UB|MD OBSTETRICS & GYNECOLOGY

Welcome to UBMD Obstetrics & Gynecology

UBMD Obstetrics & Gynecology offers the full spectrum of obstetric and gynecologic care from initial exam to childbirth, menopause and beyond. We provide routine and special gynecologic care, including preventive care, diagnosis and treatment for women with gynecologic illnesses, endocrine disorders and urologic disorders. Our patients benefit from the latest techniques, technology and treatments in their customized care plans, and we care for them at every stage of their life with exceptional skill and compassion. We provide continuity, open communication and a partnership between you, the patient, and the provider, so we can provide you with optimal care.

Our physicians have expertise in every area of obstetrics and gynecology, including:

- Prenatal care
- High-risk obstetrics
- Complex contraception
- General gynecologic care
- Pediatric and adolescent gynecology
- Reproductive endocrinology and infertility
- Polycystic ovary syndrome
- Amenorrhea
- Ultrasound
- Gynecologic surgery
- Minimally invasive surgery
- Female pelvic medicine and reconstructive surgery
- Treatment of disorders of female urinary incontinence
- Menopause management
- Hormone therapy
- Vulvar disorders

The practice is open Monday through Friday including specific days with extended hours. To schedule an appointment, cancel, or if you have any questions, please call the office at 716-636-8284, Monday through Thursday, 8:30am to 4:00pm, and Friday 8:30am to 2:45pm.

- Please notify the office 24 hours in advance if you must cancel or change your appointment.
- Arrive at least 15 minutes prior to your scheduled appointment, if you arrive later than 15 minutes of your scheduled appointment, your appointment may be rescheduled.
- Insurance cards and photo ID must be present at time of visit and co-payments are due at time of visit.
- Bring a list of your current medications to your appointment.
- If you are in active labor or are having an emergency, please seek treatment at the nearest hospital or delivering hospital.

Thank you for Choosing UBMD Obstetrics & Gynecology

Clinical Offices
1020 Youngs Road, Suite 110, Williamsville, NY 14221
Conventus, 1001 Main Street, 4th Floor, Buffalo, NY 14203
Phone 716-636-8284 Fax: 716-829-3008

UB|MD OBSTETRICS & GYNECOLOGY

Patient Portal

MyUBMD is the name of our Patient Portal (powered by Follow My Health™) where you can have 24 hour/day, 7 day/week access to your records from any computer, smartphone or tablet.

The Patient Portal is an online method of:

- Making or rescheduling appointments.
- Securely sending and receiving private healthcare information*.
- Receiving email reminders from your doctor's office.
- Viewing some of your lab results.
- Tracking blood pressure and weight.
- Requesting prescription refills.
- Setting-up proxy accounts for dependent children and/or dependent adults.

***Please note that portal messages should not be used for urgent requests (including urgent prescription requests). Always call the office for assistance with urgent matters and call 911 in cases of emergency.**

Tell the front desk staff at your next office visit that you want to participate in the patient portal. You will be given your private invitation/access code.

- Next, an email invitation will be sent to the inbox of the email account you provided to us.
- Once you open the email, click on 'Create an Account.'
- Click on the green FMH or Follow My Health button.
- Create a username and a password and then click on Continue.
- Click on Accept the Terms of Service.
- Enter your Invitation or Access Code.
- You may view the 3-minute 'how to' video or not.

You are now ready to use the Patient Portal whenever you wish. Make or change an appointment, refill a prescription, or view lab test results.

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UB|MD OBSTETRICS & GYNECOLOGY

New Patient Demographic Form

Patient Information:

Legal Name: _____ Date of Birth:_____

Address: _____

Telephone: Home: _____ Cell:_____

Email: _____

Emergency Contact:

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Relationship: _____ Relationship: _____

Insurance Information:

Insurance company: _____

Policy #: _____Group #:_____

Name of Insurance holder: _____

Relationship to insurance holder (if not self): _____

DOB of Insurance holder (if not self): _____

I hereby authorize payment to UBMD Obstetrics & Gynecology for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and for all service rendered on my behalf or dependents.

I authorize the above physicians group to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature of Responsible Party Date

Please provide the additional information below in order to complete the registration process with our practice. This information is used on our electronic health record (EMR) technology to monitor your health conditions, coordinate your treatment with national quality standards and communicate care decisions. Thank you.

