GYNECOLOGICAL QUESTIONAIR

PATIENT NAME_____
Are you currently using oral contraceptives? Yes ( ) No ( ) If yes, what type_____
Do you have or have you ever used an IUD? Yes ( ) No ( ) If yes, type if known:_____
If removed, reason:_____

How frequent do you have PAP tests? 6 ( ) 9( ) 12( ) 18( ) 24( ) Month
Other_____ When was your last Pap Test performed?_____
Have you ever had an Abnormal Pap test? Yes ( ) No ( ) If yes, Type and
Outcome:_____

Have you ever had any type of venereal disease? Yes( ) No( ) Type:_____
Have you ever been told by a physician that you have Herpes Simplex Virus? Yes ( ) No ( )
Do you have frequent vaginal discharge? Yes ( ) No ( )
If yes, color of discharge: White Yellowish ( ) Clear ( ) Greenish Cloudy ( )
If yes type of treatment: Cream ( ) Tablets ( ) Suppositories ( )
Frequency of douching:_____wk/_____mo - Type used_____

Was your past Gynecologist: Male ( ) Female ( )
Please answer the questions below regarding YOUR personal preferences rather than standard accepted policies. Would you feel more comfortable or at ease with or without a nurse/attendent during:
Present ( ) Absent ( ) Your interview
Present ( ) Absent ( ) Your physical examination
Present ( ) Absent ( ) Your pelvic examination
Present ( ) Absent ( ) Your post exam/counseling

Measurements: Waist_____ Hips_____ Breast (size & cup)_____Midthigh_____
Are you currently on a diet? Yes ( ) No ( ) Type_____

Have you ever had any masses in your breasts? Yes ( ) No ( )
If yes, by whom were they detected: You ( ) Doctor ( ) Other ( )
Have you ever had any discharge from the nipple? Yes ( ) No ( )
Have you ever had any trauma (injury) to your breast or chest? Yes ( ) No ( )
If yes, right, left or both breasts?_____

Do you have any self or family history of Breast Cancer? Yes ( ) No ( )
If yes, relationship_____
Do you practice the Breast Self Exam Technique? Yes ( ) No ( )
How often do you practice BSE? _____
Does you r gynecologist examine your breasts on each visit? Yes ( ) No ( )
Does your family physician examine your breasts? Yes ( ) No ( )

Age of onset menstruation_____ Are your periods normal? Yes ( ) No ( )
Length of periods: _____ days. Periods – Light ( ) Moderate ( ) Heavy ( )
Number of pad/tampons per cycle__ Type: Pads ( ) Tampons ( ) Both( ) Other ( )

Do you take any type of vitamins? Yes ( ) No ( ) Type:_____

Age of first sexual contact (intercourse)_____ Sexual Preference Male ( ) Female( )
Approximate frequency of intercourse_____ week _____month
Is your current husband/partner circumcised? Yes ( ) No ( )

Do you have any self or family history of Cancer of the Reproductive Tract or Organs? Yes ( ) No ( )
If yes, relationship_____ What type of cancer?_____

GYNECOLOGY HISTORY & PHYSICAL

CliniForms™ Inc.

Name
Address — Ins. No.
Date of birth — Age — Phone (O) (H) — Date

NAME

PATIENT PROFILE

MENSTRUAL HISTORY	LMP	PMP	ONSET	DURATION	MENOPAUSE
CONTRACEPTION	CURRENT			PAST	
LAST PAP TEST					

OBSTETRICAL HISTORY

Premature births — Miscarriages — Abortions

Month/Year	Anesthesia	Dur of gestation	Dur of labor	Type of delivery	Born A or D	Sex	Wt	Complications	
								Maternal	Child

CHIEF COMPLAINT

PAST GYNECOLOGICAL HISTORY

PAST MEDICAL HISTORY

	PATIENT	FAMILY	COMMENTS
Hypertension			
Headaches			
HEENT			
Respiratory Problems			
Breast Disease			
Jaundice/Hepatitis			
Gall Bladder Disease			
Bowel Disorders			
Kidney Problems			
Urinary Tract Problems			
Anemia/Blood Disorders			
Blood Transfusions			
Varicose Veins/Phlebitis			
Diabetes			
Thyroid Disease			
Cancer			
Epilepsy/Neurol. Disord.			
Smoking Cig./Day			
Alcohol Oz./Wk.			

