The Midwives & Associates, Inc.

NAME_____
Last First MI

DATE OF BIRTH_____MARITAL STATUS_____

ADDRESS_____
Street City State Zip Code

HOME #_____WORK#_____CELL#_____

SOCIAL SECURITY#_____FAMILY DOCTOR_____

YOUR EMPLOYER_____LOCATION_____

___SPOUSE ___SIGNIFICANT OTHER: NAME _____
(please check one)

DATE OF BIRTH_____ SOCIAL SECURITY#:_____

EMERGENCY CONTACT#_____INSURANCE_____

SUBSCRIBER_____SUBSCRIBER'S EMPLOYER_____

RELATIONSHIP_____SECONDARY INS:_____
(Ex: husband/ parent)

HOW DID YOU HEAR ABOUT US?_____

New regulations are now in effect as to how we handle your protected health information. This is known as HIPAA (Health Insurance Portability & Accountability Act of 1996). We will provide a copy of our "Notice of Privacy Practices" to you. We request your signature to verify that you have received this information. In the questions below, we are giving you the opportunity to specify how we may communicate with you and you may designate others to also be given your health information.

Release of Information

It is the policy of The Midwives & Associates, Inc. and staff to not release protected health information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave health information if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

over…

I authorize The Midwives & Assoc. Inc. and staff to communicate health information pertaining to my care by the following methods and will assume responsibility to notify them when this information changes:

Home Telephone	____Yes ____No	Answering Machine	____Yes ____No
Work Telephone	____Yes ____No	Voice Mail	____Yes ____No
Cell phone/or voice mail	____Yes ____No	Pager	____Yes ____No

Any special requests in contacting you or confirming appointments? _____

_____

Please list names of authorized people with whom we may discuss your care:

Spouse_____ _____Yes _____No

Parent_____ _____Yes _____No

Others: Name _____Relationship _____

Name _____Relationship _____

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Client/GuardianSignature_____Date_____

Print Name _____ Relationship if not self_____

Assignment of Benefits

I hereby authorize The Midwives & Associates, Inc. to release to my insurance carriers or its intermediaries, any information needed for processing my claims, including the medical record. I request payment of medical benefits to The Midwives & Associates, Inc. I understand that any service not covered by my insurance company is my responsibility to pay.

Client/Guardian Signature_____Date_____

Print Name_____ Relationship if not self_____

Responsible party: Please complete ONLY if you are a minor:

Mother's Name:_____SS#:_____DOB:_____

Father's Name:_____SS#:_____DOB:_____

Other Responsible party:_____SS#:_____DOB:_____

Address:_____Phone#:_____

Name_____ **Age**____ **Date of exam**_____**Initial**___ **Annual**___**Other**___

Medical History

List Allergies/ Drug Reactions:

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO	NOW
Asthma/ Lung Condition?			
Blood Problems/ Anemia?			
Bowel Disease/ Polyps?			
Breast Problems/ Disease/ Cysts?			
Cancer? Type:_____			
Diabetes/ High Cholesterol/ Gestational Diabetes?			
Depression (prolonged)/ Nervous Breakdown?			
Epilepsy/ Convulsions/ Fainting?			
Fever? (recent)			
Gallbladder Disease?			
German Measles (Rubella) or Immunization?			
Heart Problems/ Murmurs/ High BP/ Stroke?			
Headaches (severe)/ Dizziness/ Blurred Vision?			
Kidney/ Bladder Problems or Infection?			
Liver Problems /Jaundice/ Mononucleosis/ Hepatitis)?			
Pelvic/ Ovary/ Uterus Problems?			
Rh Negative Blood Type?			
Skin Problems/ Acne?			
STD/ Gonorrhea/ Syphilis/ Herpes/ Venereal Warts?			
Thyroid Problems?			
Vaginal Infections/ Genital Lesions?			
Varicose Veins/ Blood Clots in Legs?			
Ever been hospitalized, had surgery, genital injuries?			
Ever experienced domestic/ sexual or other abuse?_____			
Do you: Wear contacts/ Glasses?			
Smoke? Pks per day?_____ # of yrs?_____			
Use Alcohol/ Drugs? Amt/week?_____			

Have any other medical problems/ chronic illnesses?_____

Family History

DOES YOU NATURAL MOTHER, FATHER, SISTER, BROTHER, GRANDPARENTS HAVE OR HAVE THEY EVER HAD THE FOLLOWING? (If yes, specify who)	Yes	NO	WHO
Cancer? Type:			
Diabetes (age onset_____)/ High Cholesterol?			
Heart Attack/ Disease under age 50?			
High Blood Pressure/ Stroke?			
Mother took Drugs, Hormones, DES while pregnant?			

Father _____Living _____Deceased Cause: Age:

Mother_____Living _____Deceased Cause: Age:

DID OR DO ANY OF THE FOLLOWING RELATE TO YOU, YOUR FAMILY, YOUR PARTNER OR YOUR PARTNER'S FAMILY? Specify:	YES	NO	WHO
Birth Defects? (including Club Foot/ Cleft Lip or Palate)			
Heart Defects/ Spina Bifida?			
Blood Disorders? (Hemophilia, Sickle Cell Anemia)			
Mental Retardation/ Down's Syndrome?			
Two or more Miscarriages? (#) Infertility?			
Lost a child after the 5th month of pregnancy or shortly after birth? (# before birth___) (# after birth___)			
Do you or your partner come from the following background: Black___ Jewish___ Mediterranean___ Southeast Asian___			
Do you plan children in the future?			
Are you and your partner blood relatives?			
Do you have concerns about your family medical history or your future children? _____			

Medication History

List all medications you are taking now (Including birth control, prescription and nonprescription drugs and vitamins):

Gynecological/Menstrual History

Date of Last PAP Smear:

Last PAP _____ Normal _____ Abnormal____

Date/result last pelvic exam_____

First day of last menstrual period:

Amount: Heavy___ Medium___ Light___

Total number of days of flow:

Number of days between periods:

Age period again: Age first intercourse:	YES	NO
Have you missed a period within the last 6 mo?		
Do you have severe cramps/pain with your period?		
Do you have bleeding/spotting between periods?		
Do you have any unusual vaginal discharge?		
Do you have any signs of infection now?		
Do you have pain or bleeding during sexual intercourse?		
Do you douche?		
Do you examine your breasts?		
Have you ever had a Mammogram?		
Have you had unprotected sex since last exam?		
Have you ever tried to become pregnant and could not?		
Have you ever had an abnormal Pap smear?		
Have you had a new partner in the last year?		

