PATIENCE MILLER OB-GYN, PLLC

PATIENT INFORMATION SHEET

REVISED 01/2013 (PLEASE PRINT)

PLEASE ANSWER **ALL** QUESTIONS. DO NOT LEAVE ANYTHING BLANK. IF NONAPPLICABLE, PLEASE WRITE N/A. IF ANY INFORMATION IS MISSING, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE COMPANY AND THEREFORE WE WILL BILL YOU.

PATIENT NAME _____
LAST FIRST MI

DATE OF BIRTH _____ AGE _____SSN# _____-____-_____ PHARMACY# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER NAME AND ADDRESS _____

OCCUPATION _____ HIGHEST LEVEL OF EDUCATION _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

WHO REFERRED YOU TO US? _____

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED SEPARATED WIDOW

ETHNICITY (CIRCLE **ALL** THAT APPLY): HISPANIC SCANDINAVIAN GERMAN SLOVAK SLAVIC AFRICAN ARAB

MEDITERRANEAN SHEPHARDIC JEW INDIAN IRANIAN CHINESE JAPANESE AUS/ABORIGINE ASHKENAZIJEW OTHER

RACE (CIRCLE ONE): BLACK/AFRICAN AMERICAN WHITE ASIAN AMERICA INDIAN ALASKA NATIVE UNKNOWN

LANGUAGE (CIRCLE ALL THAT APPLY): ENGLISH SPANISH OTHER _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ OFFICE CO-PAY _____

POLICY HOLDER NAME _____ RELATIONSHIP _____ DOB _____

POLICY HOLDER ID# _____ GROUP# _____

POLICY HOLDER SS# _____

PRIMARY CARE PHYSICAN: _____

SECONDARY/ OTHER INSURANCE _____ OFFICE VISIT COPAY _____

POLICY HOLDER NAME _____ RELATIONSHIP _____ DOB _____

POLICY HOLDER ID# _____ GROUP# _____

POLICY HOLDER SS# _____

I HEARBY AUTHORIZE MY INSURANCE CARRIER TO FURNISH OR RELEASE INFORMATION TO MY PHYSICIAN'S OFFICE CONCERNING MY ILLNESS, TREATMENT, ELIGILBILITY AND BENEFITS. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED WHICH ARE NOT MEDICALLY NESCESSARY FOR MY CARE.

SIGNATURE OF REPONSIBLE PARTY _____ **DATE** _____

PATIENCE MILLER OB-GYN, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have been notified that
(Patient name)
Patience Miller Ob-Gyn, PLLC is in compliance with HIPAA privacy rule. The HIPPA Privacy Rule mandates the protection and privacy of all health information.

_____ _____
Patient's Signature Date

Patience Miller Ob-Gyn, PLLC was unable to obtain acknowledgement because:

- Emergency
- Patient Sedated
- Patient Non-Responsive
- Patient Confused/Disoriented
- Patient Refused – Reason _____
- Other

Staff Signature: _____ Date: _____

PATIENCE MILLER OB-GYN, PLLC

7922 Ewing Halsell, Suite 420 San Antonio, Texas 78229 Office: 210-614-8900 Fax: 210-614-8901

AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

____ _____________________

Name of Patient (Please Print) Date of Birth

____ _____________________

Street City State Zip Phone

____ _____________________

Maiden name or other name used for records Practice Use: MedRec#

I hereby authorize (Please Print)

____

____

____

To release to:

Dr. Patience Miller

7922 Ewing Halsell, Suite 420

San Antonio, Tx 78229

The following information from my records:

- ◊ Complete Health Record(s)
- ◊ History & Physical
- ◊ Radiology Reports/Films
- ◊ Operative Report
- ◊ Laboratory Report
- ◊ Sonograms/ Ultrasound Reports
- ◊ Progress Notes
- ◊ Discharge Summary
- ◊ Other (please specify)____________________

I ◊ do ◊ do not (check applicable box) authorize this information to be faxed. If yes, fax number: ______________

Covering period from ____________________________________ to ________________________________

_____ (Initial) I understand that this authorization will include information relating to:

√ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection

√ Treatment for alcohol and/or drug abuse

√ Genetic Testing

If any, except as specifically stated here: ____

This information is to be disclosed for the purpose of ____

The date, extent or condition upon which this authorization expires is 12 months. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization.

I understand and agree to pay a reasonable copying fee of $1.00 per page to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than **Dr. Patience Miller** and therefore are not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by **Dr. Patience Miller** concerning me, including incorporated records. I acknowledge that **Dr. Patience Miller & Dr. Lillian Jones** have no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **Dr. Patience Miller** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **Dr. Patience Miller** is not responsible for completeness, legibility, or omissions caused by the copying of any medical records from another institution.

____ ______________________

Signature of patient or patient's representative **Date**

Printed name of patient's representative ___________________________ Relationship to patient___________

☺☺

Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provisions of this law shall be fined or imprisoned.