Preferred Name: _____

Preferred Pronouns: _____

Current Gender Identity: _____

Primary Language:

- ☐ English
- ☐ Other (Please specify) _____

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Unknown

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Unknown

UB|MD Obstetrics & Gynecology

New Patient History Form

Name: _____ **Date of Birth**: _____ **Email**: _____

Phone Numbers: *Home* _____ *Cell* _____ *Work* _____

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy: _____ **Phone**: _____

Emergency Contact Information

Name: _____ *Relationship*: _____

Home Phone: _____ *Work Phone*: _____

Please check any and all of the reasons listed below why you came to the doctor today.
If not listed, please explain after "other".

☐ urinary frequency ☐ urinary urgency ☐ urinary leakage
☐ urinary tract infections ☐ night-time urination ☐ vaginal bulge
☐ pelvic pain ☐ discomfort with sexual activity ☐ blood in urine
☐ difficulty controlling bowels ☐ incomplete bladder or bowel emptying
☐ Other_____

When did the problem begin? _____

Obstetrical History

NUMBER		NUMBER		NUMBER	
Pregnancies	_____	Abortions	_____	Miscarriages	_____
Premature Births	_____	Term births	_____	Cesarean Section	_____

	Yes/ No	Pregnancy #
Forceps or Vacuum Deliveries		
Large tears at time of delivery		
Significant pregnancy complications not listed		

Gynecological History (Please provide information on any of the following that apply to you:)

How old were you when you had your first period? _____

Skip the next box if you are post menopausal or have had a hysterectomy

Date of last menstrual period _____ Average number of days per cycle _____
Are your periods regular? ☐ Yes ☐ No How long do they last? _____
Bleeding between periods? ☐ Yes ☐ No If yes, duration _____
Heavy periods? ☐ Yes ☐ No If yes, duration _____
Pain with periods? ☐ Yes ☐ No If yes, duration _____
Birth Control Method _____

Gynecological History continued….

Yes	No	
☐	☐	Have your menstrual periods stopped? If yes, at what age? _____
☐	☐	Have you had a hysterectomy? If yes, ☐abdominal ☐vaginal
☐	☐	Are you on hormone replacement therapy? If yes, which one? _____
☐	☐	Do you have Endometriosis, Cysts, Fibroids, or Pelvic pain? Please circle
☐	☐	Have you ever had an abnormal pap smear? If yes, when was your last abnormal? _____
☐	☐	Are you currently sexually active?
☐	☐	If not, have you been sexually active in the past?
☐	☐	Have you ever been treated for sexually transmitted disease?
		If yes, which one(s)? ☐Gonorrhea ☐ Chlamydia ☐ Syphilis
		☐ Herpes ☐ Warts ☐ Other
☐	☐	Is your sex life satisfactory to you?
☐	☐	Do you have pain with intercourse?
☐	☐	Do you have bleeding with intercourse?

How long have you been with your current sexual partner? _____
Do you have any questions about sex that you would like to ask?
_____

Preventative Health

When was your last pap smear?	_____	ever abnormal? _____
When was your last mammogram?	_____	abnormal? _____
When was your last DEXA bone density?	_____	abnormal? _____
When was your last colonoscopy?	_____	abnormal? _____

Medical History **(**check all that apply to you, **and add any other medical problems)**

☐ Heart disease (high blood pressure, heart disease)
☐ Heart Murmur
☐ High Cholesterol
☐ Stroke
☐ Kidney disease _____
☐ Diabetes : how long _____
☐ Osteoporosis
☐ Recurrent muscle or joint pain
☐ Glaucoma
☐ Breathing Problems (COPD, Asthma)
☐ Thyroid Condition
☐ Bleeding Problems or Deep Vein Thrombosis
☐ Liver Problems
☐ Back Pain
☐ Neurologic Problems (Parkinson's, MS)
☐ Mental Illness
☐ Cancer_____
☐ **Any other medical problems** _____
_____
_____
_____
_____

Surgical History (Please list any operations and the approximate date)

Operation	Date	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Allergies (Please list all medication, food and environmental allergies and describe the reaction.)

Allergy	Reaction

Medications (Please list all medications, vitamins and supplements you currently take. Include the dose and how often you take each medication.)

