THE
WOMAN'S
GROUP

*Obstetrics, Gynecology, Infertility & Menopause*

EXCELLENCE IN WOMEN'S HEALTHCARE

To Our New Patients:

Welcome to our practice! We are glad you have chosen The Woman's Group as your OB/GYN provider. Our mission is to provide high-quality obstetrics and gynecological care and to educate you, our patients, in a compassionate and personable manner.

Your appointment with _____ is scheduled on_____ at ☐ 5380 Primrose Lake Circle
☐ 2716 W. Virginia Avenue
☐ 3815 Atmore Grove Drive
☐ 13005 S. US Hwy. 301

Enclosed you will find the patient forms that you must complete and return to our office at the time of your scheduled visit. Please plan to spend at least one hour with us on your initial visit.

If you are unable to keep your appointment, please notify us as soon as possible. Since failure to efficiently utilize available appointment times denies our patients access to needed health care, it is our policy to charge $25.00 to patients who do not show up for appointments and fail to notify our office in advance.

It is our policy to see patients at their scheduled appointment times. We try not to keep anyone excessively waiting, however, emergencies, deliveries, or office patients with problems that require more time than anticipated may disturb our schedules. If you cannot wait, we will be happy to reschedule your appointment.

Thank you for understanding, and we look forward to meeting you.


To Our Patients:

On behalf of the physicians and staff of The Woman's Group I would like to thank you for choosing one our practitioners to care for your health. As you may be aware, the rapidly increasing costs of medical liability insurance has contributed greatly to the rising cost of health care and has forced many physicians to limit their practice, or leave the state of Florida to practice in other states that have more affordable professional liability insurance. This state of affairs seriously threatens the long-term access by Florida citizens to medical care, especially in some specialty areas such as OB/GYN. Many obstetrician-gynecologists who continue to practice in Florida are currently unable to afford professional liability insurance and they are practicing without malpractice insurance coverage.

In order to offer the liability coverage that you, as our patient deserve, The Woman's Group in partnership with our professional liability insurance carrier, First Professionals Insurance Company (FPIC) offers a binding arbitration program to settle all professional liability claims. Through this arbitration program you, as well as our physicians, will benefit from a more prompt and efficient method of claims settlement in the unlikely event that such a claim is necessary.

You will learn more about this program at your upcoming visit or you may visit our website at www.thewomansgrouptampa.com and click on the binding arbitration link located at the side of the home page. By choosing to access this information online, you will save time at your next visit, during which we will ask you to confirm that you have reviewed this information and that you approve of its approach.

All of us here at The Woman's Group look forward to a continuing and long term relationship with you.

Sincerely,

Madelyn E. Butler, M.D.
Medical Director


A Nuestros Pacientes:

En nombre de nuestros médicos y demás empleados, les doy las gracias por elegir a The Woman's Group como su centro médico.

Como usted quizás sepa, el costo de las primas relacionadas a los seguros de obligación médica han aumentado al punto de que muchos médicos en el estado de la Florida no pueden costearlas. Algunos han dejado de pagar las primas y practican bajo gran riesgo de perder sus prácticas y posesiones en caso de un fallo judicial en su contra, otros han abandonado la Florida con rumbo a otros estados donde las primas son mas bajas. Basado en estos hechos se puede concluir que en el futuro, el acceso a médicos puede ser dificultoso para muchas personas en la Florida, especialmente para aquellas que necesitan de especialidades con primas excesivas, como la obstétricia y ginecología.

Es por esto que The Woman's Group, junto con nuestro proveedor de seguro de obligación medica, First Professional Insurance Company (FPIC), está en proceso de implementar un programa que no solamente ofrece protección a nuestros pacientes, pero a nosotros también y trae consigo la promesa de reducir los costos de las primas a largo plazo, pues las disputas serán resueltas fuera de la corte vía un proceso de arbitraje profesional mucho mas eficiente y menos costoso para nosotros y nuestros pacientes.

