SHOEMAKER GYNECOLOGY

TODAY'S DATE:_____

NAME: _____ DOB: _____

CURRENT MEDICATIONS:_____
_____
_____

MEDICATION ALLERGIES: _____
_____

LIST ANY SURGERY OR MEDICAL PROBLEMS YOU HAVE HAD:_____
_____
_____

DO YOU OR HAVE YOU EVER USED TOBACCO? □ YES □NO

If yes, how much per day? _____ How long? _____ Date you quit: _____

DO YOU DRINK ALCOHOL? □ YES □NO HOW MUCH/OFTEN? _____

MARITAL STATUS: _____ SPOUSE'S NAME:_____

WHERE DO YOU WORK? _____

LIST ANY MEDICAL CONDITIONS YOU (OR A FAMILY MEMBER) HAS EVER HAD AND SPECIFY YOUR RELATIONSHIP:

ALLERGY/SINUS: _____ HEADACHES:_____

ASTHMA: _____ SEIZURES: _____

EMPHYSEMA:_____ STROKE: _____

TUBURCULOSIS:_____ INDIGESTION: _____

HEART DISEASE: _____ ULCERS: _____

HEART ATTACK: _____ BOWEL PROBLEMS: _____

CHEST PAINS: _____ IRREGULAR HEART BEAT: _____

KIDNEY INF/STONES/FAILURE:_____ THYROID PROBLEMS: _____

HIGH BLOOD PRESSURE: _____ DIABETES: _____

ARTHRITIS: _____ CANCER: _____

MUSCULAR WEAKNESS/ DEFORMITY: _____

Patient's Name _____D.O.B_____ **Date**_____

Risk assessment for Hereditary Cancers

(Please circle YES or NO. If yes, list relationship to relative and their age of diagnosis)

1st degree relatives: Mother, Father, Brother, Sister, or Children
2nd degree relatives: Aunts, Uncles, Grandparents, Grandchildren, Nieces, and Nephews
3rd degree relatives: Great-Grandparents, 1st cousins

Breast and Ovarian Cancer

Y/ N Have you, **OR** a relative(s) ever been diagnosed with breast cancer at age 45 or younger?

WHO? (Maternal/Paternal)_____**AGE(S**)_____

Y/N Have you, **OR** a relative(s) ever been diagnosed with ovarian cancer?

WHO? (Maternal/Paternal)_____**AGE(S)**_____

Y/N Has any male relative ever been diagnosed with breast cancer?

WHO? (Maternal/Paternal)_____**AGE(S)**_____

Y/N Have you, **OR** a relative(s) ever been diagnosed with multiple breast cancers?

WHO? (Maternal/Paternal)_____**AGE(S)**_____

Y/N Do you have 3 or more relatives from the same side of the family that have had breast cancer?

WHO? (Maternal/Paternal)_____**AGE(S)**___

Y/N Are you of Jewish ancestry?

Colon and Uterine Cancer

Y/N Have you, **OR** a relative ever been diagnosed with colon cancer before age 50?

WHO? (Maternal/Paternal)_____**AGE(S**)_____

Y/N Have you, **OR** a relative ever been diagnosed with endometrial (uterine) cancer before age 50?

WHO? (Maternal/Paternal)_____**AGE(S**)_____

Y/N Have you, **OR** a relative ever been diagnosed with one of the following cancers? (specify cancer)

Ovarian, stomach (gastric), pancreas, ureter/renal pelvis, biliary tract, brain, & small bowel.

WHO? (Maternal/Paternal)_____**AGE(S**)_____

Genetic Testing History

Y/N Have you **OR** any member of your family ever had genetic testing for a hereditary risk of cancer?

If yes, please explain_____

Marshall Shoemaker, M.D. P.C.

Patient's Legal Name: _____/_____/_____/_____
Last First Middle/Maiden Nickname

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ DOB: ___/___/___ Age: _____

Cell # (_____) _____ Home # (_____) _____

Marital Status (circle one): S M W D Sep DL #: _____ SSN: _____

E-mail Address: _____

Patient's Employer: _____Employer's Phone#(____)_____
Please check preference of contact: ___ Cell phone ___ Home phone ___ Text message ___ E-mail

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Spouse Information

Name of Spouse: _____ DOB: ____/____/_____

Spouse's Employer: _____

Work Phone # ( ) _____ SSN _____

Copy of insurance card and driver's license MUST be provided

Patient Insurance Information

1st Insurance Company: _____ Contract # _____Group #_____

Subscriber's Name: _____ DOB: ____/____/_____

Subscriber's SSN: _____ Relationship to Patient: _____

Subscriber's Employer: _____ Employer's Phone #_____

Employer's Address: _____

2nd Insurance Company: _____Contract # _____ Group #_____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employer's Phone #_____

