



3268 Hospital Drive, Suite B  
Juneau, AK 99801  
(P) 907-586-1717  
(F) 907-586-2677

Dear Valued Patient,

Thank you for taking the time to complete this packet prior to your appointment. We value your time and therefore want to be as efficient as possible with it. By filling out this paperwork prior to your appointment, you will allow us to expedite the check-in process. We kindly ask the following of you:

- Arrive 15 minutes prior to your scheduled appointment time.
- Allow a minimum 24 hours advanced notice if you are unable to make an appointment or need to reschedule (*we will charge a \$50 administrative fee if timely notice is not given*).
- Bring your most current insurance card(s) and photo ID with you.
- Notify the staff if there has been any change to your personal information including legal name, mailing address or phone number.
- Please let us know if there is something we can do better or if there is a service that you think would make your office visit a better experience.

Thank you, and we look forward to working with you.

Regards,

The Juneau OB/Gyn team



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## DEMOGRAPHIC INFORMATION

Name \_\_\_\_\_ Maiden/Previous Names \_\_\_\_\_

### Contact Information

Home Phone ( ) _____	Cell Phone ( ) _____	Work Phone ( ) _____
Mailing Address _____	Physical Address _____	
	<input type="checkbox"/> same as mailing	
City _____ State _____ Zip _____	City _____ State _____ Zip _____	

### Personal Information

Social Security # _____	Birthdate _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Sep. <input type="checkbox"/> Div. <input type="checkbox"/> Wid.
Employer _____	Occupation _____	
Name of Spouse/Partner _____	Their Employer _____	

### Responsible Party (If different than above)

Name _____	Address _____
Phone ( ) _____	_____
Employer _____	Phone ( ) _____
City _____	State _____ Zip _____

### Emergency Contact

Name _____	Phone ( ) _____
Relationship _____	

### Insurance

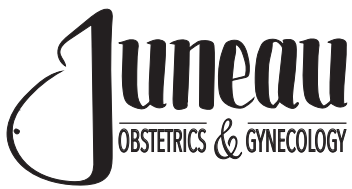
	<u>Insurance #1</u>	<u>Insurance #2</u>
Insurance Company	_____	_____
Subscriber Name	_____	_____
Subscriber SSN	_____	_____
Subscriber Birthdate	_____	_____
ID Number	_____	_____
Group Number	_____	_____

All private Insurance holders are responsible for calling their insurance company and knowing when second opinions and preauthorization for surgery and/or admission to the hospital is necessary. If payment is refused because of non-compliance with insurance requirements regarding these issues, the patient will be responsible for payment.

**Release of Benefits and Information:** I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for the charges that are not covered by insurance and agree to pay the balance due. I authorize the doctor or insurance company to release any information required for processing claims associated with the services rendered.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about us? \_\_\_\_\_



## Health History Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Primary care doctor: \_\_\_\_\_

Gynecologic History			
First day of last period _____	How many days between cycles? _____	Are they regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many days do you bleed _____	<b>Flow:</b> Light / Moderate / Heavy	<b>Pain:</b> Mild / Moderate / Severe	
Date of last mammogram _____	Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of 1 <sup>st</sup> period: _____	
Date of last pap smear _____	Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birth control method _____	Comments: _____		

Pregnancy History			
Total number of pregnancies _____	Number of vaginal deliveries _____	Number of miscarriages _____	
Number living children _____	Number of cesarean sections _____	Number of terminations _____	

Medications (include dose)	Allergies (include reaction)	Surgeries (include year)