Medication	Dose	How often	Medication	Dose	How often

Personal History (Please provide as much information as possible. If not applicable, put N/A)

What do you do for a living? _____

Who do you live with? _____

Do you drink alcohol? ☐ No | ☐ Yes, for how long? _____, how much _____ Do you smoke? (cigarettes, cigars, marijuana?) ☐ No | ☐ Yes, for how long? _____, how much _____ Have you ever smoked? ☐ No | ☐ Yes , when did you quit? _____	Do you have trouble sleeping? (not rested in AM, use of medications to sleep, frequent awakening, trouble falling asleep, trouble staying asleep) ☐ No ☐ Yes, describe _____
Life Style ☐Active ☐ Sedentary Do you exercise? ☐ No | ☐ Yes , how much? _____	Do you have a health care proxy? ☐ Yes ☐ No

Family History (Please list any chronic health problems of blood relatives, including cancer history.)

Mother _____ Deceased? ☐ Yes ☐ No

Father _____ Deceased? ☐ Yes ☐ No

Siblings _____

Children _____

Review of Systems (Please check all symptoms that have occurred in the past 6 months

CONSTITUTIONAL
☐ Fever
☐ Feeling poorly
☐ Recent weight change
☐ Chills
☐ Feeling tired

EYES
☐ Eye pain
☐ Itchy eyes
☐ Dry eyes
☐ Wearing glasses
☐ Vision changes
☐ Blurry vision

EAR/NOSE/THROAT
☐ Earaches
☐ Nose bleeds
☐ Sore throat
☐ Loss of hearing
☐ Sinus problems
☐ Dental problems

CARDIOVASCULAR
☐ Chest pain
☐ Heart rate is fast
☐ Palpitations
☐ Leg swelling (Edema)
☐ Heart rate is slow

RESPIRATORY
☐ Shortness of breath
☐ Cough
☐ Shortness of breath with lying flat
☐ Wheezing
☐ Sleep Apnea
☐ Shortness of breath on exertion

GASTROINTESTINAL
☐ Abdominal pain
☐ Constipation
☐ Heartburn
☐ Vomiting
☐ Diarrhea
☐ Black stool (Melena)
☐ Nausea
☐ Early feeling of fullness
☐ Maroon colored stool

URINARY
☐ Blood in urine
☐ Cloudy urine
☐ Burning with urination
☐ Odor in urine
☐ Leakage of urine

OBGYN
☐ Abnormal bleeding
☐ Vulvar/Vaginal itching
☐ Irregular menses
☐ Mid-cycle bleeding
☐ Pelvic pain
☐ Pain with menses
☐ Post coital bleeding
☐ Vaginal dryness
☐ Pain with intercourse
☐ Vulvar pain
☐ No orgasm
☐ Decreased sexual drive
☐ Vaginal odor

MUSCULOSKELETAL
☐ Arthralgia (joint pain)
☐ Joint swelling
☐ Limb pain
☐ Joint stiffness
☐ Limb swelling

INTEGUMENTARY (SKIN)
☐ Acne
☐ Itching/Skin Rash
☐ Breast pain
☐ Breast discharge
☐ Change in a mole
☐ Breast lump

NEUROLOGICAL
☐ Confused
☐ Dizziness
☐ Limb weakness
☐ Memory problems
☐ Headaches/Migraines
☐ Difficulty walking
☐ Tremor

PSYCHIATRIC
☐ Suicidal
☐ Anxiety
☐ Change in personality
☐ Sleep disturbances
☐ Depression
☐ Emotional problems

ENDOCRINE
☐ Hair loss
☐ Muscle weakness
☐ Hot flashes
☐ Deepening of the voice
☐ Dry skin
☐ Heat/Cold intolerance

HEMATOLOGY/IMMUNOLOGY
☐ Easy bleeding
☐ Swollen glands
☐ Easing bruising
☐ Seasonal Allergies
☐ Hay fever

Supplementary Medication List

(Please list all medications, vitamins and supplements you currently take.
Include the dose and how often you take each medication.)

Medication	Dose	How Often?

Notes:

NOTICE OF PRIVACY PRACTICES

UBMD Obstetrics-Gynecology

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.

EFFECTIVE DATE OF THIS NOTICE: April 14, 2003 **REVISED DATE OF THIS NOTICE: May 26, 2017**

1. UBMD Obstetrics-Gynecology (PRACTICE PLAN) LEGAL OBLIGATIONS

We are required by law to maintain the privacy of your protected health information (PHI). This includes information that can be used to identify you that we have created or received about your past, present or future health or condition, the provision of health care for you, or the payment of this health care.

We are required by law to provide you with a Notice of Privacy Practices (NPP) which describes our legal duties and privacy practices with respect to PHI. This notice will tell you about the ways in which we may use and disclose PHI about you. It also describes your rights and our obligations regarding the use and disclosure of your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this NPP. We are required to post the NPP within our facility and website and we are required to abide by the terms of the NPP that is currently in effect.

