



PAMELA A. MCQUILLIN, M.D., P.A.

OBSTETRICS AND GYNECOLOGY

Thank you for choosing OBGYN – Total HealthCare for Women and Dr. McQuillin as your women’s healthcare provider.

To help your first visit go more smoothly, please print and completely fill out the provided forms, sign, and bring them with you on your first visit. Also please bring your Insurance Card and Picture Identification (ex. Drivers License) with you. Also please request any needed records or labs that need to be transferred to us at least 2 weeks in advance. Please review your insurance coverage regarding annual exams and other coverage. These have been changing a lot lately due to insurance plan changes, and we don’t want you to be surprised about your insurance coverage. Please remember that your health plan expects us to collect your co-payment and deductible at the time of service.

Please use the checklist below to make sure you have completed all needed forms. In addition, depending on your insurance provider, there may be some extra forms to fill out once you get to the office.

We never know exactly when new babies are going to arrive or when emergencies will develop at the hospital. Because of this, you may find that the office is running behind schedule every now and then. We will try to call you if we are running very behind to allow you the opportunity to re-schedule your appointment. Please be sure we have your most current phone number. Having your cell phone number on file will help us contact you.

Thank you again for choosing us as your Total HealthCare for Women provider.

- Registration Form
- Health History Questionnaire
- Financial Policy
- Acknowledgment of Receipt of Notice of Privacy Practices



Pamela A. McQuillin, M.D., P.A.

REGISTRATION FORM

(Please Print Clearly)

Today's Date ____/____/____

Primary Care Provider _____

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)	Birth Date / /	Age	Sex F
Street Address		City	State	ZIP Code	Social Security Number	
P.O. Box		City	State	ZIP Code	Home Phone No. ()	
Occupation		Employer Name and Address			Employer Phone No. ()	
Chose Clinic Because/Referred to Clinic by (Please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital						
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____						

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)		Home Phone No. ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation	Employer	Employer Address		Employer Phone No. ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please indicate primary insurance <input type="checkbox"/> Group Resources <input type="checkbox"/> BCBS <input type="checkbox"/> AETNA <input type="checkbox"/> CIGNA <input type="checkbox"/> HealthSmart				
<input type="checkbox"/> PHCS <input type="checkbox"/> United <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____				

You must present your current insurance card to be seen

Insurance Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

Normal Method of Payment CASH ___ CHECK ___ VISA ___ MASTERCARD ___ DISCOVER ___ CARE CREDIT ___ AMEX ___

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Pamela A. McQuillin, M.D., P.A. I understand that I am financially responsible for any balance on my account. I also authorize Pamela A. McQuillin, M.D., P.A. or my insurance company to release any information required to process my claims. I hereby acknowledge that I/my child/my ward needs medical care and treatment. I voluntarily consent to the performance of medical services and the use of all means of diagnostic and laboratory work of any kind (including but not limited to the taking of blood, tissue, fluids and other body samples and videotapes, photographs and or other radiographic or ultrasound procedures.) upon myself/my child/my ward, which are deemed necessary or prudent by the attending physician or any other medical staff person. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as to the results of the care I hereby authorize.

DISCLOSURE: Please carefully review the information contained in this notice. Odessa Regional Medical Center and Basin Healthcare Center both meet the definition of a "physician-owned hospital" under 42 CFR 489.3. The hospitals are owned in part by physicians. Pamela McQuillin, M.D., is a shareholder at both of these facilities. A list of physician ownership is available from each hospital. You have the right to choose the provider of your health care services. Although we believe that both Odessa Regional Medical Center and Basin Healthcare Center will be able to meet your needs, you have the option to use a facility other than Odessa Regional Medical Center or Basin Healthcare Center, specifically, in Odessa, Texas, you may choose to use the County Hospital, (Medical Center Hospital). You will not be treated differently by your physician if you choose to use a different facility. Your physician may have an on-call physician covering at another hospital. If desired, your physician or any staff member can provide information about alternative health care providers. If you have any questions concerning this notice, please feel free to ask your physician or any representative of either Odessa Regional Medical Center or Basin Healthcare Center. We welcome you as a patient and value our relationship with you.

X _____
 PATIENT/GUARDIAN SIGNATURE DATE



Original Date: ____/____/____

Dates Revised: ____/____/____
 ____/____/____
 ____/____/____
 ____/____/____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____
 (Last, First, M.I.)

