

Michael J. Wolpmann, M.D., FACOG, FACS
New Patient Information
Welcome to our practice!

| | | | | |
|-------------------|-------------------|------------------------------|-----------------------|----------------|
| Name | Last Name | First Name | Middle | Marital Status |
| | | | | |
| Personal | Date of Birth | Social Security Number | Driver License Number | |
| | | | | |
| Address | Number and Street | City and State | Zip Code | |
| | | | | |
| Contact | Home Phone | Work Phone | Cell/Mobile | |
| | | | | |
| Other | Referred By | Primary Care Physician | Your Email Address | |
| | | | | |
| Employer | Name/Company | Occupation | Address | |
| | | | | |
| Spouse/Parent | Name | Address | Phone | |
| | | | | |
| Emergency Contact | Name | Address | Phone | |
| | | | | |
| Insurance | Insurance Carrier | Policy/Identification Number | Group Number | |
| | | | | |
| Insured Info | Insured's Name | Social Security No | Date of Birth | Rel to Patient |
| | | | | |
| | | | | |

Dear Patient,

Please note that some insurance carriers, such as Medicare, do not cover routine annual exams. If you are here for your annual "well-woman" exam and your insurance does not cover it, you will be responsible for payment in full. If you have other problems that require additional time with your Provider, he/she will code your visit accordingly or have you return for a subsequent office visit. We cannot re-code sick or annual visits to coincide with your benefits. Under Federal and State regulations doing so would be a false claim representing fraud of which there are severe penalties. Please verify your insurance benefits prior to your visit and obtain any authorizations required. If you have questions, please talk with any of our office staff prior to your visit and they will be happy to help you. Thank you.

 Initials

 Date

Bayside Gynecology
Michael J. Wolpmann, M.D., FACOG, FACS

PATIENT HISTORY FORM

Name: _____ Date of Birth: _____

What problem or concern brought you to our office?

- Primarily to establish ongoing gynecological care.
- Other: _____

Gynecologic History

If having periods, are your periods: regular irregular light moderate heavy

Date of last menstrual period: _____

Are you taking Hormone Replacement Therapy? Yes No If yes, what type? _____

Obstetric History

Please list year of delivery, vaginal or c-section, sex and weight. Also list any miscarriages or abortions.

Past or Chronic Medical Conditions. Please check all that apply and list the date of diagnosis.

- | | | |
|---|--|--|
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Kidney problems _____ | <input type="checkbox"/> Cancer (list type) _____ |
| <input type="checkbox"/> Heart attach/angina _____ | <input type="checkbox"/> Liver disease / hepatitis _____ | <input type="checkbox"/> Bleeding problem _____ |
| <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Thyroid problem _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Breast problem _____ |
| <input type="checkbox"/> Irregular heart rhythm _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Fibromyalgia _____ |
| <input type="checkbox"/> Congestive heart failure _____ | <input type="checkbox"/> Urinary tract infections _____ | <input type="checkbox"/> Chronic fatigue _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Depression or anxiety _____ | <input type="checkbox"/> Emphysema/chronic bronchitis _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Osteoarthritis _____ | <input type="checkbox"/> Gastroesophageal reflux _____ |
| <input type="checkbox"/> Stomach ulcer _____ | <input type="checkbox"/> Bowel/digestive problem _____ | |
- Other: _____

Medications

Please list all medications, dosages, and frequency with which you take them.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Allergies

Please list any medication or severe food/environmental allergies and your reaction to them.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Name: _____

Other

- Do you ever experience urine loss associated with coughing, laughing, sneezing, or exertion? Yes No
- Do you ever experience urine loss associated with urgency? Yes No
- Do you need to wear a pad for urine loss? Yes No Only when leaving home
- Do you get up at night to go to the bathroom? Yes No If so, how many times? _____
- Do you ever feel your bladder is "falling down" or experience vaginal pressure? Yes No
- Are you sexually active? Yes No If yes, do you have any pain during intercourse? Yes No

Past Surgical History

| Procedure | Date | Procedure | Date |
|---------------------------|------|-------------------|------|
| Hysterectomy | | Mastectomy | |
| Heart Bypass | | Joint replacement | |
| Carotid artery surgery | | Other: | |
| Leg artery bypass | | Other: | |
| Abdominal aneurysm repair | | Other: | |
| Gallbladder removed | | Other: | |
| Appendix removed | | Other: | |

Family History

- Any family history of: Breast Cancer Uterine Cancer Ovarian Cancer
 Colon Cancer Heart Disease starting before age 65

Social History

- Marital Status: Single Married Divorced Widowed Occupation: _____
Do you smoke? Yes No If so, how many per day? _____ How many years _____
Do you drink alcohol? Yes No If so, how often? _____

Health Maintenance

- Colonoscopy Date: _____ Last Pap Smear Date: _____ Abnormal? Yes No
 Bone Density Date: _____ Last Mammogram Date: _____ Abnormal? Yes No

Review of Systems.

