5550 E. Hampton St.
Tucson, AZ 85712
Phone: 520-721-8605
Fax: 520-721-4209
copperstateobgyn.com

WELCOME TO COPPERSTATE OB/GYN!

Outstanding medical care begins with obtaining accurate information.

Federal and state laws, as well as your health insurance company, require ever increasing amounts of information. Please note the attached notice of privacy practices securely protects your information. While no one enjoys completing forms, we need you to take your time to thoughtfully complete and/or read each of the following documents.

- **PATIENT INFORMATION**
- **MEDICAL HISTORY**
- **CONSENT TO THE USE/DISCLOSE HEALTH INFORMATION**
- **NOTICE OF PRIVACY PRACTICES**
- **ACKNOWLEDGEMENT OF PRIVACY POLICY**
- **PATIENT EASY PAY CONSENT FORM[1]**
- **PATIENT EASY PAY CONSENT FORM[2]**

Please print legibly as errors can adversely affect your care or result in unnecessary billing errors. Finally, we strive to see patients on time and by completing these forms in advance, as opposed to waiting to do them upon your arrival at our office, we can work together to achieve this common goal.

Respectfully,

The doctors and staff at Copperstate OB/Gyn

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PATIENT INFORMATION:

Your appt is with Doctor ______________________ Referred by ______________________

Patient Name ______________________ (circle one) MS MRS MISS

Date of Birth ____ / ____ / ____ Soc Sec Number ______________ Marital Status (circle one) S M D W

Address ______________________

City ______________ State ______ Zip Code ______

Home Phone (______) ________ Cell Phone (______) ________ Primary Phone (______) ________

Employer ______________ Occupation ______________ Phone (______) ________

Emergency Contact ______________ Phone (______) ________ Relationship to Patient ________

COPPERSTATE WILL ASSIST YOU IN FILING WITH YOUR INSURANCE COMPANY IF ALL INFORMATION TO PROCESS A CLAIM HAS BEEN PROVIDED. THIS INCLUDES THE PLAN NAME, BILLING ADDRESS, NAME, DOB, AND SS# OF THE POLICY HOLDER, GROUP #'S, AND ANY OTHER INFORMATION NECESSARY TO FILE TO YOUR INSURANCE COMPANY (PROVIDE COPY OF CARD)

Primary Insurance ______________________ ID# ______________

Group #______________ Co-pay ________ Effective Date ______________

Policy Holder ______________________ Relationship ______________

Policy Holder's: Date of Birth ______________ SS# ______________

Secondary Insurance ______________________ ID# ______________
(if any)

Group # ______________ Co-pay ________ Effective Date ______________

Policy Holder ______________________ Relationship ______________

Policy Holder's: Date of Birth ____/____/____ SS#______________

I AUTHORIZE COPPERSTATE OB/GYN ASSOCIATES TO RELEASE INFORMATION NECESSARY TO PROCESS CLAIMS AND ASSIGN INSURANCE BENEFITS TO BE PAID DIRECTLY TO COPPERSTATE OB/GYN. I UNDERSTAND THAT COPPERSTATE BILLS MY INSURANCE AS A COURTESY AND I AGREE TO BE RESPONSIBLE FOR ANY SERVICES THAT ARE DENIED OR ARE NOT COVERED. I UNDERSTAND THAT COPPERSTATE MEETS ALL MEDICARE AND HIPPA COMPLIANCE GUIDELINES AND WILL MAINTAIN CONFIDENTIALITY IN DEALING WITH MY PERSONAL/MEDICAL INFORMATION

SIGNATURE ______________________ DATE ____/____/____

COPAYS ARE DUE AT THE TIME OF THE VISIT. THERE IS A $25.00 SERVICE CHARGE FOR RETURNED CHECKS.

COPPERSTATE OB/GYN ASSOCIATES LTD.

Women's Health Specialists

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MEDICAL HISTORY

Name______________________ Age ______________

Date of Birth______/______/______

Referring Doctor______________________ Marital Status ______________

Today's Date______/______/______

Reason for seeing Doctor: [ ] Annual Exam Other: ______________________

I GYN History:

1. 1st day of last menstrual period __/__/__ ☐ Regular ☐ Irregular ☐ Heavy Bleeding
2. What are you using to prevent pregnancy, if needed?______________
3. When was your last PAP smear (recommended yearly)? ______/______
4. Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
5. When was your last Mammogram (recommended after 40)? ______/______
6. If you are menopausal, are you taking hormone replacement? ☐ Yes ☐ No
7. Do you experience urine leakage? ☐ Yes ☐ No

Doctor's Comments

II Pregnancy History: (Please list the number)

Term Birth______ Premature Birth______ Miscarriages ______ Abortions ______
Living Children______

#	Born Mos/Day/Yr	Weight lb oz	Sex	Weeks Preg.	Type of Delivery	Complications Yes	Complications No
1						☐	☐
2						☐	☐
3						☐	☐
4						☐	☐
5						☐	☐

II Medical History:

1. Do you have any medical illnesses? (please list) ☐ None

______________________ ______________________
______________________ ______________________
______________________ ______________________

2. Medications: (please list name & dose) ☐ None

______________________ ______________________
______________________ ______________________
______________________ ______________________

3. What medications are you allergic or had a reaction to? ☐ none

______________________ ______________________
______________________ ______________________
______________________ ______________________

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Medical History (continued)

Doctor's Comments

IV. Surgical & Hospitalization History: [ ] None:

Date Mos/Yr	Operation or Illness	Complications Yes	Complications No
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐

V. Family History:

Do any 1st degree family members (parents, sister, or children) have the following?

