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## ***Welcome to MOGA!***

Our physicians and staff members are committed to providing you with the highest quality of care.

We realize that your time is very valuable, so we ask that you complete this paperwork and bring it with you to your scheduled appointment. Additionally, on the day of your appointment, we ask that you **arrive fifteen minutes early**. Please bring your **insurance card**, a **photo ID** (example: driver's license), your **pharmacy phone number**, and any applicable **copay, deductible, or co-insurance**. We look forward to meeting you!

### ***Did You Know?***

MOGA offers **3-D screening mammography** at our East, Wolfchase, and Germantown locations and **2-D screening mammography** at our Desoto location. MOGA also offers **bone density testing** at our East, Germantown, and Wolfchase locations. **If you are due for either of these tests, please make sure to schedule them conveniently at the time of your appointment.**

*At MOGA, it is our mission to serve as a leader and premier provider of women's healthcare services for the mid-south community by continuously learning, growing, and partnering with our patients, employees, and other healthcare providers. As we strive to achieve excellence on a daily basis, it is our commitment to deliver the highest level of quality and compassion to every patient.*

6215 Humphreys Blvd., Ste. 401  
Memphis, TN 38120  
(901) 767-8442

7900 Airways Blvd., Ste. 2, Bldg. C  
Southaven, MS 38671  
(662) 349-5554

6570 Stage Road, Suite 160  
Bartlett, TN 38134  
(901) 373-9221

7705 Poplar Ave., Ste. 210  
Germantown, TN 38138  
(901) 755-8696

# **Your Insurance Company and Our Office**

## *What You Need to Know About Getting Your Healthcare Services Covered*

Many of the services provided in this office are covered by your insurance company. We gladly file claims for you so that you do not have the additional worry and effort of dealing with this during a time of illness or pregnancy.

Unfortunately, not all services are covered by every insurance company. In cases where the service is not covered, you will be personally responsible for the balance. Before we bill you, we will make sure that all of the information sent to your insurance company is accurate, and clearly describes the services you received.

### **Your Financial Responsibility:**

We will file your insurance claim, but you are ultimately responsible for paying for services received in our office. Please remember that insurance companies do not pay for all medical services. This includes many that are especially helpful to the patient.

When a service is not covered by your insurance policy, you will be responsible for paying the bill. We cannot change the information on an insurance claim simply so that the claim will be paid. If you are not sure whether a service is covered by your plan, we will be happy to call your insurance company in advance to see if you will likely be responsible. Non-covered services are your responsibility.

### **Insurance Filing and the Law:**

Recent federal laws addressing all insurance companies require that we submit every claim accurately, reporting the exact services performed and the exact reason for performing them. We are unable to change this information simply for purposes of getting the claim covered. Our practice is committed to compliance with these laws, and will submit all claims in the appropriate manner.

### **Annual Examinations:**

As a commitment to your health, we recommend that every patient have an annual examination, which allows us to evaluate your overall health and attempt to detect any unexpected complications or illnesses.

During this visit, we will update our records on all of your known conditions, as well as look for signs of any new problems. Unless there is a major finding during this annual examination, we must submit the service to your insurance company as an *annual examination*, which may not be paid by some carriers.

Along with the examination, your doctor may suggest that some “screening” tests be performed to allow him to get a better picture of your health. These services may also be considered “non-covered” by your insurance company. If so, you will be expected to cover the costs. Even if the results of these tests show a problem, we must submit these tests as “screening” to your insurance company, and cannot change this information simply to receive payment.



**PATIENT INFORMATION**  
Please complete all blanks

PATIENT #
DATE
DOCTOR
EMPLOYEE NAME

**PATIENT**

NAME LAST	FIRST	M.I.	AGE	DATE OF BIRTH	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
ADDRESS			CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS			
SOCIAL SECURITY NO.	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	UNDER WHAT NAME	DATE	
OCCUPATION	NAME OF EMPLOYER OR SCHOOL	WORK PHONE			
ADDRESS			CITY	STATE	ZIP
RACE (for Multi-Racial, please check ALL that apply) <input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> PACIFIC ISLANDER / NATIVE HAWAIIAN <input type="checkbox"/> BLACK / AFRICAN-AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> UNKNOWN / DECLINED TO REPORT			ETHNICITY <input type="checkbox"/> HISPANIC / LATINO <input type="checkbox"/> NON-HISPANIC / NON-LATINO <input type="checkbox"/> UNKNOWN / DECLINED TO REPORT	PREFERRED LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH; CASTILIAN <input type="checkbox"/> DECLINED TO REPORT <input type="checkbox"/> OTHER	

HOW DID YOU HEAR ABOUT MOGA?

