

### Contents of New Gyn Forms Packet

[This packet should be PRINTED ONE-SIDED. Thank you.]

Starting in April 2023, FOWH is part of the Huntington Hospital-Cedars-Sinai Healthcare system. We are still the same doctors and staff in the same location providing the same ob/gyn medical care that you trust.

**Bold forms require filling out and returning.**

1. Contents of this Gyn Forms Packet	1 page
2. Welcome Letter	1 page
<b>3. Patient Information Form please fill out, sign and return</b>	<b>1 page</b>
<b>4. Insurance Information Form fill out, sign and return</b>	<b>1 page</b>
<b>5. New Gyn Pt History Form fill out and return</b>	<b>5 pages</b>
6. FOWH CS HIPAA Privacy Notice for your information	5 pages
<b>7. FOWH CS Receipt of Privacy Notice fill out, sign and return</b>	<b>2 pages</b>
<b>8. FOWH CS Communicate PHI fill out, sign and return</b>	<b>1 page</b>
<b>9. FOWH CS Conditions of Treatment fill out, sign (x3) and return</b>	<b>5 pages</b>
10. TOTAL	22 pages

This is only for NEW GYN patients to our practice. Thank you very much for your time.

## WELCOME TO OUR PRACTICE

Thank you for choosing Fair Oaks Women's Health for your ob/gyn medical care! In preparation for your upcoming appointment, we would like you to get a head start with some of the paperwork and also tell you a bit about our practice.

Fair Oaks Women's Health is Pasadena's Premier Ob/Gyn group practice, right next door to Huntington Hospital. We offer comprehensive and convenient women's healthcare. Our obstetrical services include everything from routine prenatal care to high-risk pregnancy care. We have our own ultrasound department, fetal non-stress testing (NST's) and lab collection station on the premises.

Our wide range of gynecology services includes well-woman exams, pap smears with HPV testing, minimally invasive gyn surgery (such as laparoscopic hysterectomy), abnormal pap smear evaluation and management, birth control including IUD's and Nexplanon, STI (sexually transmitted infection) evaluations, menopause and hormone evaluations and treatments, fertility testing and much more.

### **FOWH is affiliated with Huntington Hospital/Cedars-Sinai**

Since April 2023, FOWH is part of the Huntington Hospital/Cedars-Sinai Healthcare system. We are still the same doctors and staff in the same location providing the same ob/gyn medical care that you trust. But there are some changes:

- Bills and statements come from Cedars-Sinai. If you have questions regarding your Cedars-Sinai bill, please call Cedars Patient and Financial Services at 866-803-1777.
- Our forms have changed. Some are new and some are modified.
- Our office workflow, systems, hardware and software are being upgraded.

We apologize for any inconveniences or disruptions that might arise from our new affiliation. Please share your concerns with us at any time. Call (626) 304-2626 and ask for the Office Manager.

### **EMR (electronic medical record)**

Our practice uses a computerized health record, called an EMR. It takes time to enter your information into the computer. It would be very helpful if you would complete your New Patient forms and then mail (or fax or e-mail) them to us before your appointment. If you do not send these forms, your visit could be delayed while we update the computer before you see the doctor. Email your forms to: [obgyn@fowh.com](mailto:obgyn@fowh.com).

### **Please arrive early for your FIRST appointment**

It takes time to enter or update your personal, insurance and health information. At your first visit we scan your driver's license and insurance card for entry into our EMR. *We guarantee to keep all of your personal information private.* This is the law (a Federal law called HIPAA).

### **Parking – we do not validate**

Please note that you pay the cashier BEFORE returning to your car. To save money (but with a little more walking) some patients park in the Huntington Hospital EAST Parking structure, a building just south of ours. The entrance is off Fairmount Ave. across from the Emergency Dept.

### **Lab – Huntington Hospital**

For your convenience, we have an on-site lab staffed and provided to us by Huntington Hospital. This lab runs most of our standard tests. The Huntington lab is contracted with the same insurance plans as our office. ***If your insurance requires you to use a different lab than Huntington Hospital, let us know.***

**Note: Marina's Oasis is a separate medical practice and is not affiliated with Cedars-Sinai Medical Care Foundation.**

Feel free to call us at any time if you have any questions. Call (626) 304-2626.



PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY \_\_\_\_\_  
LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_  
PREFERRED FIRST NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ (PO Boxes Not Allowed)  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PH# \_\_\_\_\_ MOBILE PH# \_\_\_\_\_ WORK PH# \_\_\_\_\_

PREFERRED Ph# WEEKDAYS (CIRCLE ONE): HOME MOBILE WORK

EMAIL \_\_\_\_\_ PREFERRED CONTACT METHOD: \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ DRIV LIC. # \_\_\_\_\_

Optional - We invite you to share your race, ethnicity, sexual orientation, and gender identity information:

RACE \_\_\_\_\_ ETHNICITY \_\_\_\_\_  
SEXUAL ORIENTATION \_\_\_\_\_ GENDER IDENTITY \_\_\_\_\_  
SEX AT BIRTH \_\_\_\_\_ PRONOUN \_\_\_she/her \_\_\_they/them \_\_\_he/him

Are you employed? \_\_\_\_\_ If yes, YOUR OCCUPATION \_\_\_\_\_  
EMPLOYER NAME \_\_\_\_\_ PH.# \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

(If you are married/committed, may we have your spouse/sig other information)

SPOUSE/PARTNER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
MOBILE PH# \_\_\_\_\_ WORK PH# \_\_\_\_\_

HOW DID YOU HEAR OF US? \_\_\_\_\_  
PRIMARY CARE PROVIDER (PCP – FIRST AND LAST NAME) \_\_\_\_\_

PHARMACY NAME AND ADDRESS \_\_\_\_\_  
PHARMACY CITY, STATE, ZIP \_\_\_\_\_ PH# \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_ RELN \_\_\_\_\_  
MOBILE PH# \_\_\_\_\_ OTHER PH# \_\_\_\_\_

Please sign below if you give us permission to message you (such as test results) via voice mail or e-mail:

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_



Fair Oaks Women's Health

625 S. Fair Oaks Ave., Suite 255
Pasadena, CA 91105
P: (626) 304-2626 | F: (626) 585-0695
www.fowh.com

INSURANCE INFORMATION FORM

Please take a few minutes to complete this form. All information provided is completely confidential. Thank you. We use this information only for medical insurance verification and billing.

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

\_\_\_\_\_ I am insured under my own plan \_\_\_\_\_ I am insured under someone else's plan

INSURANCE COMPANY NAME \_\_\_\_\_

CLAIM FILING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BILLING PH# \_\_\_\_\_

NAME OF POLICY HOLDER (GUARANTOR): [ ] MYSELF or \_\_\_\_\_

MEMBER ID NUMBER of POLICY HOLDER \_\_\_\_\_

POLICY GROUP NUMBER \_\_\_\_\_

DATE POLICY ISSUED \_\_\_\_\_

DATE POLICY EXPIRES \_\_\_\_\_

CO-PAY AMOUNT (SPECIALISTS) \_\_\_\_\_

CO-INSURANCE PERCENTAGE \_\_\_\_\_

PRIMARY CARE PROVIDER \_\_\_\_\_

TYPE OF INSURANCE: [ ] INDEMNITY [ ] PPO [ ] POS [ ] EPO [ ] MEDICARE

RELEASE OF INFORMATION

By signing below, I authorize Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment.

NAME \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

Insurance Verification

\_\_\_\_\_

\_\_\_\_\_

**NEW GYN PATIENT HISTORY FORM**  
**(OB PATIENTS, please DO NOT USE THIS FORM. Thanks.)**

TODAY'S DATE \_\_\_\_\_ Your age \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

YOUR NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

REFERRED HERE BY \_\_\_\_\_

**YOUR PAST MEDICAL HISTORY**

*(If YOU have EVER had any of these conditions, please indicate with an X or a √)  
Thank you for answering all of the following questions. Your health is important to us.*

**Breast Conditions**

- \_\_\_\_\_ Recent Mammogram When? \_\_\_\_\_
- \_\_\_\_\_ History of Abnormal Mammogram
- \_\_\_\_\_ Breast Cancer
- \_\_\_\_\_ Breast Implants
- \_\_\_\_\_ Fibrocystic Breast
- \_\_\_\_\_ Other \_\_\_\_\_

**Gyn Conditions**

- \_\_\_\_\_ Abnormal Pap Smear
- \_\_\_\_\_ Endometriosis
- \_\_\_\_\_ Fibroids
- \_\_\_\_\_ Herpes (circle which type- oral and/or genital)
- \_\_\_\_\_ HPV (Human Papilloma Virus)
- \_\_\_\_\_ Menopause
- \_\_\_\_\_ Ovarian Cysts or PCOS (polycystic ovary)
- \_\_\_\_\_ Severe PMS
- \_\_\_\_\_ Other \_\_\_\_\_

**Heart or Circulation Conditions (Cardiovascular)**

- \_\_\_\_\_ Blood Clot (DVT or Pulmonary Embolism)
- \_\_\_\_\_ Fainting (Syncope)
- \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Varicose Veins
- \_\_\_\_\_ Other \_\_\_\_\_