Employer's Address: _____

In case of emergency contact: _____

Relationship to patient: _____ Phone # (_____) _____

How did you hear about us: __ Doctor __ Friend __ Website __ Facebook __ Advertisement

Please read and sign

I understand there may be certain services that are necessary for the maintenance of my good health that are not covered by my insurance and ***I agree to pay for those services in full.***

I agree to be contacted or notified by the office and/or it's agents, by mobile devices, text messaging, e-mail, and/or any contact information that I have provided.

I hereby authorize my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required in the processing of any claim. In instances where I have been referred to another physician or medical facility, I hereby give my permission to fax or mail pertinent medical information for continuity of my care.

I have read the above policies and agree to pay for services not covered by my insurance. I also agree to pay reasonable attorney's fees and costs of collection if this matter is referred to an attorney.

Signature: _____ Date: _____

Let us reassure you that we will order only tests that we feel are necessary for your treatment and care. If you have any questions, someone in our office will be happy to assist you. Thank you very much for your understanding. Please review annually.

Marshall D Shoemaker, M.D. P.C.

188 Hospital Drive Suite 304

Fairhope, Al 36567

(251) 990-1950 phone (251) 990-1951 fax

Authorization to Release Information to parents, guardian, spouse or other designated person.

Patient Name:_____

Date of Birth:_____

You may release my information to the following people ONLY:

_____

_____

_____

Patient Signature:_____**Date:**_____

Marshall D Shoemaker, M.D. P.C.

188 Hospital Drive Suite 304

Fairhope, Al 36567

(251) 990-1950 phone (251) 990-1951 fax

Dear Patient:

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

Therefore, we urge you, as the patient, to please check with your insurance company prior to any testing or surgery being performed. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Please remember your insurance policy is between you and your insurance company, and not with the insurance company and the doctor.

Patient Signature: _____ Date: _____

Witness: _____

Guarantee of Payment

I, the undersigned, hereby agree to pay all amounts and charges incurred by members of my family for services rendered by our physician(s). I further agree that it is my responsibility to know and understand the provisions and limitations stated in my insurance policy, as well as the current list of providers in my contract and accept full responsibility for all charges not covered by my insurance. Failure to make payment requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable fee and waives his/her right of exemption under law of the State of Alabama and any other state.

Assignment of Benefits

In consideration of care and services rendered to me by physician(s) during all office visits, I assign the benefits payable under my insurance policies for physician's services to the physician furnishing the services or to their authorized billing agent insofar as necessary to cover their charges. I authorize such physician(s) (or their billing agent) to submit a claim to my insurance carrier for payment for me and authorize payment to be made directly to said physician(s), billing agent, or organization.

Assignment of Claims Against Third Parties

In consideration of care rendered to me by physician(s), I hereby assign to the physician(s) rendering services all claims that I may have against third parties who may be liable for any of my medical expenses, to the extent necessary to cover my expenses for physician(s) care and services. Any funds received by me in connection with such claims against third parties, or settlement of such claims, shall be paid to the said physician(s) to cover my expenses. I hereby authorize payment directly to said physician(s) or their authorized billing agent of any of the above-mentioned funds which are otherwise payable to me but not to exceed the regular reasonable charges for all office/physician services.

Medicare Benefits to Physician(s)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to be by physician(s). I authorize any holder of medical or other information about me to be released in order to process claim(s) and request payment of my benefits to the physician rendering service.

Medicaid Authorization and Assignment

I authorize any holder of medical information about me to release information needed for any Medicaid claims to the Alabama Medicaid Agency and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the Alabama Medicaid Agency all claims against third parties who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid; I also assign all rights, whether or not a portion of any such settlement is designated as being for medical expenses. Any such funds received by one shall be paid to the Alabama Medicaid Agency. I permit a copy of the Authorization and Assignment to be used in place of the original. **I also agree to pay any fees or charges incurred if my Medicaid policy does not cover/denies services provided at any office visit.**

Authorization to Release Information

I hereby authorize physician rendering services to release to my insurers: billing and certain medical information including final diagnosis and operative procedure(s) relative to this or any related hospital claim(s) and/or office claim(s) for the purpose of determining eligibility for coverage and payment of charges for services rendered in connection with any hospitalization and/or office care. I also give permission for my physician to release my medical information to another physician/provider assisting in my healthcare.