Please note, however, that special privacy protections apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information and genetic information, which are not set forth in this notice. Uses and disclosures for these purposes reflect other more stringent, applicable laws. For more information please contact the person listed in Section 4. Contact, of this NPP.

We reserve the right to change the terms of the NPP and our privacy policies at any time. Any changes made will apply to the PHI we already have about you as well as any information we create or receive in the future. We will promptly post the revised NPP, with a new effective date. Upon your request, a copy of the revised NPP will be made available to you.

We will notify you promptly and in no case later than 60 days after the discovery of the breach that may have compromised the privacy or security of your PHI.

2. HOW Practice Plan MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations. The following categories describe different ways that we may use or disclose your PHI. Examples are provided where appropriate, although it is impossible to list every use and disclosure in each category.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with another physician. We will also disclose PHI to other physicians or health care professionals who may be treating you. For example, to a physician to whom you have been referred to ensure that he/she has the necessary information to diagnose or treat you.

Payment: We may use and disclose PHI about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose PHI to a health plan in order for the health plan to pay for the services rendered to you. We may also tell your health plan about a treatment or procedures you are going to receive in order to obtain prior approval or to determine whether your health plan will cover the services.

Health Care Operations: We may use and disclose PHI about you for Practice Plan operations. These uses and disclosures are necessary to run our Practice Plan in an efficient manner and ensure that all patients receive quality care. For example, your medical records and PHI may be used in the evaluation of health care services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing. We may also disclose PHI about you to medical students and residents for review and learning purposes.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. For example, we may provide a written or telephone reminder that your next appointment is coming up.

UBMD, of which Practice Plan is a member, shares an integrated electronic medical record so that your caregivers at various UBMD offices can provide you with high quality, coordinated care. Access to the integrated medical record is expressly restricted to those clinicians and staff involved in your care, or to those who need the information for payment or health care operations or other purposes as set forth in this Notice.

To the extent we are required to disclose your PHI to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations, we will have a written agreement to ensure that our business associates also protect the privacy of your PHI.

Other Uses and Disclosures that Require Your Prior Written Authorizations.
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described in this NPP. If you choose to sign an authorization to disclose your PHI, you may revoke such authorization in writing, at any time, except to the extent that action has been taken in reliance of the use or disclosure indicated in the authorization.

Other Uses and Disclosures Where You Have the opportunity to Agree or Object.
Disclosures to Family, Friends or Others (Individuals Involved in your Care or Payment of your Care): We may release PHI about you to a friend or family member who is involved in your medical care or the payment of your health care, unless you object in whole or part. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Uses and Disclosures that May Be Made Without Your Consent, Authorization or Opportunity to Object. We may use and disclose your PHI without your consent or authorization for the following reasons:

Required by Law: We will disclose PHI about you when required to do so by federal, state or local law and the use or disclosure complies with and is limited to the relevant requirements of such law.

For Public Health Activities: We will report information about births and deaths; to prevent or control various diseases; to report child abuse and neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease. All such disclosures will be made in accordance with the requirements of federal, state or local law.

About Victims of Abuse, Neglect or Domestic Violence: We may release your PHI to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.

For Health Oversight Activities: We may disclose PHI about you to a health oversight agency for activities authorized by law. These health oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

Lawsuits and Disputes: We may disclose your PHI if we are subpoenaed or ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

For Law Enforcement Purposes: We may release your PHI if asked to do so by a law enforcement official for any of the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's consent; about a death we believe may be the result of criminal conduct; about criminal conduct that occurred on our property; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

For Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner when authorized by law. This may be necessary, for example, to determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

For Organ or Tissue Donation Purposes: If you are an organ donor, we may release PHI to organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

To Avert a Serious Threat to Health or Safety: In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

Specialized Government Functions: We may disclose PHI for national security purposes to authorized federal officials authorized by law. In addition we may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign head of state or to conduct special investigations.

Military and Veterans Activities: If you are a members of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing PHI that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation: We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Emergency Situations: We may use or disclose your PHI if you need emergency treatment and we are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

Communication Barriers: We may use or disclose your PHI if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with the patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs or on decedents. Under other limited circumstances, we will ask for your written authorization before using your PHI for research purposes.

Health–Related Benefits or Services: We may use or disclose PHI to give you information about treatment alternatives or other health care services or benefits we offer and/or provide or that may be of interest to you.

