ALAN L. JOFFE, MD, F.A.C.O.G.
Diplomat, American Board of Obstetrics and Gynecology
NORTHSIDE OB/GYN, P.C.
Telephone: 404.256.2811
Facsimile 404.257.9855
993-C Johnson Ferry Road
Suite 120
Atlanta, GA 30342
3400-A Old Milton Parkway
Suite 200
Alpharetta, GA 30005

GYNECOLOGY VISIT

Patient Name: ______________________________ **Date:** ____________________

When was the first day of your last menstrual period? __________ **Was it normal?** ☐ Yes ☐ No

Why are you here today? ____

____

____

Have you had any illness since your last visit? ☐ Yes ☐ No

☐ **Colds** ☐ **Sore Throat** ☐ **Virus** ☐ **Other:** ____________________

Have other members of your family had any illness?

☐ **Colds** ☐ **Sore Throat** ☐ **Virus** ☐ **Other:** ____________________

What medications/drugs are you taking? ***(Please list)***

☐ **Over-the-counter drugs** **List:** ______________________________

☐ **Prescription drugs** **List:** ______________________________

☐ **Other** **List:** ______________________________

What do you drink?
☐ **Coffee** **Number of cups per day** ______________
☐ **Soda** **Number per day** ______________
☐ **Alcohol** **Number of drinks per day** ______________
☐ **Other** **Number per day** ______________

Do you smoke? ☐ **Yes** ☐ **No** **How much?** ______________

________________________________ ____________________
Patient Signature **Date**

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HIV Antibody Testing Acknowledgement of Counseling and Consent for Voluntary AIDS Testing

Patient Name: ________________________________ Date: ________________________

The American Medical Association recommends that we offer patients routine voluntary testing for antibody to the ***AIDS*** virus. Women at higher risk for carrying the ***AIDS*** virus are:

a. Those women with a history of intravenous drug use.
b. Those women who have sexual contact with homosexual or bisexual males.
c. Those women who have had blood transfusions prior to March 1985.
d. Those women not having a monogamous sexual relationship.
e. Those women who have had sex with a partner who is at risk.
f. Those women who **emigrate** from a country with a high rate of ***AIDS***.
g. Those women who have had artificial insemination.
h. Those women who have been raped.

The ***HIV*** antibody test is not always accurate. The test may result in a false negative by failing to detect antibodies to the virus which are in the blood. This test may also result in a false positive by indicating that there are antibodies which are not really in the blood.

For our pregnant patients, we want you to know that the ***AIDS*** virus is freely transmitted to the fetus. Newborns infected with the ***AIDS*** virus usually do not survive.

We will keep your test results as part of your complete medical record, and will not release that information without your consent, unless required or authorized by law.

My signature below acknowledges that:

a. I have read **this consent form (or it has been read to me),** and I understand **the provisions contained herein**.
b. All questions regarding the ***HIV*** antibody test have been answered **to my satisfaction**.
c. I understand that further information and counseling is available from the Georgia Department of Human Resources.
d. I give **Northside OB/GYN, P.C.** permission to collect one or more blood specimens (as in other blood tests) to detect whether **such blood contains Human Immunodeficiency Virus *(HIV)* antibodies which are associated with Acquired Immune Deficiency Syndrome *(AIDS).***
e. I consent to the release and use of **the** test results as set forth above.
f. If consenting on behalf of another, I confirm that I am the patient's parent, legal guardian or next of kin, and that the patient is unable to sign **this form** because: ____
____
____.

_____ I request to have the ***AIDS*** test done at this time.

_____ I do not request to have the ***AIDS*** test done at this time.

______________________	______________________	__________
SIGNATURE	RELATIONSHIP TO PATIENT	DATE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/01/2001), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it, in writing, at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or other person responsible for your care, of your location, your general condition, or your death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the

person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request, in writing, to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $35.00 for your records and depending on the number of pages, the rate will increase, and postage if you want copies mailed to you. If you request an alternative format, we will change a cost-based fee for providing your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation on how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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NOTICE OF PRIVACY PRACTICES

PURPOSE: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good faith attempt to obtain written acknowledgment of receipt of this Notice from the patient. We must also have the Notice available in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

I, ____, acknowledge receipt of the **above** Notice
PRINT RECIPIENT'S NAME

of Privacy Practices.