HOSPITALIZATIONS	Mos/Yr	Illness/Operation	Mos/Yr	Illness/Operations

MEDICATIONS

ALLERGIES

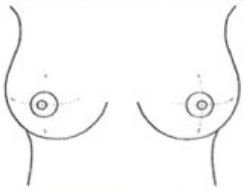
PHYSICAL EXAM

HT	WT	BMI	BP

NAME

HEENT
NECK
LUNGS
COR
THORAX
ABD
EXTREMITIES

BREASTS



GALACTORRHEA

PELVIC

EXT. GENITALIA
BUS
VAGINA
CERVIX
UTERUS
ADNEXAE
RECTAL/VAGINAL — HEMOCULT™

INVESTIGATIONS

CBC
ULTRASOUND
URINE
PAP
WET MOUNT
CULTURES
PREG. TEST — URINE — BLOOD

ASSESSMENT/PLAN

RETURN VISIT

TODAY'S DATE_____

PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS

PATIENT'S PERSONAL INFORMATION

NAME_____DOB_____
first last middle

ADDRESS_____APT_____ AGE_____

CITY_____STATE_____ZIP CODE_____

SOCIAL SECURITY #_____ DRIVERS LICENCE#_____

HOME PHONE ( )_____WORK PHONE ( )_____

CELL PHONE ( )_____ RACE_____

EMPLOYER:_____FULL TIME _____ PART TIME_____

OCCUPATION:_____E-MAIL_____

MARITAL STATUS_____ STUDENT STATUS_____

WHOM MAY WE THANK FOR REFERRING YOU TO US_____

RESPONSIBLE PARTY INFORMATION

NAME_____ DATE OF BIRTH_____
ADDRESS_____ CITY_____ ST_____Zip_____
RELATIONSHIP TO PATIENT: SELF___ SPOUSE___CHILD___ OTHER_____
HOME PHONE:( )_____ WORK PHONE ( )_____
SOCIAL SECURITY #_____
EMPLOYER_____FULL TIME_____PART TIME_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO_____

POLICY #_____GROUP#_____

SECONDARY INSURANCE CO_____

POLICY # _____ GROUP #_____

FINANCIAL POLICY

According to policy, we will file a claim with your medical insurance carrier. However, any co-payments, percentages or deductibles are expected to be paid at the time of your visit. Co-payments will be accepted in cash only.

It is our policy to collect a deposit for all inpatient and outpatient surgeries. This deposit will be based on the surgery fee and information provided to us by your insurance company. The surgery deposit is due at the time of the pre-operative visit. Once the surgery has been performed and your insurance has made payment, any unpaid balance minus your initial deposit will be your responsibility.

If there are any discrepancies as to the payment amount paid by your insurance company, it is your responsibility to contact your insurance company to discuss the situation. In the meantime, you, the patient are responsible for payment of all balances on your account.

Any patient who has an unpaid balance which is more than 45 days old from the date of the billing cycle will be subject to a 1.5% finance charge every month until the balance is paid in full.

If we find it necessary to pursue legal actions to collect a patient's balance, all attorney fees and court costs will be added to the patients account.

_____ _____

Signature of Patient or Guardian **Date**

Acknowledgment of Notice of Privacy Practices

I acknowledge by my signature below that I have been provided by The Camellia Women's Center (Dr. Robert J. Muller) with a Notice of Privacy Practice for my review.

_____

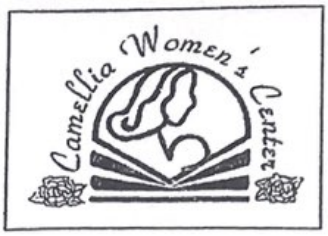
Signature of acknowledgment

_____

Date

_____

Witness **Date**



Appointment Cancellation Policy

We strive to render excellent care to you as well as our other patients. In order to do so, specific appointment times are reserved. When an appointment is scheduled the time has been allocated to YOU and when it is missed, that time cannot be used for another patient unless sufficient notice of 24 hours or more has been given to us.

We request that you give our office at **least 24 hour notice** in the event you need to reschedule or cancel your appointment.

If you cancel the day of your scheduled appointment, OR fail to show for your appointment without notifying our office, you will be billed a **$25.00 charge** which is NOT covered by your insurance and is your responsibility for payment.

Additionally, if a patient is more than 15 minutes late for her appointment, the appointment may have to be rescheduled or cancelled in order to accommodate our patients that have scheduled appointments.

By your signature below, you attest that you understand and agree to the term above.

Thank you for choosing our practice for your Gynecological care and we look forward to providing you the best and most efficient care with your help and participation.

---------- _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES
OF
CAMELLIA WOMENS'S CENTER

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.

EFFECTIVE: APRIL 14, 2003

If you have any questions or requests, please contact Dr. Robert Muller at (985) 641-2100

❖ **We have a legal duty to protect health information about you.**

We are required to protect the privacy of health information about you and that can be identified with you, which we call "**protected health information**" or **PHI** for short. We must give you notice of our legal duties and privacy practices concerning PHI:

This means that we must protect PHI that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for you health care. We must notify you about how we protect PHI about you. We must explain how and why we use and/or disclose PHI about you, and we may only use and/or disclose PHI as we have described in this Notice.

This Notice describes the types of uses and disclosures that we may make and gives you some examples. In addition, we may make other uses and disclosures that occur as a result of the permitted uses and disclosures described in this Notice.

We are required to follow the procedures in the Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first posting the revised notice in our office and making copies of the revised notice available upon request.

