PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Dear Patient,

We appreciate you choosing ***Palomar Health Medical Group*** for your healthcare needs. We continually strive to provide the highest quality gynecologic and obstetric healthcare in a professional caring environment.

We want to understand your health concerns and goals. Enclosed is your new patient packet for completion—thank you for taking the time to begin our conversation by completing this information. **This packet needs to be completed prior to scheduling your appointment**.

Due to limited capacity and to provide you with the best medical care possible, appointments are limited to the patient, regardless of age of minority and one adult.

Please arrange child care accommodations prior to your appointment time>

We understand that English may not be the primary language of all of our patients. To alleviate any delays in your care related to language, if you need a translator, we ask that you notify us prior to your appointments and we will provide a translator.

You must bring your insurance card or proof of insurance to all appointments. Co-payments and/or deductibles, if applicable, are required to be paid at the time of your visit.

Lastly, we ask that you arrive ***15 minutes prior to your appointment.*** Please be advised that if you are late to your appointment, you may be rescheduled.

Thank you for your cooperation.
We look forward to caring for you,

Palomar Health Medical Group - OB/GYN

Enclosures

Brano Cizmar MD, PhD *Paul Hinshaw, DO* *Damon Cobb, MD* *Natalia Babkina, MD PhD*

Rachel Krochmal, FNP *Karen Manchester, FNP* *Elizabeth Saez, FNP*

www.palomarhealthmedicalgroup.org

07/28/2022

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Patient Registration Information

HOW DID YOU HEAR ABOUT US? ☐ NEWSPAPER ☐ SOCIAL MEDIA/WEB SEARCH ☐ INSURANCE REFERRAL ☐ FAMILY/FRIEND

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐ M ☐ F
	N/A				

BILLING ADDRESS	CITY	STATE	ZIP

PHYSICAL ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL (example@test.com)

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

EMERGENCY CONTACT NAME	Relationship	EMERGENCY PHONE XXX-XXX-XXXX

ADDRESS	PHONE#	OCCUPATION

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
WORK PHONE / OCCUPATION	WORK PHONE / OCCUPATION

POLICY HOLDER/GUARANTOR (If different than patient)

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMT. PCP $	SPECIALIST
ADDRESS OF INSURANCE COMPANY		DEDUCTIBLE AMT. SELF	DEDUCTIBLE AMT. FAMILY
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMTOUNT $	
ADDRESS OF INSURANCE COMPANY		DEDUCTIBLE AMTOUNT	
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

REFERRAL INFORMATION

NAME OF REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Palomar Health Medical Group to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Palomar Health Medical Group.

Patient / Guardian Signature _____ Date _____ Relationship to Patient _____

Patient Financial Agreement

PALOMAR HEALTH MEDICAL GROUP®
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PATIENT INFORMATION

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. **Initials** _____

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived. **Initials** ____

Checks: Returned checks may be subject to a $30.00 fee. **Initials** ____

Cash Pay Patients: The amounts you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, X-ray tests, any injections, special procedures or additional office visit charges. **Initials** ____

Claims Submission: As a courtesy, Palom Health Medical Group will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency. **Initials** ____

Preventative Care Services: Routine exams may be covered by your insurance. When a medical concern is addressed at the time of your visit, preventative benefits will no longer apply. Additional fees may incur including but not limited to co-pays, deductibles and co-insurance. **Initials** ____

Ancillary Services: Laboratory and outpatient radiology procedures will be billed separately by an outside provider. Please contact them directly with any questions regarding your bill. **Initials** ____

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Palomar Health Medical Group for all services rendered. **Initials** ____

Missed Appointments: Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

I have read and understand the above statements. I**nitials** ____

I agree to comply with the financial policies of Arch Health Medical Group and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____

Patient / Guardian Signature Date

_____ _____

Patient Name (Please print) Date of Birth

PALOMAR HEALTH MEDICAL GROUP®
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Authorization for Use or Disclosure of Health Information from Palomar Health Medical Group to Designated Persons

Completion of this document authorizes the disclosure and use health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT INFORMATION	
*NAME (Last, First, M.I.)	MAIDEN OR OTHER NAME
*DATE OF BIRTH	PHONE

I, _____(patient) (please print) hereby authorize **Palomar Health Medical Group** to release **any and all** information about my *health*, *medical condition* or *billing for services* to members of family or other persons, as specified below. This includes verbal discussions with the medical/nursing staff and copies of my medical record.

DESIGNATED PERSONS	
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE

***THE PURPOSE OF THIS RELEASE IS**

☒ At my request ☐ Continuing medical care ☐ Other _____

Specify limitations (if any) on the use of the information: _____

Authorization for Use or Disclosure of Health Information from Palomar Health Medical Group to Designated Persons

*Expiration of Authorization

This authorization becomes effective upon signing and will expire upon my written revocation.

Patient Rights

I, the patient or the patient's legal representative, understand that:

- I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered or mailed to:

  Palomar Health Medical Group
  15611 Pomerado Road Poway,
  CA 92064

If I revoke this authorization, the revocation will not have any effect on actions taken prior to Palomar Health Partners receiving the revocation.

- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I have a right to a copy of this Authorization.