Review of Symptoms by System (leave blank if answer is <u>no</u> )				
	Current	Past	Notes	
<b>1. CONSTITUTIONAL</b> Weight loss <input type="checkbox"/> <input type="checkbox"/> Weight gain <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/>				<b>8. GENITOURINARY</b> Bloody urine <input type="checkbox"/> <input type="checkbox"/> Incontinence <input type="checkbox"/> <input type="checkbox"/> Vaginal lesions/discharge <input type="checkbox"/> <input type="checkbox"/>
<b>2. SKIN</b> Rashes or Moles <input type="checkbox"/> <input type="checkbox"/>				<b>9. ENDOCRINE</b> Menopause symptoms <input type="checkbox"/> <input type="checkbox"/> Sexual problems <input type="checkbox"/> <input type="checkbox"/>
<b>3. EYES</b> Irritation <input type="checkbox"/> <input type="checkbox"/> Vision Change <input type="checkbox"/> <input type="checkbox"/>				<b>10. MUSCULOSKELETAL</b> Muscle aches <input type="checkbox"/> <input type="checkbox"/> Muscle weakness <input type="checkbox"/> <input type="checkbox"/> Joint or back pain <input type="checkbox"/> <input type="checkbox"/>
<b>4. EARS, NOSE, THROAT</b> Hearing loss <input type="checkbox"/> <input type="checkbox"/> Sinus Problems <input type="checkbox"/> <input type="checkbox"/> Dry Mouth <input type="checkbox"/> <input type="checkbox"/> Sores in mouth <input type="checkbox"/> <input type="checkbox"/>				<b>11. NEUROLOGIC</b> Headache <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Seizures <input type="checkbox"/> <input type="checkbox"/> Numbness <input type="checkbox"/> <input type="checkbox"/> Weakness <input type="checkbox"/> <input type="checkbox"/>
<b>5. RESPIRATORY</b> Wheezing <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> <input type="checkbox"/>				<b>12. PSYCHOLOGICAL</b> Depression <input type="checkbox"/> <input type="checkbox"/> Alcoholism <input type="checkbox"/> <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> <input type="checkbox"/>
<b>6. CARDIOVASCULAR</b> Chest Pain <input type="checkbox"/> <input type="checkbox"/> Palpitations <input type="checkbox"/> <input type="checkbox"/> Unable to lie flat <input type="checkbox"/> <input type="checkbox"/>				<b>13. HEMATOLOGIC/LYMPH</b> Swollen glands <input type="checkbox"/> <input type="checkbox"/> Easy bruising <input type="checkbox"/> <input type="checkbox"/>
<b>7. GASTROINTESTINAL</b> Difficulty swallowing <input type="checkbox"/> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> <input type="checkbox"/> Diarrhea/constipation <input type="checkbox"/> <input type="checkbox"/> Bloody stool <input type="checkbox"/> <input type="checkbox"/>				<b>14. ALLERGY/IMMUNE</b> Runny nose <input type="checkbox"/> <input type="checkbox"/> Itching/hives <input type="checkbox"/> <input type="checkbox"/> Frequent sneezing <input type="checkbox"/> <input type="checkbox"/>

Health Maintenance		Immunization			
Colonoscopy _____	DEXA Scan _____	Flu Shot _____	Tetanus _____	Pneumonia _____	HPV _____
date	date	date	date	date	date

Social History					
<b>HABIT</b>	<b>YES</b>	<b>NO</b>			
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Amount _____	Years: _____	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks _____	Per: _____	(day, week, month etc.)
Drug use	<input type="checkbox"/>	<input type="checkbox"/>	Type _____		

Personal and Family Medical History (Presently treated for or in the past)								
MAJOR ILLNESSES	SELF	FAMILY MEMBER:	MAJOR ILLNESSES	SELF	FAMILY MEMBER:	MAJOR ILLNESSES	SELF	FAMILY MEMBER:
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Bowel disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blood clot/DVT	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
<b>List any other personal conditions:</b>								

Risk Assessment for Hereditary Cancer				
List relative and give <b>age of diagnosis</b> : Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren				
CANCER	YOU	PARENTS/SIBLINGS/CHILDREN	RELATIVES ON MOTHER'S SIDE	RELATIVES ON FATHER'S SIDE
Example:	45		Aunt -45 Cousin - 61	Grandmother - 53
<input type="checkbox"/> Breast Cancer (female or male)				
<input type="checkbox"/> Ovarian Cancer Fallopian tube, peritoneal				
<input type="checkbox"/> Uterine (Endometrial) Cancer				
<input type="checkbox"/> Colon/Rectal Cancer				
<input type="checkbox"/> 10 or more lifetime colon polyps (give #)				
<input type="checkbox"/> Other Cancers* (Specify Type)				
*Other cancers to consider: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid				
<input type="checkbox"/> Are you of Ashkenazi Jewish descent?				
<input type="checkbox"/> Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)				

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date reviewed with patient: \_\_\_\_\_



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## HIPAA RECEIPT OF NOTICE

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I understand that Juneau Obstetrics and Gynecology may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that Juneau Obstetrics and Gynecology has the right to change this notice at any time. I understand that I may obtain a current copy by contacting the office.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices and that I agree to the terms of the document.

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if not self



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## HIPAA NOTICE OF PRIVACY AND PRACTICES

Effective 10/19/2019

### 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.

*If you have any questions about this notice, please contact Carrie Macaulay.*

#### 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:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose 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. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**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 example, we may give your health plan information about you so that they will pay for your treatment.

**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. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a

relationship with you (for example, your health plan) for their health care operation activities.

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

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

#### SPECIAL SITUATIONS:

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

**To 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 the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate 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. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

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

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally 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 they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority 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, for example, audits, investigations, inspections, and licensure. These activities are necessary for 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 even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information 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.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

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## 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 such information as necessary if we determine that 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 a disclosure whenever we practically can do so

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## 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, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Nicholas Newbury, DO. 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 associated with your request. 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 transmitted 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 it is readily producible in such form or format. 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 if you do not want this form or format, 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, you must make your request, in writing, to Nicholas Newbury, DO.

**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, you must make your request, in writing, to Nicholas Newbury, DO.

**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 make your request, in writing, to Nicholas Newbury, DO. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service 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, you must make your request, in writing, to Nicholas Newbury, DO. 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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, [www.juneauobgyn.com](http://www.juneauobgyn.com).

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## 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 on the first page, in the top right-hand corner.

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## 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, contact Carrie Macaulay. All complaints must be made in writing. You will not be penalized for filing a complaint.