Privacy Notice

I hereby acknowledge receipt of your practice's privacy notice attached to the paper work given at my first appointment.

Guarantor (Please Print Clearly)

Name:_____ Street:_____

City: _____State:_____ Zip:_____Phone:_____

_____ _____

Signature of Patient Date Signature of Guarantor Date

_____ _____

Witness Date Witness Date

Marshall Shoemaker, M.D. P.C.

NOTICE OF PRIVACY PRACTICES

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.

Marshall Shoemaker, M.D. P.C. is required to protect the privacy of your confidential personal health information, referred to below as protected health information ("PHI"), under state and federal law. This Notice of Privacy Practices ("Notice") is provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice describes how Marshall Shoemaker, M.D. P.C. may use and disclose your PHI to carry out treatment, payment and healthcare operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Marshall Shoemaker, M.D. P.C. will make a good faith effort to obtain from you a written acknowledgement of receipt of this Notice

Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

Uses and Disclosures for Treatment, Payment and Health Care Operations. Marshall Shoemaker, M.D. P.C. may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

For Treatment. Marshall Shoemaker, M.D. P.C. may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may generally take place between physicians, nurses, technicians, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment. Marshall Shoemaker, M.D. P.C. may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, Marshall Shoemaker, M.D. P.C. may need to give PHI to your health plan in order to be reimbursed for the services provided to you. Marshall Shoemaker, M.D. P.C. may also disclose PHI to its business associates, such as billing companies, claims processing companies and others that assist in processing health claims. Marshall Shoemaker, M.D. P.C. may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. Marshall Shoemaker, M.D. P.C. may use and disclose PHI for health care operations, including for quality assessment and improvement. For example, Marshall Shoemaker, M.D. P.C. may use and disclose PHI to evaluate the treatment and services you receive and the performance of our staff in caring for you, provider training, underwriting activities, compliance and risk management activities, planning and development, and management and administration of Marshall Shoemaker, M.D. P.C.. Other examples of health care operations include disclosures of PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and education purposes, to help make sure Marshall Shoemaker, M.D. P.C. is complying with all applicable laws, and to help Marshall Shoemaker, M.D. P.C. continue to provide health care to its patients at a high level of quality. In addition, under certain circumstances Marshall Shoemaker, M.D. P.C. is permitted to disclose PHI to other health care providers and health plans for their health care operations, including their quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance.

Other Uses and Disclosures For Which Authorization is Not Required. In addition to using or disclosing PHI for treatment, payment and health care operations, Marshall Shoemaker, M.D. P.C. may use and disclose PHI without your written authorization under the following circumstances:

As Required by Law and Law Enforcement. Marshall Shoemaker, M.D. P.C. may use or disclose PHI when required to do so by applicable law. Marshall Shoemaker, M.D. P.C. also may disclose PHI (but only under certain circumstances) when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, the location of the crime or victims, or the identity, description, or location of a person who committed a crime, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. Marshall Shoemaker, M.D. P.C. may disclose PHI (but only under certain circumstances)to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition and other similar activities permitted by law.

For Health Oversight Activities. Marshall Shoemaker, M.D. P.C. may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. Marshall Shoemaker, M.D. P.C. may disclose PHI to coroners and medical examiners (and may use PHI if acting in those capacities) for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law. In addition, Marshall Shoemaker, M.D. P.C. may disclose PHI to a funeral director as permitted by law and as needed to carry out his or her duties.

Organ, Eye, and Tissue Donation. Marshall Shoemaker, M.D. P.C. may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, Marshall Shoemaker, M.D. P.C. may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. Under certain circumstances, Marshall Shoemaker, M.D. P.C. may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. Marshall Shoemaker, M.D. P.C. may use and disclose PHI of military personnel and veterans under certain circumstances. Marshall Shoemaker, M.D. P.C. may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, Marshall Shoemaker, M.D. P.C. may disclose your PHI to the correctional institution or official in certain circumstances.

Workers' Compensation. Marshall Shoemaker, M.D. P.C. may disclose PHI to comply with workers' compensation or other

similar laws. These programs provide benefits for work-related injuries or illnesses.

Fundraising Activities. In certain circumstances, some of your PHI may be used or disclosed to a related foundation or business associate to contact you in an effort to raise money for Marshall Shoemaker, M.D. P.C.. The money raised in connection with these activities would be used to expand and support Marshall Shoemaker, M.D. P.C.'s provision of health care and related services to the community.