PREFERRED PHARMACY: NAME	TEL.#	DO YOU HAVE AN ADVANCE DIRECTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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WHO IS YOUR PRIMARY CARE PHYSICIAN? NAME	ADDRESS	PHONE
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IN CASE OF EMERGENCY NOTIFY:	NAME	STREET ADDRESS, CITY, STATE & ZIP CODE	PHONE
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**INSURANCE POLICYHOLDER INFORMATION**

NAME	ADDRESS	PHONE		
SOCIAL SECURITY NO.	OCCUPATION	NAME OF EMPLOYER	DATE OF BIRTH	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	PHONE

**INSURANCE**

PRIMARY INSURANCE	MAIL FORM TO: STREET ADDRESS	CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> WIFE <input type="checkbox"/> HUSBAND	<input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE	POLICY OR I.D.#	GROUP OR OTHER NO.
SECONDARY INSURANCE	MAIL FORM TO: STREET ADDRESS	CITY	STATE	ZIP	PHONE

POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> WIFE <input type="checkbox"/> HUSBAND	<input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE	POLICY OR I.D.#	GROUP OR OTHER NO.
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**PLEASE READ AND SIGN**

**AUTHORIZATION**—I hereby give my permission to Memphis Obstetrics and Gynecological Association, PC (MOGA) for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment. I authorize MOGA to release any information concerning my treatment and irrevocably assign to them all insurance benefits for my treatment. I understand that I am financially responsible for payment of all charges at the time they are rendered including any changes in excess of my insurance as reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage and pre-certifying my benefits with my insurance company. I also understand that I am responsible for 33% collection costs and/or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**RECEIPT OF PRIVACY PRACTICES**

- I acknowledge that I have received or been allowed to view a copy of MOGA's Notice of Privacy Practices as required by HIPAA. This notice describes how MOGA may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initial

**DISCLOSURE OF TENNCARE COVERAGE**

- By initialing you are certifying one of the following:
  - NO, I do NOT have** active or pending TennCare coverage
  - YES, I DO have** active or pending TennCare coverage

Initial

**PATIENT PAYMENT POLICY AND COVERED SERVICES**

- It is the policy of MOGA to collect all patient balances, co-pays, and deposits due from patients at the time of service.
- If you are being seen for maternity care or for certain other surgical or medical procedures, our office may contact your insurance carrier to verify your insurance coverage and benefits. An estimation of your financial responsibility will be determined according to the contractual agreement between MOGA and your insurance company for these services. Our Benefits Coordinators will review your benefits with you to explain your financial obligations to MOGA, and you may be required to pay a deposit prior to these services being rendered.
- If your insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for your services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from MOGA for any future care and services, which includes all providers at MOGA. Additionally, a collection fee of 33% will be added to your account balance.
- Your health insurance plan **may not** provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. It is your responsibility to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- If you do not have medical coverage with an insurance for which MOGA participates or if you are a new patient and cannot supply your valid insurance card or for which coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.
- If you are required to have a referral or other prior authorization for medical services, it is your responsibility to obtain this.
- WE will require that accounts with self-pay balances to pay their balances to zero (0) prior to receiving further services by our practice.

Initial

**RETURNED CHECK CHARGE**

- MOGA will charge the patient account \$25.00 for any returned checks to cover MOGA's cost for any related bank charges.

Initial

**CANCELLATION POLICY**

- MOGA requires a 24 hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a \$20.00 charge for missed office visits and \$150.00 for missed surgeries or procedures. This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

Initial

**WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS**

- If during your annual/well-woman preventive care exam, you have or need treatment for a problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductible.

Initial

**PERSONAL INFORMATION VERIFICATION**

- It is our policy to verify your demographic and insurance information at every visit to help insure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you EVERY VISIT. Additionally, a photo ID will be requested from all patients.

Initial

**FORMS AND PAPERWORK**

- There is a minimum fee of \$20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of \$0.50 per page for all pages exceeding the first twenty (20) pages. A \$20.00 fee will be charged to complete up to two (2) forms for FMLA and standard disability. An additional fee of \$25.00 will be charged for submitting subsequent forms.