DOB ____/____/____

Marital

Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor: _____

Date of Last Annual
 Physical Exam: ____/____/____

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Immunizations and Dates: Tetanus _____ Pneumonia _____
 Hepatitis _____ Chickenpox _____
 Influenza _____ MMR _____
 Other _____ (Measles, Mumps, Rubella)

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Please turn to next page

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex: Are you sexually active? Yes No
 If yes, are you trying for a pregnancy? Yes No
 If not trying for a pregnancy list contraceptive or barrier method used? _____
 Any discomfort with intercourse? Yes No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? Yes No

Personal Safety: Do you live alone? Yes No
 Do you have frequent falls? Yes No
 Do you have vision or hearing loss? Yes No
 Do you have an Advance Directive and/or Living Will? Yes No
 Would you like information on the preparation of these? Yes No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times. Keep children in protective seats.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Mother's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Father's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			

Continued on Back Side

MENTAL HEALTH

- Is stress a major problem for you? Yes No
- Do you feel depressed? Yes No
- Do you panic when stressed? Yes No
- Do you have problems with eating or your appetite? Yes No
- Do you cry frequently? Yes No
- Have you ever attempted suicide? Yes No
- Have you ever seriously thought about hurting yourself? Yes No
- Do you have trouble sleeping? Yes No
- Have you ever been to a counselor? Yes No

WOMEN

- Age at onset of menstruation: _____ Date of last menstruation: ____/____/____
- Period every _____ days. Heavy periods, irregularity, spotting, pain or discharge? Yes No
 - Number of pregnancies _____ Number of live births _____
 - Are you pregnant or breastfeeding? Yes No
 - Have you had a D&C, hysterectomy or cesarean section?..... Yes No
 - Any urinary tract, bladder or kidney infections within the last year? Yes No
 - Any blood in your urine? Yes No
 - Any problems with control of urination? Yes No
 - Any hot flashes or sweating at night? Yes No
 - Do you have menstrual tension, pain, bloating,
irritability or other symptoms at or around time of period? Yes No
 - Experienced any recent breast tenderness, lumps or nipple discharge? Yes No
 - Date of last pap and rectal exam? ____/____/____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin _____ <input type="checkbox"/> Head/Neck _____ <input type="checkbox"/> Ears _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Lungs _____ <input type="checkbox"/> Chest/Heart _____	<input type="checkbox"/> Back _____ <input type="checkbox"/> Intestinal _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowel _____ <input type="checkbox"/> Thyroid _____ <input type="checkbox"/> Circulation _____ Recent Changes In: <input type="checkbox"/> Weight _____	<input type="checkbox"/> Energy Level _____ <input type="checkbox"/> Ability to Sleep _____ Other Pain/Discomfort: _____ _____ _____ _____
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Patient Signature

Date



OBSTETRICS AND GYNECOLOGY

HOSPITAL DISCLOSURE

Please carefully review the information contained in this notice. Basin Healthcare Center and Odessa Regional Medical Center both meet the definition of a "physician-owned hospital" under 42 CFR 489.3. The hospitals are owned in part by physician investors. Pamela A. McQuillin, M.D., is a shareholder at both of these facilities. A list of physician ownership is available from each hospital. You have the right to choose the provider of choice for your health care services. Although we believe that both Basin Healthcare Center and Odessa Regional Medical Center will be able to meet your needs. You have the option to use a facility other than Basin Healthcare Center or Odessa Regional Medical Center; specifically you may choose to use the county hospital. Depending on the insurance you have, these hospitals may or may not be in network for you. This may or may not affect the amount of money you may owe the hospital after a procedure. You are free to choose any hospital regardless of its insurance network status. Each hospital will provide you with information regarding any out of network or early payment arrangements that they may have to offer you. You will not be treated differently by your physician regardless of the facility you choose. Your physician may have an on-call physician covering at a hospital due to scheduling conflicts. If desired, your physician or any staff member can provide information to you about alternative health care providers. If you have any questions concerning this notice, please feel free to speak to us, or any representative of the hospitals. We respect you as a patient and value our relationship with you.

Please make a choice of hospital below:

I choose Basin Healthcare Center for my procedure. I am aware of my insurance obligations and coverage limitations for this facility.

I choose Odessa Regional Medical Center for my procedure. I am aware of my insurance obligations and coverage limitations for this facility.

I choose the county hospital for my procedure. I am aware of my insurance obligations and coverage limitations for this facility.

