yes ☐ No	If yes, how is that person related to you? _____
High Blood Pressure	☐ Yes ☐ No	If yes, how is that person related to you? _____
Cancer	☐ Yes ☐ No	If yes, how is that person related to you? _____
Hepatitis	☐ Yes ☐ No	If yes, how is that person related to you? _____
HIV	☐ Yes ☐ No	If yes, how is that person related to you? _____
Twins/multiple gestation pregnancy	☐ Yes ☐ No	If yes, how is that person related to you? _____

7. Please list any other concerns you have about birth defects or inherited disorders:
   _____
   _____

8. Will you be 35 or older at the time the baby is born? ..... ☐ Yes ☐ No
9. Will the father be 50 or older? ..... ☐ Yes ☐ No

_____ _____ _____
Patient Signature Print Name Date

Physician Notes: _____
_____
_____
_____