Initial

Patient Signature \_\_\_\_\_ Patient Printed Name \_\_\_\_\_

Date \_\_\_\_\_ Patient Chart # \_\_\_\_\_ MOGA Initials \_\_\_\_\_ eff: 12/15/16



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**I hereby authorize this office to release my protected health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to the persons I have listed below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Any person who is not listed above will not be able to obtain my protected health information (PHI). It is not necessary to list other treating physicians or insurance companies.**

**PHI Patient Communication:**

**When notifying me of lab or test results, matters relating to prescriptions, appointments and accounts status the practice may call:**

\_\_\_\_\_Hm \_\_\_\_\_ Cell \_\_\_\_\_Other

**May the practice leave you a message at the above phone numbers? \_\_\_Yes \_\_\_No**

**Mail to:** \_\_\_\_\_  
 \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Acct #** \_\_\_\_\_

6215 Humphreys Blvd., Ste. 401  
 Memphis, TN 38120  
 (901) 767-8442

7900 Airways Blvd., Ste. 2, Bldg. C  
 Southaven, MS 38671  
 (662) 349-5554

7865 Educators Lane, Ste. 200  
 Memphis, TN 38133  
 (901) 373-9221

7705 Poplar Ave., Ste. 210  
 Germantown, TN 38138  
 (901) 755-8696

**CONFIDENTIAL PATIENT MEDICAL HISTORY**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Chart # \_\_\_\_\_ Date: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

Do you have a **LATEX Sensitivity / Allergy**: Yes:  No:  **Other Allergies** (circle): Iodine, X-ray dye, Eggs, Peanuts

**MEDICATIONS:** Please list ALL medications that you take, the strength, and how often you take them

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**PHARMACY** (Name and Number): \_\_\_\_\_

**IMMUNIZATIONS:** Please check if you have received these adult immunizations and indicate when

<input type="checkbox"/> Influenza (Flu) / Date: _____	<input type="checkbox"/> Tetanus / Date: _____
<input type="checkbox"/> Pneumonia / Date: _____	<input type="checkbox"/> Tdap (Tetanus, Diptheria & Pertussis)/ Date: _____
<input type="checkbox"/> HPV Vaccine/Gardasil (Series of 3 shots – Initial shot, 2 months later, then 6 months from 1 <sup>st</sup> shot) Dates (Approx. date is ok): #1 _____ #2 _____ #3 _____	

**HEALTH MANAGEMENT:** Date and Location of last preventative screenings

Last <b>Pap Smear</b> : Date: _____ Location: _____
Last <b>Mammogram</b> : Date: _____ Location: _____
Last <b>Complete Physical Exam with Primary MD</b> : Date: _____ Provider Name: _____
Last <b>DEXA Scan (Bone Density)</b> : Date: _____ Location: _____
Last <b>Colonoscopy</b> : Date: _____ Provider Name: _____

**FAMILY HISTORY:** Check illnesses of your **IMMEDIATE BLOOD RELATIVES** and **LIST THE RELATION**

<input type="checkbox"/> Adopted: Family history unknown	Cancer: (please list relative)	<input type="checkbox"/> Breast: _____	<input type="checkbox"/> Cervical: _____
<input type="checkbox"/> Heart Disease / list details		<input type="checkbox"/> Colon: _____	<input type="checkbox"/> Uterine: _____
<input type="checkbox"/> Early Death / relation:	<input type="checkbox"/> Ovarian: _____	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> High Cholesterol /relation:	<input type="checkbox"/> Stroke / list details:		
<input type="checkbox"/> High Blood Pressure /relation:	<input type="checkbox"/> Seizure Disorder / type & relation:		
<input type="checkbox"/> Asthma / relation:	<input type="checkbox"/> Alcoholism /relation:		
<input type="checkbox"/> Diabetes / relation:	<input type="checkbox"/> Drug Abuse / relation:		
<input type="checkbox"/> Thyroid Disease / type & relation:	<input type="checkbox"/> Birth Defects/Genetic Disease /type & relation:		
<input type="checkbox"/> Gastrointestinal Disorder / list details:	<input type="checkbox"/> Other Family History:		
<input type="checkbox"/> Osteoporosis / relation:			
<input type="checkbox"/> Blood or Clotting Disorder / type & relation:			

