TOTAL HEALTHCARE OBGYN® FOR WOMEN

BOARD CERTIFIED IN 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 (i.e. Drivers License) with you. Please request any needed records from other health care providers 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 with Obama Care, and we don't want you to be surprised about your insurance coverage.

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. We have an automated notification system that works with your e-mail and text messages.

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.
FAX (949) 862-7691 • http://www.dr-pam.com
1330 EAST 8TH STREET, SUITE 420 • ODESSA, TX 79761-4733 • PHONE (432) 580-9191

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

REGISTRATION FORM

(PLEASE PRINT CLEARLY)

LAST NAME:_____ FIRST NAME:_____ MI:_____

MAILING ADDRESS:_____ CITY:_____ STATE:_____

ZIPCODE:_____ SOCIAL SERCURITY#:_____DATE OF BIRTH: ___/___/____

HOME # :(____) ____-____ CELL #: (____) _____-_____ WORK #: (____) _____-_____

MARITAL STAUS: (CHECK ONE) SINGLE____ MARRIED_____DIVORCED_____WIDOWED_____

E-MAIL (PRINT CLEARLY) _____

PATIENTS EMPLOYER NAME & ADDRESS: _____

INSURANCE INFORMATION

NAME OF INSURANCE:_____ SUBSCRIBERS NAME:_____

SUBSCRIBERS EMPLOYER NAME & ADDRESS: _____

SUBSCRIBERS DOB: _____ SOCIAL SECURITY #:_____

RELANTIONSHIP TO PATIENT: (CHECK ONE) SELF____SPOUSE___CHILD_____OTHER____

PHARMACY NAME & ADDRESS: _____

IN CASE OF EMERGENCY – (NOT IN THE SAME HOUSEHOLD)

NAME:_____ RELANTIONSHIP:_____PHONE#:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to 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 claim. I hereby acknowledge that I/my child/may need 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 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 me as to the results of the care I hereby authorize.

DISCLOSURE: Please carefully review the information contained in this notice. ORMC meets the definition of a "physician owned hospital" under 42 CFR 489-3. The hospital is owned in part by physicians. Pamela A. McQuillin M.D is a shareholder at this facility. 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 ORMC will be able to meet your needs, you have the option to use a facility other than ORMC, 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 healthcare providers. If you have any questions concerning this notice please feel free to ask your physician or any representative of ORMC. We welcome you as a patient and value our relationship with you.

X_____

PATIENT/GUARDIANS SIGNATURE **DATE**

OB GYN TOTAL HEALTHCARE FOR WOMEN™

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

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting?..... ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ..... ☐ Yes ☐ No
# of meals you eat in an average day?_____
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

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

Alcohol:
Do you drink alcohol? ..... ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____
Are you concerned about the amount you drink? ..... ☐ Yes ☐ No
Have you considered stopping? ..... ☐ Yes ☐ No
Have you ever experienced blackouts? ..... ☐ Yes ☐ No
Are you prone to "binge" drinking? ..... ☐ Yes ☐ No
Do you drive after drinking? ..... ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ..... ☐ Yes ☐ No
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

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

Drugs:
Do you currently use recreational or street drugs? ..... ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ..... ☐ Yes ☐ No

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
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

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.

☐ Skin _____	☐ Back _____	☐ Energy Level _____
☐ Head/Neck _____	☐ Intestinal _____	☐ Ability to Sleep _____
☐ Ears _____	☐ Bladder _____	**Other Pain/Discomfort:**
☐ Nose _____	☐ Bowel _____	_____
☐ Throat _____	☐ Thyroid _____	_____
☐ Lungs _____	☐ Circulation _____	_____
☐ Chest/Heart _____	**Recent Changes In:**	_____
	☐ Weight _____	_____

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_____ _____

Patient Signature Date

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Patients Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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1330 EAST 8TH STREET, SUITE 420 • ODESSA, TX 79761-4733 • PHONE (432) 580-9191

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 _____ DATE OF BIRTH_____

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 HIPPA 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. l 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_____ **Date:** _____

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_____Date_____

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

HIPAA Notice of Privacy Practices
OBGYN – Total HealthCare for Women

Effective Date: *September 23, 2013*

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.

If you have any questions about this notice, please contact the Privacy Officer, Dr. Eric Pokky at (432) 332-9191.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the privacy officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the privacy officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the privacy officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the privacy officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the privacy officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.dr-pam.com. To obtain a paper copy of this notice, please contact the front office at (432) 332-9191.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the privacy officer. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____ (printed name of patient or personal representative), acknowledge that **Pamela A. McQuillin, M.D., P.A.** has provided a written copy of its Notice of Privacy Practices for Protected Health Information to (check one) ❑ myself or ❑ specify: _____
(*If signing as a personal representative, documentation of your legal right to do so must be provided.*)

_____	___/___/20___	_____	_____
Signature of Patient or Personal Representative	Date (mm/dd/yyyy)	Printed Name	Relationship to Patient (if not self)

To be completed by Pamela A. McQuillin, M.D., P.A.

❑ We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____
_____

_____	_____	_____	___/___/20___
Signature	Title	Printed Name	Date (mm/dd/yyyy)

TOTAL HEALTHCARE OB GYN® FOR WOMEN

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 JAMA[1] 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

TOTAL HEALTHCARE OB GYN FOR WOMEN

BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY

Important Patient Policies

Financial Policies: (Please Initial next to each policy)

_____Payment is due at the time of service unless other arrangements have been made in advance.

_____As a courtesy to our patients, we participate in and directly bill many health plans. However, you are ultimately responsible for payment of services. Please be aware of your specific plan benefits and limitations. If your insurance carrier fails to pay in timely manner, or fails to pay at all, you will be responsible for the charges.

_____There will be a $35 charge on all returned checks. Returned checks not paid within 21 days will be referred to the County Attorney's office for collections.

_____ If your insurance provider decides at a later date that your charges are not covered, even after they initially approved them, you will be responsible for all charges reversed by the insurance company. Please note, the insurance companies can reverse charges several years after the charges were approved and paid.

Policy Regarding Completion of Forms and Medical Records:

_____All forms including Disability, FMLA, STD (Short Term Disability), etc. will be completed as time permits. Please allow 3-5 business days for completion of the forms. Due to the large increase in the volume of form requests, we must now charge a $25 fee. This is due prior to completion of any forms. Your insurance company does not cover this fee.

_____A fee of $25 will apply to paper medical record request for the first 20 pages and an additional $0.50 per page thereafter. Additional fees will apply to other items including ultrasound images and postage. Electronic records are charged at $25 for 500 pages or less; $50 for more than 500 pages. A combined fee will be charged if both paper and electronic records are needed. There is no charge to for us directly provide records to another physician. Please allow up to 15 days for records to be retrieved.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPPA), and in order for Dr. McQuillin or her staff to discuss your medical condition with members of your family or other individuals that you designate, we must obtain an authorization from you.

_____I **do not** authorize Dr. McQuillin to verbally release any information concerning my medical care to any individual except as set forth in HIPAA.

_____I authorize Dr. McQuillin to verbally release any or all information concerning my medical care to the following individuals:

_____	_____
Name	Relation to patient
_____	_____
Name	Relation to patient
_____	_____
Patient Signature	Date

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