**Endocrine (Glandular) Disorders**

- \_\_\_\_\_ Diabetes (circle which type: Type 1 or Type 2)
- \_\_\_\_\_ Pituitary Gland Disease
- \_\_\_\_\_ Thyroid Disease
- \_\_\_\_\_ Other \_\_\_\_\_

**Immune System Diseases**

- \_\_\_\_\_ Lupus or Rheumatoid Arthritis
- \_\_\_\_\_ Other \_\_\_\_\_

**Gastrointestinal (GI) Problems**

- \_\_\_\_\_ Blood in Stool
- \_\_\_\_\_ Crohn's Disease or Ulcerative Colitis
- \_\_\_\_\_ Hemorrhoids
- \_\_\_\_\_ Hepatitis
- \_\_\_\_\_ Irritable Bowel Syndrome
- \_\_\_\_\_ Had Colonoscopy? When? \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

**Blood (Hematologic) Disorders**

- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Clotting Disorder
- \_\_\_\_\_ Sickle Cell Trait or Disease
- \_\_\_\_\_ Thalassemia
- \_\_\_\_\_ Other \_\_\_\_\_

**Musculoskeletal Disorders**

- \_\_\_\_\_ Fractures or Broken Bones
- \_\_\_\_\_ Arthritis or Joint Pain
- \_\_\_\_\_ Severe Back Pain or Back Disease
- \_\_\_\_\_ Other \_\_\_\_\_

**Neurologic Disorders**

- \_\_\_\_\_ Migraines or Severe Headaches
- \_\_\_\_\_ Seizure Disorder (Epilepsy)
- \_\_\_\_\_ TIA or Stroke
- \_\_\_\_\_ Other \_\_\_\_\_

**Mental Health Conditions**

- \_\_\_\_\_ Bipolar (Manic-Depressive)
- \_\_\_\_\_ Nervous Breakdown
- \_\_\_\_\_ OCD (Obsessive-Compulsive)
- \_\_\_\_\_ Severe Anxiety or Panic Attacks
- \_\_\_\_\_ Severe Depression or Postpartum Depression
- \_\_\_\_\_ Other \_\_\_\_\_

**Respiratory (Lung) or ENT Disorders**

- Allergies, Hay Fever
- Asthma
- Bronchitis/Pneumonia
- Lung Cancer
- Sinusitis or Sinus Problems
- Sleep Apnea
- Other \_\_\_\_\_

**Urinary (Urological) Disorders**

- Frequent Bladder Infections
- Kidney Stones or Other Problems
- Other \_\_\_\_\_

**Skin Conditions**

- Acne (severe)
- Eczema
- Excess Hair Growth
- Hives
- Psoriasis
- Other \_\_\_\_\_

**What is your height?** \_\_\_\_\_

**What is your recent weight?** \_\_\_\_\_

**REVIEW OF SYSTEMS – RECENT ABNORMAL SYMPTOMS**

*(Are you currently experiencing any of the following symptoms to a significant degree?)*

*(If so, please indicate with an X or a √)*

**General**

- Fatigue or Weakness
- Fever, Chills or Sweats
- Unexplained weight gain or loss

**Skin**

- Lesions, Moles or Sores
- Rash

**Eyes, Ears, Nose and Throat**

- Sore Throat
- Trouble Swallowing
- Vision or Hearing Changes
- Nose Bleeds

**Breasts**

- Breast Lump or Lumps
- Breast Pain or Tenderness
- Nipple Discharge (other than white)

**Cardiovascular**

- Chest Pain or Tightness
- Irregular Heartbeat or Palpitations

**Respiratory**

- Chronic Coughing
- Shortness of Breath or Wheezing

**Gastrointestinal**

- Heartburn
- Nausea or Vomiting
- Diarrhea (watery stool)
- Severe Constipation
- Abdominal Pain
- Rectal Bleeding

**Urinary**

- Burning with Urination
- Urgency and/or Frequency of Urination
- Leakage of Urine
- Waking at night 2 or more times to urinate

**Gyn (also see Menstrual History ahead)**

- Genital sores, lesions or bumps
- Irregular periods
- Bleeding Between Periods
- Pain Before or During Periods
- Vaginal Itching, Burning or Dryness
- Vaginal Discharge
- Vaginal Dryness
- Pain during intercourse
- Vulvar Pain
- Severe PMS Symptoms

**Endocrine (Glandular)**

- Menopause Symptoms (hot flashes)
- Intolerance to Heat or Cold
- Low Sex Drive
- Excessive Hair Loss
- Excessive Hair Growth