Please check any symptoms/problems that you currently or commonly experience.

- Excessive Fatigue
- Chest pain
- Shortness of breath
- Wheezing
- Palpitations
- Swelling
- Dizziness
- Numbness / tingling
- Hoarseness
- Weight loss / gain
- Leg cramps
- Passing out
- Insomnia
- Diarrhea
- Constipation
- Balance problems
- Memory loss
- Frequent urination
- Burning with urination
- Nausea
- Abdominal pain
- Hearing loss
- Ringing in ears
- Heat / cold intolerance
- Blurred vision
- Balance problems
- Menstrual changes
- Sexual problems
- Cough
- Easy bruising
- Increased thirst
- Rash / changing mole
- Joint pain / stiffness
- Fever / chills
- Severe sweating
- Depression
- Anxiety
- Back pain
- Trouble swallowing

Patient Authorizations and Office Policies

Name: _____ Date of Birth: _____

Authorization to Disclose Protected Health Information (PHI)

I hereby authorize Dr. Michael Wolpmann and his staff to release protected health information (PHI) included in my health record to the following individuals or entities:

Primary Care Physicians/Other Healthcare Professionals:

| Name | Phone | Fax |
|------|-------|-----|
|------|-------|-----|

| Name | Phone | Fax |
|------|-------|-----|
|------|-------|-----|

Family Members/Others:

| Name | Phone | Fax |
|------|-------|-----|
|------|-------|-----|

| Name | Phone | Fax |
|------|-------|-----|
|------|-------|-----|

I understand that my medical records may contain information about, but not limited to: alcohol/drug treatment, mental health, or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my PHI in accordance with the Notice of Privacy Practices. I also understand that records may be sent via telefax and I relieve Dr. Wolpmann and his staff from any liability from mistransmission by telefax. A photocopy of this authorization shall have the same effect as the original.

✳️Initials _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of a Notice of Privacy Practices from Bayside Gynecology. I understand that: 1) the Notice may be amended at any time, 2) notice of such amendment will be posted in the front office, and 3) I may obtain an updated copy from the office during regular business hours.

✳️Initials _____

Methods of Communication

I prefer to be contacted by the following means: (Circle all that apply and please provide numbers):

Home phone _____ Work _____ Cell _____ US Mail _____

I understand that Dr. Wolpmann and his staff may leave general messages with others who may receive communications at the above locations or leave messages on answering devices at these locations. General messages include appointment reminders and billing/payment reminders, NOT test/examination results or other medical or personal information.

✳️Initials _____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Michael J. Wolpmann, MD or staff for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company.

✳️Signature _____

Financial Policy

Payment is due at the time of service. This includes any past balances, deductibles, co-payments and any other charge that is not covered by your insurance policy.

Cancellation Policy

We require at least 24 hours notice if you need to cancel your appointment. We do charge a cancellation fee should your office visit or procedure not be cancelled within this time frame (emergencies are excluded).

Notice of Privacy Practices for Bayside Gynecology

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Introduction

At **Bayside Gynecology**, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14th, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Bayside Gynecology, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party can verify that services billed were actually provided
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Bayside Gynecology, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy practices upon request
- Inspect and copy your health record as provided for in 45CFR 164.524
- Amend your health record as provided for in 45CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction of certain uses and disclosures of your information as provided by 45CFR 164.522
- Revoke your authorization to use or disclose health information from a certain date forward (not retroactively)

Our Responsibilities

Bayside Gynecology is required to:

- Maintain the privacy of your health information
- Provide you with a copy of this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revisions and have an updated brochure available at our office upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received proper written revocation of the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our Privacy Officer at 941-485-5700.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, or with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or with the OCR. The address for OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201 Web address: www.hhs.gov/ocr/

Disclosures for Treatment, Payment, and Health Operations

Treatment

We will use your information for treatment. For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your file and used to determine the course of treatment that will work best for you. Your Provider will document in your health record his/her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, your Provider will know how you are responding to treatment. Upon your authorization to do so, we will also provide copies of various reports or tests to another physician to assist him or her in treating you if you are discharged from this practice.

Payment

We will use your information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies.

Regular Health Operations

We will use your information for regular health operations. For example, members of our medical staff or the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide. Other administrative departments may use your health information when they have an operational function and need the information in order to complete their job duties.

Business Associates

There are some services provided in our organization through contacts with business associates. Examples include transcription and copying services, diagnostic testing facilities, and outpatient/inpatient facilities. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require the business associate to appropriately safeguard your information.

Communications with Family

We may use or disclose information to notify or assist notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has established protocols to ensure the privacy of your health information.

Funeral Directors

We may disclose health information to funeral directors, consistent with applicable law, in order for them to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs or tissues.

Marketing

We may contact you to provide appointment reminders, either by telephone or via message on your telephone answering machine, or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA)

We may disclose health information to the FDA relative to adverse events with respect to supplements, products or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs as established by law.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with the prevention or control of disease, injury, or disability.

Law Enforcement

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.