❖ **We may use and disclose PHI about you without your authorization in the following circumstances.**

Treatment: We may use medical information about you to provide you with medical treatment or services, to coordinate your health care and any related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you if you are in the hospital. In addition, we may use and disclose PHI about you when referring you to another health care provider.

Example- We may share information about you with another health care provider that you have identified or one that we have referred you in order to ensure that they have the necessary information to provide care to you.

Payment: Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. Before you receive scheduled services, we may share information about these services with your health plan. Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of your

medical information with the following: billing departments, collection agencies, insurance companies, health plans and their agents, which provide you coverage, and consumer reporting agencies.

Example- Let's say that you need a hysterectomy or other surgery performed. We may need to give your health plan information about your condition and surgery that we will be performing, so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Operations: We may use or disclose your PHI for our business activities. These activities may include quality assessment activities, employee review activities, training of nurse, allied health or medical students, or other business activities needed for the operation of this practice. We will share your information with business associates of ours for accounting, legal, billing, collection, etc. We require our business associates to sign a contract that contains terms requiring them to maintain the confidentiality and privacy of your PHI.

Example- We may share information with nursing students for learning purposes. Again, they are required to maintain your confidentiality.

Appointment Reminders and Follow-up: We may use and disclose your information to contact you by telephone to provide a reminder to you about an appointment, to call you with test results, or to follow up after treatment. We will send reminders cards (postcards) to inform you of the need for a return visit.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a family member or friend who is involved in your medical care unless you object. We may also give information to someone who helps pay for your care. We may also tell your family or friends your general condition or that you are in the hospital. In addition, we may disclose health information about you to an agency assisting in a disaster relief effort so that your family can be notified about your condition and location.

Other Circumstances: We may use and/or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. These circumstances include:

- When the use and/or disclosure is required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease.
- When the disclosure relates to victims of abuse, neglect, or domestic violence.

- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency that is authorized by law to oversee our operations.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner for the purposes of identifying you should you die.
- When the use and/or disclosure relates to organ, eye, or tissue donation purposes.
- When the use and/or disclosure relates to medical research. Under certain circumstances, we may disclose PHI about you for medical research.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent a serious threat to the health or safety of yourself, another person, or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

❖ **You have several rights regarding PHI about you.**

You have the right to request restrictions on uses and disclosures of PHI about you. You have the right to request that we restrict or limit the health information we use or disclose about you for treatment, payment, and health care operations. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed such as in emergency treatment or disclosures to the Department of Health and Human Services. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. <u>You must request a restriction by writing your request and giving it to our privacy officer.</u>

You have the right to request different ways to communicate with you. You have the right to request that we communicate with you about medical matters in a certain way. For example, you may request that we contact you only at your work phone number or address. Unless otherwise requested by you, we will use any of the numbers or addresses that you provide to us in order to reach you. We will accommodate all

reasonable requests. You must make requests for alternative communications in writing and submit them to the privacy officer.

You have the right to see and copy PHI about you.
You have the right to request to see and receive a copy of PHI contained in clinical, billing, and other records used to make decisions about you. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may request to see and receive a copy of your PHI by submitting your request in writing to the office. We may charge you a fee for the costs associated with your request.

You have the right to request amendment of PHI about you.
If you feel that health information we have about you is incomplete, you may ask us to amend the information. This includes clinical, billing, and other records. You have the right to request an amendment as long as the information is kept by or for our office. Your request must be submitted in writing and must explain your reason(s) for the amendment. We may deny your request if: 1)the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2)the information is not part of the records used to make decisions about you; 3)we believe the information is correct and complete; or 4)you would not have the right to see and copy the record under certain circumstances. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need amendment.

You have the right to a listing of disclosures we have made.
You have the right to receive a written list of certain disclosures of PHI about you if you request it. You may ask for disclosures made up to 6 years before your request (not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following: for your treatment; for billing and collection of payment for your treatment; for our health care operation; made to or requested by you or that you authorized; occurring as a byproduct of permitted uses and disclosures; made to individuals involved in your care, for notification purposes, or for other purposes described in this paper; allowed by law when the use and/or disclosure relates to certain specialized governmental functions or relates to correctional institutions and in other law enforcement custodial situations; and as part of a limited set of information which does not contain information which could identify you.
The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information.

If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You may request a listing of disclosures by submitting your request in writing to the privacy officer.

You have the right to a copy of this Notice.
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. If you wish to have a paper copy of this notice, ask any office personnel.

- **Changes to this Notice will be made if necessary.**

A current copy will be posted in our office. The effective date will be displayed on the first page. You may review the Notice at any of your visits to our office.

- **You may file a complaint about our privacy practices.**

If you think we have violated your privacy rights, or you want to complain about our privacy practices, you may contact Carol Raymond, 105 Smart Place, Slidell, LA 70458, phone number (985) 641-2100. Your complaint must be in writing. You may also send a written complaint to the United States Secretary of the Department of Health and Human Services.
If you file a complaint, we will not take any action against you or change our treatment of you in any way.

- **Other uses of health information**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.