Marketing: We will not disclose your PHI for marketing purposes unless you give us permission.

Fundraising: We may use PHI to contact you in an effort raise funds for our Practice Plan and its operations. We may also disclose PHI to other foundations or business associates so that these foundations or business associates may contact you in raising money for our Practice Plan. We would only release information such as name, address and phone number, the dates you received treatment or services, outcomes, and the name of the health care professional who treated you. For all other fund raising activities, you have the opportunity to opt out of receiving any further fundraising communications. To opt out, please contact the person listed in Section 4. Contact, of this NPP.

De-identified Information: We may also disclose your PHI if it has been de-identified or if it is not possible for anyone to connect the information back to you.

Incidental Disclosure: While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your PHI may occur during, or as an unavoidable result of our otherwise permissible uses and disclosures of your PHI. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your PHI.

3. INDIVIDUAL RIGHTS

The Right to Request Restrictions on Certain Uses and Disclosures of PHI.
You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We will consider your request for restrictions, but we are not legally required to accept it. If we accept your request, we will comply with your request except in emergency situations. To request restrictions, you must make your request in writing to the contact person listed in Section 4. Contacts of this NPP. The request must include 1. what information you want to limit; 2. whether you want to limit our use, disclosure or both; and 3. to whom you want the limits to apply, for example, disclosures to your spouse.

The Right to Receive Confidential Communications of PHI.
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You do not have to state a reason for your request. We will accommodate all reasonable requests. Your request must be in writing and specify how or where you wish to be contacted. To make a request please contact the person listed in Section 4. Contact, in this NPP.

The Right to Restrict Disclosure of PHI When You Pay For a Service in Full.
If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

The Right to Inspect and Copy PHI.
You have the right to access (inspect and/or copy) medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes that are maintained in separate files.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the contact person listed in Section 4. Contact, in this NPP. We will respond to your request to inspect within 10 days. We will respond to your request to copy within 30 days. If you request a copy of the information electronically or on paper, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In addition, instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to any associated costs in advance. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial, explain your right to have the denial reviewed, and the process by which you may complain to Practice Plan or Secretary of the Department of Health and Human Services (See Section 5. Complaints, of this NPP). If you request that the denial be reviewed, another licensed health care professional chosen by Practice Plan will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

The Right to Amend PHI.
If you feel that medical information maintained about you is incorrect or incomplete, you may request that we amend the information. You have the right to request an amendment for as long as the information is kept by Practice Plan.

You must provide the request and your reason for the request in writing to the contact person listed in Section 4. Contact, in this NPP. We will ordinarily respond within 60 days of receiving your request. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and a date by which you will have a final answer to your request, which shall be no later than 90 days from the date of the original request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that 1. was not created by us, unless the person or entity that created the information is no longer available to make the amendment; 2. is not part of the medical information kept by or for Practice Plan; 3. is not part of the information which you would be permitted to inspect or copy; or 4. is accurate and complete. Our written denial will state the reasons for the denial, explain your right to file a written statement of disagreement with the denial, and the process by which you may complain to Practice Plan or Secretary of the Department of Health and Human Services (See Section 5. Complaints, of this NPP). This statement must be submitted in writing to the contact person listed in Section 4. Contact, of this NPP. If you do not file such a statement, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done so and tell others that need to know about the changes to your PHI.

The Right to Receive an Accounting of Disclosures of PHI.
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI, but will not include uses or disclosures that you have already been informed of in this NPP, such as those made for treatment, payment or health care operations, directly to you, or to your family or pursuant to a signed authorization. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or those made before April 14, 2003.

To request this list or accounting of disclosures, please submit your request in writing to the person listed in Section 4. Contact, of this NPP. Your request must state the time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We 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. We will respond to your request within 60 days. The list you receive will include 1. date of the disclosure; 2. to whom the PHI was disclosed, including their address, if known; and 3. a brief description of the PHI disclosed and the reason for the disclosure.

The Right of an Individual to Receive a Paper Copy of this NPP.
You have the right to a paper copy of this NPP. You may ask us to give you a copy of this NPP at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this NPP, please contact the person listed in Section 4. Contact.