**Musculoskeletal**

- Joint Pain (Back, Knee, Wrist, Hip)
- Joint Swelling
- Muscle Cramping or Pain

**Hematologic**

- Swollen Glands
- Easy/Frequent Bruising

**Neurologic**

- Dizziness
- Headaches
- Numbness
- Memory Problems

**Psychiatric**

- Excessive Anxiety, Worries, Stress
- Severely Depressed
- Insomnia

Patient Name \_\_\_\_\_

**PAST SURGERY or HOSPITAL ADMISSIONS**

List all Surgeries or Hospital Admissions - EVER	Year

**PHARMACY INFO (so we can e-prescribe -eRx - for you)**

Pharmacy Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Fax # \_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATIONS YOU ARE TAKING**

Medication name, dosage (amount) and reason (include meds "as needed")
<b>Recent Vaccines (Please enter here):</b>

**VITAMINS, HERBS AND SUPPLEMENTS YOU ARE TAKING**

Product name and how often (include dosage if known)

**ALLERGIES (circle choices)**

*If yes, please list all allergies and your allergic reaction*

Do you have ANY allergies? NO ALLERGIES

Allergic to Latex? YES NO

Allergic to	Reaction

Patient Name \_\_\_\_\_

## FAMILY MEDICAL HISTORY

**FOR THE ITEMS BELOW, PLEASE CONSIDER the following relatives:** (*Yourself, Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, and Nephews*). This is a screening method to see if you are at increased risk for having a genetic mutation that can cause hereditary cancer.

OTHER CONDITIONS	Please <u>CIRCLE CONDITION</u> (on the left) and indicate below who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, BLOOD CLOTS, STROKE	
3. ASTHMA or OTHER LUNG DISEASE	
4. KIDNEY DISEASE or KIDNEY STONES	
5. GI or LIVER PROBLEMS, LIVER TUMORS OR CANCER, IBS, COLITIS	
6. GYN DISEASES, OVARIAN, CERVICAL OR UTERINE CANCER, UTERINE FIBROIDS	
7. MUSCULOSKELETAL DISEASES, OSTEOPOROSIS or OSTEOPENIA	
8. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
9. SEVERE DEPRESSION or OTHER MENTAL HEALTH CONDITION	
10. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
11. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
12. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	

**Comments:**

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## SOCIAL HISTORY

Level of Education: \_\_\_\_\_ Employment/Occupation: \_\_\_\_\_

Type of Diet: \_\_\_\_\_ Type of Exercise: \_\_\_\_\_ How Often? \_\_\_\_\_

Seat Belts Routine:  YES  NO Sunscreen Routine  YES  NO

Smoking (Vaping?) History: NONE or \_\_\_\_\_

Alcohol Intake: NONE or \_\_\_\_\_

Drug Use: NONE or \_\_\_\_\_

General Life Stress:  LOW  MED  HIGH Sexually Active:  YES  NO If yes, condoms used? \_\_\_\_\_

In a Relationship?:  YES  NO  OTHER Members of Household: \_\_\_\_\_

Your Primary Care Provider (PCP) Name and Location: \_\_\_\_\_

Patient Name \_\_\_\_\_



## MENSTRUAL HISTORY

AGE of FIRST MENSTRUAL PERIOD \_\_\_\_\_ \*CYCLE LENGTH (28 days or ?) \_\_\_\_\_

# of DAYS of BLEEDING during a \*PERIOD \_\_\_\_\_ # days heavy \_\_\_\_\_ # days light/spotting \_\_\_\_\_

DATE of LAST NORMAL MENSTRUAL PERIOD (if abnormal, describe) \_\_\_\_\_

BIRTH CONTROL METHOD \_\_\_\_\_ If none, please enter reason \_\_\_\_\_

LAST Pap Smear (MM/YY) \_\_\_\_\_ By who? \_\_\_\_\_

(\***period** means # of bleeding days; **cycle length** means total # of bleeding & non-bleeding days starting with a period)

### PREGNANCY SUMMARY (how many...?)

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Comments: \_\_\_\_\_

### PREGNANCY DETAILS

Child's Birthdate	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location

Comments: \_\_\_\_\_

Revised April 2023

Patient Name \_\_\_\_\_

Gyn Hist 5

## JOINT NOTICE OF PRIVACY PRACTICES OF CEDARS-SINAI MEDICAL CENTER AND CEDARS-SINAI MEDICAL CARE FOUNDATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

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### WHAT IS THIS NOTICE AND WHO WILL FOLLOW IT?

