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):

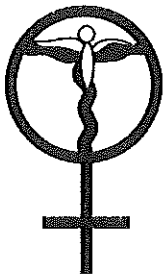
_____
Specific information to be discussed (ie ANY; PREGNANCY ONLY; Appt Times & Date)
_____
Name of Designated person to receive information Relationship to patient

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

_____
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

4915 E. Baseline, Bldg #10, Suite 126
Gilbert, Arizona 85234
Phone 480-969-3096 Fax 480-969-0963



UNIVERSITY OBSTETRICS AND GYNECOLOGY

Eric G. Huish, D.O., FACOOG
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PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

Patient Name: _____
(First) (Middle) (Last)

SEX: M ___ F ___ Date of Birth: _____ Marital Status: S ___ M ___ D ___ W ___

Race _____ Ethnicity _____

Language: _____ Dominant Hand: _____

Patient's Social Security Number: _____

Street Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Second Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Check which phone number is to be called first; Home _____ Cell _____ Work _____

Home phone: (_____) _____

Work phone: (_____) _____

Cell/Pager number: (_____) _____

Email Address: _____

Drivers License: _____ State _____

Responsible Party Name: _____ Relationship to Patient: _____

Primary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Phone Number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____
(Insured Subscriber)

Patient Relationship to Insured: _____

Insurance ID Number: _____ Group Number: _____

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(480) 969-3096 Office
(480) 969-0963 Fax

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Secondary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Phone number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____

(Insured Subscriber)

Patient Relationship to Insured: _____

Insurance ID Number: _____ Group Number: _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____) _____ Relationship _____

Guarantor's Social Security Number: _____ - _____ - _____

Guarantor's Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Cell/Pager number: (_____) _____

Employer's Name: _____ Work Phone: (_____) _____

Employer's Address: _____

City: _____ State _____ Zip Code: _____

Primary Care Physician _____ Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Referring Physician _____ Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Pharmacy _____ Phone (_____) _____

Address _____

City _____ State _____ Zip Code: _____

Please Read and Sign this Form:

I hereby authorize my insurance benefits to be paid directly to University OB-GYN. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

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

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Single: ___ Married: ___ Divorced: ___ Widowed: ___ Occupation: _____

FOR OFFICE USE: Height:	Weight:	Blood Pressure:

Gynecologic History

Age at 1st menstrual period: _____ Date of last menstrual period: _____

How often are your periods? _____ How long do your periods last? _____

Is your menstrual flow: Light ____ Moderate ____ Heavy ____

Do you have painful periods? Yes __ No __ Do you have pelvic pain of any nature? Yes__ No__

****

Age at menopause: ____ Are you on hormone replacement? _____

Do you take calcium supplements? Yes ___ No ___ If so, what type and dosage? _____

Do you exercise regularly? Yes ___ No ___ How often? _____

What exercise do you do? _____

****

Date of last Pap Smear: _____ Any history of abnormal Pap Smears? Yes ___ No ___

HPV? Yes___ No ___ If yes, when? _____

What treatment did you have for the abnormal Pap? _____

****

Are you sexual active? Yes ___ No ___ Do you use contraception? Yes ___ No ___

If so, what type(s) and name(s): _____

Any history of sexually transmitted diseases? Yes ___ No ___ If so, what type? _____

Were you treated? Yes ___ No ___ If so, what medication? _____

Date of last mammogram: _____ Any history of abnormal results? Yes ___ No ___

Do you practice self breast exams? Yes ___ No ___ How often? _____

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Obstetrical History

Number of pregnancies: _____ Number of living children: _____ Miscarriages: _____

Number of premature births (before 37wks): _____ Number of abortions: _____

Please list details:

YEAR:	Weeks Gestation:	Baby's Weight:	Baby's Sex:	Delivery Type:	Complications:

Surgical History

Past Surgeries/ Hospitalization Date Reason

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Physicians notes: _____

_____

Social History

Tobacco use Yes ___ No ___ How many cigarettes per day? _____

Alcohol use Yes ___ No ___ Quantity per day: ___ Per week: ___ Socially: Yes ___ No ___

Recreational / Illicit drugs: Yes ___ No ___ If so, what kind & how often? _____

Sexually active? Yes ___ No ___ Domestic violence? Yes___ No ___

Family History

Please indicate relationship to patient (i.e. Maternal/Paternal grandmother, Maternal/Paternal aunt)

Breast Cancer Y__ N__ _____ **Ovarian Cancer** Y__ N__ _____

Uterine Cancer Y__ N__ _____ **Colon Cancer** Y__ N__ _____

Diabetes Y__ N__ _____ **Hypertension** Y__ N__ _____

Heart Disease Y__ N__ _____ **Stroke** Y__ N__ _____

Other inherited abnormalities: _____

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Past Medical History

Drug Allergies: _____ Reaction: _____

Current medications, strength and dosage: _____

Cardiovascular:

Heart attack:	Y__ N__	Coronary Artery Disease:	Y__ N__
Heart Disease:	Y__ N__	Congestive Heart Failure:	Y__ N__
High Blood Pressure:	Y__ N__	Heart Murmurs:	Y__ N__
High Cholesterol:	Y__ N__	Mitral Valve Prolapse:	Y__ N__

Endocrine:

Diabetes Mellitus Type 1:	Y__ N__	Diabetes Mellitus Type 2:	Y__ N__
Obesity:	Y__ N__	Hyperthyroidism:	Y__ N__
Hypothyroidism:	Y__ N__		

Respiratory:

Seasonal Allergies:	Y__ N__	Asthma:	Y__ N__
COPD:	Y__ N__	Acute Bronchitis:	Y__ N__

Immune/Other: HIV: Y__ N__

Gastroenterology:

Acid Reflux:	Y __ N __	Hepatitis:	Y __ N __

Genitourinary:

Kidney Infections:	Y __ N __	Renal Disorders:	Y __ N __
Renal Failure:	Y __ N __	Urinary Tract Infections:	Y __ N __

Musculoskeletal:

Osteoarthritis:	Y __ N __	Lumbago (low back pain):	Y __ N __
Osteoporosis:	Y __ N __		

Psychiatric:

Anxiety Disorders:	Y __ N __	Depression:	Y __ N __

Neurological:

Stroke Syndrome (CVA):	Y __ N __	Migraines:	Y __ N __

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Review of symptoms

Do you have any of the following complaints?

General:	None:___	Wt loss/gain:___	Fever:___	Night Sweats:___	Fatigue:___
Urinary:	None:___	Blood in urine:___	Urgency:___	Burning w/urination:___	
		Loss of urine:___	Frequency:___		
GI:	None:___	Diarrhea:___	Nausea/vomiting:___	Blood in stool:___	Constipation:___
Genital:	None:___	Heavy Period:___	Pelvic Pain:___	Vag. Discharge:___	Painful periods:___
		Irreg. Periods:___	Pain w/ intercourse:___	Vag. Dryness:___	
Breast:	None:___	Discharge:___	Pain:___	Skin Change:___	Lump(s):___
MS:	None:___	Weakness:___	Joint Pain:___	Muscle Pain:___	
Psychiatric:	None:___	Depression:___	Mood Swings:___	Anxiety:___	Crying:___
Endocrine:	None:___	Hot Flashes:___	Decreased sex drive:___	Male Pattern Hair:___	
Hema/lymph	None:___	Easy Bruising:___	Calf Tenderness:___	Enlarged Lymph nodes:___	Easy bleeding:___
Skin:	None:___	Skin Lesions:___	Rash:___	Acne:___	

Reason for today's visit:

_____

_____

_____

_____ _____

Signature Date