Durante la próxima visita a nuestra oficina, usted podrá aprender más sobre este programa, obtener respuestas a sus preguntas y darnos su consentimiento. Si usted tiene acceso al Internet, podrá encontrar información sobre este programa con anticipación si visita el enlace www.TheWomansGroupTampa.com y luego selecciona el tópico: “Binding Arbitration”donde encontrará una explicación en Español. Si tiene tiempo de revisar esta información por anticipado, su visita con nosotros será mas corta.

Los médicos y empleados de The Woman's Group esperamos que usted vea el beneficio a todos que este programa trae consigo, pues es nuestro deseo cuidar de su salud durante una larga vida.

Muy atentamente,

Madelyn E. Butler, M.D.
Managing Partner and Founder
The Woman's Group

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*Obstetrics, Gynecology, Infertility, & Menopause*

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# Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act (HIPAA) and
Health Information Technology for Economic and Clinical Health Act (HITECH)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. THIS NOTICE ALSO ADDRESSES YOUR RIGHTS AS A PATIENT.**

**PLEASE REVIEW THIS NOTICE CAREFULLY**

## A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records pertaining to you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required, by law, to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

## B. USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The following describe the different ways in which we may use and disclose your PHI:

**1. Treatment** - Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

**2. Payment** - Our practice may use and disclose your PHI in order to bill and collect payment for the products and services you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for products and services. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

**3. Health Care Operations** - Our practice may use and disclose your PHI in order to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

**4. Appointment Reminders** - Our practice may use and disclose your PHI to contact you and remind you of an appointment.

**5. Treatment Options** - Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

**6. Health-Related Benefits and Services** - Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**7. Disclosures Required By Law** - Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

## C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe the unique scenarios in which we may use or disclose your protected health information.

**1. Public Health Risks** - Our practice may disclose your PHI to public health authorities that are authorized, by law, to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or devise they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

**2. Health Oversight Activities** - Our practice may use and disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**3. Lawsuits and Similar Proceedings** - Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**4. Law Enforcement** - We may release PHI if asked to do so by a law enforcement official:

- regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- concerning a death we believe has resulted from criminal conduct
- regarding criminal conduct at our offices
- in response to a warrant, summons, court order, subpoena or similar legal process
- to identify/locate a suspect, material witness, fugitive or missing person
- in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

**5. Deceased Patients** - Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**6. Research** - Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without access to and use of the PHI.

**7. Serious Threats to Health or Safety** - Our practice may use and disclose your PHI, when necessary, to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**8. Military** - Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**9. National Security** - Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**10. Inmates** - Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**11 Workers Compensation** - Our practice may disclose your PHI for workers' compensation and similar programs.

**D. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

**1. Confidential Communications** - You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to The Woman's Group, Attn: Privacy Officer, 1908 Land O Lakes Blvd., Lutz, FL 33549 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

**2. Requesting Restrictions** - You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care options. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to The Woman's Group, Attn: Privacy Officer, 1908 Land O Lakes Blvd., Lutz, FL 33549. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both, and
(c) to whom you want the limits to apply

**3. Inspection and Copies** - You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to The Woman's Group, Attn: Privacy Officer, 1908 Land O Lakes Blvd., Lutz, FL 33549 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. You may request copies of your PHI in paper or electronic format.

**4. Amendment** - You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to The Woman's Group, Attn: Privacy Officer, 1908 Land O Lakes Blvd., Lutz, FL 33549. You must provide us with a reason that supports your request for amendment. However, we do have the ability to deny a request for an amendment.

Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures** - All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to The Woman's Group, Attn: Privacy Officer, 1908 Land O Lakes Blvd., Lutz, FL 33549. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper or Electronic Copy of This Notice** - You are entitled to receive a paper or electronic copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact The Woman's Group, Attn: Privacy Officer, 1908 Land O Lakes Blvd., Lutz, FL 33549, (813) 428-7030.

