CARITAS
Caritas Center for Women's Health

Welcome to Our Practice!

About our focus on Natural Family Planning

As a new patient to this office, we would like to welcome you and tell you a little bit about what we feel is a very unique and exciting approach to obstetrical and gynecological care. In our desire to offer the best and most respectful gynecological care, we have tried to base our medical evaluation and treatment upon appreciation for and deep understanding of the normal menstrual cycle… in other words, fertility awareness (often also called Natural Family Planning).

This emphasis gives a whole new perspective to the practice of obstetrics and gynecology and allows us to diagnose and treat problems often in a less interventional way. Fertility awareness allows every woman to know how her body works and to understand the reproductive processes that are integral to her person as a woman.

We believe that a woman's reproductive processes are good and beautiful in themselves, that fertility is a condition of a healthy woman, and that the result of that healthy function, a child, is always a gift worthy of our care, protection, and nurturing. Because of this, we also believe that the best way for couples to plan the spacing and ultimate number of children is by utilizing the knowledge of the fertile and infertile phases of the woman's cycle to either achieve or avoid pregnancies.

The art and science of Natural Family Planning has progressed tremendously in the last 30 years and now provides 98% effectiveness for couples who are trained by experienced teachers and thus is both safer and more effective than oral contraceptives or barrier methods such as condoms.

We realize that this approach may be unfamiliar to you, but we would encourage you to consider it. If you are presently on birth control pills, we would welcome the chance to discuss this with you or send you more information about Natural Family Planning. We also would be happy to see you for any other problem or issue. However, you should be aware that *we will not be able to prescribe or recommend any contraceptive methods at that visit.*

We look forward to seeing you at your appointment.

Sincerely,

Philip V. Fleming, MD

Mary E. Bieniasz, CNP

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Demographic Information

Legal Name: _____ Preferred Name: _____
(How would you like us to address you?)

Your Date of Birth (MM-DD-YYYY) _____ Your Social Security # _____

Your Occupation_____ Your Religion _____

Address: _____City_____State_____Zip_____

Race: _____ Ethnicity: _____ Language: _____
(leave blank if you prefer not to state) (leave blank if you prefer not to state)

Marital Status (check one): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Spouse/Significant Other Name:_____ Spouse/Significant Other Occupation: _____

Primary Care Physician _____ Phone _____

Preferred Pharmacy _____ Preferred Laboratory _____

Contact Information

It is sometimes very important that we contact you. Please complete this section carefully and completely.

Your Home Phone _____

Your Work Phone _____

Your Cell Phone _____

Your E-mail _____

Contact Preference:
- ○ Home
- ○ Work
- ○ Mobile
- ○ Mail
- ○ Portal

May we leave a detailed message for you?
○ Yes ○ No

Emergency Contact Name:_____ Phone number: _____
(This contact will only be used to get a message to you about contacting us if all your personal contact information fails.
NO medical information will be given to the emergency contact.)

Insurance Information

Primary Insurance _____ Effective Date (if known)_____

Group # _____ Contract # or ID _____

Copay Amt _____ Office Visit Coverage? Y N

Subscriber's Name _____ SS#_____ Date of Birth _____

Secondary Insurance _____ Effective Date (if known)_____

Group # _____ Contract # or ID _____

Copay Amt _____ Office Visit Coverage? Y N

Subscriber's Name _____ SS#_____ Date of Birth _____

CARITAS
Caritas Center for Women's Health

Confidential Communication Authorization (Optional)

In order to respect your privacy, we cannot communicate with anyone other than you regarding medical or financial issues without your written consent. This includes discussing medical concerns, appointment scheduling, billing issues, and anything else that may come up.

If you would like to authorize this office to speak to any family members or friends in some situations, please give their names below.

You may revoke this permission at any time by informing Caritas staff or by filling out a new confidential communication authorization form.

☐ Caritas may speak ONLY with me.

or

☐ I give permission for Caritas Center for Women's Health to speak with _____ regarding

- ☐ my medical care
- ☐ financial matters

_____ _____
Signature Date

_____ _____
Printed Name Date of Birth

CARITAS

Caritas Center for Women's Health

Authorization for Services

Financial and Privacy Policies

Financial Policy

Caritas Center for Women's Health will bill for services in accordance with government and insurance guidelines. Please do keep us up to date with your current insurance information, and let us know if there are any billing concerns.

It is your responsibility to understand the benefits and limitations of your insurance plan. You are also responsible for obtaining any referrals that may be required by your insurance plan prior to your office visit.

Insurance copayments and non-covered services are expected to be paid at the time of service. We accept cash, check, Visa, MasterCard, Discover, and American Express.

Assignment and Release

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- I have received a copy of the Caritas Center for Women's Health, P.C.'s HIPAA NOTICE OF PRIVACY PRACTICES.
- I understand that this office uses automated phone calls for appointment and billing reminders and to let me know when test results have returned. If I have provided a cell phone number to this office, I authorize reminders to go to that number. I can revoke this permission at any time by informing Caritas staff or by changing my privacy settings in my portal account.