______________________________ ______________________________
SIGNATURE ***DATE***

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information ("PHI"). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: (____) ____________________
- ☐ O.K. to leave message with detailed information

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number: (____) __________

☐ Work Telephone: (____) ____________________
- ☐ O.K. to leave message with detailed information ____________
- ☐ *Leave message with call-back number only*

☐ Other: ______________________________
____

______________________________ ________________
PATIENT SIGNATURE DATE

______________________________ ________________
PRINT NAME BIRTHDATE

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T = Treatment Records; P = Payment Information; O = Healthcare Operations

(3) Enter how disclosure was made: F = Fax; P = Phone; E – Email; M = Mail; O = Other

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PATIENT'S PERSONAL MEDICAL HISTORY

DATE: ______________________

Confidential Record:
Information contained here will not be released except when you have authorized us to do so.

Name: ____
Last Name First Name Middle Name

Race: ____

Religion: ____

FAMILY HISTORY

	If Living				If Deceased	
	Sex		Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters* *(Circle Sex)*	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband						
Sons/Daughters* *(Circle Sex)*	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

**Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter. Use last page if more space needed*

Do you or any member of your family have or ever had? *(Circle and give Relationship)*

Asthma ____________________
Diabetes ____________________
Hepatitis ____________________
Bleeding Tendency ____________________
Cystic Fibrosis ____________________
Mental Retardation ____________________
Downs Syndrome ____________________
Hydrocephalus/Spina Bifida ____________________
Tay Sachs ____________________
Colitis/Ulcers ____________________
Epilepsy ____________________
Heart Disease ____________________
High Cholesterol Level ____________________
Heart Defects ____________________
High Blood Pressure ____________________
Stroke ____________________
Herpes ____________________
Goiter/Thyroid Problem ____________________
Congenital Defects ____________________
Sexually Transmitted Disease ____________________

CANCERS *(Family or Self)*

Breast ____________________
Cervix ____________________
Other ____________________
Uterus ____________________
Ovaries ____________________

MEDICATIONS:

Are you presently taking any of the following medications? *(Circle)*

Yes	No	Aspirin, Bufferin, Anacin	Yes	No	Tranquilizer
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis (Heart pills)	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water Pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbiturates
Yes	No	Laxatives	Yes	No	Birth control pills, brand name: ____________________
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	No	Other drugs not listed. If so, please list.

____

____

List the operations (major or minor) you have had as well as the hospital location and date: __________________________

____

____

____

Name any drugs to which you are allergic, and state the reaction you have had: ______________________________

____

____

____

Write in the names of any diseases or illnesses you have now or had in the past: _____________________________

____

____

____

Serious injuries or accidents: ____

____

____

____

____

MENSTRUAL HISTORY:

Age at onset of Menses ___________ Duration of Menses _____________ Interval between Menses __________

First day of last menstrual period: ___________________________________

(CIRCLE)

Yes No Have you ever missed a period except when pregnant?
Yes No Has your period ever lasted more than eight days or less than two days?
Yes No Did you ever pass large clots during your period?

CONTRACEPTIVE HISTORY:

Yes No Have you ever taken birth control pills?
Yes No Are you presently taking birth control pills? Which one? ____
Yes No If no, what form of contraception do you use? ____

OTHER

Yes No Do you have any urinary problems? Please explain: ______________________________

Yes No Varicose veins?
Yes No Phlebitis or inflamed leg veins?

PERSONAL HABITS AND PRACTICES

Yes No Do you regularly smoke? Cigarettes __________ Packs/day __________ For how many years? ________
Yes No Do you usually drink over 4 cups of coffee per day?
Yes No Do you regularly drink alcohol? 1 oz. per day 2 oz. per day ☐ 4 oz. per day ☐ over 5 oz. **per day** ☐
Yes No BEER: 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day ☐
Yes No Do you regularly have a pap smear?
☐ Normal Abnormal ☐
Yes No Have you ever had abnormal pap smear?
If yes, please explain: ______________________________
Yes No Do you regularly perform monthly breast self-examination?
Yes No Have you ever had a mammogram?
If yes, date and result of last mammogram: ______________________________
Yes No Have you ever had your cholesterol checked?
If yes, date and result: ______________________________

OBSTETRICAL HISTORY *(including miscarriages and elective abortions)*

DATE (Month/ Year)	Full Term, Premature or Abortion	Vaginal or C-Section Delivery	Hours in Labor	Sex and Birth Weight	Complications Mother or Baby

If you do not understand any of the questions, please ask the doctor.

