How to Get The Most Out Of Your Doctor Visit

- When you make your appointment, let us know if you have lots of questions and concerns, or is this a well-woman visit to get a refill on your pills or hormones? This will assist us in allowing the appropriate amount of time for your visit.
- Make sure you are familiar with your insurance benefits and restrictions.
  - Does your insurance require a referral from your primary care physician (PCP) before you see another doctor? If “yes,” please obtain a referral before coming to your appointment.
  - Does your plan have only certain doctors that “participate”? Is Dr. Biggerstaff on your list? Check your physician directory or call your carrier. Dr. Biggerstaff does not participate in all plans – you could be responsible for additional charges if you see a doctor who is “out of network.”
  - Do you have a deductible to pay before your insurance starts paying? If so, have you met the deductible?
  - Does your plan have a set co-pay or percentage that you are responsible for? Deductibles and co-insurance are payable at the time services are rendered.
  - Be aware of specific labs, x-ray facilities, and hospitals you are to use and notify us accordingly.
  - Does your insurance require prior approval before you have any diagnostic tests, lab, etc.?
- Be aware that the cost of your visit may vary if a significant amount of extra time is needed to address your questions and concerns. Also, lab or procedures performed may increase the cost of your visit. If you have concerns about the amount you will be responsible for, please discuss with us prior to treatment being rendered.
- It may be necessary to schedule an additional appointment to allow ample time to properly meet your needs.
- Feel free to call the office to see if Dr. Biggerstaff is running on time.
- Have a list of your symptoms and concerns along with a list of questions or topics you wish to discuss.
- Please make every effort to keep your appointment and arrive on time. For the benefit of other patients, kindly advise us at least 24 hours ahead if you are unable to keep an appointment. This will allow us to work in patients who have emergencies or urgent needs while still maintaining a minimal wait time.
- Make sure you understand everything Dr. Biggerstaff and his staff say before you leave the office. Do not be afraid to take notes or ask questions.
- Feel free to call back if you get home and have a question or concern.
- We strive to continually improve our services, please let us know how we can better serve you.
# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Please complete this form to assist your physician in accurately maintaining your personal professional record. Please fill in all information that applies.

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>First</th>
<th>M.I.</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
<td>Alternate Phone # (Cell)</td>
<td>SS #</td>
<td></td>
</tr>
<tr>
<td>Birthdate</td>
<td>Age</td>
<td>Sex (circle one) M F</td>
<td>Race</td>
<td>Marital Status</td>
</tr>
<tr>
<td>Patient Employer</td>
<td>Patient’s Occupation</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
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</tbody>
</table>

## RESPONSIBLE PARTY (If other than patient)

<table>
<thead>
<tr>
<th>Name/First</th>
<th>M.I.</th>
<th>Last</th>
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</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
<td>SS #</td>
</tr>
<tr>
<td>Employer</td>
<td>Address</td>
<td>City</td>
</tr>
</tbody>
</table>

## INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Primary Insurance Company</th>
<th>Relationship to Patient</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Insured’s Name</td>
<td>ID #</td>
<td>Group #</td>
</tr>
<tr>
<td>Secondary Insurance Company</td>
<td>Relationship to Patient</td>
<td>Phone</td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Insured’s Name</td>
<td>ID #</td>
<td>Group #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Phone</th>
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<td>Address</td>
<td>City</td>
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<tr>
<td>Nearest Relative (not living with you)</td>
<td>Relationship to Patient</td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Whom may we thank for referring you?</td>
<td>Date</td>
</tr>
</tbody>
</table>
ALL PATIENTS:

1. I consent to treatment necessary for the care of the above named patient.
2. I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information to the physicians involved in my medical care and to my insurance company, if applicable.
3. I permit fax transmittal of my protected health information.
4. I understand that payment of all co-pays, deductibles and services not covered by insurance is due at the time of service unless other financial arrangements have been made prior to treatment.
5. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to E. Daniel Biggerstaff, III, M.D. I fully understand that I am responsible for all charges incurred as a result of services rendered to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.
6. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

SIGNATURE ___________________________________ DATE ____________

MEDICARE PATIENTS:

1. I request that payment of Medicare/Other Insurance company benefits be made either to me or on my behalf to E. Daniel Biggerstaff, III, M.D. for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
2. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

SIGNATURE ___________________________________ DATE ____________
Please complete the following questionnaire and bring it with you to your appointment. We feel this is the best way to consistently obtain a thorough medical history. The information given will be kept in strictest confidence.

