



## Personal and Insurance Information

Personal Information	Date:	
Name: _____		
Home Address: _____		
_____		
City	State	Zip code
Date of Birth: _____		
Home Phone: _____	Cell Phone: _____	
E-mail (Home): _____		
Employer: _____	Occupation: _____	
Work Address: _____		
_____		
City	State	Zip code
Work Phone: _____	E-mail (Work): _____	
Insurance Information		
Primary Insurance: _____		
Policy Holder Name: _____		
Policy Holder Date of Birth: _____		
Insurance ID #: _____		
Insurance Group #: _____		
Relationship to Patient: _____		
Secondary Insurance (if any): _____		
Policy Holder Name: _____		
Policy Holder Date of Birth: _____		
Insurance ID #: _____		
Insurance Group #: _____		
Relationship to Patient: _____		



## Pharmacy and Emergency Contact Information

Pharmacy Information:
Pharmacy Name _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

Primary person to be notified in case of an emergency:
Name: _____
Relationship:    Relative _____    Friend _____    Other _____
Home Address: _____
<span style="margin-right: 100px;">Street Address</span> <span style="margin-right: 100px;">City</span> <span style="margin-right: 100px;">State</span> <span>Zip code</span>
Home Phone: _____    Work Phone: _____    Cell Phone: _____
E-mail Address: _____

Secondary person to be notified in case of an emergency:
Name: _____
Relationship:    Relative _____    Friend _____    Other _____
Home Address: _____
<span style="margin-right: 100px;">Street Address</span> <span style="margin-right: 100px;">City</span> <span style="margin-right: 100px;">State</span> <span>Zip code</span>
Home Phone: _____    Work Phone: _____    Cell Phone: _____
E-mail Address: _____

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used Gynecologic Oncology Surgeons of North Houston and emergency personnel. Please ensure that the form has the most updated & accurate information.

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this form may be notified in an emergency as needed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## HIPAA Notice of Privacy Practice

*Effective Date: April 19, 2017*

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.

If you have any questions about this notice, please contact Ms. Peggy duPont at 936-207-4287.

### **OUR OBLIGATIONS:**

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:**

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer, Ms. Peggy duPont.

***For Treatment.*** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

***For Payment.*** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

***For Health Care Operations.*** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

***Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.*** We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Individuals Involved in Your Care or Payment for Your Care.*** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

***Research.*** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special

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approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

### **SPECIAL SITUATIONS:**

***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law.

***To Avert a Serious Threat to Health or Safety.*** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Organ and Tissue Donation.*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Public Health Risks.*** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

***Health Oversight Activities.*** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

***Data Breach Notification Purposes.*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

***Lawsuits and Disputes.*** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

***Law Enforcement.*** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

***Coroners, Medical Examiners and Funeral Directors.*** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

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**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

## **USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT**

**Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

**Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

## **YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

## **YOUR RIGHTS:**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to North Houston Gynecologic Oncology Surgeons. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

**Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

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**Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to North Houston Gynecologic Oncology Surgeons.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to North Houston Gynecologic Oncology Surgeons.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to North Houston Gynecologic Oncology Surgeons. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to North Houston Gynecologic Oncology Surgeons. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**CHANGES TO THIS NOTICE:**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Ms. Peggy duPont at 936-207-4287. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Date: \_\_\_\_\_ Print Patient Name \_\_\_\_\_

Signature: \_\_\_\_\_

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## Privacy Practice

You may revoke this authorization, at any time, in writing, except to the extent that your physicians or the physician's practice has taken an action in reliance on the sue or disclosures indicated in the authorization.

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 treatment, payment or healthcare operations. You may also require that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state specific restrictions and whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health care information, this information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of the notice from us, upon request, even if you have agreed to accept this notice alternative i.e. electronically.

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

We deserve 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 the Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our private contact of your complaint. We will not retaliate against you for filling a complaint.

This notice was published and becomes effective on/or before January 4, 2016.

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 HIPAA Compliance Officer Kendyl Parker in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Date: \_\_\_\_\_ Print Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_



I, \_\_\_\_\_, give my authorization to release my protected Health information including results of my laboratory test, x-ray, and/or other test results to the following designated representative(s):

**Patient Initials:** \_\_\_\_\_

\_\_\_\_\_ My Spouse (Name) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ My Child (Name) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ My Child (Name) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Other (Name) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Other (Name) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ May be left on my answering machine at home/work.

\_\_\_\_\_ May not be given to anyone other than myself.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_



I authorize \_\_\_\_\_

To release: \_\_\_\_\_ or receive from: \_\_\_\_\_

Nefertiti duPont, MD, MPH at 9201 Pinecroft Drive, Suite 240, Shenandoah, Texas 77380  
936-447-9490 (office) or 832-442-4657 (facsimile).

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's Social Security Number

History & Physical

Lab Work

Consultation

Pathology Report

Radiology Reports

Other: \_\_\_\_\_

This information is being released for the following purposes:

Continued Care

Attorney/Litigation

Insurance

Disability Services

Other: \_\_\_\_\_

**TO THE PARTY RECEIVING THE INFORMATION:** This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent to the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or **for patients records applicable under federal law 42 CFR Part 2.**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date



## New Patient Information

Today's Date: \_\_\_\_\_

### Patient Information

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### Referral

Name of Referring Physician: \_\_\_\_\_

Address/ Phone: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Address/ Phone: \_\_\_\_\_

### Chief Complaint (current problem)

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### Medical History (illnesses)

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New Patient Information (page 3)

**Medication Allergies**

Name of medication	Reaction

**Past Obstetrical and Gynecologic History**

Age of onset of menstrual cycle (approximate): \_\_\_\_\_

Duration of menstrual cycle (how long do you bleed?): \_\_\_\_\_

Date of last menstrual cycle: \_\_\_\_\_

Age of menopause (if applicable): \_\_\_\_\_

Any history of bleeding in between cycles? \_\_\_\_\_

Any history of bleeding after menopause? \_\_\_\_\_

Any history of a dilatational and curettage (D&C)? \_\_\_\_\_

Number of living children: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Number of miscarriages or terminations: \_\_\_\_\_

Have you ever received a blood transfusions? \_\_\_\_\_

Have you ever taken any hormones (include birth control pills)? \_\_\_\_\_

**Screening Tests & Immunizations**

Test or recent immunization	Approximate date	Result or test
Mammogram		
Colonoscopy		

New Patient Information (page 4)

**Family History**

Any history of Ashkenazi Jewish ancestry?

Have you or any of your relatives been tested for a hereditary cancer syndrome (i.e. BRCA, Lynch or Cowden syndrome)?

Any history of male breast cancer in your family?

	Medical problems	Cancer history and age of cancer diagnosis	If deceased, age and cause of death
<i>Example</i>	<i>Diabetes</i>	<i>Colon cancer, age 50</i>	<i>Died at age 60, colon cancer</i>
Father			
Mother			
Sibling			
Sibling			
Sibling			
Child			
Child			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Aunt			
Uncle			
Other			

New Patient Information (page 5)

**Social History**

Marital status (married, single, divorced, widow):

Most recent or current job:

Substance	Never	Current use & how much <i>Example: smoke 1 pack per day, drink 1 beer per day</i>	Former use & how much <i>Example: smoke 1 pack per day, drink 1 beer per day</i>
Alcohol use			
Tobacco			
Drug use			