Contraceptive History

Current method of birth control:

How long have you used this method?

Are you satisfied with this method?

How is your health? Excellent___ Good___ Fair___ Poor___

Do you have personal concerns which need discussion or help?
Yes___ No___

I have completed the above information which is true and accurate to the best of my knowledge.

Client Signature Date

Ht_____ Wt_____ lbs. Urine_____/_____ BP_____/_____

G_____ P_____

_____

Staff Signature Date

Rev. 09/2006

Our 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

Our Pledge Regarding Your Health Information

The Privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. We may not use or disclose any more of your health information than is necessary. Below we have described the ways we may use and share your health information about you. We also describe your rights and certain duties we have regarding the use and disclosure of your health information.

Our Legal Duty .

The Law Requires Us To:

1. Keep your health information private
2. Give you this policy describing our legal duties, privacy practices and your rights regarding your health information.
3. Follow the terms of the notice that is now in effect.

We Have the Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and make the new terms effective of our notice effective for all health information that we keep, including information previously created or received before the change.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Health Information .

Under the law, we may use and disclose health information for many different reasons. We will not use or disclose your health information for any purpose not listed below, without your specific written authorization. If you give us an authorization, you may revoke it in writing at any time.

For Treatment:
We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, midwifery students or other people who are taking care of you.
Example: * Our backup physician requires details of your health information in order to advise the midwife in your care.
*The perinatologist or other specialist we have referred you to for testing and consult requires information on your prenatal lab results.
*The pharmacist needs information about other medications you are taking.

We may share medical information with your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your health information for payment purposes.
Example: *We may need to give your health insurance plan information about care you received at our organization so that your health plan will pay us or repay you for any care that you paid for.
*We may need to give your health information to your insurance company in order to get approval or to determine if your plan will pay for services.

For Health Operations:
We may use and disclose your health information to support our business activities. Examples of this would include internal quality assurance or employee evaluation, employee training, and getting necessary credentialing and certificates.

Family and Others Involved in Your Health Care:
We may share health information to the extent necessary to obtain help from a family member or other person you indicate is involved in your care. This may include information to your employer for disability or leave of absences. In the event emergency treatment is needed, we will use our professional judgement to act in your best interest in sharing information with family or your representative. This may include such things as picking up filled prescriptions, x-rays, or other protected health information.

Disaster Relief:
Health information may be shared with a public or private organization authorized by law, for the purpose of providing disaster relief.

Our Notice of Privacy Practices

Research, Funeral Directors, Coroner, Organ Donation:
We may use or disclose your health information for research purposes in limited circumstances. We may disclose health information to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Public Health Activities:
We may disclose your health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your health information to a government agency authorized to oversee the health care system or government programs or its contractors and to public heath authorities for public health purposes.

Victims of Abuse, Neglect, or Domestic Violence:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes.

Required by Law:
We may disclose your health information when we are required to do so by law. For example, we must disclose health information to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws. We may disclose your health information when authorized by worker' compensation or similar laws.

Process and Proceedings:
We may disclose your health information to an authorized agency providing health oversight activities such as audits. We may disclose information in response to a court or administrative order, subpoena, or other lawful process. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your health information to law enforcement officials or federal officials for lawful intelligence and other national security activities.

Your Individual Rights

You have the following rights with respect to your protected health information.

The Right to Request Access to Your Health Information. In most cases you have to right to look at or obtain a copy of your health information. This request must be made in writing on a form available from our staff. There will be a charge for copies made and postage.

The Right to Request an Amendment to Your Health Information. If you believe that the health information we have about you is incorrect or incomplete, you have the right to request that we correct or update this information. We may deny the request if we received the information from another source. If we deny your request for an amendment, you may respond with a statement, which will be attached to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to inform others that need to know about the change to your information.

The Right to Receive an Accounting of Certain Disclosures of Your Health Information.
You have the right to receive a list of certain instances in which we have disclosed your health information to our associates since April 14, 2003. This list will not include any disclosures that we make for the purposes of treatment, payment, and health care operations and other specified exceptions. This list will not include yourself, your family or others involved in your care.

The Right to Request Confidential Communication.
You have the right to request that we send your health information to you by alternative means or to an alternative location if this is required to avoid harm to you. Requests are made in writing to the practice Privacy Officer.

The Right to Request a Restriction on Uses and Disclosures of Your Health Information.
You have the right to ask that we place additional limits on how we use and disclose your health information. However we are not required to agree to such requests.

The Right to Receive a Written Copy of our Notice of Privacy Practices. You have the right to receive a paper copy of this Notice of Privacy Practices at any by requesting from our Privacy Officer.

Privacy Questions and Complaints

If you are concerned that we may have violated your privacy rights, please ask to speak to our Privacy Officer or request the form needed to issue a complaint. You may also submit a complaint with the U.S. Department of Health and Human Services. That address will be provided upon request.

Contact our office to reach the privacy officer.