HIPAA Notice of Privacy Practices

University Obstetrics and Gynecology
4915 E. Baseline Road, Suite 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 your rights to access and control your 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 or 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 heath care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your 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 treat 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: Required Uses and Disclosures: Under the law, we must make disclosures to you ad when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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

HIPAA Notice of Privacy Practices

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

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

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 purposes of treatment, payment, of health care operations. You may also request 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 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 otice 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 in person or by phone at our main phone number.

University Obstetrics & Gynecology

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/noncovered 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. **This is to include a 30% surcharge if your account is sent to collections for failure to pay. Accounts may be sent to collections after 90 days of non payment.**

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.

PHONE POLICY: I agree to allow University OB-GYN, and companies affiliated with them, to make contact regarding the care of son/daughter/self at any number associated with my account, including wireless telephone numbers which could result in charges to me. They may also contact me by sending text messages or email using any email address I have provided to them. I am aware that the methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree to the terms listed above.

Signature: _____ Date: _____

Print Name: _____

4915 E. Baseline Rd, Ste. 126 Gilbert, AZ 85234 Ph: 480.969.3096 Fax: 480.969.0963

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
Melissa A. Craig, P.A.-C.
Erika L. Biggs, P.A.-C

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: _____

4915 East Baseline Road, Suite 126
Gilbert, Arizona 85234

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

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

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.

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

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

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

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 ☐

Arizona Section, ACOG, Mutual Insurance Company of Arizona © 11.2011

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

Arizona Section, ACOG, Mutual Insurance Company of Arizona © 11.2011

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: _____
_____
_____
_____

Arizona Section, ACOG, Mutual Insurance Company of Arizona © 11.2011