
**Patient Information (Please Print)** Date_____

Name_____ Date of Birth_____Age____

SSN_____ Race_____ Marital Status_____

Address_____ City_____ State_____ Zip_____

Home Phone_____Work Phone_____ Cell Phone_____

Employer_____ Physician_____

Email Address_____ Preferred Pharmacy_____

**Insured Person/Spouse Information**

Name_____ Date of Birth_____

Employer_____ Relationship_____

SSN_____ Work Phone_____

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**If Patient Is A Minor, Person Responsible For Bill**

Name_____ Relationship_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____

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**How Did You Hear About Us?**

Newspaper Website Internet Search Yellow Pages Community Event Friend

Physician Referral_____ Other_____

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**Nearest Relative To Notify In Case Of Emergency** (Other Than Spouse)

Name_____ Relationship_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____

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**Please List The Name And Relationship Of Person(s) To Which We May Release Your Medical Records To:**

Name_____ Relationship_____

Name_____ Relationship_____

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**Authorizations:** **Benefits To Physician**

I hereby authorize payment of medical benefits directly to the physician for services received. I also understand that I am responsible for any portion of my bill not covered by my insurance company.

Signed_____ Date_____

Patient or Parent/Guardian if Minor

**Please present your insurance card(s) and photo i.d. to the receptionist. Thank you.**


Name_____ Date_____ Age_____

Allergies to medication_____

**Menstrual History:**

Age at first period____

How often do your periods come (in days)_____

Do you spot or bleed between periods? Yes No (circle one)

Have you missed a period other than pregnancy? Yes No (circle one)

Do you have cramps during your period? Yes No (circle one)

Do you have mood swings before or during your period? Yes No (circle one)

What was the first day of your last period? _____

Was it a normal period? Yes No (circle one)

If no, explain _____

**Pregnancy History:**

Number of pregnancies_____ Number of live births_____

Number of stillbirths_____ Number of miscarriages_____

Number of abortions_____ Number of living children_____

Date of last pregnancy_____

Have you ever experienced complications with a pregnancy? Yes No (circle one)

If yes, What?

_____

How many children do you have? _____

**Contraceptive History** (Circle those used)**:**

Pills IUD Diaphragm Foam Condoms Rhythm

Other_____

Current contraceptive method _____

Have you had problems with this method? Yes No (circle one)

What method would you like prescribed today? _____

**Surgical History** (Type and Date)**:**

OB/GYN Surgery_____

_____

Breast Surgery_____

_____

Other Surgery_____

_____

**Hospitalizations** (excluding Childbirth):

Reason/Date_____

_____

**Medications:**

List current medications and dosage_____

_____


Name_____ Date_____

**Personal Medical History (past and present):**

| | | |
|---|---|---|
| ___Headaches | ___Rheumatic Fever | ___Epilepsy/Seizure |
| ___Bleeding Disorder | ___Depression | ___Anemia |
| ___Nervous Disorder | ___Sickle Cell Disease | ___Sickle Cell Trait |
| ___Thyroid Disorder | ___Ulcers | ___Bronchitis |
| ___Asthma | ___Emphysema | ___Gallbladder Disease |
| ___Muscular Disorder | ___Hepatitis | ___Blood Clots/Phlebitis |
| ___Liver Disease | ___High Blood Pressure | ___Diabetes |
| ___Heart Disease | ___Heart Murmur | ___ Kidney Disease |
| ___Urinary Tract Infection | ___Cancer | ___Varicose Veins |

Do you smoke___ If so, how many cigarettes daily?_____
Do you now or have you ever had an alcohol problem?____
Do you now or have you ever had an drug problem?____
Have you ever taken Pondimin or weight reduction drugs?____
Have you been immunized for Rubella?____

**Personal Gynecology History:**

Date of last Pelvic Exam_____ Date of last Pap Smear_____

| | | |
|---|---|---|
| ___Breast Disease | ___Endometriosis | ___Abnormal Pap Smear |
| ___Ovarian Cyst/Tumor | ___Cervical Cryosurgery | ___ Cervical Surgery |
| ___GYN Cancer | ___ Rape or sexual assault | ___Gonorrhea |
| ___DES Exposure | ___Syphilis | ___Infertility |
| ___Herpes | ___Vaginal Infections | ___Abnormal Uterus |
| ___Infection in tubes | ___Vaginal Warts | ___ Condylomata |
| ___HPV | ___HIV | ___Pain with intercourse |

___Loss of urine when coughing or sneezing
___Bleeding or spotting after intercourse

**Family History:**

| | | |
|---|---|---|
| ___Family History Unknown | ___Cancer | ___Stroke |
| ___High Blood Pressure | ___Heart Disease | ___Sickle Cell Disease/Trait |
| ___Diabetes | ___ Epilepsy/Seizure | |

**Additional Information or Comments:**_____
_____
_____


1800 South Douglas Blvd.
Midwest City, OK 73130
405-733-4985

**Date:_____**

To whom it may concern:

I_____, parent or legal guardian of

_____, give permission for one or all

physicians or nurse practitioners below to provide medical care.

Belinda G. Broady-Symes, M.D.

Thomas R. Bryant, M.D.

Jonathan A. Egly, M.D.

Angela M. Hawkins, M.D.

Sara M. Botchlet, N.P.