**SOCIAL HISTORY:** Provide the following information about **YOURSELF**

Do you exercise regularly? _____ How Often? _____	Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
Marital Status: (circle one) Single Married Widowed Divorced Separated	Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which one(s) and how often? _____
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take herbal supplements or vitamins? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____
Work Status: (circle one) Part-time Full-time Retired Unemployed Disabled	Are you currently in a situation or relationship that makes you feel unsafe or threatened? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____
Occupation: _____	
Tobacco or Cigarette Use: <input type="checkbox"/> Never Smoked <input type="checkbox"/> Former Smoker - Date Quit _____ <input type="checkbox"/> Current Smoker - # per day _____ # of years _____ <input type="checkbox"/> Other: _____	

**CONFIDENTIAL PATIENT MEDICAL HISTORY**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Chart # \_\_\_\_\_ Date: \_\_\_\_\_

**PAST MEDICAL HISTORY:** Please check illnesses or conditions **YOU** have had.

Do you refuse blood products or medical treatment of any kind because of religious beliefs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____	
Birth Control Method _____	<input type="checkbox"/> <b>Eye Disease</b> _____
# of Pregnancies: _____ Living Children: _____	<b>Heart Disease:</b>
Deliveries: Vaginal: _____ C-Section(s): _____ VBAC # _____	<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> CAD
Miscarriages: _____ Abortions: _____	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure (HTN)
<input type="checkbox"/> Infertility	<b>Lung Disease:</b> <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia
Age of first period _____	Do you use a CPAP machine for sleep apnea? <input type="checkbox"/> Yes
Age of Menopause _____	<b>Kidney Disease:</b> <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Other _____
Menses: ( <b>only complete if still having periods</b> ) <input type="checkbox"/> Regular (21-35 days apart) <input type="checkbox"/> Irregular Duration of menses: _____ days Menstrual Flow: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Dysmenorrhea (Painful Periods)	<b>Gastrointestinal Disorders:</b> <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Diverticulitis <input type="checkbox"/> GERD (Reflux) <input type="checkbox"/> Hepatitis <input type="checkbox"/> Irritable Bowel <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Uterine Disorder _____	<b>Musculoskeletal:</b>
<input type="checkbox"/> Abnormal Pap Smear Date: _____	Arthritis: <input type="checkbox"/> Osteo Arthritis <input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Colposcopy/Date: _____ <input type="checkbox"/> Cryo/Date: _____	<input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other _____
<input type="checkbox"/> LEEP/Date: _____ <input type="checkbox"/> CKC/Date: _____	<input type="checkbox"/> Blood Clots in legs /DVT <input type="checkbox"/> PE (clot in lung) <input type="checkbox"/> Phlebitis
<b>Infection(s):</b> <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> HIV	<input type="checkbox"/> Blood Transfusion: Date(s): _____
<input type="checkbox"/> Breast Problems (specify) _____	Sickle Cell : <input type="checkbox"/> Trait <input type="checkbox"/> Disease
<b>Cancer:</b> <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian <input type="checkbox"/> Uterine <input type="checkbox"/> Colon	<b>Psychological:</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression <input type="checkbox"/> ADD
<input type="checkbox"/> Other Cancer(specify) _____	<b>Neurological:</b> <input type="checkbox"/> Seizure Disorder / Epilepsy <input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chicken Pox (Disease) <b>or</b> <input type="checkbox"/> Had Vaccine
<input type="checkbox"/> <b>Thyroid Disorder:</b> <input type="checkbox"/> Goiter <input type="checkbox"/> Underactive <input type="checkbox"/> Overactive	Autoimmune Disorder: <input type="checkbox"/> Lupus <input type="checkbox"/> Other _____
<b>Other History or Hospitalizations:</b>	