Date_____________________

Your full name _____________________________________________________ Age_______________
Name you prefer we use ___________________________________________________________________
Height _____ ft. ______ in. Current weight _______ lbs. Weight one year ago _______ lbs.
Weight five years ago _______ lbs.

Please indicate the number of:
Pregnancies_______ Full term deliveries_______ Premature deliveries ______ Living children_______
Miscarriages_______ Pregnancy terminations_______ Ectopic pregnancies_______ Multiple births____

Please indicate the dates (when applicable) of your most recent:
Menstrual period______________ Prior menstrual period________________ Menopause___________
PAP smear___________ Cholesterol test___________ Mammogram_________ Bone density_________
Colonoscopy/sigmoidoscopy__________

Please write the reason you made the appointment____________________________________________
What is your main medical problem, and how long have you had it (if none, please state so)?_______

Please list allergies to drugs or reactions to medicines or other substances:

_____________________________________________________________________________________

Please list prior surgical operations with the date and the surgeon if known:

_____________________________________________________________________________________

Anesthetic problems or complications:_____________________________________________________

Social, Dietary, and Exercise History:
Do you smoke now?_______ In the past?_______ Amount?________
How long have you smoked (or did you smoke)?___________ How long ago did you quit?__________
Do you drink alcoholic beverages?_______ Weekly amount and kind?________________________
Do you use street drugs?_______ In the past?_____ What kind?______________________________
Risk factors for AIDS? Skip to Dietary History if never sexually active.
Have you ever had a positive test for AIDS?_______ Has (any of) your sexual partner(s) ever had a positive test for AIDS?_______ Have you ever had sexual relations with a bisexual? ______

Have you or your sexual partner(s):
Had more than one sexual partner in the last five years?______ Used intravenous street drugs?______
Received a blood transfusion prior to 1985?______ Had sexual relations with a prostitute(s)?______
Been exposed to AIDS through your occupation (i.e. nurse with inadvertent needle stick)?______
Received medication to treat or prevent AIDS?______

Other possible sexually transmitted diseases - Have you or your sexual partner(s) ever had or been treated for: Pelvic inflammatory disease?______ Gonorrhea?______ Syphilis?______ Chlamydia?______
HPV or venereal warts (condyloma)?______ Herpes?______
If yes, when was the most recent treatment or outbreak?____________

Dietary History:

How much cholesterol is in your diet?
______Low (I never or rarely eat red meats, fish packed in oil, foods made with eggs and fat, whole milk and dairy products made from milk, nuts and seeds, oily dressings and spreads -- I do not eat fried foods).
______Moderate (I eat moderate amounts of the above but not on a daily basis).
______High (I eat much more red meat than chicken and fish, and frequently eat other high cholesterol foods).

How much fiber is in your diet?
______Low (I never or rarely eat whole grain cereals, whole wheat breads, fresh fruits and vegetables -- I use highly refined grains such as white flour and their products).
______Moderate (I eat moderate amounts of the above but not on a daily basis).
______High (I conscientiously eat a high fiber diet and/or use a fiber supplement).

How much sugar do you eat?
______Low (I do not add sugar to coffee or tea, I rarely eat desserts or sweet snacks, I do not consume alcohol on a regular basis, I do not eat highly refined grains such as white flour on a regular basis).
______Moderate (I eat moderate amounts of the above but not on a daily basis).
______High (I consume the above on a regular basis).

How much seafood is in your diet? (seafood contains Omega-3 fatty acids which help reduce cholesterol levels)
______Low (I occasionally eat fish and other seafood, but only rarely).
______Moderate (I eat at least two portions of seafood per week).
______High (I eat more than two portions of seafood per week).