Appointment Reminders; Health-related Benefits and Services; Marketing. Marshall Shoemaker, M.D. P.C. may use and disclose your PHI to contact you and remind you of an appointment at Marshall Shoemaker, M.D. P.C., or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs. Marshall Shoemaker, M.D. P.C. may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to-face communication or by giving you a promotional gift of nominal value without obtaining your express authorization.

Disclosures to You or for HIPAA Compliance Investigations. Marshall Shoemaker, M.D. P.C. may disclose your PHI to you or to your personal representative (who generally is someone who has the legal authority to act on your behalf), and is required to do so in connection with your rights described below. Marshall Shoemaker, M.D. P.C. also must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate the compliance of Marshall Shoemaker, M.D. P.C. with HIPAA).

Uses and Disclosures That May be Made With Your Agreement or Opportunity to Object. You will have the opportunity to agree or object to these uses and disclosures of PHI that Marshall Shoemaker, M.D. P.C. may make:

Patient Directories. Unless you object, Marshall Shoemaker, M.D. P.C. may use some of your PHI to maintain a directory of individuals at Marshall Shoemaker, M.D. P.C.. This information may include your name, your location in the facility, your general condition (*e.g.* fair, stable, etc.), and your religious affiliation (which will only be disclosed to members of the clergy). Except for your religious affiliation, the information may be disclosed to other persons who ask for you by name. Under limited circumstances, we may use your PHI for facility directory purposes in certain emergency situations.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, Marshall Shoemaker, M.D. P.C. may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. Marshall Shoemaker, M.D. P.C. may also notify those people about your location or condition. When you are unable to agree or object, Marshall Shoemaker, M.D. P.C. may still disclose your PHI in certain circumstances.

Uses and Disclosures of PHI For Which Authorization is Required. Other types of uses and disclosures of your PHI not described in this Notice will be made only with your written authorization, which you have the right, with some limitations, to revoke in writing.

Regulatory Requirements. Marshall Shoemaker, M.D. P.C. is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. (That is, the version that is currently in effect.) Marshall Shoemaker, M.D. P.C. reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before Marshall Shoemaker, M.D. P.C. makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in all applicable areas and on Marshall Shoemaker, M.D. P.C.'s website.

Individual Rights. You have the following rights regarding your PHI:

- You may request that Marshall Shoemaker, M.D. P.C. restrict the use and disclosure of your PHI. Marshall Shoemaker, M.D. P.C. is not required to agree to any restrictions you request, but if Marshall Shoemaker, M.D. P.C. does so it will be bound by the restrictions to which it agrees except in certain emergency situations.
- You have the right to request that communications of PHI to you from Marshall Shoemaker, M.D. P.C. be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your requests must be made in writing and sent to our Privacy Officer. Marshall Shoemaker, M.D. P.C. will accommodate your reasonable requests.
- Generally, you have the right to inspect and copy your PHI that Marshall Shoemaker, M.D. P.C. maintains, provided that you make your request in writing to our Privacy Officer. If you request copies of your PHI , Marshall Shoemaker, M.D. P.C. may impose a reasonable fee to cover copying, postage, and related costs. Marshall Shoemaker, M.D. P.C. may deny access in certain circumstances. If Marshall Shoemaker, M.D. P.C. denies access to your PHI, it will explain the basis for denial and whether you have an opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision). If Marshall Shoemaker, M.D. P.C. does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.
- If you believe that your PHI maintained by Marshall Shoemaker, M.D. P.C. contains an error or needs to be updated, you have the right to request that Marshall Shoemaker, M.D. P.C. correct or supplement your PHI. Your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. In certain circumstances, you have the right to amend your PHI. We may deny your request in certain circumstances.
- You generally have the right to request and receive a list of certain disclosures of your PHI Marshall Shoemaker, M.D. P.C. has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). You should submit any such request to the Medical Records Department. Marshall Shoemaker, M.D. P.C. will provide the first list to you at no charge, but if you make more than one request in a year you will be charged a fee of $_____ for each additional request. Marshall Shoemaker, M.D. P.C. will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred to you.
- You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. You can receive a copy of this notice at our Web site, www.thomashospital.com. To obtain a paper copy of this notice, please contact our Privacy Officer.
- You may complain to Marshall Shoemaker, M.D. P.C. if you believe your privacy rights with respect to your PHI have been violated by contacting our Director of Risk Management and submitting a written complaint. Marshall Shoemaker, M.D. P.C. will in no manner penalize you or retaliate against you for filing a complaint regarding Marshall Shoemaker, M.D. P.C.'s privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

If you have any questions about this notice, please contact Marshall Shoemaker, M.D. P.C. Effective Date: June 1, 2006