Cedars-Sinai understands that information about you and your health is confidential. We are committed to protecting the privacy of this information. We use and share your health information only as permitted by federal and state laws.

We are required by law to maintain the privacy of your protected health information, to provide you with this Notice of our legal duties and privacy practices with respect to your health information, to notify affected individuals following a breach of unsecured protected health information, and to follow the terms of the Notice currently in effect.

This Notice describes the privacy practices of Cedars-Sinai Health System, including Cedars-Sinai Medical Center<sup>1</sup> (“the Hospital”) and Cedars-Sinai Medical Foundation and its affiliated physicians and medical groups (“the Foundation”), and that of all Cedars-Sinai facilities, offices, and personnel, including non-employees such as volunteers, who have a need to use your health information to perform their job, and physicians and allied health professionals while they are caring for you in Cedars-Sinai facilities and offices.

In addition, these entities may share health information with each other for treatment, payment, or health care operations purposes as described in this Notice. This Notice applies to all of the records of your care generated at Cedars-Sinai, whether made by Cedars-Sinai personnel or your personal doctor when caring for you in the Hospital or Foundation. Your personal doctor may have different policies regarding his or her use and disclosure of your health information.

### HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories are different ways that we may use and disclose health information. Not every possible use or disclosure in a category is described below.

#### **Treatment**

We may use and share health information about you to provide, coordinate, or manage your medical treatment and related services.

We may share health information about you with doctors, nurses, technicians, students in health care training programs, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes might slow the healing process. Additionally, different departments of Cedars-Sinai may share health information about you in order to coordinate the services you need, such as prescriptions, lab work, and x-rays. We may also disclose your health information to health care providers outside of Cedars-Sinai for the purpose of coordinating your care.

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<sup>1</sup>All departments, units, and programs of the Hospital except the Voluntary Blood Donor Program and Research Institute (except clinical research-related activities involving protected health information).

## **Payment**

We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain preauthorization or payment for treatment.

## **Health Care Operations**

We may use and disclose information about you for the purpose of our business operations. These business uses and disclosures are necessary to make sure that our patients receive quality care and cost effective services. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Cedars-Sinai patients to decide what additional services Cedars-Sinai should offer, what services are not needed, and whether certain new treatments are effective.

## **Business Associates**

Some of our functions are accomplished by individuals or companies with whom we contract, called "business associates," to perform certain specialized work for us. We may disclose your health information to our business associates so they can perform the tasks we have asked them to do.

## **Electronic Records**

Currently, some or all of your health information may be stored in an electronic format. When permissible for valid purposes (e.g., providing treatment or billing for services), your health care providers may access your health information from their offices or other locations outside of Cedars-Sinai facilities. Additionally, Cedars-Sinai may provide access for certain affiliated physicians or other health care providers to store your health information that they create outside of Cedars-Sinai in Cedars-Sinai's electronic systems. All access to your health information will be permitted only in a manner consistent with applicable law.

## **Other Uses or Disclosures**

We may also use or disclose your information for certain other purposes allowed by applicable state or federal laws and regulations, including the following:

- For public health activities such as reporting communicable diseases, reactions to medications, problems with products or other adverse events, or for vital statistics such as reporting a baby's birth.
- As required by state or federal law such as reporting abuse, neglect, or certain other events.
- For certain health oversight activities such as audits, investigations, or licensure actions.
- If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 (which may include written notice to you) or to obtain an order protecting the information requested.
- When requested by law enforcement, but only as authorized by law, such as to identify or locate a suspect, fugitive, material witness, or missing person.
- To coroners, medical examiners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

- For research purposes if certain conditions are satisfied. All research projects are subject to a special approval process that evaluates a proposed research project and its use of health information to ensure appropriate safeguards. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave Cedars-Sinai. If you do not want to participate in research efforts, you may notify us using the contact information provided later in this Notice.
- To avoid a serious threat to your health or safety or the health or safety of others.
- As allowed by workers compensation laws for use in workers compensation programs.
- If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- For certain specialized government functions such as intelligence and national security activities.
- We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be 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) for the safety and security of the correctional institution.
- We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management, or treatment of an abused child and the child's parents, or elder abuse and neglect.
- In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this Notice. For example, there are special restrictions on the use or disclosure of certain categories of information — e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

### **Disclosures We May Make Unless You Object**

Unless you instruct us otherwise, we may disclose your information as described below:

- To a member of your family, relative, friend, or other person who is involved in your health care or payment for your health care. We will limit the disclosure to the information relevant to that person's involvement in your health care or payment. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition (e.g., serious, fair, good, etc.), and location in our facility. The facility directory allows the Hospital to help visitors find your room or talk to you by phone and generally know how you are doing.