How much salt do you eat?
______None (I do not eat any salty foods and never add salt either while cooking or at the table).
______Minimal (I rarely eat salty foods and add only small amounts while cooking and at the table).
______Moderate (I do not watch my salt, but do not salt my food heavily).
______Large amounts (I consistently use large amounts of salt).
How much **caffeine** do you ingest?
_____ None (no coffee, decaf coffee or tea, tea, caffeine-containing soft drinks, or chocolate).
_____ Low (I only occasionally eat or drink caffeine-containing products - one cup of coffee per day).
_____ Moderate (I consume two to four cups of coffee or other sources of caffeine per day).
_____ Large amounts (I consume large amounts of caffeine daily).

What is your daily intake of **milk/calcium**?
_____ Low (I rarely drink milk or consume dairy products, and do not take calcium supplements).
_____ Moderate (I consume an equivalent of two glasses of milk per day or its calcium equivalent).
_____ Large amounts (I consume at least three glasses of milk per day or its equivalent - this will provide the recommended daily amount of 1200 mg calcium).

Are you a **vegetarian**? _____ If yes, what type? __________________________________________________________

**Physical Activity**
Do you lead a **sedentary or active** life?
_____ Very sedentary (no exercise, always take the elevator, do not do yard work, always ride in a car and park close to the destination, do not walk or ride a bicycle for fun, do not participate in any sports)
_____ Sedentary (occasional exercise, usually take the elevator, not much work in the yard, occasionally go for a walk, etc.)
_____ Active (regular exercise, regular participation in sports, regular work in the yard, regular play with children or grandchildren, frequently walk up steps rather than ride an elevator, etc.)
_____ Very active (frequent exercise, regular participation in sports, usually walk up steps rather than take the elevator, always active)

How much do you **exercise**, on average, per week (formal exercise, not counting running after the children, etc.)?
_____ Medically limited - describe limitation(s) __________________________________________________________
_____ None
_____ Occasionally (less than regularly)
_____ Regularly (20-30 minutes, 3-4 times per week)
_____ Frequently (30-60 minutes, 4-7 times per week)
_____ Very frequently (daily for 7 or more hours per week)

**Environmental Factors:**
What is your occupation? __________________ Education (last grade completed)? __________________
What are your hobbies? __________________________________________________________
Do you have pets? __________________________________________________________

What is your source of **water supply**? _____ Public with fluoride _____ Public without fluoride
_____ Public (do not know if have fluoride) _____ Private well _____ Other

What do you use for **birth control**? __________________________________________________________
_____ Husband (partner) vasectomy?

Please list all **Current Medications** (with dosage and frequency, if known):
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Please check **Illnesses or Conditions** you have had:

- [ ] High blood pressure
- [ ] Headache/migraine
- [ ] Heart disease
- [ ] Sugar diabetes
- [ ] Rheumatic fever
- [ ] Thyroid problems
- [ ] Heart murmur
- [ ] Bowel problems
- [ ] Mitral valve prolapse
- [ ] Hepatitis or liver disease
- [ ] Blood transfusion
- [ ] Kidney disease
- [ ] Phlebitis
- [ ] Nervous or mental problems
- [ ] Blood clot in a vein or lungs
- [ ] Epilepsy/neurological disorder
- [ ] Rh sensitized
- [ ] Breast disease
- [ ] Osteoporosis/osteopenia
- [ ] Bleeding tendencies
- [ ] Major accidents
- [ ] Asthma
- [ ] Tuberculosis/positive skin test
- [ ] Cancer
- [ ] Emphysema

Please describe or explain any positive responses:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Review of Systems -- Please check (X) ONLY if "yes":

**Problems Unique to Women:**

- [ ] Do you currently have any symptoms of **vaginal problems**?
  - [ ] vaginal discharge
  - [ ] vaginal itching
  - [ ] unpleasant odor
  - [ ] vaginal dryness
  - [ ] vaginal irritation
  - [ ] difficulty lubricating with intercourse

- [ ] Do you have or have you recently had any **abnormal bleeding**? How long?
  - [ ] bleeding in between periods
  - [ ] excessively long periods
  - [ ] more than one period per month (even a brown, pink, or red discharge)
  - [ ] bleeding after menopause or the change (even a brown, pink, or red discharge)
  - [ ] bleeding after intercourse
  - [ ] vaginal bleeding this pregnancy

- [ ] Do you have a history of **fibroid tumors of the uterus**?

Do you currently have any **pelvic or low abdominal pain**?

- [ ] Pain with your menstrual periods
  - [ ] mild
  - [ ] moderate
  - [ ] severe
  
- [ ] Does the pain start
  - [ ] before your period
  - [ ] at the same time
  - [ ] after

- [ ] pain when you have intercourse
  - [ ] at the entrance to the vagina
  - [ ] when your partner goes in deep

- [ ] when on your feet for long periods of time

- [ ] history of **endometriosis**
- [ ] history of **pelvic infection**
- [ ] other -- please describe:

Have you ever had an **abnormal pap smear**: When? What was the diagnosis and treatment?

Did your mother take DES while pregnant with you?
Fertility Problems:
Have you been attempting to become pregnant for more than one year without success?______
How long?_________________
What fertility testing have you had and what were the results?
_____________________________________________________________________________________
_____________________________________________________________________________________

Have you ever had (please check) or been advised to have any pelvic surgery?
_____biopsy of cervix biopsy
_____other biopsy (please describe)
_____colposcopy
_____cryosurgery
_____cone biopsy
_____hysteroscopy
_____D&C
_____tubal ligation
_____laparoscopy
_____laser surgery
“tubes tied”
_____removal of one or both tubes/ovaries (please describe)

_____hysterectomy (removal of uterus or womb)
___________laparoscopic
___________large abdominal incision
___________removal through vagina
___________bladder repair (anterior repair)
___________rectal repair (posterior repair)

What was the reason(s) for your surgery (ies)?
_____________________________________________________________________________________

Do you currently have any symptoms possibly relating to premenstrual syndrome (PMS)? Symptoms are on a regular, cyclic basis, either before, during, and/or after menses. How long do they start before your period? ______days. Please check all that apply.
_____cyclic (monthly) weight gain
_____bloatedness or swelling
_____mood swings
_____headaches
_____vision changes
_____severe breast tenderness
_____tiredness
_____other (describe)

Are those symptoms severe enough for you to desire therapy to reduce or eliminate them?

_____Do you currently have any problem or question regarding your sexual function? If you have a problem, how long has it existed?_________________
_____decreased sex drive (libido)
_____difficulty becoming aroused (difficult lubrication)
_____difficulty reaching orgasm or climax
_____other (describe)

Do you have any questions or problems related to the menopause or “change”?
_____hot flashes
_____hot flashes with sweats
______daytime
______nighttime
_____mood swings
_____fatigue and tiredness
_____headaches
_____irregular bleeding
_____vaginal dryness
_____memory problems
_____dry skin
_____other (describe)

_____Do you currently have any breast problems or have you had any surgery?
_____discharge from your breasts
_____lumps in your breasts
_____breast pain
_____breast biopsy
_____mastectomy
_____augmentation
_____reduction

Have you been instructed to perform breast self-examination?_____Yes_____No
Do you examine your breasts monthly?_____Yes_____No
Have you ever had a breast mammogram?_____Yes_____No
When?_________________________

_________

5
Do you understand that very tiny breast cancers may not be felt by your doctor, and that is why repeat examinations are necessary? _____Yes _____No
Do you understand that mammograms are very helpful, but that not all breast cancers can be seen on X-Ray? _____Yes _____No

______Do you or have you had urinary tract problems?
   _____bladder infection(s) or cystitis
   How many in the last year? ______  Last one when?__________
   _____kidney infection(s)
   _____other urinary tract disease (describe):_____________________________________________________
   _____burning or pain on urination
   _____frequency of urination
   _____need to urinate during the night -- how many times?______
   _____loss of urine with coughing, sneezing, running, lifting or straining
   _____feeling you cannot make it to the bathroom
   _____is the loss of urine a significant problem?
   _____other urinary tract problems (describe):_____________________________________________________

______Do you currently have gastrointestinal problems?
   _____constipation  _____diarrhea  _____constipation and diarrhea
   _____rectal pain or pressure _____rectal itching  _____rectal bleeding or blood in the stool
   _____regular use of laxatives  _____hemorrhoids
   _____difficulty having a bowel movement so that you have to put a finger in the vagina to assist
   _____other (describe):__________________________________________________________

______Do you currently have constitutional symptoms?
   _____fever or chills
   _____weight gain _____lbs. in ______months    weight loss _____lbs. in ______months
   _____tiredness
   _____difficulty getting to sleep     _____difficulty staying asleep

______Do you currently have skin and hair problems?
   _____complexion problems  _____dry skin
   _____recent change in size or color of nevus (mole) -- Where?_______________________________
   _____increased hair growth (chin, lip, etc.) _____Does this run in your family?
   _____hair loss

Do you have ANY OTHER MEDICAL PROBLEMS that are not covered in this questionnaire? If so, please list:__________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
### Past Pregnancies:

<table>
<thead>
<tr>
<th>Delivery Date</th>
<th>Weeks Gestation</th>
<th>Length of Labor</th>
<th>Vaginal or C-section</th>
<th>Type of Anesthesia</th>
<th>Sex</th>
<th>Birth Weight</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
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</table>

### Family History: (includes father of the baby if pregnant or anticipating pregnancy)

Do any family members have (had) the following (please indicate which relative or relatives):

- endometriosis
- breast cancer
- ovarian cancer
- uterine cancer
- colon cancer
- high blood pressure
- heart disease
- stroke
- osteoporosis
- sugar diabetes
- thyroid disease
- AIDS
- mental retardation
- epilepsy
- neural tube defect (including spina bifida)
- Down's syndrome
- Tay Sach's
- Sickle cell
- Muscular dystrophy
- Huntington's chorea
- hemophilia
- cystic fibrosis
- other birth defects
- multiple pregnancy losses
- multiple pregnancies (twins, etc.)
- Tuberculosis

<table>
<thead>
<tr>
<th></th>
<th>Living</th>
<th>Age or age at death</th>
<th>Present health or cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>Brothers' and sisters' other medical problems:</td>
<td></td>
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</tr>
</tbody>
</table>

Children's other medical problems:

Other relatives' other medical problems:
Religious and Ethnic Background: _________________________________________________________
(Certain diseases may run in families of certain religious or ethnic background).

I have noted or listed all medical problems or conditions that I am aware of in the above questionnaire.

I have provided complete information concerning medical problems or conditions of which I am aware.

Signature__________________________________________  Date__________________

Copyright, 2001  E.Daniel Biggerstaff, III, M.D.
COPAYS The patient is expected to present the current insurance card at each visit. All co-pays and any previous balance are due at the time of service.

SELF-PAY ACCOUNTS Self-pay accounts are patients who are covered by insurance plans that the practice does not participate in, patients without an active insurance card on file, or at the time of service, have not met their deductible. Payment is required at the time of service for all services including lab, procedures, exams and surgeries.

EXTENDED PAYMENT ARRANGEMENTS If charges exceed those estimated in advance or if insurance payments are less than estimated in advance, any remaining balance is to be paid in three equal payments within 90 days of the service date. Patients who fail to meet their financial obligation are subject to collection proceedings and may be released as a patient from the practice.

NONPARTICIPATING INSURANCE PLANS The financial obligations of patients who are insured by carriers that the practice does not participate with are considered a self-pay account. The insurance company will be billed as a non-assigned claim as a courtesy to the patient. The patient will be responsible for charges in full at the time of service. The insurance company should reimburse the patient directly for any monies due. If the check is sent to the practice, the patient will be sent a refund in a timely manner.

AUTOMOBILE ACCIDENT CASES The patient will be treated as a self-pay account unless a subrogation agreement is provided by health insurance. If a subrogation agreement is provided and the physician participates with the insurance carrier, the health insurance is billed. If an attorney is involved in the case, a letter of protection will be obtained whether an insurance company is involved or not.

PATIENT REFUNDS The following criteria must be met prior to a patient refund being issued: There are no outstanding patient balances on the account and there are no outstanding insurance claims on the account.

DIVORCE CASES In cases of divorce where the spouse may be responsible for medical bills, the patient is expected to pay at the time of service. The practice will not bill a divorced spouse for the patient’s services.

CHILD CUSTODY CASES AND TREATMENT OF MINOR CHILDREN The parent accompanying the child at the time of her appointment will be responsible for payment at the time of service. The practice will bill any insurance carried on the child. The practice will not get involved in any split payments, etc. set up by the court system, etc.

This financial policy allows us to focus on rendering quality care to our valued patients. If you have any questions or need clarification of any of the specific policies, we encourage you to ask a member of our staff.

_________________________________                                         ________________
Patient Signature                                                                                  Date
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider’s Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and State law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SIGNATURE                                                                   DATE

RELATIONSHIP TO PATIENT
PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my health care, Advanced Healthcare for Women originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the healthcare professionals who contribute to my care
- A source of information of applying my diagnoses and treatment to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as quality assessments and physician certifications

I understand and have been provided with a copy of your Privacy Practices, which gives a more complete description of uses and disclosures of my health information. I have been given the opportunity to review the notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requests. I understand that I may revoke this consent in writing at any time, except to the extent that you have already taken action relying on this consent. I further understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand and ACCEPT the terms of this consent.

Patient Name: ________________________________

Signature: ___________________________________

Relationship to Patient: ________________________

Date: _______________________________________

Patient Authorization for Use or Disclosure of Protected Health Information

I authorize the release or disclosure of the protected health information as described below:

Name of Patient_____________________________ Date of Birth____________________

Name and Address of Person/Organization releasing information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name and Address of Person/Organization receiving information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I authorize the following information to be disclosed:

[ ] Copies of the patient’s medical records for the period ___/___/___ to ___/___/___

[ ] Copies of information described below for the period ___/___/___ to ___/___/___
Medical Data/Information as related to:
[ ] Specific condition(s): ________________________________
[ ] Specific professional service(s): __________________________
[ ] Specific medication(s): ________________________________
[ ] Other: __________________________________________________

[ ] Other: _____________________________________________________________

Purpose(s) of disclosure:
________________________________________________________________________
________________________________________________________________________

Candler Professional Building, Suite 518
5354 Reynolds St., Savannah, Georgia 31405
912.355.7717  fax 912.355.0979
www.womensdoctor.com  OVER PLEASE
I am aware of and specifically waive any privilege regarding the following information which may or may not be contained in these records:

- History of acquired immunodeficiency syndrome (AIDS)
- Sexually transmitted disease
- Human immunodeficiency virus (HIV)
- Behavioral health services/psychiatric care
- Treatment for alcohol and/or drug abuse or similar conditions

I understand that there is the potential for redisclosure of the protected health information by the recipient and that Advanced Healthcare for Women assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Advanced Healthcare for Women from all legal liability that may arise from this authorization.

The patient or the patient’s representative may revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Advanced Healthcare for Women must receive the revocation in writing. The revocation must include:

- The patient’s name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient’s desire to revoke this authorization, and
- The date of the revocation, and the patient’s signature.

Advanced Healthcare for Women will accept written revocations of this authorization via:

[ X ] Certified U.S. mail
[ X ] Facsimile at this number: 912/355-0979

ALL revocations must be sent to Advanced Healthcare for Women to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on _______________________________. After this date, Advanced Healthcare For Women can no longer use or disclose the patient’s protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_______________________________________                             _______________________
Patient’s Signature                                                                 Date

If signature is not that of patient, I am acting on behalf of the patient because: __________

____________________________________________________________

_________________________________________           _________________________
Relationship to patient                                                         Witness