4. CONTACT

John Garbay
UBMD Obstetrics-Gynecology
1001 Main St, Floor 5
Buffalo, NY 14203
716-323-0616

If you have any questions about this NPP or our privacy practices please contact:

The Site Manager for the location at which you are being seen or

5. COMPLAINTS

If you think your privacy rights have been violated or you disagree with a decision we made about access to your PHI, you may file a complaint with UBMD Obstetrics-Gynecology by contacting the person listed above in Section 4. You may also send a written complaint to the Secretary of the Department of Health and Human Services at Office of the Secretary, Department of Health & Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

THIS DOCUMENT IS ALSO AVAILABLE IN LARGER PRINT.

Wehrle Office
755 Wehrle Drive
Cheektowaga, NY 14225

Conventus Office
1001 Main St, Floor 4
Buffalo, NY 14203

UB|MD OBSTETRICS GYNECOLOGY

UBMD Obstetrics-Gynecology Practice Information

Thank you for choosing UBMD and trusting us with your medical care. Our practice is committed to providing you with the highest quality care, service and access. In order to help accomplish these goals, we would like to provide you with the following information regarding our practice, including our financial policy.

General Information

- **Contact Information – Billing Office**
  - Billing Office: 716.878.2480
  - Hours: Monday - Friday 7:30 am – 4:30 pm

- **Contact Information - Clinical Offices**
  - If you wish to contact a physician regarding a medical matter, please call the office at **716.636.8284** or use the ***online Patient Portal*** (see information below). **DO NOT contact physicians via e-mail**, as we would like to ensure a secure HIPAA compliant communication of your protected health information. A medical provider is on call seven (7) days per week to take urgent calls outside normal business hours. Your call will be returned within one (1) hour. **For emergencies, call 911.**

- **Patient Portal (Secure, Online Communication)**
  - The ***UBMD Follow My Health (online) Patient Portal*** provides all participating UBMD patients the ability to communicate securely and manage their own healthcare with UBMD providers, 24 hours, 7 days a week. All messages received through the ***online Patient Portal*** will be answered within one business day. The ability to view portions of your medical records, verify or request appointments, request prescriptions, update demographic information, receive reminders and ask a question to your provider are some functions of the portal. All patients are encouraged to notify our UBMD Obstetrics-Gynecology staff by phone/at your next visit to request an invitation to create an account on Follow My Health to become participants of the UBMD Patient Portal.

- **Address and/or Phone Number Change**
  - Please advise our practice anytime there is a change in your address, phone number, or other contact information. Our staff is required to verify all demographic and insurance information at every visit.

- **Policy and Fee Changes**
  - These policies and fees are subject to change. We will do our best to keep you informed of any modifications

Appointments

- **Set Up and Arrival**
  - Please arrive 15 minutes prior to your appointment time to register. For your benefit and the benefit of all our patients, we try to stay on schedule (though emergencies sometimes occur) and aim for patients to be in the exam room at their appointment time. You will receive an automated pre-appointment reminder call two (2) business days before your appointment. It is important for you to notify our office if your phone number has changed. Please specify if you prefer your home or mobile number as your primary contact.
- **Test Results**
  - Please allow seven (7) business days for laboratory results or other diagnostic test results unless instructed by your physician. Your physician will review all test results, and will contact you if needed. Routine lab results may be relayed by patient portal or telephone.

- **Address and/or Phone Number Change**
  - Please advise our practice anytime there is a change in your address, phone number, or other contact information. Our staff is required to verify all demographic and insurance information at every visit.

- **No show/cancellation fee**
  - The practice requires 24-hour notice of appointment cancellation. If this requirement is not followed, a fee is assessed to the patient. A fee of $50.00 will be assessed for office visits and/or procedures and $100.00 for hospital surgeries.

Financial and Insurance

- **Financial Policy**
  - Your clear understanding of our Patient Financial Policy is important to us. Please ask if you have any questions about our fees, policies, or your responsibilities.

- **Insurance Verification and Copayments**
  - Patients are expected to present valid photo identification and their insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing supervisor. Failure to pay your copay will result in your appointment being rescheduled. We accept cash, check, credit card or flexible spending card. No post-dated checks are accepted. A $35.00 returned check fee is added to any insufficient funds amount owed by the patient. The patient may be placed on a cash-only basis following any returned check.