DO NOT WRITE IN SHADED AREA

	Office Tests
Height: _____ **Feet** ______ **Inches**	**Urinalysis: Blood** ______ **Keotone** _______
Weight (lbs.): ____________________	**Protein** ______________ **pH** ____________
Blood Pressure: ____________________	**Leukocytes:** ____________________
Pulse: ____________________	**Micro** ***(if done)*** ____________________
	Hematrocrit: ____________________
	Wet Smear: ____________________
	Urine Pregnancy Test: ____________________

Notes:

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DATE: ____________________

PATIENT INFORMATION

NAME: ____
LAST NAME / FIRST NAME / MIDDLE NAME / MAIDEN NAME

ADDRESS: ____
STREET / CITY/STATE / ZIP CODE

HOME PHONE: ( ) __________

CELL PHONE: ( ) __________

BIRTHDATE: ___/___/___ AGE: ______ MARITAL STATUS: S M W D *(CIRCLE ONE)* SOCIAL SECURITY NO. ___/___/___

EMPLOYED BY: ______________________ OCCUPATION: ______________________

ADDRESS: ____
STREET / CITY/STATE / ZIP CODE

WORK PHONE: ( ) __________

SIGNIFICANT OTHER (SPOUSE) NAME: ______________________ SOCIAL SECURITY NO. ___/___/___

EMPLOYED BY: ______________________ WORK PHONE: ( ) __________

IN CASE OF EMERGENCY, CONTACT: ______________________ PHONE: ( ) __________

REFERRED BY: ______________________

NEAREST RELATIVE NOT LIVING WITH YOU: ______________________ PHONE: ( ) __________

INFORMATION ON PERSON RESPONSIBLE FOR BILL

GUARANTOR NAME: ____
LAST NAME / FIRST NAME / MIDDLE NAME / MAIDEN NAME

ADDRESS: ____
STREET / CITY/STATE / ZIP CODE

HOME PHONE: ( ) __________

WORK PHONE: ( ) __________

SOCIAL SECURITY NO. ___/___/___ RELATIONSHIP TO PATIENT: ______________________

EMPLOYED BY: ______________________ HOW LONG: ________ OCCUPATION: ______________________

INSURANCE INFORMATION

Do you have insurance to cover the FEES for services rendered? ☐ Yes ☐ No

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY: ______________	COMPANY: ______________
ADDRESS: ______________	ADDRESS: ______________
PHONE #: ( ) ______ INSURED DOB: ___/___/___	PHONE #: ( ) ______ INSURED DOB: ___/___/___
ID #: ______ GRP #: ______	ID #: ______ GRP #: ______

I authorize payment of medical benefits to Northside OB/GYN, P.C. for services rendered as described. I understand I am legally responsible for full payment such services regardless of insurance coverage.

I authorize the release of all medical information to Northside OB/GYN, P.C. which is necessary to process this claim. Additionally, I request payment of my Medicare benefits to myself or the party who accepts assignment. I also request the assignment of my Medicare benefits to Northside OB/GYN, P.C. in payment of this claim.

______________________ SIGNATURE OF INSURED ______________ DATE

______________________ SIGNATURE OF INSURED ______________ DATE

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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

______________________	____________	______________________
PATIENT NAME	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER**

I authorize the use and/or disclosure of my Protected Health Information **("PHI")** as described below:

1. I authorize: ____
   NAME
   ____
   MAILING ADDRESS
   ____
   CITY/STATE/ZIP

   to release the information described below. Only this information may be used and/or disclosed pursuant to this Authorization:

   ____

   ____

   ____

2. I authorize the following persons (or class of persons) to receive my **PHI**:

______________________	______________________
NAME	**NAME**
______________________	______________________
MAILING ADDRESS	**MAILING ADDRESS**
______________________	______________________
CITY/STATE/ZIP	**CITY/STATE/ZIP**

3. I understand that, if my **PHI** is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

4. I understand the following Notice will appear in the disclosure of my **PHI** to the above recipient(s): the attached medical information pertaining to ______________________ (patient) is confidential and legally privileged. Northside OB/GYN, P.C. has provided **said PHI** to ____ ***as authorized by the patient**. **The recipient may not further disclose the PHI without the express written(?) consent of the patient or as authorized by law.***

5. I understand that I have the right to revoke this Authorization at **any time**. My revocation must be in writing, addressed to Northside OB/GYN, P.C. 993-C Johnson Ferry Road, Suite 120, Atlanta, GA 30342. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my **PHI** have acted in reliance upon this Authorization.

6. If the patient is a minor (under 18 years **of age**) or incapacitated, **this** Authorization must be signed by a parent or legal guardian. If **the** parent is deceased, **the** next of kin, executor or estate must sign **this** Authorization.

7. This Authorization expires on: ___________________________.

______________________	______________________	__________
PATIENT/LEGAL REPRESENTATIVE'S SIGNATURE	**RELATIONSHIP TO PATIENT**	**DATE**