Dr. Caroline Conner

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PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE: _____

PATIENT INFORMATION

Patient's Name:_____ Age: _____
Date of Birth:_____ Social Security #:_____
Driver's License #:_____ ☐Single ☐Married ☐Widowed ☐Divorced

Address:_____

Cell #: _____Work #:_____

WHICH NUMBERS MAY WE LEAVE DETAILED MESSAGES INCLUDING HEALTH INFORMATION, TEST RESULTS, ETC. AT THE NUMBERS ABOVE?
☐ CELL ☐WORK ☐HOME

Email Address:_____
Occupation:_____ Employer:_____
Employer's Address:_____

SPOUSE'S INFORMATION

Spouse's Name:_____ Date of Birth:_____
Spouse's Social Security#:_____ Employer:_____
Spouse's Occupation:_____ Phone#:_____

PHARMACY/REFERRING PHYSICIAN INFORMATION

Pharmacy Name:_____ Phone#:_____
How did you hear about our office?:_____

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MEDICAL INSURANCE INFORMATION

Primary Insurance
Name of Insurance Company:_____ Effective Date:_____
Insured's Name:_____ Relationship:_____
ID#:_____Group#:_____

Secondary Insurance (if any)
Name of Insurance Company:_____ Effective Date:_____
Insured's Name:_____ Relationship:_____
ID#:_____Group#:_____

EMERGENCY INFORMATION

Emergency Contact Name:_____ Relationship:_____
Emergency Contact Phone Number:_____

ASSIGNMENT & RELEASE

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO PAID DIRECTLY TO **CAROLINE CONNER MD INC**. I AM FINANCIALLY RESPONSIBLE FOR NONCOVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS.

Patient Signature:_____ Date:_____

PARENTS AND GUARDIANS OF MINOR CHILDREN

I hereby authorize treatment of:_____(my minor child) by Caroline Conner MD INC.

Parent/Guardian Signature:_____ Date:_____

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Financial Policy

We are pleased that you have chosen our practice to serve your health care needs. The following is a statement of our financial policy. We ask you to read and sign below prior to any treatment.

Insurance Billing

Your insurance policy is a contract between you and your insurance company. **It is your responsibilityto know your benefits and how they apply to your treatment.** We bill your insurance as a courtesy to you, but please be aware that not all services provided may be covered by your insurance plan. If your insurance company has not paid your account within 90 days the balance will be transferred to you. We accept CASH, CHECKS, VISA, MASTERCARD, and AMEX, and ZELLE.

Cash patients

All services must be paid in full at the time of treatment.

Administrative Fees

- **All co-pays will be collected at the time of service, prior to seeing your provider.** If co-payment is not made you will not be seen.
- All Medical Records requests are subject to a **$45 preparation fee plus/minus shipping.**
- A fee of **$40 will be applied to all returned checks.**
- A fee of **$35 dollars for all STATE forms, $50 for private forms**. These forms will not be submitted until the fee is paid.
- A fee of **$50 will be charged for office visits cancelled without 24 hours advance notice.**

Credit Card Transaction Fee

All credit card transactions will be charged a 3.99 percent fee. There is no fee for debit cards that are run by the machine and PIN is entered. Debit payments **over the phone** will be charged the fee.

Surgery Deposits

We charge only for professional services provided by the physician at our office. You may also receive a bill from the hospital, surgery center, anesthesiologist, assistant surgeon, or pathology department. They will bill your insurance directly. When your surgery is scheduled the scheduler will provide you with your estimated financial responsibility. This is usually 3-5 days prior to your surgery. The estimated responsibility will be collected as a deposit at the time of your pre-op appointment. **If you cancel surgery your deposit will be nonrefundable.**

I hereby attest that the insurance information I have provided is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits. I will be financially responsible for all charges that are not covered by my insurance plan.

Patient Signature: _____

Date:_____Patient Name:_____

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FEMALE HEALTH HISTORY QUESTIONNAIRE

Patient Name:_____ Age:_____ Date of Birth:_____

Reason for Visit:_____

_____

Please List:

Current Medications	Drug Allergies & Reactions

Gynecological History

Age you began menstruation:_____ Last Menstrual Period:_____

Menstrual Flow: ☐Regular ☐ Irregular ☐ Painful

Length of Cycles:_____ Days of Flow:_____ Heavy?:_____

Are you in menopause?:_____ If so what age did you start menopause:_____

Pregnancy

Year	# of weeks at delivery	Hours of labor	Weight	Sex	Delivery type (Vaginal or C-section)	Location of delivery	Complications

