Yasmin B-Khan, M.D., FACOG
Catherine Nipper, W.H.C.N.P.,B-C
Obstetrics & Gynecology
403 W. Campbell Rd. Suite 305
Richardson, TX 75080
(972) 498-4510

PATIENT INFORMATION FORM

DATE: _____

PATIENT NAME_____AGE_____ SEX_____DOB_____
ADDRESS_____ APT #_____SS#_____
CITY_____ STATE_____ZIP_____
EMAIL ADDRESS_____ MARITAL STATUS_____

PRIMARY PHONE_____CELL PHONE_____OTHER PHONE_____
WHICH PHONE # WOULD YOU PREFER TO BE CONTACTED AT? [] PRIMARY [] CELL [] OTHER
WHAT IS THE BEST TIME TO REACH YOU? [] MORNING [] AFTERNOON [] LATE AFTERNOON

EMPLOYER_____OCCUPATION_____
ADDRESS_____CITY_____STATE_____
ZIP_____ PHONE/EXT_____

DO YOU HAVE HEALTH INSURANCE? [] YES [] NO [] PRIVATE PAY
WHICH HEALTH INS. COMPANY? [] BCBS [] AETNA [] CIGNA [] UHC [] OTHER_____

INSURED
NAME_____DOB_____ SS# _____
HOME ADDRESS_____CITY_____STATE_____ ZIP_____
RELATIONSHIP TO YOU _____ EMPLOYER _____
WORK PHONE _____ CELL _____

SPOUSE
NAME_____ DOB_____SS#_____
EMPLOYER_____WK#_____CELL#_____

PHARMACY NAME_____PHARMACY PHONE_____
PHARMACY ADDRESS_____

REFERRING PHYSICIAN_____
REFERRING PHYSICIAN ADDRESS & TELEPHONE_____
_____

EMERGENCY CONTACT NAME & NUMBER _____
THEIR RELATION TO YOU_____

I HERBYAUTHORIZE ANY AND ALL INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED BY ABOVE INSURANCE COMPANY. I AUTHORIZE TREATMENT BY DR. YASMIN KHAN AND STAFF.

PATIENT SIGNATURE_____

Name:_____Date:_____Age:_____Marital Status:_____Occupation_____

The reason for your visit today:_____

# of Pregnancies_____# of Full term_____# of Living_____# of Premature_____# of Miscarriages_____

# of Abortions_____# of Ectopics_____ # of Normal deliveries_____ # of Cesarean-sections_____

Last Menstrual Period:_____How many days between periods?_____

How long does the flow last?_____ What age did your period start?_____

Have you had: [] Irregular Cycles [] Heavy Cycles Prolonged Cycles [] Short Cycles

What methods of contraception do you and your partner use?_____

Have you had: [] Tubal Ligation [] Essure

Have you ever taken contraceptive pills, if so when and for how long? _____

Have you ever had: [] Migraines [] Blood clots in your legs, etc. from birth control pills

Have you ever had an IUD? [] Mirena [] Paragard if so, when and for how long? _____

Have you ever had a sexually transmitted disease (i.e, Gonorrhea, Chlamydia, venereal warts, PID,

Syphilis, Herpes, and HIV)?_____

Do you have any urinary problems/loss of urine on coughing?_____

Have you ever had ovarian cysts?_____When_____ Fibroids?_____When_____

When was your last pap smear?_____ Mammogram?_____Colonoscopy?_____ Bone Density_____

Any problems with intercourse?_____

Have you ever had an abnormal pap smear? _____

Have you ever had an abnormal mammogram?_____ [] Breast Cyst [] Lumps [] Biopsy

Have you had a hysterectomy?_____ []Abdominal [] Vaginal [] Laparoscopic [] Ovaries removed

Have you had: [] Leep [] D&C [] Laparoscopy

Medical Problems:	[] Asthma	[] Thyroid Prob	[] Endometriosis
	[] High Blood Pressure	[] Depression	[] Diabetes
	[] Migraines	[] Heart Disease	[] Cancer

Any serious illness? _____

List any surgeries and injuries, with dates and hospitals _____

_____

_____

List current medications and health conditions being treated with each medication (including non-prescription,

herbs)_____

Have you had?: [] TDAP (tetanus/whooping cough vaccine) [] Hepatitis vaccine [] Gardasil (HPV vaccine) When_____

Family History:	Breast Cancer_____	High blood pressure_____
	Colon Cancer _____	Ovarian Cancer_____
	Uterine Cancer _____	Heart Disease _____
	Diabetes_____	Stroke_____
	Thyroid Problems _____	

Other conditions and illnesses in family_____

_____

Do you have any allergies to medications?_____Are you allergic to Iodine/Peanuts/Latex/IV dyes/Eggs

Do you smoke?_____Drink alcohol?_____Drink caffeine?_____

Who is your family doctor or doctor you are currently seeing?_____

Are there any personal matter you would like to discuss after today's exam?_____

Yasmin B. Khan, M.D., FACOG
General Consent for treatment as approved by the Texas Medical Association.