- **Insurance Claims**
  - The practice will bill the patient's primary insurance company. In order to properly bill the insurance company, the practice requires that the patient disclose all insurance information including primary and secondary insurance, as well as any insurance changes. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. Although the practice may estimate the amount the insurance company may pay, it is the insurance company that makes the final determination of the patient's eligibility and/or benefits. The patient is responsible and agrees to pay for any non-covered services provided. If the insurance company is not contracted with the practice, the patient agrees to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

- **Participating Insurances**
  - The practice participates with most insurance plans including but not limited to: Blue Cross/Blue Shield, Empire, Fidelis, Independent Health, Univera, United Healthcare, Wellcare, Tricare and Medicare. Participation in insurance plans may change. It is your responsibility to verify if UBMD participates in your plan. If your physician does not participate with your insurance, you have the right to request a cost estimate.

- **High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)**
  - ***Office Visits**
    - If your insurance is a High Deductible Plan, you will be required to pay a $100.00 deposit prior to your visit. If the total cost of services rendered is more than $100.00 you will be billed for the remaining amount. If the cost of your visit is less than $100.00 we will send you a refund for the difference. Refunds will be issued within 60 days if the overall patient account has a credit balance.
  - ***Obstetrics**
    - There is a $500.00 deposit for services obstetrics related. You will be billed $250.00 per month until your balance is paid in full.

- **Referrals and Authorizations**
  - It is the patient's or guarantor's responsibility to be aware of the details of his/her insurance coverage, including any requirements for referrals and/or authorizations. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage. If your insurance company requires a referral and/or authorization (for specialist visits/testing), you are responsible for obtaining it. You cannot be seen without a required referral or authorization and will be rescheduled. To verify if we have received the appropriate referral or authorization, please contact our office.

- **Self-pay Accounts**
  - Self-pay accounts are patients without insurance coverage or patients without an insurance card on file with UBMD. This includes patients who have applied for Medicaid but who do not yet have a valid Medicaid number. The practice does not accept attorney letters or contingency payments. It is always the patient's responsibility to know if the practice participates with their insurance plan. If there is a discrepancy with the insurance information on file with the practice, the patient is considered self-pay unless otherwise proven. Self-pay patients are expected to make a down payment at the time of service *($115.00 for new patients* and *$75.00 for established patients*). If the down payment does not cover all treatment charges, the patient is billed for the remaining balance. Payment plans are available if needed. Please contact the billing office to discuss a mutually agreeable payment plan. It is not the intention of the practice to cause hardship to patients, only to provide them with the best care possible and the least amount of stress. . Failure to make the deposit at the time of service will result in your appointment being rescheduled.

  - ***Obstetrics**
    - All obstetrics self-pay cases will be given a quote for services prior to their first appointment. Payment for services is due in full. If you are unable to pay for services at time of first visit, patient can call the Billing Manager to arrange for possible payment plan options.

- **Workers' Compensation and Automobile Accidents (No Fault)**
  - In the case of a workers' compensation injury or automobile accident, the patient must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to the visit. If this information is not provided, the patient will be asked to either reschedule the appointment or pay for the visit at the time of service.

- **Minors**
  - The parent or guardian who holds the insurance for the child is considered the guarantor for the child and is responsible for full payment regardless of personal circumstances. A signed release to treat may be required for unaccompanied minors.

- **Outstanding Balance Policy**
  - A billing statement is sent to the patient/guarantor upon rendering of services. Statements are mailed every twenty-eight (28) days thereafter. If a patient's account is sixty (60) days past due, the patient is sent a Final Collection letter requesting payment within fifteen (15) days. Telephone calls may be made to the patient prior to sending an account to collection in a final attempt to collect the outstanding balance. If no payment is received, the account is sent to a collection agency. Statements returned with an invalid address, will be sent to the collection agency. Any account sent to a collection agency will include collection, attorney and court fees and may be credit reported.
  - Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made, pursuant to this agreement, your account may be turned over to a collection agency.
  - Regardless of any personal arrangements that a patient might have outside of the office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other individual.

<u>Other Services and Fees</u>

- **Prescription Refills**.
  - For routine refills, please contact your pharmacy and have them send a prescription refill request electronically. Refills can be requested through our ***<u>online patient portal</u>*** for those who are currently enrolled. Please allow five (5) business days to have all medications refilled. For refill requests needed in less than 5 business days, contact the office.

- **Form Completion Fee**
  - There will be a $10.00 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of request. Please allow seven (7) business days for us to complete any forms.

- **Medical Record Copies**
    - Patients requesting copies of medical records are charged $.75 per page. A charge of $15.00 applies for the retrieval of records in off-site storage including those medical records transferred from another practice.

