



## 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, 4<sup>th</sup> Floor, Buffalo, NY 14203  
Phone 716-636-8284 Fax: 716-829-3008

## 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.

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_  
 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.

**Marital Status:**

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

**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

**Email address to send you an invite to the Patient Portal?**

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Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for Today's visit: \_\_\_\_\_

**OBSTETRIC HISTORY:**

Number of previous pregnancies: \_\_\_\_\_ (If more than 4, list last 4 below)

Year	Outcome of pregnancy (term, preterm, ectopic, miscarriage, abortion)	Live Birth (Yes/No)	Type of Delivery (vaginal or cesarean)

**GYNECOLOGIC HISTORY:**

Age at first menstrual period: \_\_\_\_\_

Last menstrual period: \_\_\_\_\_

How often are your periods? \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

Flow: ☐ Heavy ☐ Average ☐ Light Last Pap smear: \_\_\_\_\_ ☐ NORMAL ☐ ABNORMAL

Have you ever had a Colposcopy? ☐ YES ☐ NO

POST MENOPAUSAL: Post-Menopausal at age: \_\_\_\_\_

Did you use Hormone Replacement Therapy? ☐ NO ☐ YES (If yes, specify and how long): \_\_\_\_\_

Do you now have, or ever had, the following? Check all that apply:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Chlamydia         | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Abnormal Pap test   |
| <input type="checkbox"/> Gonorrhea         | <input type="checkbox"/> Uterine fibroids            | <input type="checkbox"/> Urinary incontinence       | <input type="checkbox"/> Recurrent vaginitis |
| <input type="checkbox"/> Herpes            | <input type="checkbox"/> Pain with sex               | <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Vaginal dysplasia   |
| <input type="checkbox"/> HIV               | <input type="checkbox"/> Ovarian cyst                | <input type="checkbox"/> Abnormal uterine structure | <input type="checkbox"/> Vulvar dysplasia    |
| <input type="checkbox"/> HPV/genital warts | <input type="checkbox"/> Chronic pelvic pain         | <input type="checkbox"/> Yeast                      | <input type="checkbox"/> Vulvar pain         |
| <input type="checkbox"/> Syphilis          | <input type="checkbox"/> Premenstrual syndrome (PMS) | <input type="checkbox"/> Bacterial vaginosis (BV)   | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Trichomonas       |  |   |  |

**MEDICAL HISTORY:** Do you now have, or ever had, the following? Check all that apply:

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes Type I     | <input type="checkbox"/> Bone/Joint disease   | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Migraines    |
| <input type="checkbox"/> Diabetes Type II    | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Osteopenia   |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer (type?) _____ | <input type="checkbox"/> Hypothyroidism  | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> GI illness      | <input type="checkbox"/> Seizures     |
| <input type="checkbox"/> Bleeding disorder   | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Hot flashes     | <input type="checkbox"/> Sleep Apnea  |
| <input type="checkbox"/> Blood transfusion   |   |  | <input type="checkbox"/> Other: _____ |

Have you ever had a mammogram? ☐ NO ☐ YES if yes, when: \_\_\_\_\_

Have you ever had a colonoscopy? ☐ NO ☐ YES if yes, when: \_\_\_\_\_

**SEXUAL HISTORY:**

Are you currently sexually active? ☐ NO ☐ YES Is your current partner(s): ☐ MALE ☐ FEMALE ☐ BOTH

Do you or your partner have more than one partner? ☐ NO ☐ YES

Current birth control method: \_\_\_\_\_

**SOCIAL HISTORY:**

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Engaged ☐ Significant other ☐ Same sex partner

What is your occupation? \_\_\_\_\_

Do you drink Alcohol? ☐ NO ☐ YES If yes, how much per week? \_\_\_\_\_

Do you use Recreational Drugs? ☐ NO ☐ YES If yes, specify type, amount and frequency: \_\_\_\_\_

Tobacco use: ☐ NEVER ☐ CURRENT (\_\_\_\_# of cigarettes per day) ☐ FORMER (Quit at age \_\_\_\_)

