

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. All information provided on this form is confidential. Please print.

Patient Name: Last _____ First _____ M.I. _____
SSN _____ - _____ - _____ Birth Date _____ Sex _____ CDL _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ - _____ Cell Phone () _____ - _____ Marital Status _____
Patient's or Parent's employer _____ Work Phone () _____ - _____
Work address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____
Address _____ City _____ State _____ Zip _____
Emergency contact _____ Relationship _____
Emergency Contact's Phone () _____ - _____ Office Referral _____

RESPONSIBLE PART

Name of Party: Last _____ First _____ M.I. _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ - _____ Work Phone () _____ - _____ CDL _____
Birth Date _____ Employer _____

INSURANCE INFORMATION

Name of Insured: Last _____ First _____ M.I. _____
SSN _____ - _____ - _____ Birth Date _____ Relationship _____
Employer _____ Employer's Phone () _____ - _____
Employer address _____ City _____ State _____ Zip _____
Insurance Company _____ ID# _____ PPO _____ HMO _____
Insurance address _____ City _____ State _____ Zip _____
Deductible amount _____ Deductible amount used _____ Co-pay _____

Do you have any additional medical insurance? Yes ___ No ___ If yes, complete the following:

Name of Insured: Last _____ First _____ M.I. _____
SSN _____ - _____ - _____ Birth Date _____ Relationship _____
Employer _____ Employer's Phone () _____ - _____
Employer address _____ City _____ State _____ Zip _____
Insurance Company _____ ID# _____ PPO _____ HMO _____
Insurance address _____ City _____ State _____ Zip _____
Deductible amount _____ Deductible amount used _____ Co-pay _____

Genesis OB-GYN Medical Group

PAYMENT OF SERVICES

I realize that contributions made by my insurance company may not represent the full payment for the services rendered. I will be responsible for any additional charges. If my insurance does not cover all or only covers a portion of this visit(s), I will be responsible to pay this office the remaining balance.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Genesis Ob-Gyn Medical Group of the medical benefits, if any for services rendered to my dependents or me. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I authorize release of any information concerning my (or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Date _____ **Signature Patient** _____
Date _____ **Signature Parent/Guardian** _____

CONSENT FOR TREATMENT

I _____ or _____
(Patient) *(Parent or Guardian)*
For _____
(Patient)

Hereby voluntarily, give consent to Dr. Wanda Wilburn and nurse to provide examination, diagnostic and medical procedures as are deemed necessary or desirable in my case.

I am aware that the practice of medicine is not an exact science and I acknowledge that no assurances or guarantees have been given to me as to the result of such examination, diagnostic and medical procedures. This consent is valid until such time as revoked in writing by the undersigned.

I understand that responsibility for payment for medical services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½ % percent finance charge (18% annually) will be added to any balance over 60 days. In the case of default I (we) promise to pay legal interest on the indebtedness. Together with such collection costs and reasonable attorney's fees which may be required to effect collection of this note.

Consent must be signed by the parent, legal guardian or next of kin when patient is a minor or physically or mentally incompetent.

Date _____ **Signature Patient** _____
Date _____ **Signature Parent/Guardian** _____
Date _____ **Signature Witness** _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a physician, or other healthcare providers, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- Tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing and
- A tool with which we can assess and continually work to improve the care we render and the outcome we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where and why others may access your health information
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in 45CFR 164.524
- Amend your health record as provided in 45CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45CFR 164.28
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without authorization, except as described in this notice.

Information to Report a Problem

If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For Example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from the hospital.

We will use your health information for payment. For Example: a bill may be sent to you or a third party payer. The information accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations. For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the results and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the Emergency Department and Radiology, certain laboratory tests, and a copy service we use which make copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. Our business associate is required to appropriately safeguard your health information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgment, disclose to a family member or other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose health information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organization: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling a disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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CONSENT TO MEDICAL SERVICES BY PHYSICIAN ASSISTANT OR NURSE PRACTITIONER

The undersigned patient, and/or responsible relative, or person acknowledges that he/she has been informed that a Physician Assistant or Nurse Practitioner may provide services under the direction and supervision of a physician.

The undersigned consents to authorize said Physician's Assistant/Nurse Practitioner to administer and perform any and all medical examination, treatments, diagnostic procedures and immunizations against disease which may now or during the course of the patient's care be deemed advisable by the supervising physician.

Printed Name

Signature

Date Signed

Witness

IF PATIENT UNABLE TO SIGN

Printed Name

Signature of Husband/wife/Parent/Guar

Date Signed

Relationship

Witness

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the Genesis OB/GYN Medical Group, Inc. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Genesis OB/GYN Medical Group, Inc. and how I may obtain access to and control this information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Today's Date

Description of Personal Representatives Authority

1. Please list who you want to have access to your pertinent medical information? (i.e.: family members, spouse, significant other)

2. May we leave messages on your answering machine? Yes _____ No _____

3. Preferred method of contact: Home # _____

Cell# _____ Work # _____