**7. Right to File a Complaint** - If you believe your privacy rights have been violated, you may file a complaint with our practice or with the U.S. Department of Health and Human Services' Office of Civil Rights (OCR). To file a complaint with our practice, contact The Woman's Group, Attn: Privacy Officer, 1908 Land O Lakes Blvd., Lutz, FL 33549, (813) 428-7030. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

**8. Right to Provide an Authorization for Other Uses and Disclosures** - Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in **writing**. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. The practice will obtain an authorization from you before using or disclosing: PHI in a way that is not described in this notice; psycotherapy notes (although not likely a part of your PHI maintained by this office); PHI for marketing purposes; PHI in a way that is considered a sale of PHI.

**9. Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket** - You have the right to restrict certain disclosures of PHI when you pay out-of-pocket in full for services provided by this practice.

**10. Right to be Notified if there is a Breach of your Unsecured PHI** - You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) the practice's risk assessment fails to determine that there is a low probability that your PHI has been compromised.

**11. Right to Opt Out of Fundraising Communications** - You have the right to decide that you would not like to be included in fundraising communications that the practice may send to you.

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*Obstetrics, Gynecology, Infertility & Menopause*

EXCELLENCE IN WOMEN'S HEALTHCARE

# RECEIPT OF NOTICE OF PRIVACY PRACTICES

## WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of The Woman's Group
(Patient Name)

Notice of Privacy Practices.

_____ _____

Signature of Patient Date

5380 Primrose Lake Circle • Tampa, FL 33647 • Telephone (813) 769-2778 • Fax (813) 769-2779
2716 W. Virginia Avenue • Tampa, FL 33607 • Telephone (813) 875-8032 • Fax (813) 875-0227
3815 Atmore Grove Drive • Lutz, FL 33548 • Telephone (813) 428-7030 • Fax (813) 428-7040
www.TheWomansGroupTampa.com

THE WOMAN'S GROUP

*Obstetrics, Gynecology, Infertility & Menopause*

**PATIENT INFORMATION**
**Please Print Clearly**

TODAY'S DATE_____

LAST NAME | FIRST NAME | MIDDLE NAME

HOME ADDRESS (Number & Street) | APT. # | CITY | STATE | ZIP CODE

MAILING ADDRESS (If Different)

CELL PHONE NO. | HOME PHONE NO. | WORK PHONE NO. | EMAIL ADDRESS

DATE OF BIRTH (Month, Day & Year) | AGE

SOCIAL SECURITY NUMBER | OCCUPATION

EMPLOYER'S NAME

EMPLOYER'S COMPLETE ADDRESS | CITY | STATE | ZIP CODE

EMPLOYER'S PHONE NUMBER(S) | EXT.

FULL NAME OF SPOUSE

SPOUSE'S EMPLOYER & ADDRESS | SPOUSE'S S.S. # | EMPLOYER'S PHONE NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY

EMERGENCY CONTACT'S COMPLETE ADDRESS AND TELEPHONE NUMBER

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU

NEAREST RELATIVE'S COMPLETE ADDRESS AND TELEPHONE NUMBER

NAME OF PLACE OR PERSON WHO REFERRED YOU

PRIMARY CARE PHYSICIAN | PHARMACY NAME | PHARMACY PHONE

WITH WHOM MAY WE SHARE YOUR PROTECTED HEALTH INFORMATION?

NAME | RELATIONSHIP

NAME | RELATIONSHIP

NAME | RELATIONSHIP

PATIENT'S SIGNATURE | DATE

THE WOMAN'S GROUP

# GENERAL ADMINISTRATIVE AND FINANCIAL AGREEMENT

The doctors and staff at The Woman's Group would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible. The following is our administrative and financial policies.

## I agree and understand the following general administrative policies:

- It is my responsibility to inform The Woman's Group of any address or telephone number changes.
- My account is to be kept current-accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, American Express, Discover, or Care Credit.
- A returned check will result in a $25.00 service charge ***and*** all future payments being required in the form of cash, credit or debit card.
- I will only be sent a statement if my balance exceeds $5.00. In the event that a refund is due, I understand that refunds will be issued within 2 weeks from the date requested provided there are no insurance pending claims.
- There is a $35.00 charge for the completion of paperwork (ex. Disability, FMLA, etc.). This fee is due when paperwork is dropped off. Forms are completed within 7-10 business days.
- If my account is turned over to a collection agency, I will be responsible for an initial placement charge of $12.00 as well as any costs incurred in collection of said balance, which may include collection agency fees up to 35% of my outstanding balance, court costs and attorney fees.
- I understand that I will be charged $25.00 for non cancellation of my appointment within 24 hours.