Medical Records may be released to the following persons:

_____ _____

_____ _____

_____ _____ _____

Parent of Guardian Signature Date Witness

**Renaissance Physicians Group**

# PRIVACY PRACTICES NOTICE

**Effective Date: _____**

**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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

If you have any questions about this notice please contact our privacy officer at:

(405) 610-8087

## Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **04/14/2003**, and will remain in effect until we replace it.

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 medical information that we maintain, including medical 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.

## Who Will Follow This Notice

This notice describes our hospital's practices and those participants listed below in our organized health care arrangement. As such, we may share your medical information and the medical information of others we service with each other as needed for treatment, payment or health care operations relating to our organized health care arrangement.

**This notice does not imply any joint venture or any other special association or legal relationship between the hospital and its medical staff. This notice is an administrative tool permitted by federal law allowing the hospital and medical staff to tell you about common privacy practices.**

Along with the hospital, the following participate in our organized health care arrangement:

- Members of our medical staff and their employees or workforce who provide services or support to the physician at the hospital.
- Our employed physicians and their office staff.

## Uses and Disclosures of Medical Information

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

**Treatment**: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

**Payment:** We may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal and state Privacy Rules so they can obtain payment.

**Health Care Operations:** We may use and disclose your medical information in connection with our health care operations. These uses are necessary to make sure that all our patients receive quality care.

Some examples are:

- Review of our treatment or services to evaluate the performance of our staff providing your care;
- sending you a satisfaction survey;
- review of information about many of our patients to determine if additional services should be added or perhaps are no longer needed;
- information may be given to our doctors, nurses, medical and health care students, and other personnel to be used for education and learning purposes;
- we may remove information that identifies you from the medical information so others may use it for studies in health care delivery without learning who the patients are; and
- we may disclose your medical information to another provider who has a relationship with you and is subject to the same Privacy rules, for their health care operation purposes.

**On Your Authorization:** You may give us written authorization to use your medical 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 medical information for any reason except those described in this notice.

**Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

**To Your Family and Friends:** Unless you object, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of medical information.

**Hospital Directory:** We may use your name, your location in our facility, your general medical condition, and your religious affiliation in our facility directories. We will disclose this information to members of the clergy and, except for religious affiliation, to other persons who ask for you by name. We will provide you with an opportunity to restrict or prohibit some or all disclosures for facility directories unless emergency circumstances prevent your opportunity to object. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so your family can be notified about your condition and location.

**By Law or Special Circumstances:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- to law enforcement officials after receiving subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for

purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

**Health Related Benefits and Services:** We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Use and Disclosure of Certain Types of Medical Information. For certain types of medical information we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your medical information:

Communicable Disease and Venereal Disease Information. We may not disclose communicable disease and venereal disease information unless required by law, pursuant to an authorization or the disclosure is to you or your personal representative; to the individual who is the subject of the information; pursuant to court order; when the State Department of Health determines disclosure is necessary to protect the health and well-being of the public; to persons who are at risk of exposure to the communicable disease or venereal disease; to health care providers (including their employees and agents) within the continuum of care for the purpose of your diagnosis and treatment.

Mental Health Information. We may only use or disclose your mental health information without specific authorization to the following persons: persons involved actively engaged in your treatment or related administrative work; to other facilities pursuant to a qualified service agreement with the state; to a person whose health and safety is at risk if disclosure is not made; to law enforcement officers related to the commission of a crime; to persons authorized to receive reports of child abuse; to criminal justice personnel if you participate in such a program; health care providers who have a need to know in order to treat you; to other persons as may be required by law.

Alcohol and Drug Abuse Information. We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or pursuant to an authorization or as may otherwise be allowed by law.

## Your Rights Regarding Medical Information About You

**Right to Inspect and Copy:** You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a fee for copying and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. You must make a request in writing to request a listing of disclosures. You may obtain a form to request the accounting by using the contact information at the end of this notice. 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. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Restriction:** You have the right to request that we place certain restrictions on our use or disclosure of your medical 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). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information by using the contact information listed at the end of this notice. We will not be bound to the restrictions unless our agreement is signed by you and the appropriate hospital representative.

**Confidential Communication:** You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. You may obtain a form to request alternative communications by using the contact information listed at the end of this notice. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information**.** Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice. We may deny your request if we did not create the information you want amended and the individual who provided the information remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

**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. Please contact us using the information listed at the end of this notice to obtain 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 using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical 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.

Contact: **Cheryl Doudican**

Telephone: 405-610-8087_____ Fax: 405-610-1354_____

E-mail: Cheryl.doudican@hma.com_____

Address: 2825 Parklawn Drive Midwest City, OK 73110_____

**THIS NOTICE IS YOUR COPY TO RETAIN FOR ANY FUTURE QUESTONS OR CONCERNS REGARDING THE USE OF YOUR PROTECTED HEALTH INFORMATION.**

Please sign the Acknowledgement to signify your receipt and understanding of this document for our records.

Thank you.

# Renaissance Physicians Group

## PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Date of Birth: _____ Notice Version (Date): _____

**Acknowledgement of receipt of Privacy Practices Notice.**

I, _____, acknowledge that I have received a Privacy Practices

Notice from: _____

**Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.**

Patient Signature: _____ Date: _____

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: _____

**If a personal representative on behalf of the individual signs this authorization, complete the following:**

Personal Representative's Name: _____

Relationship to Individual: _____

**IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt.)**

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

**SIGNATURE. (Hospital Representative)**

I attest that the above information is correct.
Signature: _____ Date: _____

Print name: _____ Title: _____

**Include this acknowledgement form in the individual's records.**