Do you exercise? ☐ NO ☐ YES If yes, specify type and frequency: \_\_\_\_\_

**SURGICAL HISTORY:**

Surgical Procedure	Hospital	Year

Any difficulties/problems with anesthesia? ☐ NO ☐ YES if yes, specify: \_\_\_\_\_

**FAMILY HISTORY:** ☐ NO ☐ YES if yes, please indicate below

ILLNESS	MOTHER	FATHER	SIBLING	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER
Diabetes							
Heart Disease							
Cancer (type)							
Mental health disease							
Other: Specify							

**Allergies (Medication and Environmental):** \_\_\_\_\_

**Current Medications (include all prescription, over the counter and topical medications):**

Medication	Dose and Frequency	Condition

Pharmacy Name

Address

Telephone Number

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Referring Provider's Name and Address:

\_\_\_\_\_

**Chief Concern** for Today's Visit:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_

What do you think is causing your symptoms? \_\_\_\_\_

\_\_\_\_\_

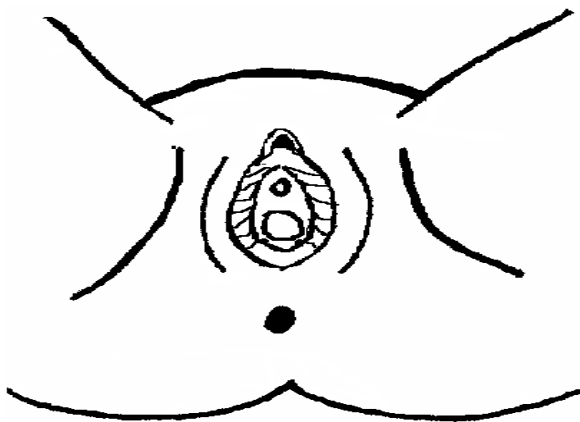
Is there an event that you associate with the onset of your pain? ☐ Yes ☐ No

If so, what? \_\_\_\_\_

\_\_\_\_\_

**Pain Map:**

Please shade areas of pain and write a number from 1 to 10 at the site of pain, (10 = worst pain imaginable).



## Pain Dairy:

For each of the symptoms listed below, please check your level of pain over the last month using a 10-point scale:

0 = no pain, 10 = worst pain imaginable	0	1	2	3	4	5	6	7	8	9	10
Pain at ovulation (mid-cycle)											
Pain just before your period											
Deep pain with intercourse											
Pain in groin with lifting											
Pelvic pain lasting hours/days after sexual intercourse											
Pain with full bladder											
Muscle/joint pain											
Cramps with menstrual period											
Pain after menstrual period is over											
Burning vaginal pain after sex											
Pain with urination											
Backache											
Migraine headache											
Pain with sitting											

## Demographic Information:

Are you (check all that apply):

- ☐ Married ☐ Widowed ☐ Separated ☐ Committed Relationship  
☐ Single ☐ Remarried ☐ Divorced

Who do you live with?

Education: ☐ Fewer than 12 years ☐ High School graduate  
☐ College degree ☐ Postgraduate degree

What type of work are you trained for?

What type of work are you doing?

## Obstetrical History

How many pregnancies have you had? \_\_\_\_\_

Resulting in (#): \_\_\_\_\_ Full 9 months \_\_\_\_\_ Premature \_\_\_\_\_ Miscarriage / Abortion  
\_\_\_\_\_ Living children

Were there any complications during pregnancy, labor, delivery, or postpartum?

- ☐ 4° Episiotomy ☐ C-Section ☐ Vacuum ☐ Post-partum hemorrhage  
☐ Vaginal laceration ☐ Forceps ☐ Medication for bleeding ☐ Other \_\_\_\_\_



**Health Habits:**

How often do you exercise?

☐ Rarely ☐ 1-2 times weekly ☐ 3-5 times weekly ☐ Daily

What is your caffeine intake (number cups per day, coffee, tea, soft drinks, etc)?

☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6

How many cigarettes do you smoke per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks per week \_\_\_\_\_

Have you ever received treatment for substance abuse? ☐ Yes ☐ No

What is your use of recreational drugs? ☐ Never used ☐ Used in the past, but not now ☐ Presently using ☐ No answer

☐ Heroin ☐ Amphetamines ☐ Marijuana ☐ Barbiturates ☐ Cocaine ☐ Other \_\_\_\_\_

How would you describe your diet? (check all that apply)

☐ Well-balanced ☐ Vegan ☐ Vegetarian ☐ Fried food

☐ Special diet \_\_\_\_\_ ☐ Other \_\_\_\_\_

**Medical History:**

	You	Family Member (specify)
Fibromyalgia		
Depression		
Chronic Pelvic Pain		
Interstitial Cystitis		
Endometriosis		
Irritable Bowel Syndrome		
TMJ		
Other Chronic Condition		

Please list all other **Medical Problems/Diagnoses:**

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**Allergies** (including latex allergy):

Who is your primary care provider?

Have you ever been hospitalized for anything besides childbirth? ☐ Yes ☐ No

If yes, please explain:

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Have you had major accidents such as falls or a back injury? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy

Birth control method: ☐ Nothing ☐ Pill ☐ Vasectomy ☐ Vaginal ring ☐ Depo-

provera ☐ Condom ☐ IUD ☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization

☐ Other \_\_\_\_\_

Please list all treatments you have had for your condition, including prescribed medications, over the counter medications and surgical treatments, when you tried each treatment, and if the treatment was of benefit:

Treatment	Year	Benefit?

Sexual and Physical Abuse History	As a Child (< 13)		As an Adult (> 14)	
	Yes	No	Yes	No
Have you ever been the victim of emotional abuse?				
Has anyone ever exposed their sex organs to you against your will?				
Has anyone ever threatened to have sex with you against your will?				
Has anyone ever touched your sex organs against your will?				
Has anyone ever made you touch their sex organs against your will?				
Has anyone forced you to have sex against your will?				
Have you had other unwanted sexual experiences? If yes, please specify below:				

When you were a child (13 or younger), did an older person do the following?

Hit, kick, or beat you? ☐ Never ☐ Seldom ☐ Occasionally ☐ Often

Seriously threaten your life? ☐ Never ☐ Seldom ☐ Occasionally ☐ Often

Now that you are an adult (14 or older), has any other adult done the following?

Hit, kick, or beat you? ☐ Never ☐ Seldom ☐ Occasionally ☐ Often

Seriously threaten your life? ☐ Never ☐ Seldom ☐ Occasionally ☐ Often

Please Circle Best Answer for					
<b>Bladder Function Questions</b>	0	1	2	3	4
How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20 or more
How many times do you go to the bathroom at night?	0	1	2	3	4 or more
Does it bother you if you get up to void (empty your bladder) at night?	Never	Mildly	Moderately	Severely	
Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
If you have urgency, is it usually?	Never	Mild	Moderate	Severe	
Does your urgency bother you?	Never	Occasionally	Usually	Always	
Do you have pain associated with your bladder or in your pelvis?	Never	Occasionally	Usually	Always	
If you have pain, is it usually?	Never	Mild	Moderate	Severe	
Does your pain bother you?	Never	Occasionally	Usually	Always	

## The Female Sexual Distress Scale-Revised (FSDS-R; revised 2005)

Below is a list of feelings and problems that women sometimes have concerning their sexuality. Please read each item carefully, and check the box that corresponds with the number that best describes **HOW OFTEN THAT PROBLEM HAS BOTHERED YOU OR CAUSED YOU DISTRESS DURING THE PAST 30 DAYS INCLUDING TODAY.**

NEVER=0    RARELY=1    OCCASIONALLY=2    FREQUENTLY=3    ALWAYS=4

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\* DeRogatis L, et al. *J Sex Med.* 2008;5:357-364.