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instruction of the Physician of Yasmin B. Khan, M.D., P.A. and associates.

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examinations by Yasmin B. Khan, M.D., P.A. and associates.

_____ _____
Printed Name Signature and Date

Private Health Information

Check all that apply:

□ You may mail information to my home address
□ You may contact me on my home phone
□ You may contact me on my cell phone
□ You may contact my on my work phone
□ You may contact me by fax# _____
□ You may leave a detailed message on my voice mail □ Cell □ Home □ Work
□ **Do not** leave messages

Please list any persons to whom we may release your private health information.
If you do not list their name, including husband, we cannot speak to them.

Husband _____
Mother _____
Relative _____
Friend _____

Please list any special instructions regarding your private health information here:

_____
_____
_____
_____

_____ _____
Patient signature Date

YASMIN B. KHAN, MD, FACOG / *Obstetrics & Gynecology*

403 W. Campbell Road *Ph:* *(972)498-4510*
Suite 305, Medical Plaza I *Fax:* *(972)498-4511*
Richardson, Texas 75080

FINANCIAL POLICY

We are dedicated to providing the best possible OB/GYN care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss them with us.

FEES
For those insurance plans in which we participate, your predetermined portion of charges set by your insurance plan is **due at the time of services**. This includes all co-payments and deductible amounts. For your convenience, we will accept cash, checks, VISA, MasterCard, Discover, and American Express. All patient percentages will be determined by your insurance company once any reduction in fee is necessary, and you will be billed for the remainder.

The patient is responsible for all accounts regardless of insurance coverage within 60 days after the date of treatment. We make every effort to follow the guidelines required by your insurance company, however, every contract is unique. Every effort is made to file claims on your behalf with your insurance company. Unfortunately, if we are unable to collect payment from your insurance company within 60 days, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

This office makes every attempt to verify benefits. All patients are responsible for any balances on their account regardless of insurance company verification or pre-certification. Please remember that verification of benefits or pre-certification does not guarantee payment by any insurance company. Any overdue balances are subject to being sent to an outside collection agency.

All phone consultations are subject to a charge. All additional paperwork/letters requested by a patient are subject to additional fees. Same day requests have additional charges.

A $25.00 service charge will be assessed for returned checks, and must be paid in cash.

MINOR PATIENTS
For all services rendered to minor patients (under 18 years of age), we will look to the adult accompanying the patient and to the custodial parent or guardian for payment. We will not disclose any confidential information to the parent or guardian without written or verbal consent of the minor.

CANCELLATION POLICY/MISSED APPOINTMENTS
It is the office policy to bill the patient (not the insurance company) a $25.00 fee for cancellations not made 24 hours in advance prior to their appointment. Please call to cancel or reschedule your appointment 24 hours so we can accommodate others as a courtesy. We try to make reminder calls to confirm appointments but patients are expected to be responsible for their appointments as there are times we cannot make the reminder calls.

As a courtesy for those who come to their appointment early or on time, patients who arrive late will most likely be asked to reschedule.

MEDICAL RECORDS
A copy of medical records will be furnished to a physician upon written request from the physician or patient. An Authorization for Release of Medical Records form must be completed and signed by the patient. A fee will be accessed to the patient for this request and is payable in full prior to the release of records.

TERMINATION OF TREATMENT
The treating doctor reserves the right to terminate treatment with patients who are non-compliant with office policies.

I have read and understand the financial policies of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Responsible Party Relationship

Yasmin B. Khan, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____
_____
_____
_____
_____
_____
_____
_____

Yasmin B. Khan. M.D.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning you health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 1/1/2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a coy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information to connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $25.00 for the first 20 pages, then 50¢ for each additional page. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 13, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means to alternative location. You must make your request in writing. Your request must specify that alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Yasmin B. Khan, M.D.
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Contact Officer: Nancy Brown
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