- To contact you to raise funds for Cedars-Sinai programs and operations. You may opt out of receiving such communications at any time by contacting Cedars-Sinai Community Relations and Development at (323) 866-6899.

### **Uses and Disclosures With Your Written Authorization**

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your identifiable health information. You may revoke your authorization by submitting a written notice to the applicable health information representative or privacy contact using the contact information provided later in this Notice. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

### **Your Rights Concerning Your Protected Health Information**

You have the following rights concerning your health information. To exercise the rights in this section, except for requesting a copy of this Notice, you must submit a written request. You may obtain additional information and instructions for exercising these rights by contacting the health information representative where services were provided:

**CEDARS-SINAI  
MEDICAL CENTER**  
Release of Information  
Health Information Department  
8700 Beverly Blvd, Room 2901  
Los Angeles, CA 90048  
310-423-2259

**CEDARS-SINAI  
MEDICAL CARE FOUNDATION**  
Director, Health Information Management  
8501 Wilshire Blvd, Suite 340  
Beverly Hills, CA 90211  
310-248-7058

- Request additional restrictions on the use or disclosure of information for treatment, payment, or health care operations. We are not required to agree to the requested restriction except in the limited situation in which you request we not send information about a health care service or related item to your health plan for the purposes of payment or health care operations if you or someone else pays in full for that service or item at the time of the request and if you notify us in advance (so we do not automatically bill your health plan).
- Request that we contact you in a certain way or at a certain location. For example, you may ask that we contact you at a work phone number or address. We will accommodate all requests that are reasonable for our system capabilities.
- Inspect and obtain a copy of records that are used to make decisions about your care or payment for your care (including an electronic copy if we maintain the records electronically). We may charge you a reasonable cost-based fee for providing the records. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Cedars-Sinai will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- Request that your protected health information be amended. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

In addition, we may deny your request if you ask us to amend information that:

- a) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- b) Is not part of the medical information kept by or for the entity receiving the amendment request;
- c) Is not part of the information which you would be permitted to inspect and copy; or
- d) Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- Request an accounting of certain disclosures we have made of your protected health information. The accounting will provide information about disclosures made outside of Cedars-Sinai for purposes other than treatment, payment, health care operations, disclosures excluded by law, or those you have authorized. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Request a paper copy of this Notice, even if you agree to receive it electronically.

### **Changes To This Notice**

We reserve the right to change our Notice of Privacy Practices from time to time, and to make the new Notice effective for all protected health information that we maintain. If we make a material change to our Notice, we will post the revised Notice in our facilities and offices and on our website. You may obtain a copy of the current Notice by accessing our website at [www.cedars-sinai.edu](http://www.cedars-sinai.edu) or contacting us as indicated below.

### **Complaints**

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying us as set forth below. All complaints must be made in writing. We will not retaliate against you for filing a complaint.

### **Privacy Contact Information**

If you have any questions about this Notice, wish to request a copy of the current Notice, or if you want to file a privacy complaint, please contact the Medical Center or Foundation as applicable at:

**CEDARS-SINAI  
MEDICAL CENTER**  
Privacy Manager  
Corporate Integrity Program  
8700 Beverly Blvd  
Los Angeles, CA 90048  
323-866-7877

**CEDARS-SINAI  
MEDICAL CARE FOUNDATION**  
Privacy Officer  
8501 Wilshire Blvd, Suite 340  
Beverly Hills, CA 90211  
310-385-3425

## ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES OF CEDARS-SINAI MEDICAL CENTER AND CEDARS-SINAI MEDICAL CARE FOUNDATION

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By signing this form, you acknowledge receipt of our Joint Notice of Privacy Practices. The Notice of Privacy Practices tells you how we may use and disclose your protected health information.

We reserve the right to change our Notice of Privacy Practices from time to time. If we change our Notice, you may obtain a copy of the revised Notice by accessing our website at [www.cedars-sinai.edu](http://www.cedars-sinai.edu) or contacting us as indicated below. We will keep a copy of the current Notice posted in our facilities and offices. If you have questions, please contact the Medical Center or Foundation as applicable as follows:

**Cedars-Sinai Medical Center**  
Privacy Manager  
Corporate Compliance Department  
8700 Beverly Blvd  
Los Angeles, CA 90048  
323-866-7877

**Cedars-Sinai Medical Care  
Foundation**  
Privacy Officer  
8501 Wilshire Blvd, Suite 340  
Beverly Hills, CA 90211  
310-385-3425

I hereby acknowledge that I received a copy of the Cedars-Sinai Joint Notice of Privacy Practices and that I am authorized to attest to this as the individual or legal representative (parent/permanent legal guardian/conservator) by my signature recorded electronically on the signature notepad.

