Women's Care of Beverly Hills Medical Group

Ruth Cousineau, M.D. Robert F. Katz, M.D. Jay M. Goldberg, M.D.

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8920 Wilshire Boulevard, Suite 511 -- Beverly Hills, California 90211

MEDICAL HISTORY QUESTIONNAIRE

Name: ________________________________ Date of Birth:______________

Name of Spouse/Partner:______________________________ Date of Birth:______________

E-mail:___________________________ Are you interested in e-mail communication? Y / N

Primary Phone:______________________ Is this number ok to leave results messages? Y / N

Preferred Pharmacy and Phone Number:____

Referred by:_________________________________

Allergies to Medications (include reaction):_______________________________________

1. What brings you in for medical attention? Describe onset, duration, characteristics of and factors influencing your present illness.

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2. Date of Last Menstrual Period:______________Are periods regular? Y / N________________

What age did your periods first start?__________ What age did you reach menopause?______________

Do you suffer painful and/or heavy periods?______________________________________

When was your last pap smear? _____________ Have you had an abnormal pap? Y / N____________

Have you received Gardasil ® (HPV) vaccine? Y / N If so, all 3 shots?____________________

When was your last mammogram?__________ Any abnormal mammograms? Y / N____________

When was your last colonoscopy?__________ When was your last bone density?_____________

Do you use birth control? Y / N If yes, what kind?_________________________________

Any history of STD's? (Herpes, Gonorrhea/Chlamydia)______________________________

3. Obstetric History: How many times have you been pregnant?________

Number of children (if any):__________Miscarriages:__________Abortions:__________Ectopics:__________

Date	Type (vaginal/c-section)	Weight	Weeks (full-term?)	Complications	Name of Child

Are you planning a pregnancy? Y / N If so, when?__________________________________

Any problems with infertility? Please explain:

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5. Past Medical History: Do you have any chronic medical conditions (or have you been hospitalized)?

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What medications/herbs/hormones do you take on a regular basis?

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6. Past Surgical History: Have you ever had any surgeries? Please list procedures with year.

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7. Family History: Do you have any family history of cancer, high blood pressure, diabetes, stroke, heart disease? Please list relation, age at diagnosis and whether family member is living or deceased:

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8. Social History: Do you smoke? Y / N If yes, how much?____________________

Do you use alcohol? Y / N If yes, how much?____________________

Do you use illegal drugs? Y / N If yes, how much?____________________

Have you ever been physically or sexually assaulted? Y / N If yes, please explain:

____

9. Have you ever had a serious or chronic condition of: If yes, please explain.

Eyes/Ears/Nose/Throat:____

Thyroid/Skin:____

Breasts:____

Heart/Blood Clots/Blood Pressure:____

Lungs:____

Stomach/Intestine:____

Bladder/Kidney: (Do you leak urine?)_____________________________________

Vulva/Vagina: (Problems with intercourse?)________________________________

Bones/Joints:____

Nerves/Muscles:____

10. Is there any other issue you would like to address with your provider today?

____

____

____

RELEASE OF INFORMATION: I, the undersigned, authorize release of any information needed to act on this request.

MEDICARE RELEASE OF INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

ASSIGNMENT OF INSURANCE BENEFITS: I, the undersigned, hereby authorize to Women's Care of Beverly Hills for benefits payable due me under any terms of the insurance policy or policies that may cover professional services rendered to me. I understand that I am financially responsible to Women's Care of Beverly Hills for charges not covered by this authorization.

THE UNDERSIGNED AGREES TO ALL OF THE ABOVE:

Date____________________Signed by:____

From all of us at Women's Care of Beverly Hills, thank you for entrusting us with your care! Let us know how we can serve you better.

Women's Care of Beverly Hills Medical Group

❑ Ruth Cousineau, M.D. ❑ Robert Katz, M.D. ❑ Jay Goldberg, M.D.
❑ Suzanne Gilberg-Lenz, M.D. ❑ ____________ ❑ ____________