UBMD Obstetrics-Gynecology

Assignment of Benefits, Financial Responsibility, Release of Information And Receipt of Notice of Privacy Practices

- **Assignment of Benefits**
  I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to UBMD Obstetrics-Gynecology for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.
  Please initial x_____
- **Financial Responsibility**
  I have requested medical services from UBMD Obstetrics-Gynecology on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment. I also acknowledge that I have read the financial policy of the practice, agree to be bound by its terms, and understand that such terms may be amended from time-to-time by the practice.
  Please initial x_____
- **Release of Information**
  I authorize the release of necessary medical information to UBMD Obstetrics-Gynecology for the purpose of processing this or any related claim. I also authorize UBMD Obstetrics-Gynecology to release requested documentation of this claim or any related claim to myself and/or other health care providers involved in the treatment of my condition.
  Please initial x_____
- **Teaching Facility**
  I acknowledge that UBMD Obstetrics-Gynecology is affiliated with the University at Buffalo School of Medicine and Biomedical Sciences and, as such, students may become involved in my care. If I am concerned about the involvement of medical students, I must speak to the physician responsible for my care.
  Please initial x_____
- **Phone Notifications**
  I authorize UBMD Obstetrics-Gynecology to remind me of my appointments and other useful information using automatic, prerecorded or artificial voice calls to me on the phone number I listed; even if it is a cellular phone number.
  Please initial x_____
- **Notice of Privacy Practices**
  UBMD Obstetrics-Gynecology is required to provide me a copy of their Notice of Privacy Practices which describes how medical information about me may be used and disclosed and how I can get access to this information. Any restrictions concerning the use of my personal medical information must be made in writing. By signing below, I acknowledge that I received a copy of UBMD Obstetrics- Gynecology Notice of Privacy Practices.
  Please initial x_____

Documentation of Good Faith Efforts – For UBMD Obstetrics-Gynecology use only

A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of UBMD Obstetrics-Gynecology Notice of Privacy Practices. However, such acknowledgment was not obtained because:

_____ Patient refused to sign
_____ Due to an emergency, it was not possible to obtain an acknowledgement
_____ Unable to communicate with patient
_____ Other (please provide specific details)

_____

_____

_____ _____
Employee Signature Date

_____ _____
Patient Name (print) Patient Date of Birth

_____ _____
Patient Signature or Responsible Party if a Minor Date

Name: _____

Date of Birth: _____

Receipt of Notice of Privacy Practices

I, _____have received a copy of the UBMD Obstetrics & Gynecology, Notice of Privacy Practice.

Authorization to release information to family and/or friends

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

Authorization to leave messages (Check all that apply)

- ☐ Home Answering Machine
- ☐ Cell number
- ☐ Work number _____
- ☐ Mailing
- ☐ Email

Restrictions to release of information

_____

_____

_____

_____ _____

Signature of Patient/Representative Date

HEALTHeLINK Authorization for Access to Patient Information Through HEALTHeLINK

Patient First Name

Patient Last Name

Date of Birth M M / D D / Y Y Y Y

Patient Address

Street _____ Apartment _____

City _____, State _____ Postal Code _____

Gender

☐ Male

☐ Female

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at www.wnyhealthelink.com.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

SELECT ONLY ONE

My Consent Choice. Only ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

☐ **1. YES**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **4. NO, EXCEPT IN AN EMERGENCY**	**I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.
☐ **5. NO, EVEN IN AN EMERGENCY**	**I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative

X_____

Date of Signature M M / D D / Y Y Y Y

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other_____

This Box To Be Filled Out Only By The Provider

UBMD Obstetrics & Gynecology

Entity Consent Received By

Witness*

*Required if NOT completing this form in a Participant's office.

Print Name of Witness _____ Signature of Witness _____

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.) _____

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information May Be Used.** With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information About You Are Included.** If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other eHealth organizations that exchange health information electronically. A complete list of current Information Sources is available from HEALTHeLINK at www.wnyhealthelink.com or by calling 716- 206-0993 ext. 311.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at www.wnyhealthelink.com/PhysiciansandStaff/CurrentParticipants/ParticipatingHEALTHeLINKProviders or by calling 716-206-0993 ext. 311 if you want a hard copy which will be provided at no charge within 5 business days of the request.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at www.wnyhealthelink.com; or call HEALTHeLINK at 716- 206-0993 ext. 311; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

6. **Re-disclosure of Information.** Any Participant(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

7. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation ***(or until 50 years after your death whichever occurs first)***. If HEALTHeLINK merges with another Qualified Entity our consent choices will remain effective with the newly merged entity.

8. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Participant(s) that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.