

Client Information Sheet

PLEASE PRINT

Date _____

Account # _____

(TO BE COMPLETED BY OFFICE)

Name:

Last First Middle

Date of Birth ____/____/____ Age _____ Social Security # _____

Marital Status Single Married Other

Address: _____ Apt. # _____ City: _____ Zip: _____

Home Phone# _____ Cell Phone# _____ Work# _____

Patient employer: _____

E-mail: _____

Referred by: _____

Confidential Contact: SOME ONE WE MAY CONTACT IF WE CANNOT REACH YOU

Name: _____

Contact phone# _____

New and Existing patients please complete the following insurance information;

Primary Insurance: _____ ID# _____ GROUP# _____

Secondary Insurance _____ ID# _____ GROUP# _____

Name of policy holder _____ D.O.B. _____ S.S. # _____

BILLING AND INSURANCE INFORMATION (please have insurance card ready, we will make a photo copy) I give my permission for Dr. Friedman to bill my insurance company. I understand I am responsible for this bill whether or not insurance pays.

Signature: _____

Date: _____

PATIENT HISTORY

Full name _____ D.O.B. _____ Age _____ Date _____

Reason for today's visit _____

Date of last Pap smear _____ Result _____ Any abnormal Pap smears in the past? Yes/No

If yes, any biopsy or procedure done? _____

Last menstrual period _____ Are your periods regular? _____ How long do they last? _____

Problems with periods? _____ Age first period began: _____

Current birth control method _____

Please list date of last: Mammogram _____/Result _____ Bone density _____/Result _____

List any surgeries and approximate date:

List all pregnancies (including miscarriages, terminations and ectopics):

Year	Sex	Weight	Full-term?	Vaginal or c-section?	Where?	Complications

Have you ever had a STD (sexually transmitted disease)? Yes/No

If Yes, what kind? _____

Were you treated? _____

Have you had the Gardasil vaccine? Yes/No

List current medications you are taking with dosages (including over-the-counter medications and supplements): _____

Allergies to any medications/latex/iodine and your reaction to it: _____

Patient name _____

Patient History, page 2

Do you smoke? ___ How many packs day? ___ Do you drink alcohol? ___ If yes, drinks / week ___

Occupation: _____ Spouse/Partner name: _____

Have you ever been diagnosed with the following? (Circle all that apply)

Asthma	Heart attack/disease	Lung disease
Breast disease	Heart murmur	Migraine headaches
Cancer	Stroke	Neurological disease
Depression/anxiety	Hepatitis	Osteoporosis/osteopenia
Diabetes	High blood pressure	Blood clots
Ovarian cyst or tumor	High cholesterol	Bleeding problems
Infection of tubes or ovaries	Kidney disease	Thyroid disease
Other _____		

Is there a member of your family with a history of:

___ Bleeding problems	Who? _____
___ Cancer - what type? _____	Who? _____
___ Congenital (Inherited) Disease	Who? _____
___ Diabetes/Thyroid Disease	Who? _____
___ Heart Disease	Who? _____
___ High Blood Pressure	Who? _____
___ High Cholesterol	Who? _____
___ Lupus/Rheumatoid	Who? _____

HIPAA Notice of Privacy Practices

ROBERT H. FRIEDMAN, M.D.
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(281) 578-6868

ID: 74-1886755

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

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

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Robert H. Friedman, M.D.
Quynh-Thu Doan, M.D.
21376 Provincial Blvd.
Katy, TX 77450

Notice of Privacy Practices Acknowledgement

I understand that, under the Health insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Patient Record of Disclosures/ Release of Medical Information

I give my permission to release information regarding test results and to discuss any treatment for my care received in your office. I additionally request that this person or persons have the availability to discuss any billing issues for the treatment that I have received.

Name(s) to whom we may release information;

Name: _____ relationship; _____ Phone # _____

Name: _____ relationship: _____ Phone # _____

Name: _____ relationship: _____ Phone # _____

Patient Name: _____

Signature: _____

Date: _____