RIVERCITY
WOMEN'S HEALTH

To: RiverCity Women's Health, PLLC From: _____

Fax: (210) ___ - _____ Phone: _____

Thank you for choosing RiverCity Women's Health PLLC. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

1). New Patient Forms

2). Insurance Card(s)

3). Any and all recent Ultrasound, CT Scan, X-rays, and MRI's

4). Medications

Office Information:
RiverCity Women's Health, PLLC
5534 Rogers Road
San Antonio, Texas 78251
Ph: (210) 384 – 1000
Fax: (210) 384 -1003

Location:
On Rogers Road
Two Blocks South of Culebra Road
In-Between Wiseman and Culebra Roads

Thank you for choosing RiverCity Women's Health, PLLC. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

☐ New Patient ☐ Updated Information

Patient Demographics

Patient Name:_____ Birth Date:_____/_____/_____
LAST FIRST MI

Social Security No: _____-_____-_____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ____-_____-_____ Cell #: _____-_____-_____ Work #: _____-_____-_____

Are we able to Communicate with you via : ☐ Text ☐ Email: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: _____
Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other
Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: _____-_____-_____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:_____ Insured's Name:_____

Policy #:_____ Group #:_____ Insured's Date of Birth: _____

Secondary Insurance

Secondary Company:_____ Insured's Name:_____

Policy #:_____Group #:_____ Insured's Date of Birth: _____

Self-Pay Agreement

I agree to pay for medical services rendered from RiverCity Women's Health PLLC. I understand that payment must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Preferred Pharmacy: _____ **Phone #** ( ) -

Allergies / Sensitivity to Medications: _____

Reason for Visit: _____

_____

_____

_____.

Current Symptoms: *(Please check all that apply.)*

☐ Headaches	☐ Hoarseness	☐ Bowel Problems
☐ Vision Problems	☐ Throat Problems	☐ Bladder Problems
☐ Nasal Congestion	☐ Swallowing problems	☐ Sexual Difficulties
☐ Runny Nose	☐ Dizziness	☐ Weakness
☐ Ear Problems	☐ Breathing Problems	☐ Numbness
☐ Chest Pain	☐ Stomach Problems	☐ Weight Changes
☐ Abnormal Vagina Discharge	☐ Menopausal Problem	☐ Menstrual Problem

Past Medical History: *(Please check all that apply.)*

☐ Deafness/Decreased Hearing	☐ Epilepsy / Seizures	☐ Diabetes Mellitus
☐ Heart Problems	☐ Mental Illness	☐ Hemorrhoids
☐ Heart Attack	☐ Nervous Breakdown	☐ Stomach / Bowel Problems
☐ High Blood Pressure	☐ Mental Retardation	☐ Ulcers
☐ Blood Transfusion	☐ Cancer	☐ Migraines
☐ Anemia	☐ Stroke	☐ Arthritis
☐ Bleeding Disorder	☐ Blindness	☐ Hepatitis
☐ High Cholesterol	☐ Glaucoma	☐ Liver Problems
☐ Lung Problems	☐ Sinus Infection	☐ Gout
☐ Asthma	☐ Urine Infection	☐ Broken Bones
☐ Pneumonia	☐ Kidney Disease	☐ Joint Dislocation
☐ Rheumatic Fever	☐ Kidney Stone	☐ Birth Defects
☐ Scarlet Fever	☐ Thyroid Problems	☐ Amputations
☐ Tuberculosis	☐ Venereal Disease	☐ HIV
☐ Allergies		

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Current Medications:

List ALL medication that you are currently taking including Non-Prescriptions Medication & Herbal remedies.
(Please DO NOT Substitute a List. Please write medications: Over the counter & or Herbs below)

Medications	Dose	How Often	Approximately Start Date (Month/Year)

Obstetric and Gynecologic History:

Total Pregnancies: _____ Premature: _____ Stillborn: Miscarriages: _____
Total Living Children: _____ Pregnancy Complications: _____
First Day of your last Menstrual Cycle: ____/____/____ Age at first Menstruation: _____
How long does your Menstrual Cycle last: _____
How often does Menstruation occur: (e.g., monthly, every six weeks) _____
On the heaviest day, how many pads or tampons do you use: _____ Any Cramps: _____
Any PMS symptoms: _____ If so, describe: _____
Do you spot or bleed between cycles or after intercourse: _____ if so, describe: _____
Is this your first GYN exam: _____ Any history of STD's: _____ If yes, which one(s): _____
Date of your last Pap smear: _____ Have you ever had an abnormal Pap smear: _____
Any Breasts Problems: _____ Do you examine your breasts regularly: _____
Have you had a Mammogram recently: _____ If Yes, Date: ____/____/____ Outcome: _____

Sexual History:

Have you had sex with: ☐ Male ☐ Female ☐ Both How old were you when you first had sex: _____
Have you had more than one partner in the past year: _____
Do you have any pain with intercourse: _____
If you use contraception, what form(s) do you use: _____
Do you wish to continue with this method: _____
Have you ever experienced sexual assault or incest: _____
Is there any violence in any of your relationships: _____

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Periodic Examinations:
(Please Check Exam and State when.)

☐ *Pap Smear:*	/ /	☐ *Mammogram:*	/ /
☐ *Bone Density:*	/ /	☐ *Colonoscopy Exam:*	/ /
☐ *Lipid:*	/ /		

Immunizations:

Description	Last Known Date	Description	Last Known Date
☐ PNEUMONIA	/ /	☐ FLU	/ /
☐ TETANUS	/ /	☐ RUBELLA	/ /
☐ HPV	/ /	☐ OTHER	/ /
☐ HEPATITIS B	/ /		/ /

Surgical History:

Have you ever had any surgery (including oral surgery, tonsils, abdominal surgery, etc.)