_____ _____

Patient or Responsible Party Signature Date

Note: state relationship if patient is unable to sign.

CARITAS CENTER FOR WOMEN'S HEALTH — *HIPAA NOTICE OF PRIVACY PRACTICES*

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review This Notice Carefully. If you have any questions about this notice, please contact Kathy Fleming at (734) 712-1995.

www.caritascenter.com

5333 McAuley Dr. R-2106
Ypsilanti, MI 48197
Phone: (734) 712-1990 Fax: (734) 712-1991

Effective Date: September 23, 2013

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Except for the purposes described below, we will use and disclose health information that identifies you ("Health Information") only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. Reports of your care may be sent to your primary care physician.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you of an appointment with us or to tell you about treatment alternatives or health-related benefits and services.

Research. We may use and disclose Health Information for research (such as comparing the health of patients who received different treatments for the same condition).

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or that of the public or another person.

Business Associates. We may disclose necessary Health Information to business associates that perform functions on our behalf or provide us with services. For example, we may use a company to perform billing services on our behalf. Our business associates are obligated to protect your privacy and may not use or disclose information except as specified in our contract.

Organ and Tissue Donation. For organ donors, we may use or release Health Information to organizations for organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. Examples include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products; and report if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure and are used by the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is:

1. in response to a court order, subpoena, warrant, summons or similar process
2. limited information to identify or locate a suspect, fugitive, material witness, or missing person
3. about the victim of a crime
4. about a death we believe may be the result of criminal conduct
5. about criminal conduct on our premises
6. in an emergency to report a crime or details of a crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner or to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. We may release Health Information to correctional institutions or law enforcement officials regarding inmates or individuals in custody if necessary:

1. for you to be provided with health care
2. to protect your health and safety or the health and safety of others
3. safety and security of the institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose necessary information if we determine it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such disclosure if we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures for marketing purposes
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. Disclosures made before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this Health Information, you must submit a signed request to Caritas Center for Women's Health. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, submit a signed request to Caritas Center for Women's Health.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, submit a signed request to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must submit a signed request to Caritas Center for Women's Health. We are not required to agree to all requests other than restricting access to information for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. 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 by mail or at work. To request confidential communications, submit a signed request to Caritas Center for Women's Health. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. A copy of this notice is on our web site, www.caritascenter.com. To obtain a paper copy of this notice, contact the office.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date at the top of the first page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, write to Caritas Center for Women's Health. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Gyn History: Menstrual Information Sexual History

Menstrual History:

Age at first menses: _____ Usual cycle length: _____ # days of flow: _____

Pain with periods? Yes No Heavy flow? Yes No

Any other problems with your periods_____

Family Planning History:

Current method of family planning: _____

Methods used in the past:

____ Birth control pills ____ Condom/Barriers ____ Depo-Provera

____ IUD ____ Diaphragm ____ Norplant

____ Natural Family Planning (which method?_____)

Sexual History:

Age at first intercourse _____ Age at first pregnancy _____

# of lifetime sexual partners _____ Do you have pain with intercourse? Y N

Have you had a new sexual partner in the last 3 months? Y N

Any history of STDs? (genital warts, condyloma, HPV, Herpes, Chlamydia, or Gonorrhea?) Y N

Any other issues or concerns you'd like to discuss with the doctor:

_____

_____

_____

_____

_____

_____

GYN HISTORY: MEDICAL / SOCIAL HISTORY

Medical History: Have you ever had: please check yes or no and then explain.

	Y	N	Explanation
Heart attack/angina (chest pain)	___	___	_____
Heart murmur	___	___	_____
Rheumatic Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
Migraine/ seizures	___	___	_____
Lung disease (tb, asthma)	___	___	_____
Diabetes	___	___	_____
Thyroid disease	___	___	_____
Liver disease (hepatitis, cirrhosis)	___	___	_____
Stomach, bowel, gall bladder disease	___	___	_____
Bleeding problems	___	___	_____
Transfusions	___	___	_____
Mental illness	___	___	_____
Cancer	___	___	_____

Social History/ Habits

	Y	N	Explanation
Do you smoke? If yes, how much?	___	___	_____
Do you drink alcohol? How often?	___	___	_____
Do you use street or recreational drugs?	___	___	_____
Do you eat a vegetarian diet?	___	___	_____
Do you exercise regularly? How much?	___	___	_____

Have you been hit, slapped, or beaten or otherwise hurt by anyone? _____

Caritas Center for Women's Health

Medical History

Does not include pregnancy-related events.

No.	Date	Surgeries/Hospitalizations	Physician/Provider
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Family History										
	High Blood Pressure	Stroke/ Blood Clots	Diabetes	Breast Cancer	Ovarian Cancer	Uterus Cancer	Colon Cancer	Other	Com-ments	Update
Father										
Mother										
Sisters										
Brothers										
Mat. GM										
Mat. GF										
Pat. GM										
Pat. GF										
Others										

Comments _____

_____

_____

_____

_____