X

Signature:

Date:

X

Print Name:

### If signed by other than Patient:

Print Name (legal representative):

Relationship:

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:



**Fair Oaks Women's Health**

HEALTH INFORMATION DEPARTMENT  
**AUTHORIZATION FOR COMMUNICATION  
OF PROTECTED HEALTH INFORMATION**

PATIENT I.D.

\_\_\_\_\_  
Last name, First name (please print)

\_\_\_\_\_  
Today's date

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Medical record number

Protected health information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used or disclosed in the course of providing a healthcare service such as diagnosis or treatment. For other than test results, a valid HIPAA-compliant release must be completed. You may further authorize us to release your PHI to answering machines, faxes or electronic mail (email). To ensure your privacy, we will not leave messages containing PHI on answering devices without your permission. You may also authorize us to provide your confidential PHI to another person or persons. Test results related to HIV, hepatitis, substance abuse or malignancy/cancer require your prior authorization be transmitted via electronic means (voicemail, fax, email or My CS-Link™).

When you provide us with your contact information, you authorize us and our agents to use any mailing address, email address or telephone number (landline, wireless, residential or business) for the purpose of communicating with you regarding appointment information, test results, discharge instructions or other clinical information as well as account information or other information pertinent to medical services. You are also agreeing to accept live or autodialed calls and other messages to these numbers or addresses where we may leave recorded messages.

I authorize physicians and/or staff to contact me via the following:

Email address: \_\_\_\_\_

Phone voicemail: \_\_\_\_\_

Fax number: \_\_\_\_\_

\_\_\_\_\_  
Name of alternative person I elect to receive my PHI (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (patient or individual legally authorized to consent to release)

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/ZIP

This authorization shall remain in effect until you notify us in writing of any requested changes. The Health Information Manager will review your request and respond in writing if your request cannot be honored. If you have any questions or concerns, you may contact the Health Information Manager at 310-248-6674.



**Fair Oaks Women's Health**  
MEDICAL CARE FOUNDATION  
**CONDITIONS OF TREATMENT**

PATIENT I.D.

**1. Patient consent for services**

I hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of the Cedars Sinai Medical Network. These may include but are not limited to: emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, or anesthesia provided to me under the general and special instructions of my physician or surgeon.

**2. Financial responsibility for services**

I hereby authorize my insurance benefits be paid directly to Cedars-Sinai Medical Care Foundation. I understand that I may have financial responsibility for all or a portion of the charges for the professional services rendered and will remit appropriate payment at the time of service, including specifically copayments and charges for services which are not covered by my insurance.

**3. Copayment policy**

If applicable, at the time of check-in I will be required to pay a copayment. If I do not pay my copayment, I understand that my visit may be canceled.

**4. Insurance coverage**

I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have questions.

**5. Referrals/authorization**

I understand that, depending on my insurance, I may need a referral from my provider to see a specialist. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I will be promptly advised of any requests that are determined not to be appropriate or necessary. I understand that if I choose to access specialty services without prior authorization from my provider, or I elect to use a Point of Service option or fail to notify Cedars-Sinai Medical Care Foundation if my insurance plan requires specific outside vendors such as laboratories to perform referred services, I may be financially responsible for the services rendered and insurance may not cover the relevant services.

**6. Ancillary services**

I understand that, depending on my insurance, I may receive a separate bill for laboratory, X-ray, anesthesia or other ancillary services.

**7. Release of information**

I authorize the release of my medical records or other information necessary to provide healthcare, to process my medical claims, and for other purposes relating to the healthcare operations. I understand that Cedars-Sinai Medical Care Foundation is affiliated with Cedars-Sinai Health System, and as such, shares information with Cedars-Sinai Medical Center and its affiliate ancillary departments (e.g., laboratory and imaging). Additional information is provided in our Notice of Privacy Practices.

**Fair Oaks Women's Health**  
MEDICAL CARE FOUNDATION  
**CONDITIONS OF TREATMENT**

PATIENT I.D.

**8. Fees for patient's health information**

I hereby understand that I may be charged a cost-based fee when requesting copies of my health information, including the cost of copying (supplies and labor), postage (if information is to be mailed), and preparation for any summary or explanation if agreed to in advance.

**9. Fee for forms**

I understand, that if I request to have any forms completed by my physician that are not directly related to patient care I will be required to pay a fee. Examples of such forms include, but are not limited to, jury duty excuse, Family and Medical Leave Act application, accident reports, and school and camp forms. There may be other forms with associated fees.

