



If you choose to sign an authorization to allow disclosure of your PHI (Personal Health Information), you can later revoke that authorization to stop any further uses and disclosures (other than for treatment, payment and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints or concerns, please contact:

Metro OBGYN
17 W. Exchange St. Suite 622
St. Paul, MN 55102
(651) 227-9141



NOTICE OF PRIVACY INFORMATION 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 IT CAREFULLY.

Metropolitan Obstetrics & Gynecology, P.A. understands that medical information about you and your health is personal, and we are committed to protecting your medical information. Individually identifiable information about your past, present and future health or condition, the provision of health care to you, or payment for such health care is considered “Protected Health Information” (“PHI”).

Our Permitted Uses and Disclosures of Your Protected Health Information.

We use and disclose PHI about you for treatment, payment and health care operations.

Treatment: We may disclose PHI to your doctor for treatment purposes. For example, your doctor may wish to provide a medical service to you but first seek information as to whether the service has been previously provided.

Payment: We may disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use your PHI in order to process your claims.

Health Care Operations: We disclose your PHI as part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of medical services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law from doing so.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI.

Metro OBGYN Health History Form

Office Patient ID # _____

Please fill in all information on front and back of form

Today's Date _____

Name _____ Date of Birth ____/____/____

Referred by _____ Primary Care Doctor _____

Reason for today's visit _____

Menstrual History

First day of last period ____/____/____ Age at first period _____

Your periods occur every _____ days and last for _____ days

Any problems with your periods? No Yes

Heavy flow Clots Pain/Cramping Irregular periods Discharge

Bleeding between periods Other _____

If menopausal

Age/year began _____ Any Postmenopausal bleeding? No Yes

Gynecological History

Have you had any of the following? (Check all that apply)

Abnormal Pap Smear Breast Pain Chronic Pelvic Pain

DES Exposure Endometriosis Genital Warts

Infertility Ovarian Cysts Pain with Intercourse

PID PMS Recurrent Miscarriage

Recurrent Vaginitis STD _____

Urinary Incontinence UTI (chronic) Uterine Fibroids

None of the above (additional medical history on the back of form)

Contraceptive History

Are you currently sexually active? Yes No Never been

How many life time partners? _____ How many in the last year? _____

Current method of birth control (Include tubal or vasectomy) _____

Any problems with current method? No Yes _____

Previously used methods (Check all that apply)

Birth Control Pill Condoms Diaphragm Depo Provera IUD

NuvaRing Implanon Nexplanon Spermicide Sponge Other

No previous birth control

Preventive Care History

Last Pap Smear Date: _____ Normal Abnormal

Last Mammogram Date: _____ Normal Abnormal

Last Colonoscopy Date: _____ Normal Abnormal

Last DEXA (Bone Scan) Date: _____ Normal Abnormal

Last Cholesterol Test Date: _____ Normal Abnormal

Vaccinations (year) Gardasil _____ Flu _____

Herpes Zoster (Shingles) _____ TDAP (Tetanus) _____

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

Date MM/DD/YYYY	Gestation Age #Wks@Delivery	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Comments/Complications Gestational Diabetes	Hospital

Surgical History (Please list all surgical procedures) None

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Allergy History (List all medication allergies and reaction) None