If yes, Date: ____/____/____ Type: _____ Complications: _____
If yes, Date: ____/____/____ Type: _____ Complications: _____
If yes, Date: ____/____/____ Type: _____ Complications: _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Domestic Violence: ☐ _____.

Employment: ☐ Employed ☐ Unemployed ☐ Retired Occupation: _____.

Living Situation: ☐ Lives alone ☐ Lives with family ☐ Lives with others

Smoking: ☐ Current Smoker, everyday ☐ Current Smoker, some days ☐ Former Smoker
☐ Never Smoker ☐ _____ packs/day ☐ _____ years smoked

Alcohol Use: ☐ YES ☐ NO
☐ Heavy drinker (1-5 drinks/day) ☐ Moderate Drinker (1-5 drinks/week)
☐ Occasional Drinker

Seat Belt Use: ☐ YES ☐ NO

Recreational Drug Use:
☐ YES ☐ NO
☐ Heavy User (daily to weekly) ☐ Moderate User (monthly) ☐ Occasional User

List Recreational drugs used: _____.

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Exercise: ☐ YES ☐ NO If Yes, Please explain: _____

_____

_____

_____.

Family Medical History: *(Please check all that Apply.)*

Conditions	Father	Mother	Brother(s)	Sister(s)	Children
Diabetes:	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐
Cancer/Type:	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐
Anemia:	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐	☐
Breast Cancer:	☐	☐	☐	☐	☐
Uterine Cancer:	☐	☐	☐	☐	☐
Ovarian Cancer:	☐	☐	☐	☐	☐
Others:	☐	☐	☐	☐	☐

Office Information:
5534 Rogers Road
San Antonio, Texas 78251
P: (210) 684 -1000
F: (210) 684 - 1003

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to RIVERCITY WOMEN'S HEALTH, PLLC and affiliated healthcare providers.

Disclosing Physician / Practice: _____ Phone: (_____) _____-_____

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Ultrasound
_____ Chest X-Rays
_____ CT Scan
_____ Echocardiograms
_____ M.R.I.
_____ E.K.G.
_____ Office Notes
_____ Labs Reports / Tests

Protected Health Information to be disclosed to:

RIVERCITY WOMENS HEALTH PLLC
Attn: MEDICAL RECORDS
5534 ROGERS ROAD
SAN ANTONIO, TX 78251
PHONE: (210) 684 - 1000

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to RiverCity Women's Health, PLLC.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). RiverCity Women's Health, PLLC will not condition treatment or payment based upon my signing of this Authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by RiverCity Women's Health, PLLC. and no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature Date Name (if other than Patient)

5534 Rogers Rd Suite 105
San Antonio, Tx 78251
Phone: 210-684-1000 Fax: 210-684-1003

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize **Rivercity Women's Health- Dr. Nkechi Ogogor** to release my Protected Health Information (information contained in my medical records) to include:

_____ Complete Medical Record (including all reports from other facilities contained in my record)
_____ M.R.I. / CT Scan
_____ Ultrasound
_____ E.K.G.
_____ Office Notes
_____ Chest X-Rays
_____ Labs Reports / Tests
_____ Echocardiograms
_____ Operative Reports / Hospital Records
_____ Physical Therapy Treatment Notes
_____ Billing Statement / Itemized Statement

Records to be disclosed for Dates of Service from: _____ to _____.

Purpose of Disclosure:

_____ Continuing Care _____Change of Doctor _____ Referral to Specialist _____ Other: _____

Protected Health Information to be disclosed to:

Physician / Practice / Person: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to **Rivercity Women's Health- Dr. Nkechi Ogogor** .
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). **Rivercity Women's Health- Dr. Nkechi Ogogor** will not condition treatment or payment based upon my signing of this Authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by **Rivercity Women's Health- Dr. Nkechi Ogogor** and no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent.
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature Date Name (if other than Patient)

NOTICE OF PRIVACY PRACTICES

RiverCity Women's Health

5534 Rogers Road, Suite 105, San Antonio, Texas 78251

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart, on a computer, and/or in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Officer.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical

practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Jorge Lozano, Regional Manage, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169, Dallas, TX 75202
Voice Phone (800) 368-1019 FAX (214) 767-0432 TDD (800) 537-7697]
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Privacy Officer: Chris Mathis
Address: 5534 Rogers Road, Suite 105, San Antonio, Texas 78251
Phone: 210-684-100 Fax: 210-684-1003

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of RiverCity Women's Health, PLLC and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of RiverCity Women's Health, PLLC and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of RiverCity Women's Health, PLLC and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of RiverCity Women's Health, PLLC and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of RiverCity Women's Health, PLLC and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of RiverCity Women's Health, PLLC and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of RiverCity Women's Health, PLLC and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of RiverCity Women's Health, PLLC and affiliated providers may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize RiverCity Women's Health, PLLC and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with RiverCity Women's Health, PLLC and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of RiverCity Women's Health, PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the RiverCity Women's Health, PLLC and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 48 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

RiverCity Women's Health, PLLC and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that RiverCity Women's Health, PLLC and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

_____	_____	_____
Patient Name (Please Print)	Date	Patient Signature