Patient's Signature: _____ Date: _____

Patient's Name Printed: _____ Date: _____

Witness's Signature: _____ Date: _____



Pamela A. McQuillin, M.D., P.A.
1330 E 8TH ST STE 420
ODESSA TX 79761

CONSENT FOR MEDICAL SERVICES AND FINANCIAL AGREEMENT

PATIENT NAME [redacted] DATE OF BIRTH [redacted]

Medical Consent: The undersigned consent authorizes any medical treatment, surgery, examination, laboratory procedure, x-ray examination, and/or physical therapy treatment that may be considered advisable or necessary for the patient in the judgment of the attending physician.

BASIC POLICY: Payment for service is due in full at the time service is provided in our office. We accept Insurance, Checks, Credit Cards, Care Credit, and Cash. No "Post Dated" Checks will be accepted. If at any point during or after my treatment in the clinic I should desire a copy of my medical records, there will be a minimum fee of \$12.00. After the first 20 pages there will be a fee of \$0.50/page. Payment must be received in advance along with a HIPAA compliant release form and an original signature. Should I desire to have them mailed, I must that Pamela A. McQuillin, M.D., P.A. with a self-addressed stamped envelope. The preparation may take up to four weeks. For any form that Pamela A. McQuillin, M.D., P.A. is asked and agrees to fill out, there will be a minimum fee of \$25.00 payable prior to completion of the form. This fee will be billed directly to me and will not be filed with an insurance company or other third party.

FOR PATIENTS WITH INSURANCE: You must present you insurance card at the time of your visit. Failure to notify us of any changes in your insurance may cause the entire charged amount to become your responsibility. We bill most insurance providers for you if proper paperwork is provided to us. We will also bill some secondary insurance providers for you as a courtesy. If your secondary provider does not pay the amount the primary insurance provider states you owe us, you will owe the difference between what the secondary provider pays and the amount the primary states you owe. Co-payments and deductibles are due at the time of service. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we my report your refusal to pay these amounts to your employer and/or insurance company representative. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. Certain tests may be ordered by Dr. McQuillin. I agree to be financially responsible for these services should they be considered "non-covered" or not medically indicated by my insurance company. If an insurance carrier has not paid us within 60 days of billing, professional fees are due and payable in full from you. Payment plans for obstetrical care and surgeries are handled through Care Credit.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments or deductibles are due and payable at the time of service is provided.

MEDICAID PATIENTS: You must present your current Medicaid Card prior to each visit.

Release of Medical Records: The undersigned authorizes the release of information in the patient's medical records to his/her private physician and to any physician, hospital, or agency to which Pamela A. McQuillin, M.D., P.A., refers the patient. The undersigned also authorizes any physician, hospital or agency to which the patient is referred the release of information to Pamela A. McQuillin, M.D., P.A. regarding treatment by said physician, hospital or agency.

SURGERY FEES: All co-pays, deductibles, and payments for surgical procedures are due prior to your surgery. Your carrier may require prior authorization. Unless it is an emergency surgery, surgeries will be rescheduled if payments have not been received by you prior to the surgery.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice for repeated missed appointments.

FAILURE TO FOLLOW MEDICAL ADVICE: You may be dismissed from the practice for failure to follow Dr. McQuillin's medical advice.

FINANCE CHARGES : Past due accounts over 90 days may be assessed a finance charge of 18% APR.

COLLECTIONS: Patient responsibility is due upon receipt of insurance explanation of benefits (EOB). Because it is extremely impractical or difficult to ascertain all items of damage or amounts thereof which would be sustained by us as a result of an account becoming delinquent, Patient and Financial Responsible Person agree that any charges which are not paid in FULL when due shall be subject to a late fee. If balance remains unpaid 90 days after the date of the EOB, a \$35.00 late fee may be charged and account may be transferred to IC Systems for collections. Should Patient's account be referred to an attorney for collection, Patient and Financial Responsible Person agree to pay, in addition to all sums due, all reasonable attorney's fees, court costs, and all reasonable costs of collection. All statements returned to us without a forwarding address may be charged \$30.00 and turned over to a collection agency.