**10. On-time arrival policy**

I understand that I must arrive at least 15 minutes before the time of my appointment in order to register and provide information prior to the time my physician is scheduled to see me. If I arrive late for my scheduled appointment, I understand that it may be necessary to reschedule my appointment. My physician attempts to maintain an "on-time" schedule, but I understand that urgent or complex needs for patients with prior appointments may cause my physician to be late for my appointment.

**11. No-show policy**

I understand that if I miss an appointment with less than 3 business hours' prior notice, I may be charged a fee for a missed visit.

**12. Medication refills**

I understand that refills may take 24-48 hours to complete and that the most efficient way to get a refill is to contact my pharmacy directly. In order to ensure timely medication refills, I agree to notify my physician's office regarding my preferred pharmacy.

**13. Photography for patient identification**

I understand that Cedars-Sinai Medical Care Foundation is deeply committed to my safety and identity protection. I agree to have my picture taken at check-in for inclusion in my medical record. I understand that my photograph will be used to protect me from identity theft, to ensure patient safety and to further personalize the services I will receive. My picture helps to confirm that all members of the Cedars-Sinai Medical Care Foundation care team are accessing the correct medical record.

**14. Photography for clinical care**

If clinically indicated, I will be advised if medical photographs need to be taken while receiving medical care through Cedars-Sinai Medical Care Foundation. I consent to medical photography, and I understand that images from such photography may be used for my treatment or for the Cedars-Sinai Medical Care Foundation's own healthcare operations, such as peer review or medical education, as Cedars-Sinai Medical Care Foundation or my treating provider(s) deem appropriate. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images. It has been explained to me that the images will be a permanent part of my medical record. At the time a photograph is recommended, I have the option to revoke this consent.

**Fair Oaks Women's Health**  
MEDICAL CARE FOUNDATION  
**CONDITIONS OF TREATMENT**

PATIENT I.D.

**15. Open Payments database notice**

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

**16. Notice to Consumers**

Medical doctors are licensed and regulated by the Medical Board of California. For more information, please visit: [www.mbc.ca.gov](http://www.mbc.ca.gov) or contact 800-633-2322.

**By signing immediately below, I understand that physicians are licensed and regulated by the Medical Board of California.**

X#1

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Patient or legal representative signature

**I certify that I have read the foregoing and received a copy thereof. I am the Patient, the Patient's legal representative, or otherwise duly authorized by the Patient to sign the above and accept its terms on his/her/their behalf.**

X#2

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Patient or legal representative name (please print)

---

Patient or legal representative signature

---

Date (MM/DD/YYYY)

---

Time

---

Relationship to patient

---

Staff witness name (please print)

---

Staff witness signature

---

Date (MM/DD/YYYY)

---

Time

**Fair Oaks Women's Health**  
MEDICAL CARE FOUNDATION  
**CONDITIONS OF TREATMENT**

PATIENT I.D.

**Staff to complete the fields below if the patient/surrogate or legal representative is unable to provide in-person signature.**

Please indicate how consent was obtained:

Telephone     Verbal     Other: \_\_\_\_\_

\_\_\_\_\_  
Second witness name (please print)

\_\_\_\_\_  
Second witness signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Time

Interpreter/Witness for interpreter

This box shall be checked when the following paragraph is applicable:

We have accurately and completely read the foregoing document to the patient/legal representative in his/her/their primary language identified below. He/She/They state that he/she/they understood all of the terms and conditions and acknowledged his/her/their agreement by signing the document in my presence.

\_\_\_\_\_  
Interpreter name (please print)/I.D. no.

\_\_\_\_\_  
Interpreter signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Time

\_\_\_\_\_  
Language

\_\_\_\_\_  
Witness name (please print)

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Time

**Fair Oaks Women's Health**  
MEDICAL CARE FOUNDATION  
**CONDITIONS OF TREATMENT**

PATIENT I.D.

**I agree to accept financial responsibility for services rendered to the Patient and to accept the terms of the Financial Agreement, Assignment of Health Plan Benefits and Health Plan provisions above.**

---

Financial responsible party name (please print)

---

X#3

---

Financial responsible party signature

---

If signed by someone other than the patient, indicate relationship

---

Date (MM/DD/YYYY)

---

Time

---

Witness name (please print)

---

Witness signature

**FOR CEDARS-SINAI USE ONLY**

\_\_\_\_\_  
Signature of Cedars-Sinai Representative:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Title of Cedars-Sinai Representative: