HIPAA PRIVACY AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

I hereby authorize WOODLANDS WOMEN'S CARE to release my Protected Health Information to the following individual(s):

☐ **DO NOT disclose my Protected Health Information to anyone other than myself.**

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Authorized phone number(s) to contact you:

Cell #_____Work #_____Home #_____

Patient Email: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the address below:

1120 Medical Plaza Dr., Suite 255 The Woodlands, TX 77380

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

HEALTH HISTORY UPDATE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		**Date**	

Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

GYNECOLOGIC HISTORY

Date of last menstruation:				
Period every _____ days				
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Are you pregnant or breastfeeding?	☐	Yes	☐	No
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐	Yes	☐	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes	☐	No
Date of last pap smear				
Are you sexually active?	☐	Yes	☐	No
If yes, are you trying for a pregnancy?	☐	Yes	☐	No
Any discomfort with intercourse?	☐	Yes	☐	No
If not trying for a pregnancy list contraceptive or barrier method used:				

Please indicate new or changed conditions or check the box for no changes

PERSONAL HEALTH HISTORY

Medical problems that other doctors have diagnosed ☐ **none**

Recent Surgeries ☐ **none**

Year	Reason	Hospital

Other recent hospitalizations ☐ **none**

Year	Reason	Hospital

FAMILY HEALTH HISTORY

New significant medical problems in your family ☐ **none**

Family member	Condition or illness

List any medications you have started or stopped since your last visit

Name the Drug	Started or stopped	Strength	Frequency Taken

Newly diagnosed allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY								
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.								
Exercise	☐ Sedentary (No exercise)							
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)							
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)							
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)							
Diet	Are you dieting?				☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?				☐	Yes	☐	No
Alcohol	Do you drink alcohol?				☐	Yes	☐	No
	How many drinks per week?							
	Are you concerned about the amount you drink?				☐	Yes	☐	No
	Have you considered stopping?				☐	Yes	☐	No
	Have you ever experienced blackouts?				☐	Yes	☐	No
	Do you drive after drinking?				☐	Yes	☐	No
Tobacco	Do you use tobacco?				☐	Yes	☐	No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day				
	☐ # of years	☐ Or year quit						
Drugs	Do you currently use recreational or street drugs?				☐	Yes	☐	No

SYSTEM REVIEW	
□ weight gain	□ frequent urination
□ weight loss	□ painful urination
□ fatigue	□ palpitations
□ fever	□ dizziness
□ nausea	□ irregular heartbeat
□ depression	□ chest pain
□ anxiety or panic	□ leg swelling
□ high stress level	□ shortness of breath
□ headache	□ cough
□ sleep disturbance	□ wheezing
□ seizures	□ sinus drainage
□ abdominal pain	□ hearing loss
□ constipation	□ ringing in ears
□ heartburn	□ blurring of vision
□ diarrhea	□ diminished vision
□ bloating	□ rash
□ blood in stool	□ dry or sensitive skin

Woodlands Women's Care
Advance Beneficiary Notice

Verification of insurance benefits does NOT mean a guarantee of payment for the services that are performed. It is the patient's responsibility to be aware of their insurance benefits prior to seeking medical attention. Examples of services that might be performed are:

- Well woman exam
- Office visit or consultation
- Pap smear
- HPV testing (human papilloma virus)
- Immunizations or injections (i.e. Gardasil, DepoProvera, Rhogam, DepoLupron)
- Ultrasounds
- Office procedures
- Laboratory testing
- Any service/procedure performed in the office
- Surgical procedures performed in or out of office

I understand that the above items may or may not be covered by my insurance carrier. I agree to be personally and fully responsible for payment if the service is denied due to non-covered benefit as well as any applicable co-pay, coinsurance and/or deductible.

This authorization will be valid for all services performed while seeking medical care from Woodlands Women's Care.

_____ _____

Patient Signature Date