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I have read, understood, and agreed to all the provisions in this agreement. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance, I am ultimately responsible for all professional fees due to Pamela A McQuillin, M.D.. I understand that I may incur a 18% finance charge if my balance goes beyond 90 days. I consent to and authorize any medical treatment and I give permission for my physician and her clinical team to take any necessary diagnostic films, lab studies, photos or study models, to properly enable complete diagnosis and treatment. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Pamela A. McQuillin, M.D.. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorizes said assignee to release all information necessary to secure the payment. Appointment times are given as estimated times that patients will be seen by the doctor. I understand the length of the office visits are based on the needs of each individual patient in the clinic and unforeseen delays at the hospital including the delivery of babies. Because of this, there may be minimal or extended delays.

Patient's Signature: X [redacted] Date: [redacted]

MEDICARE PATIENTS SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made on my behalf to Pamela A. McQuillin, M.D., P.A.. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medicare Patient's Signature: X [redacted] Date [redacted]



Pamela A. McQuillin, M.D., P.A.
1330 East 8th Street, Suite 420
Odessa, Texas 79761-4733
(432) 580-9191

NOTICE OF INSURANCE BUNDLING RULES

You are covered by _____ insurance.

Your insurance provider has a policy that does not allow for the payment of two or more unrelated services that are provided on the same date of service, or they will not pay an office visit on the same date of service that a procedure is performed, even if the office visit is for another unrelated problem. This includes a Well Woman Exam or “annual”. A Well Woman Exam only includes preventative services. If you come to your Well Woman Exam with complaints of health problems, the exam is no longer considered a Well Woman Exam by your insurance company, and different co-pays and deductibles may apply. Your insurance company does not allow a Well Woman Exam to be combined with a visit that has health problems. The combining of problems in a visit is referred to as bundling of services. These insurance policies are inconsistent with those established by the American Medical Association.

What this means is, if you have more than one problem on your visit, the insurance company will reimburse for only one problem, or at best, at a drastically reduced reimbursement for services that are provided.

For this reason, due to the insurance coverage you have, we can only address one problem per visit unless an exception is granted.

If you have additional problems, please be advised that you may have to make additional appointments in order to be covered under your insurance plan. We would prefer to address all of your problems with a single visit, but we must comply with your insurance company rules.

Your signature below signifies your understanding of this limit to your insurance coverage and the payment policies of your insurance carrier.

Patient Name Printed

Patient Signature

Date



Summary of Notice of Privacy Practices

A new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") went into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received our full Notice. The full notice is available in our office and on our web site at www.dr-pam.com.

Your Rights as a Patient. You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information. We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

Disclosures of Protected Health Information Requiring Your Authorization. For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

Disclosures of Protected Health Information Not Requiring Your Authorization. We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Communication to You of Confidential Information by Alternative Means. If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

Restrictions to Use and Disclosure. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

Access to Protected Health Information. You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments to Medical Records. You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

Accounting of Disclosures of Protected Health Information. You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

Other Uses of Your Health Information. Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights. You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.



OBSTETRICS AND GYNECOLOGY

Information About PAP Smear Charges

Pathology charges for PAP smears collected in our office are estimates for a normal PAP smear.

If your PAP smear is abnormal, there will be additional charges from the pathology lab that will be billed to you and/or your insurance company after the additional testing results have been confirmed. These charges include the fee to re-read the specimen more closely by a pathologist using a manual method, and the testing of the specimen for the human papilloma virus (HPV).

HPV is responsible for many abnormal PAP smears and is the number one cause of cervical cancer. If your PAP smear is abnormal, it is important to know if it is due to one of the high risk HPV viruses, as this may affect your treatment.

A recent study published in JAMA¹ showed that 25% of women aged 14-19 and 45% of women aged 20-24 are infected with at least one HPV virus type.

There is now a vaccine available (Gardasil) that can prevent four of the most common high risk HPV types from infecting you. This vaccine can prevent *most* but not all cervical cancer and venereal warts. Please call us for an appointment if you are interested in preventing this virus from infecting you or your daughters.

Gardasil is only effective if given before an exposure to the HPV virus.

Please visit our web site at www.dr-pam.com for more information on Gardasil.

1. Eileen F. Dunne; Elizabeth R. Unger; Maya Sternberg; Geraldine McQuillan; David C. Swan; Sonya S. Patel; Lauri E. Markowitz
Prevalence of HPV Infection Among Females in the United States
JAMA 2007 297: 813-819

PAMELA A. MCQUILLIN, M.D., P.A.

FAX (432) 332-1344 • <http://www.dr-pam.com>
1330 EAST 8TH STREET, SUITE 420 • ODESSA, TX 79761-4733 • PHONE (432) 580-9191