If I have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, <u>not</u> your insurance company***. Although we attempt to verify your *OB/GYN* benefits with your insurance company, please be advised that this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

## If I have health insurance coverage I agree and understand the following:

- It is my responsibility to inform The Woman's Group of any changes to my insurance policy so that my coverage can be re-verified prior to my appointment.
- I understand that if my insurance policy requires a referral from my primary care physician, it is my responsibility to have that provided to The Woman's Group prior to my appointment.
- I understand that not all services provided to me will be covered by my insurance plan.
- It is my responsibility to be aware of what service(s) is being provided by The Woman's Group and if it is a covered benefit under my insurance plan.
- I am responsible for any non-covered charges not payable by my insurance plan.
- I understand that The Woman's Group will file my insurance claims as a courtesy. My charges are always my responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. *<u>We are here to help you.</u>*

## I have read and understand the above administrative and financial policies and agree to meet all financial obligations.

| Patient Name (please print) | Patient Signature | Date |
|---|---|---|
| Responsible Party if other than patient (please print) | Responsible Party Signature | Date |

Rev.11/16

# HEALTH HISTORY QUESTIONNAIRE

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

***PLEASE COMPLETE BOTH SIDES***

**Name** _____ **Date of Birth** _____

**Age** _____ **Race** _____ **Primary Language**_____ **Occupation** _____

**Reason for today's visit** _____ **Primary Care Physician** _____

## Reproductive History: Menstrual Cycle

1st day of last period _____ Age of 1st period _____

If menopausal, age of onset: _____ On HRT? _____ Medication Name _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days.

Are your cycles? _____ Regular _____ Irregular _____ Heavy _____ Moderate _____ Light

Are you sexually active? _____ Never _____ Not Currently _____ Yes

Method of contraception:

_____ None _____ Tubal Ligation _____ Vasectomy _____ Rhythm Method

_____ Nexplanon _____ NuvaRing _____ IUD (Mirena/Paraguard) _____ Patch _____ Pill

_____ Depo Provera _____ Condoms _____ Other _____

## Obstetrical History (Please list all pregnancies, including miscarriages, ectopic and abortions)

EXAMPLES: **Type:** vaginal, C/S, forceps or vacuum **Anesthesia:** epidural, local, general, spinal **Complications:** preterm labor, diabetes, bleeding, high blood pressure, postpartum depression

**PAST PREGNANCIES**

| | Date | Weeks | Length of labor | Baby's Weight | Sex | Type of Delivery | Anesthesia | Complications | Location |
|---|---|---|---|---|---|---|---|---|---|
| EX: | 1/15/1975 | 40 | 12 hrs | 6lb. 2oz. | F | Vaginal | Epidural | HBP. Gest. Diabetes | BRH |
| 1) | | | | | | | | | |
| 2) | | | | | | | | | |
| 3) | | | | | | | | | |
| 4) | | | | | | | | | |
| 5) | | | | | | | | | |

Do you have any Adopted Children or Foster Children? _____ YES _____ NO

## Well Woman Update (Please provide dates where applicable)

Bone Density Exam _____ (year)

Colonoscopy _____ (year)

Mammogram _____ (year)

Pap Smear _____ (year)

HPV/ Gardasil Vaccine series completed ____ YES ____ NO

Have you had the Hepatitis B series? ____ YES ____ NO

Any Abnormal Pap smears? _____ YES _____NO

Cervical Dysplasia (precancerous cells of the cervix) ____ YES ____ NO

If yes, treatment dates:

LEEP _____

Cryo (freezing) _____

Cone Biopsy _____

Colposcopy _____

**Medical History: Do you now have or have you ever had:**

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ DVT / PE | ☐ Hepatitis A / B / C | ☐ Migraines |
| ☐ Autoimmune disorder | ☐ Elevated Cholesterol | ☐ Herpes | ☐ Osteopenia / Osteoporosis |
| ☐ Bleeding disorder | ☐ Endometriosis | ☐ IBS / IBD | ☐ PCOS |
| ☐ Blood transfusion | ☐ Fibroids | ☐ Infertility | ☐ Pelvic Inflamm. Disease |
| ☐ Bone/Joint Disease | ☐ GERD/Reflux | ☐ High Blood Pressure | ☐ Seizures |
| ☐ Cancer (type?) _____ | ☐ Gestational Diabetes | ☐ HIV | ☐ Sleep Apnea |
| ☐ Chicken pox | ☐ Gonorrhea | ☐ HPV/Genital warts | ☐ Syphilis |
| ☐ Chlamydia | ☐ Heart Attack / Stroke | ☐ Kidney Stones/Infection | ☐ Thyroid Disease |
| ☐ Depression | ☐ Heart Disease | ☐ Liver Disease | ☐ Trauma |
| ☐ Diabetes Type I / II | ☐ Heart Murmur | ☐ Melanoma | ☐ Tuberculosis |

**Other**:

**Surgical History** Please list ALL surgical procedures, including year (attach additional paper if necessary)

1)_____ 2) _____

3)_____ 4) _____

**Medications & Allergies** **Current Med & Dosage**
(attach additional paper if necessary)

1)_____

2)_____

3)_____

4) _____

**Vitamins/ Herbal Supplements (including CBD oil/teas)**

_____

_____

**Drug Allergies / Reaction** _____

_____

**Family History** Include age of onset if known

| ILLNESS | Mother | Father | Maternal Grandmother | Paternal Grandmother | Maternal Grandfather | Paternal Grandfather | Sibling/Other (Please specify) |
|---|---|---|---|---|---|---|---|
| Cancer (type) | | | | | | | |
| Diabetes (type) | | | | | | | |
| Heart Disease | | | | | | | |
| Other | | | | | | | |

**Social History**

_____ Married _____ Single _____ Engaged _____ Same Sex Partner _____Divorced _____ Widowed

Tobacco Use? _____ Never _____ Current _____ Former, Quit at age _____ Alcohol Use? _____ YES _____ Drinks per week _____ NO

Drug Use? (including Medical Marijuana) _____ YES _____ NO Type used and last use _____

Any history of violence or abuse in your current household or in your past? _____ YES _____ NO

Do you have any cultural or religious considerations that need special attention? _____ YES _____ NO

Emergency Contact Name _____ Phone # _____

***SIGNATURE*** _____ ***DATE*** _____

# CUESTIONARIO DE HISTORIA DE SALUD

Todas las preguntas contenidas en este cuestionario son estrictamente confidenciales y formaran parte de su registro medico.

***POR FAVOR COMPLETE AMBOS LADOS***

**Nombre_____ Fecha de nacimiento _____**

**Edad _____ Raza _____ Idioma principal _____ Ocupación _____**

**Motivo de la visita de hoy _____ Medico Primario _____**

**Historia reproductive: Ciclo Menstrual**

Primer dia del último periodo_____ Edad del primer periodo _____

Si es menopausica,edad de inicio _____ ¿En HRT? _____ Nombre del medicamento _____

¿Con que frecuencia obtienes tu ciclo menstrual? Cada _____ días, durando _____ días.