**SURGICAL HISTORY:** Please check operations or procedures and **provide dates** (month and/or year is fine)

<input type="checkbox"/> Ear, Nose, Throat Surgery: _____	<input type="checkbox"/> Bladder or Kidney Surgery _____
<input type="checkbox"/> Adenoids _____ <input type="checkbox"/> Tonsilectomy _____	<input type="checkbox"/> Bladder sling <input type="checkbox"/> Bladder Suspension Surgery
<input type="checkbox"/> Thyroid Surgery: _____	<b>Female/Gynecological Surgeries:</b>
<input type="checkbox"/> Lung Surgery _____	<input type="checkbox"/> C-Section (#) _____ <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Pelvic Laparoscopy
<input type="checkbox"/> Heart Surgery <input type="checkbox"/> Stents <input type="checkbox"/> Bypass	<input type="checkbox"/> D&C <input type="checkbox"/> Hysteroscopy <input type="checkbox"/> Uterine Ablation
Breast Surgery: <input type="checkbox"/> Biopsy, R / L <input type="checkbox"/> Lumpectomy, R / L	Hysterectomy: <input type="checkbox"/> Abdominal <input type="checkbox"/> Vaginal
<input type="checkbox"/> Mastectomy, R / L <input type="checkbox"/> Reduction <input type="checkbox"/> Augmentation	<input type="checkbox"/> Supracervical <input type="checkbox"/> Laparoscopic / Robotic
Abdominal Surgery: <input type="checkbox"/> Appendix <input type="checkbox"/> Abdominoplasty	Ovary(s) Removed: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
<input type="checkbox"/> Gallbladder <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Bariatric Sgy. _____	Other Ovarian Surgery: _____
<input type="checkbox"/> Orthopedic Surgery (list type of surgery and date): _____	Other Surgeries or Hospitalizations: _____

**LIST OTHER HEALTH CARE PROVIDERS YOU CURRENTLY SEE** (other than MOGA)

Provider Name	Specialty (ie: PCP, Cardio)	Phone Number:

**Please Sign and Date:**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEMPHIS OBSTETRICS & GYNECOLOGICAL ASSOCIATION, P.C.

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO OBTAIN THIS INFORMATION. PLEASE REVIEW CAREFULLY. YOU HAVE THE RIGHT TO OBTAIN A COPY OF THIS NOTICE UPON REQUEST.

### **Patient Health Information**

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

### **How We Use Your Patient Health Information**

We are permitted by law to use and disclose patient health information for treatment, payment, and healthcare operations.

### **Examples of Treatment, Payment, and Health Care Operations**

**Treatment:** We will use and disclose your health information to provide medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

**Payment:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

**Healthcare Operations.** We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others similar to it.

### **Special Uses**

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

### **Other Uses and Disclosures**

We may use and disclose identifiable health information about you for other reasons, even without your consent.

Subject to certain requirements, we are permitted to give out health information about you for the following purposes:

**Required by Law:** We are required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

**Public Health Activities:** As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

**Health Oversight:** We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

**Judicial and Administrative Proceedings:** We may disclose information in response to an appropriate subpoena or court order.

**Law Enforcement Purposes:** Subject to certain restrictions, we may disclose information required by law enforcement officials.

**Deaths:** We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

**Serious Threat to Health or Safety:** We may use and disclose information when necessary to prevent serious threat to the health and safety of you, another person, or the public.



**Military and Special Government Functions:** If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

**Research:** We may use or disclose information for approved medical research.

**Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will require written authorization before using or disclosing any protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Revocation requests must be made in writing and submitted to the clinic's Privacy Officer.

You have the following rights with regard to your health information. Please contact our office to obtain the appropriate form for exercising these rights.

**Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by them.

**Confidential Communications:** You may ask us to communicate confidentially by, for example, sending notices to a special address or not calling with appointment reminders.

**Inspect and Obtain Copies:** In most cases, you have the right to look at or obtain a copy of your health information. There may be a charge for the copies.

**Amend Information:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the existing information or add the missing information. We are not required to agree to such amendment, but must let you know our reasons.

**Accounting of Disclosures:** You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

### **Our Legal Duty**

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. Upon request, you may receive a copy of this notice.

### **Changes in Privacy Practices**

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You may also request a copy of our Notice at any time. For more information about our privacy practices, contact our Privacy Officer.

### **Complaints**

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we have made about your records, please contact our Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

### **Contact Person / Privacy Officer**

If you have any questions, complaints, or requests, please contact:

Stephanie Wheeler

3775 Covington Pike

Memphis, TN 38119

(901) 202-6122 or [swheeler@clearlymd.com](mailto:swheeler@clearlymd.com)

Ami Jennings

6215 Humphreys Blvd # 401

Memphis, TN 38120

(901) 767-8442, ext 2020 or [ajennings@spsmemphis.com](mailto:ajennings@spsmemphis.com)

This Notice became effective April 14, 2003, and was revised on February 7, 2017.