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Current Medication History

(Please include current prescriptions and medications ONLY) None

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Social & Lifestyle History

Marital Status _____ Occupation _____

Tobacco Smoker Never Former Current - Amt/Day _____

Alcohol Use No Yes If yes, Amt/Wk _____

Caffeine Use No Yes Street Drugs/Marijuana use No Yes

Domestic Abuse No Yes If yes, Current or Past

Regular Exercise No Yes Type _____ Amt/Wk _____

Monthly Breast Exam No Yes Have you had Chicken Pox No Yes

Do you have a Health Care Directive (living will) No Yes

Past Medical History

Indicate Relationship

Anemia	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Anxiety	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Asthma	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Blood Clotting Disorder	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cancer; Breast	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cancer; Cervical	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cancer; Colon	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cancer; Ovarian	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cancer; Skin-type: _____	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cancer; Uterine	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cancer; Other ->	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cardiac Arrhythmia	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Coronary Artery Disease	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Crohn's Disease	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Cystic Fibrosis	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Deep Vein Thrombosis (DVT)	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Depression	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Diabetes-type: _____	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Eating Disorder-type: _____	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Gastric Ulcer	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Gastroesophageal Reflux Disease	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Gestational Diabetes	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Hepatitis-type: _____	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Hyperlipidemia (High Cholesterol)	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Hypertension (High Blood Pressure)	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Irritable Bowel Syndrome	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Kidney Stones	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Lupus	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Migraines	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Multiple Sclerosis	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Osteoporosis	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Parkinson's Disease	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Pulmonary Embolism	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Rheumatoid Arthritis	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Scoliosis	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Seizures	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Sickle - Cell Disease	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Sleep Apnea/Disorder	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Stroke	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Thyroid Disorder-type: _____	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Tuberculosis	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->
Ulcerative Colitis	<input type="checkbox"/> Self	<input type="checkbox"/> Family	->

Other Medical History we should know about ->

Are there any other problems that are important to you today?

No Yes _____

Patient Signature: _____

Experiencing Today / Recently

Review of Systems - You are currently having any of the following:

Constitutional	Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Weight gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyes	Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Impaired Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head, Ears, Nose, & Throat	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sinus Congestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast	Lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Tenderness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nipple Discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiovascular	Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Loss of Consciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory	Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastrointestinal	Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Blood in stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Genitourinary	Urinary urgency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Urinary frequency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Urinary Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Blood in urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Integument (Skin)	Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Change in moles, lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Change in hair growth/loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurologic	Muscular weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Incoordination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Tingling or numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Musculoskeletal	Joint pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Muscle pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endocrine	Excessive thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Excessive urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Temperature intolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric	Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Feeling Confused	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Sleeping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Excessive Anger	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heme-Lymph	Easy bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Easy bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Swollen lymph glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergic-Immunologic	Sinus allergy symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Frequent illnesses	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Reviewed by: _____



Patient Name _____ Account # _____

Authorization for Release of Information

Initial _____ I authorize the release of any information, including medical and billing information, by Metropolitan Obstetrics & Gynecology to my referring doctor or insurance company.

Initial _____ My insurer may share my past, current and future health and account records with Metro OBGYN about services I've received from Metro OBGYN and other care providers unrelated to Metro OBGYN. These records may be used by Metro OBGYN as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

OR Initial _____ My insurer may not release any of my identifiable health records from providers unrelated to Metro OBGYN for the purposes described above.

Initial _____ I agree that Metro OBGYN may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes

YOUR PRIMARY PHARMACY _____
Pharmacy Name Pharmacy Address/Street Name Pharmacy City

Initial _____ I authorize payment of Medical Benefits, including Medicare and Medicaid benefits, be paid to Metropolitan Obstetrics & Gynecology, PA. for services rendered to myself.

Financial Policy of Metropolitan Obstetrics & Gynecology, P.A.

Charges are due and payable within 30 days upon receipt of statement. If no insurance coverage, please contact our business office to make arrangements for payment 651-265-6750.

Initial _____ I agree to pay for all services provided to me by Metropolitan Obstetrics & Gynecology PA, including those not covered by insurance.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Initial _____ I am aware of Metropolitan Obstetrics & Gynecology's Notice of Privacy Practices (a copy is available upon request and is posted in the reception room).

Request for family member to have access to protected health information.

The name(s) listed below are family members and/or friends to whom I wish to grant access to my healthcare information. I hereby authorize Metro OBGYN. to disclose my Protected Health Information (PHI) including appointment and billing information to the following:

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____

NONE

Initial _____ I understand this consent will be considered valid until such time I revoke it. I may revoke this authorization by sending a written request for revocation to Metro Ob/Gyn, PA. I understand the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand and agree to these terms.

I have read each section above and initialed each appropriate section.

SIGNATURE

DATE

Effective for 1 year / or specified dates