¿Son tus ciclos? _____ Regular _____ Irregular _____ Abundante _____ Moderado _____ Ligero

¿Esta sexualmente activa? _____ Nunca _____No actualmente _____ Si

Metodo de anticoncepción:

_____ Ninguno _____ Ligadura de trompas _____ Vasectomía _____ Metodo de ritmo

_____ Nexplanon _____ NuvaRing _____ IUD (Mirena/Paraguard) _____ Parche _____ Pildora

_____ Depo Provera _____ Condones _____ Otros _____

**Historia Obstetrica** (indique todos los embarazos, incluidos abortos espontaneos, ectopicos y abortos)

EJEMPLOS: **TIPO:** vaginal, C/S, forceps o vacum **Anestesia:** epidural, local, general, espinal **Complicaciones:** parto prematuro, diabetes, sangrado, presion arterial alta, depressión posparto

**EMBARAZOS PASADOS**

| | Fecha | Semanas | Duracion | Peso del bebe | Sexo | Tipo de parto | Anestesia | Complicaciones | Ubicacion |
|---|---|---|---|---|---|---|---|---|---|
| EJ: | 1/15/1975 | 40 | 12 h | 6lb. 2oz. | F | Vaginal | Epidural | HBP. Gest. Diabetes | BRH |
| 1) | | | | | | | | | |
| 2) | | | | | | | | | |
| 3) | | | | | | | | | |
| 4) | | | | | | | | | |
| 5) | | | | | | | | | |

¿Tiene hijos adoptivos? _____ SI _____ NO

**Actualizacion de Well Woman** (Indique las fechas donde corresponda)

Examen de densidad osea _____ (año) ¿Alguna prueba de Papanicolaou anormal? _____ SI _____ NO

Colonoscopía _____ (año) Displasia cervical (células precancerosas del cuella uterino) _____ SI _____NO

Mamografía _____ (año) En Caso afirmativo, fechas de tratamiento:

Papanicolaou _____ (año) LEEP _____

Serie de vacunas contra el HPV/Gardasil completadas _____ SI _____ NO Crio (congelación) _____

¿Has tenido la serie de Hepatitis B? _____ SI _____ NO Colposcopía _____

**Historial Medico:** **¿Tiene o ha tenido alguna vez?**

| | | | |
|---|---|---|---|
| ☐ Asma | ☐ DVT / PE | ☐ Hepatitis A / B / C | ☐ Migrañas |
| ☐ Trastorno Autoinmune | ☐ Colesterol elevado | ☐ Herpes | ☐ Osteopenia / Osteoporosis |
| ☐ Trastorno hemorrágico | ☐ Endometriosis | ☐ IBS / IBD | ☐ PCOS |
| ☐ Transfusion de sangre | ☐ Fibromas | ☐ Infertilidad | ☐ Inflamación pelvica |
| ☐ Enfermedad ósea/articular | ☐ GERD / Reflujo | ☐ Presión Arterial Alta | ☐ Convulsiones |
| ☐ Cancer (¿tipo?)_____ | ☐ Diabetes gestacional | ☐ HIV | ☐ Apnea del sueño |
| ☐ Varicela | ☐ Gonorrea | ☐ HPV/Verrugas genitales | ☐ Sífilis |
| ☐ Clamidia | ☐ Ataque al Corazón / Accidente cerebrovascular | ☐ Piedras renales/Infeccion | ☐ Enfermedad Tiroidea |
| ☐ Depresión | ☐ Enfermedad del corazón | ☐ Enfermedad del higado | ☐ Trauma |
| ☐ Diabetes Tipo I / II | ☐ Soplo cardiaco | ☐ Melanoma | ☐ Tuberculosis |

Otro:

**Historial Quirurgico** Enumere TODOS los procedimientos quirurgicos, incluya el año (adjunte papel adicional si es necesario)

1)_____ 2)_____

3)_____ 4)_____

**Medicamentos y Alergias** **Med y Dosis Actuales**
(adjunte papel adicional si es necesario)

**Vitaminas/Suplementos Herbales (incluyendo aceita/tes de CBD)**

1)_____ _____

2)_____ _____

3)_____ Alergias a medicamentos / Reacción _____

4)_____ _____

**Historial Familiar** Incluya la edad de inicio si se conoce

| Enfermedad | Madre | Padre | Abuela Materna | Abuela Paterna | Abuelo Materna | Abuelo Paterno | Hermanos / Otro (Por favor especifica) |
|---|---|---|---|---|---|---|---|
| Cancer (tipo) | | | | | | | |
| Diabetes (tipo) | | | | | | | |
| Enfermedad del Corazon | | | | | | | |
| Otro | | | | | | | |