Medical Issues (please list):_____

Prior Surgeries (please list):_____

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Sexual Health History

Current birth control method:_____ Name of pill:_____

Date of last pap smear:_____ ☐Normal ☐Abnormal

Have you had an abnormal pap smear before? ☐Yes ☐No

Have you ever had a sexually transmitted disease? ☐Yes ☐No

If yes, please list date and type:

_____

Date of last mammogram:_____ Result: ☐Normal ☐Abnormal

Date of last colonoscopy:_____ Result: ☐Normal ☐Abnormal

Are you a smoker? ☐Yes ☐No Packs daily?_____ Quit how many yrs?_____

Do you drink alcohol? ☐Yes ☐No Drinks per week?_____

Do you use drugs? ☐Yes ☐No What type?_____

What type of exercise do you do?_____ Frequency:_____

Have you had any of the following? Circle Yes or No

Bronchitis	Y N	Anemia	Y N	Uterine cancer	Y N
Emphysema	Y N	Diabetes	Y N	Cervix cancer	Y N
Asthma	Y N	Hypothyroid	Y N	Ovarian cancer	Y N
Covid 19	Y N	Hyperthyroid	Y N	Melanoma	Y N
Shortness of Breath	Y N	Epilepsy	Y N	Colon cancer	Y N
Breast Cancer	Y N	Seizures	Y N	Fibroids	Y N
Hypertension	Y N	Hepatitis B	Y N	Fibrocystic breast	Y N
Heart Attack	Y N	Hepatitis C	Y N	Cystic Acne	Y N
Heart Murmur	Y N	Autoimmune	Y N	Uterine ablation	Y N
Blood clotting d/o	Y N	PCOS	Y N	Hysterectomy	Y N
Stroke	Y N	Migraines	Y N	Von Willebrands	Y N
Chest Pain	Y N	Endometriosis	Y N	Factor V Leiden	Y N
Sleep Apnea	Y N				

Family History

Has anyone in your family had:

Breast Cancer	Y N	Who?_____	What age?_____
Colon Cancer	Y N	Who?_____	What age?_____
Uterine Cancer	Y N	Who?_____	What age?_____
Ovarian Cancer	Y N	Who?_____	What age?_____
Melanoma	Y N	Who?_____	What age?_____
Other Cancer	Y N	Who?_____	Type?_____Age?____
Stroke	Y N	Who?_____	What age?_____
Heart Attack	Y N	Who?_____	What age?_____

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Consent Release Form for Medical Information

Patient Name:_____
Date of Birth:_____

Primary Care Physician: _____
(First name) (Last name)

Telephone #:_____

Preferred Pharmacy Name:_____

Pharmacy City and Cross Streets:_____

May we discuss your medical information with any other person or family member?

Yes or No (Circle One)

Name:_____
(Please Print Name) (Relationship)

May we leave a detailed message (including abnormal results) on your voice mail?

Yes or No (Circle One)

Voice Mail #: _____

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HIPAA Policy

HIPAA POLICY REGARDING USE AND DISCLOSURE OF PHI FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS INCLUDING SPECIAL HIPAA RULES REGARDING USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR MARKETING PURPOSES

SCOPE OF POLICY:
All offices of Caroline Conner MD INC are covered by this policy:

What Personnel Are Covered by this Policy? This policy applies to health care providers, clinical and all employees who assist these providers in performing tasks related to health care.

PURPOSE OF POLICY: The purpose of this policy is to set forth the standards for the use of a patient's or subject's (the "Individual") Protected Health Information (PHI) for treatment, payment, and health care purposes.

DEFINITIONS:
Covered Entity: health plan; healthcare clearinghouse; or a health care provider who transmits any Health Information in electronic form in connection with a transaction covered under the HIPAA regulations.

Health Information: Any information whether oral or recorded, in any form, that is created or received by Orange Coast OBGYN that related to an Individual's past, present, or future physical health, or to the payment of such health care.

Health Care Operations: Any of the following activities of the Caroline Conner MD INC Covered Component to the extent that the activities are related to the functions of the Caroline Conner MD INC Covered component that make it a health plan, health care provider or a health care clearinghouse:

- (a) health care protocol development (excluding research protocol development)
- (b) case management and health care coordination;
- (c) contacting health care providers and patients with information about treatment alternatives;
- (d) accreditation, certification, licensing or credentialing activities;
- (e) conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

Individually Identifiable Information: Health Information, including demographic information, that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

Marketing: Marketing is:

(1) An arrangement between a Covered Entity and any other entity pursuant to whichthe Covered Entity discloses PHI to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own services that encourages the recipient of the communication to use;

(2) Making a communication about a service that encourages the recipient of the communication to use the service unless the communication is made:

(a) to describe a health related service (or payment for such service) that is provided by, or included in a plan of benefits provides by the Covered Entitythat is making the communication (including communications about entitiesthat are participating in a health care provider network or health plan network,or about replacement of or enhancement to a health plan; and health related services available only to a health plan enrollee that add value to, but are notpart of a plan of benefits);

. (b) for treatment of the Individual;

. (c) for case management or care coordination for the Individual;
. (d) to direct or recommend alternative treatments, therapies, health care providers or setting of care to the Individual

.