	0	1	2	3	4
Distressed about your sex life					
Unhappy about your sexual relationship					
Guilty about sexual difficulties					
Frustrated by your sexual problems					
Stressed about sex					
Feel inferior because of sexual problems					
Worried about sex					
Feel sexually inadequate					
Regrets about your sexuality					
Embarrassed about your sexual problems					
Dissatisfied with your sex life					
Angry about your sex life					
Bothered by low sexual desire					

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please check all symptoms that you are currently experiencing:

**Constitutional**-----

- ☐ Fever
- ☐ Chills
- ☐ Malaise
- ☐ Fatigue
- ☐ Anorexia
- ☐ Unintended weight gain

**Head and Face**-----

- ☐ Facial Pain
- ☐ Facial Pressure

**Eyes**-----

- ☐ Eye pain
- ☐ Red eyes
- ☐ Discharge from eyes
- ☐ Itchy eyes
- ☐ Blurred vision
- ☐ Vision changes
- ☐ Corrective lenses

**ENT**-----

- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing ears
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Scratchy throat
- ☐ Change in voice/hoarseness
- ☐ Dentures

**Cardiovascular**-----

- ☐ Chest pain
- ☐ Racing heart
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Lightheadedness/Fainting
- ☐ Poor exercise tolerance

**Respiratory**-----

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sleeping upright/extra pillow
- ☐ Cough
- ☐ Dry cough
- ☐ Productive cough
- ☐ Clear sputum
- ☐ Colored sputum
- ☐ Vomiting blood
- ☐ Daytime sleepiness

**Gastrointestinal**-----

- ☐ Decreased appetite
- ☐ Difficulty swallowing
- ☐ Esophageal reflux
- ☐ Abdominal pain
- ☐ Abdominal bloating
- ☐ Abdominal cramps
- ☐ Menstrual pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Unable to pass flatus
- ☐ Constipation
- ☐ Dark/bloody stools
- ☐ Rectal bleeding
- ☐ Change in color/size of stool
- ☐ Fecal incontinence

**Genitourinary**-----

- ☐ Difficult/painful urination
- ☐ Loss of urine
- ☐ Urinary hesitancy
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Night time urination
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Flank pain
- ☐ Suprapubic pain
- ☐ Pelvic pain
- ☐ Foul-smelling vaginal discharge
- ☐ Heavy menstrual bleeding
- ☐ Painful menstrual cramps
- ☐ Missed menstrual period
- ☐ Suspected pregnancy
- ☐ Confirmed pregnancy
- ☐ Difficult/painful intercourse
- ☐ Postmenopausal bleeding

**Musculoskeletal**-----

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Back pain
- ☐ Limping
- ☐ Falls

**Skin/Breast**-----

- ☐ Skin rash
- ☐ Itchy skin
- ☐ Skin wound/ulcer
- ☐ Skin lesions
- ☐ Mouth sores
- ☐ Redness
- ☐ Swelling
- ☐ Scaling
- ☐ Blisters
- ☐ Breast pain
- ☐ Breast lump
- ☐ Nipple discharge

**Neurologic**-----

- ☐ Frequent headaches
- ☐ Migraines
- ☐ Memory loss/confusion
- ☐ Dizziness
- ☐ Burning/prickling sensation
- ☐ Leg numbness
- ☐ Leg weakness
- ☐ Tingling
- ☐ Difficulty walking
- ☐ Vertigo
- ☐ Tremors

**Psychiatric**-----

- ☐ Insomnia
- ☐ Irritable
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep disturbances
- ☐ Overwhelming stress
- ☐ Suicidal ideation

**Endocrine**-----

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Heat/cold intolerance
- ☐ Abnormal thirst
- ☐ Decreased libido
- ☐ Excessive facial/chest/back hair
- ☐ Muscle weakness
- ☐ Generalized weakness

**Hematology/Lymph**-----

- ☐ Swollen lymph nodes
- ☐ Bleeding gums/Nose bleeds
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Jaundice



# 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.

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*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.

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**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.**



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## 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.

## **Other Services and Fees**

- **Prescription Refills.**
  - For routine refills, please contact your pharmacy and have them send a prescription refill request electronically. Refills can be requested through our **online patient portal** 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