**Historia Social**

____ Casada ____ Soltera ____ Comprometida ____ Pareja del mismo sexo ____ Divorciada ____ Viuda

¿Fumas?_____ Nunca ____ Actual ____ Ex, Dejar de fumar a la edad ____ ¿Bebes alcohol? ____ SI ____ # de bebidas por semana ____ NO

¿Utiliza drogas? (incluyendo marihuana medicinal) ____ SI ____ NO Tipo usado y ultimo uso _____

¿Alguna historia de violencia o abuso en su hogar actual o en su pasado? ____ SI ____ NO

¿Tiene alguna consideración cultural o religiosa que necesite atención especial? ____ SI ____ NO

Nombre del contacto de emergencia _____ Telefono # _____

***FIRMA***_____ ***FECHA*** _____

THE WOMAN'S GROUP

*Obstetrics, Gynecology, Infertility, & Menopause*

EXCELLENCE IN WOMEN'S HEALTHCARE

# AUTHORIZATION FOR REQUEST OF MEDICAL RECORD INFORMATION

**PATIENT NAME:** _____

**ADDRESS:** _____

**DATE OF BIRTH:** _____ **SOCIAL SECURITY # (last four digits only):** _____

## I hereby request and authorize:

_____

Name of healthcare facility

_____

Address

_____

City State Zip

_____

Phone Fax

## To release to:

_____

Name of person or facility requesting information

_____

Address

_____

City State Zip

_____

Phone Fax

**The foregoing is subject to such limitations as indicated below:**

( ) 1. Confined to records regarding admission and treatment for the following medical condition:

_____

( ) 2. Covering records for the period from _____ to _____

( ) 3. Confined to the following specific information: _____

( ) 4. NO LIMITATIONS PLACED ON DATES, HISTORY OR ILLNESS, OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL AND DRUG ABUSE AS PROTECTED BY FEDERAL REGULATION 42CFR, PART II, PSYCHIATRIC/PSYCHOLOGICAL INFORMATION AND AIDS RELATED INFORMATION, INCLUDING TESTING, FS 490.32 AND/OR 90.503, 381.609.

**This authorization shall expire one hundred eighty (180) days from the date signed.**

_____

Signature Date Relationship

_____

Witness Date

5380 Primrose Lake Circle • Tampa, FL 33647 • Telephone (813) 769-2778 • Fax (813) 769-2779
2716 W. Virginia Avenue • Tampa, FL 33607 • Telephone (813) 875-8032 • Fax (813) 875-0227
3815 Atmore Grove Drive • Lutz, FL 33548 • Telephone (813) 428-7030 • Fax (813) 428-7040
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(Rev. 03/18)

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# AUTHORIZATION TO RELEASE, RECEIVE, OR EXCHANGE INFORMATION

Patient's Name: _____

DOB: _____ SSN: _____

I authorize The Woman's Group to:

EXCHANGE, RECEIVE AND/OR RELEASE TO ME AND/OR ANY PHYSICIAN OR OTHER HEALTHCARE PROVIDER ALL NECESSARY MEDICAL RECORDS NEEDED FOR ONGOING HEALTHCARE.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this agreement is voluntary. I understand that if the requesting organization is not a health plan or health care provider; the release information may no longer be protected by federal privacy regulations.

I understand that this consent shall be valid for a period of one year from the date of authorization and may be revoked at any time via written notice by me, except to the extent that the information has already been released through compliance with this authorization.

I understand that I may revoke this authorization at any time by notifying The Woman's Group in writing, but if I do, it won't have any effect on any actions taken prior to receipt of my notice of revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific authorization of the undersigned, or as otherwise regulated.

_____

Signature of Patient/Legal Representative

_____

Date

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(Rev. 11/17)