Women's Care of Mid-Cities, P.A.
Dr. Pamela Asghar, M.D.
350 Westpark Way, Ste 223
Euless, TX 76040
Phone: (817) 283-4438 Fax: (817) 283-1792

WELCOME TO WOMEN'S CARE OF MID-CITIES, P.A.

Date: ___ /___ / ____ PCP/Referring Dr._____

Name: _____

Address: _____

SSN #: _____ - _____ - _____ DOB: ____ / ____ / ____ Race or Nationality of Parents: _____

Driver's License #: _____ Email: _____

Home phone #: (___) _____ - _____ Cell phone #: (___) _____ - _____

Employer/address: _____ Work #: (___) _____ - _____

Marital status: (circle one) SINGLE MARRIED DIVORCED WIDOW SEPERATED

Spouse's name: _____ DOB ___/___/___ SSN#: ____-____-____

Name of Primary insurance company: _____

Name of Primary insured cardholder: _____

Cardholders DOB: ____ /____/____ SSN#: _____ -_____ - _____

ID#: _____ Group#: _____

Secondary insurance company: _____

Secondary cardholder DOB: ____/____/____ SSN#: _____ - _____ - _____

ID#: _____ Group #: _____

Emergency contact: _____ DOB: ____/____/____ Phone#: (___) ____ - _____

Relationship to you: _____

Please note: Although you may put down an emergency contact, this person will not be contacted with any medical information. That information will need to be put on the release form given to you. All patients MUST have current insurance at the time of visit. If you do not have your card with you, payment will be due in full, or you may reschedule. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier claims; however, the patient is responsible for all fees, regardless of insurance coverage. Also, there is a $25.00 charge for all paperwork completed by our office including copies of any medical information.

I have read all of the above information provided to me and understand that I am responsible for any and all charges applied to me.

Patient signature: _____ Date: ___/___/_____

Revised March 2019

Patient History

Name: _____ DOB: ___/___/_____ Age: _____

Reason for today's visit: _____

Pharmacy: _____ Address/Cross Street: _____
City: _____ Phone: (____) _____- _____

Medical History

What have you been diagnosed with? ○ None
If **YES**, please list:

DIAGNOSES AND YEAR	

Past Surgeries / Procedures? ○ None
If **YES**, please list:

SURGERY/ PROCEDURE AND YEAR	

Family Medical History? ○ None
If **YES**, please list:

DIAGNOSES	FAMILY MEMBER	ALIVE OR DECEASED

Social Habits:

Are you Sexually Active: Y / N

Use tobacco products? Y / N ○ Former Smoker How much and how often? _____

Drink Alcohol? Y / N if yes, check one: ○ Occasional ○ 4 or more days a week

Have you EVER used recreational drugs? Y / N Currently use recreational drugs? Y / N

Exercise regularly? Y / N how often? _____

Gynecological History

First day of last menstrual cycle? ___/____/_____ if late, how many days? _____
Name/Type of Birth Control? _____ ○ None

Date of Last: PAP smear? _____ Mammogram? _____
Colonoscopy? _____ Bone Density? _____

History of? ○ Hormone Replacement Therapy ○ Abnormal PAP smear ○ Cervical Biopsy
○ Fertility Drugs ○ Irregular Menstrual Cycles

PREGNANCIES ○ None

Total # of pregnancies _____ # of Full-term _____ # of Pre-term _____
# of Miscarriages / Abortions _____ # of Living _____ # of Stillborn _____

YEAR	GENDER	VAG. OR C-SECT	HOSPITAL

Medication list

Please list all medications and dosages.

MEDICATION	DOSES	HOW OFTEN?

Allergies

No Known Drug Allergies ○

Are you allergic to Latex? Y / N

List all other allergies and reactions.

ALLERGY	REACTION

Are there any other problems or concerns you would like to discuss today?

_____

_____

_____

_____

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ATTENTION PATIENTS

I will be having a routine physical today (i.e. well-visit or yearly physical exam). I understand my insurance may not cover routine or preventative services or my policy may have a maximum annual cap for well benefits that is less than the billed charges. In the event my carrier does not cover all charges, I know I will be financially responsible for today's visit. I also understand it is my responsibility to know if it is covered.

Any issues discussed other than preventative care are not part of the routine physical (i.e. irregular bleeding, bacterial vaginosis, yeast infection, menopausal symptoms, etc.) and must be addressed in a problem visit, which may result in additional co-pays, deductible applications or co-insurance.

Our physician / provider assigns codes according to the services she provides. The physician / provider cannot alter the coding submitted to the insurance company in order for them to make payment.

_____ _____

Patient Name (please print) Date of Birth

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Designation of Those Who Can Receive Information About My Care

To allow a family member, other relative, or a close personal friend to have access to PHI

I designate the following individuals to have access to information about me that is created by or on behalf of Women's Care of Mid-Cities, P.A, and that this information can include PHI, I understand that I many revoke this designation at any time by completing a new form; and that this designation will not expire unless and until I actively revoke it. I understand that these individuals will not be able to request a paper or electronic copy of my health records without my having completed an Authorization to Release Medical information form. I understand that my healthcare treatment or payment, or my enrollment or eligibility for benefits cannot by conditioned on my designating or not designating an individual below. I understand that this designation does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions, HIV / AIDS testing or status, abortion or sexually transmitted disease, if any.

1. Name: _____ Relationship: _____
   DOB: _____ Phone #: _____

2. Name: _____ Relationship: _____
   DOB: _____ Phone #: _____

3. Name: _____ Relationship: _____
   DOB: _____ Phone #: _____

_____ _____
Patient Signature Date of Birth

_____ _____
Print Name Date

Revised March 2019

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

Procedure can include, but not limited to: EMB, Colposcopy/Cervical Biopsy, Cryotherapy/Surgery, IUD insertion/Removal, Nexplanon Insertion/Removal, Incision & Drainage, LEEP, Vulva Biopsy, Polyp Removal; etc.

The consent provides us with your permission to preform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.
You have the right to discuss the treatment plan with our physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary. To preform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Printed Name of Patient or Representative

_____ _____
Signature of Witness *Date*

_____
Printed Name of Witness

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Womens Care of Mid Cities PA
350 Westpark Way Ste 223
Euless Texas, 76040

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Womens Care of Mid Cities PA understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 04/25/2019 and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment for Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time; your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer:
Susan Dougharty
Telephone:
8172834438
E-mail:
womenscare@womenscareofmidcities.com
Address:
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