PATIENT INFORMATION

LAST NAME		FIRST NAME & INITIAL			
ADDRESS LINE					
CITY		STATE		ZIP	
HOME PHONE		SOCIAL SECURITY NO.			
WORK PHONE		CELL PHONE			
EMAIL ADDRESS					
DATE OF BIRTH		AGE		MARITAL STATUS	❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ WIDOWED
REFERRING DOCTOR		PHONE			
EMERGENCY NOTIFICATION		PHONE			
PATIENT'S EMPLOYER		OCCUPATION			
EMPLOYER'S ADDRESS					
CITY		STATE		ZIP	
				PHONE NO.	
SPOUSE NAME		SOCIAL SECURITY NO.			
SPOUSE'S EMPLOYER		WORK PHONE NO.			
NAME RELATIVE		PHONE			
NAME FRIEND		PHONE			
INS'D PERSON'S NAME		SOCIAL SECURITY NO.			
INSD'S EMPLOYER		WORK PHONE NO.			
RELATION TO INS'D PERSON		PHONE			

INSURANCE #1 INFORMATION

INSURANCE #1 NAME					
ADDRESS		INS #1 PHONE			
POLICY HOLDER'S LAST NAME		FIRST NAME		RELATIONSHIP	
ID # (NO.)		GROUP NO.		SUBSCRIBER'S DATE OF BIRTH	

INSURANCE #2 INFORMATION

INSURANCE #2 NAME					
ADDRESS		INS #2 PHONE			
POLICY HOLDER'S LAST NAME		FIRST NAME		RELATIONSHIP	
ID # (NO.)		GROUP NO.		SUBSCRIBER'S DATE OF BIRTH	

SIGNATURE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.	Signature	Date
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.	Signature	Date
I understand by not supplying my complete insurance information or no insurance information, I will be responsible for my account balance.	Signature	Date

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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.

Purpose of this Notice
This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is used appropriately.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify Our Privacy Officer.** We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We have also appointed a Privacy Officer who is responsible for ensuring that we protect your health information and that we abide by the terms of this Notice.

How We May Use or Disclose Your Health Information
The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use your health information to provide you with medical treatment or services. An example of this would include a physical examination. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

(Please read reverse side prior to signing.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Name: ____________________ Signature: ____________________

Name of Personal Representative: ____________________ Signature: ____________________

Date: ____________________

For Additional Questions Contact: Privacy Officer: Sandra E. Krutell Phone: (310) 659-0121

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20202
877-696-6775 (Toll Free)

Practice Name: Women's Care of Beverly Hills Medical Group
Address: 8920 Wilshire Blvd., #511
Beverly Hills, CA 90211
310-657-1600

WOMEN'S CARE OF BEVERLY HILLS MEDICAL GROUP

OBSTETRICS-GYNECOLOGY AND INFERTILITY

RUTH F. COUSINEAU, M.D. • ROBERT F. KATZ, M.D. • JAY M. GOLDBERG, M.D.
SUZANNE B. GILBERG-LENZ, M.D. • DAVID L. FINKE, M.D.

PATIENT NAME:_________________________________DATE OF BIRTH:__________________

1. <u>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:</u> I have received a copy of the Notice of Privacy Practices for the medical practice of Women's Care of Beverly Hills Medical Group. Our practice reserves the right to modify the privacy practices outlined in the notice.

   Please initial:X___________

2. <u>AUTHORIZATION TO RELEASE INFORMATION:</u> I agree that my physician and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to and to make copies of my medical records.

   Please initial:X___________

3. <u>AUTHORIZATION TO PAY INSURANCE BENEFITS:</u> I hereby give my authorization to bill my insurance carrier and if applicable, I authorize payment to be made directly to Women's Care of Beverly Hills Medical Group.

   Please initial:X___________

4. <u>NON-CANCELLED APPOINTMENTS:</u> I understand that when I make an appointment and do not cancel within 24 hours of said appointment, I will be charged $50.00 because another patient could have been given that appointment time.

   Please initial:X___________

5. <u>FINANCIAL AGREEMENT:</u> I hereby agree to pay all statements not covered by insurance for services rendered by the physicians and medical staff at the end of each medical service. Any balance not paid within 30 days of receipt of statement will be considered in default, unless financial arrangements have been made with our billing department in advance.

   Please initial:X___________

6. <u>SPECIAL LETTERS AND FORM COMPLETION:</u> I understand that if I request a letter describing any medical conditions and/or treatments, including disability paperwork, I will be charged a minimum of $50.00.

   Please initial:X___________

The undersigned certifies that he/she has read the foregoing, receiving a copy if requested thereof, and is the patient or is authorized by the patient's general agent to execute the above and accept its terms.

Signature:_______________________________ Date:______________________

8920 Wilshire Boulevard, Suite 511 Beverly Hills, California 90211 • Tel: (310) 657-1600 • Fax (310) 657-4598