Protected Health Information (PHI): Individually Identifiable Health Information that istransmitted by electronic media or transmitted or maintained in any other form or medium.

POLICY:

General Rule: The Caroline Conner MD Covered Component may use and disclose PHI for Treatment, Payment and Health Care Operations purposes without first obtaining a writtenauthorization (that contains all HIPAA-required elements) from the Individual who is the subject of the PHI, provided that the use or disclosure falls within one of the following categories:

. (a) the Caroline Conner MD INC Covered Component may use or disclose an Individual's PHI for it own Treatment, Payment or Health Care Operations;
. (b) the Caroline Conner MD INC Covered Component may disclose an Individual's PHIfor the treatment activities of a health care provider;
. (c) the Caroline Conner MD INC Covered Component may disclose an Individual's PHI to another Covered Entity or a health care provider for the payment activities of the entity that receives the PHI;
. (d) the Caroline Conner MD INC Covered Component may disclose an Individual's PHI to another covered entity for the Health Care Operations of the entity that receives the PHI if each entity either has, or had, a relationship with the Individual; the PHI pertainsto the relationship; and the disclosure is for quality assessment, quality control or peer review purposes or for the purpose of health care fraud, and about detection or compliance.

Consent: Although the Caroline Conner MD INC Covered Component is not required to obtain an Individual's authorization for the use of PHI for the treatment, payment and health care operations purposes in order to comply with HIPAA, it is permitted under HIPAA to obtain an individual's consent to such uses/disclosures.

PROCESS/PROCEDURE:

Consent for Treatment: The Caroline Conner MD INC Covered Component should continue to obtain a signed consent for treatment for each Individual who receives health care services. This consent for treatment may contain a consent to the use and disclosure of the Individual's PHIfor treatment, payment and health care operations purposes; however, for uses and disclosuresof PHI for the HIPAA purposes outlined above under the General Rule, a HIPAA authorizationis not required.

APPLICABILITY OF MINIMUM NECESSARY AND ACCOUNTING RULES:

Minimum Necessary Rule: The Minimum Necessary Rule does not apply to disclosures made for treatment purposes. The Minimum Necessary Rule does apply to any other uses and disclosures permitted under this policy that are not made to the Individual or made pursuant tothe written authorization of the Individual.

Accounting Rule: The Caroline Conner MD INC Covered Component is not required to keep records accounting for the disclosure of PHI used for Treatment, Payment and Health Care Operations purposes permitted under the policy, or for disclosures made to the Individual or pursuant to the written authorization of the Individual. Records of all other disclosures permitted hereunder must be maintained in order to provide an Individual with an accounting of such disclosures upon her request. These records must be maintained for a period of six years following the date of the disclosure.

I acknowledge receipt of HIPAA privacy policy:

Patient Signature:_____ **Date:**_____

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Insurance Waiver

I have chosen to receive medical services from **Dr. Caroline Conner**. I understand that my insurance benefits cannot be verified at this me.

I understand I am responsible for all deductibles, copayments and non-covered expenses, and other out -of-network expenses incurred by seeking services by a non- preferred/out-of-network provider. I am also aware that any outside services (labs, ultrasounds, mammograms, hospital care, etc.) ordered by the physician are also subjectto out-of-network reimbursement depending on my individual plan according to my insurance carrier.

Patient Signature:_____Date:_____

_____

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BHRT CHECKLIST FOR WOMEN

Name:_____ **Date:**_____

Email:_____

SYMPTOM (Please check mark)	NEVER	MILD	MODERATE	SEVERE
FATIGUE				
DEPRESSIVE MOOD				
MEMORY LOSS				
MENTAL CONFUSION				
DECREASED SEX DRIVE/ LIBIDO				
SLEEP PROBLEMS				
MOOD CHANGES/IRRITABILITY				
TENSION				
MIGRAINE/SEVERE HEADACHES				
DIFFICULT TO CLIMAX SEXUALLY				
BLOATING				
WEIGHT GAIN				
BREAST TENDERNESS				
VAGINAL DRYNESS				
HOT FLASHES				
NIGHT SWEATS				
DRY AND WRINKLED SKIN				
HAIR FALLING OUT				
COLD ALL THE TIME				
SWELLING ALL OVER THE BODY				
JOINT PAIN				