	Yes	No	Who?
Breast Cancer	☐	☐	______
Cancer of Reproductive Organs	☐	☐	______
Colon Cancer	☐	☐	______
Diabetes	☐	☐	______
Heart Attack / Stroke	☐	☐	______

VI. Social History:

1. What is your occupation? ______

	Yes	No
2. Do you smoke cigarettes?	☐	☐
2a. Number of cigarettes per day ______		
3. Do you drink alcohol?	☐	☐
4. Have you used recreational drugs in the past 5 years?	☐	☐
5. Has anyone threatened or hurt you in the last year?	☐	☐

VII. Sexual History:

1. Number of sexual partners in the past year? Male______ Female______

	Yes	No
2. Have you ever had any sexually transmitted disease? (eg. Herpes, Gonorrhea, Chlamydia, Genital Warts)	☐	☐
3. Do you have any concerns about your sex life that you wish to discuss?	☐	☐

VIII. Dietary & Exercise History:

1. How many servings of dairy products do you eat in an average day? ______

	Yes	No
2. Are you currently dieting?	☐	☐
3. Do you exercise regularly?	☐	☐

Type(s)______

CS 10/08

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of Copperstate OB/GYN) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Copperstate OB/GYN is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following:

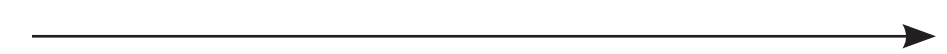
Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

PLEASE BE SURE TO READ THE SECOND PAGE 

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NOTICE OF PRIVACY PRACTICES (continued)

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Copperstate OB/GYN, 5550 E. Hampton St, Tucson, AZ 85712.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Copperstate OB/GYN, 5550 E. Hampton St, Tucson, AZ 85712. You must provide us with a reason that supports your request for amendment.

5. You have the right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you copy of this notice at anytime. To obtain a copy of this notice, contact our front desk receptionist.

6. You have the right to file a complaint. If you believe your privacy rights have been Violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Genny Esterline, Practice Administrator, 520-721-8605, ext. 3308. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice of our health information privacy policies, please contact Genny Esterline, Practice Administrator, at 520-721-8605 ext. 3308.

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ACKNOWLEDGEMENT OF PRIVACY POLICY

I, hereby acknowledge that I have been presented with a copy of Copperstate OB/GYN'S Notice of Privacy Practices.

Name of Patient: ______________________________

Signature: ______________________________ Date: ______________

Witness (CS Representative) ______________________________

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

NAME ____

BIRTH DATE____________________SOCIAL SECURITY # __________ _______ __________

I understand that as part of my healthcare, this Copperstate OB/GYN originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I hereby acknowledge that I have been presented with a copy of CopperstateOB/Gyn's Health Specialists Notice of Privacy Practices.

____

☐ I request the following restrictions to the use or disclosure of my health information:

Medical information can be discussed with
- ☐ Patient Only
- ☐ Family member or friend ____________________
- ☐ Physician
- ☐ Other______________________________________

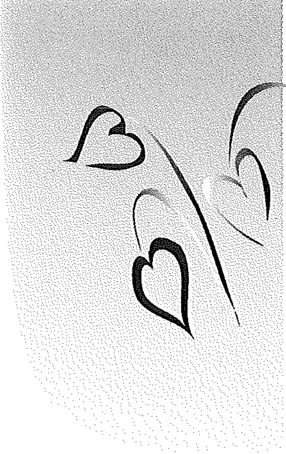
Detailed messages regarding test results can be left on your answering machine
- ☐ Yes
- ☐ No
- ☐ Phone Number ___________________________

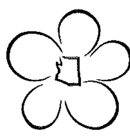
☐ OTHER RESTRICTIONS ____

PATIENT:

X ______________________________ ____________________ ______________________________

Signature of Patient or Legal Representative | Date | Witness Signature





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INFORMATION RELEASE AUTHORIZATION

I, ________________________________(patient name) authorize Copperstate to release the following information: (please check)

_____ Appointment times

_____ Test results

_____ Financial/Insurance information

_____ All information

To the following family member(s) or friend(s) if requested:

____

____

____

____

_____ I Do Not want information shared with anyone.

______________________________________ ______________

Patient Signature Date

______________________________________ ______________

Witness Date

A Legacy of Caring