*
_____ _____
Patient / Guardian Signature Date

*
_____
If Legal Representative, State Relationship to Patient

***Required for valid Authorization**

Patient Diversity Form

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

PATIENT INFORMATION

Dear Palomar Health Medical Group Patient:

The Federal Government requests the following questions be asked of every patient. Please select the preference that fits you the best and return this to the front office person. *** See below for race and ethnicity descriptons*

I identify my race as: (Please check one)

- ☐ I decline to self identify.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black, African American
- ☐ Native Hawaiian or other Pacific
- ☐ Islander Other Pacific Islander
- ☐ Other Race- _____
- ☐ White

I identify my ethnicity as: (Please check one)

- ☐ I decline to self identify.
- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino / Spanish
- ☐ Latin / American / Latin, Latino Mexican
- ☐ Not Hispanic / Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

My Language Preference is: (Please check one)

- ☐ English
- ☐ Spanish
- ☐ Tagalog
- ☐ Russian
- ☐ Persian / Farsi
- ☐ Other (Please specify) _____

***Race is defined as a "person's self-identification with one or more social group".*

***Ethnicity is defined as a "person's self-identification based on nationality, language, culture and religion, geography or family's origin."*

DO NOT FILE IN NG

Effective April 14, 2003 Revised September 10, 2013; March 23, 2015; July 29, 2019

Notice of *Privacy* Practices

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

If you have any questions about this notice, please contact the Palomar Health Medical Group Privacy Office at **1.877.376.3930**. This notice describes Palomar Health Medical Group's practices and that of:

- Any health care professional authorized to enter information into your health record.
- All departments and clinic sites of Palomar Health Medical Group.
- Any member of a volunteer group we allow to help you while you are in our care.
- All employees, staff and other Palomar Health Medical Group personnel.
- Affiliated Physicians

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

The providers participating in this notice (referred to as "we") understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive during your visit with us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by any of the Palomar Health Medical Group sites or affiliated entities, whether made by Palomar Health Medical Group personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice tells you about the ways we may use and disclose your medical information. This notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to make sure that medical information that identifies you is kept private (with certain exceptions), to notify you of our legal duties and privacy practices with respect to medical information about you, to notify you if a breach of your medical information occurs, and to follow the terms of the notice of privacy practices currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

Treatment – We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, pharmacists, health care students or other Palomar Health Medical Group personnel and workforce members who are involved in providing for your well-being during your visit with us. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Additionally, the doctor may need to tell the dietitian if you have diabetes so we can arrange for appropriate meals. Different departments within Palomar Health Medical Group also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside of Palomar Health Medical Group who may be involved in your medical care after you leave us, such as skilled nursing facilities, home health agencies and physicians or other practitioners, including, without limitation, your primary care provider, so they can provide care or coordinate continuing care.

For Payment – We may use and disclose your medical information so that the treatment and services you receive at our facilities or from us may be billed and payment collected from you, an insurance company, a third party or a collection agency For example, we may need to give information about a medical service you received at a PHMG clinic to your health plan so it will pay us or reimburse you for the medical service. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the hospital who are involved in your care, to assist them in obtaining payment for services they provide to you.

For Health Care Operations – We may use and disclose medical information about you for health care and business operations, a variety of activities necessary to run our health care facilities and ensure all of our patients receive quality care. For example, we may use medical information to review the quality and safety of our treatment and services, to evaluate the performance of our staff in caring for you, or for business planning, management and administrative services. We may also use and disclose your medical information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called business associates and are required by law to keep your medical information confidential. We may also disclose information to doctors, nurses, technicians, medical students and other hospital personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Fundraising Activities – We may use information about you, or disclose such information to a foundation related to Palomar Health Medical Group, to contact you in efforts to raise money for our health care organization and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

Marketing and Sale – Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

To Individuals Involved in your Care or Payment for your Care – We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so your family can be notified about your condition, status and location.

For Research – Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. 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 does not leave our facilities or offices.

As Required by Law – We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety – We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Psychotherapy Notes – Most uses and disclosures of psychotherapy notes require your authorization.

Organ and Tissue Donation – We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans – 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.

Workers' Compensation – We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities – We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report regarding the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify 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;
- To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Health Oversight Activities – We may disclose medical 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.

Lawsuits and Disputes – 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 allow you to obtain an order protecting the information requested.

Law Enforcement – We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our facility(ies); and
- In emergency circumstances 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 medical 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 may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities – We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others – We may disclose medical information about you to authorized federal officials so they may conduct investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates – 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 a s a uthorized o r required by law. 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.

Special Categories of Information – 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.

Health Information Exchange (HIE) – We may share your health information electronically with other organizations where you receive health care. Sharing information electronically is a faster way to get your health information to the health care providers treating you. HIE participants are required to meet rules that protect the privacy and security of your health and personal information.

Secure Patient Portal – We have established a web-based system, called a Patient Portal, which allows us to securely communicate and transfer health care information to you. With your consent, you will receive a user ID and password to access the Patient Portal. If your user ID or password to your Patient Portal is obtained by another person, your medical information is subject to improper disclosure. Please notify us immediately if you feel your Patient Portal is being improperly accessed.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION WE MAINTAIN ABOUT YOU

You have rights regarding the medical information we maintain about you. To exercise your rights regarding medical information we maintain about you, you must submit a written request to Palomar Health Medical Group, Privacy Office, 15611 Pomerado Road, Suite 400, Poway, CA 92064.

RIGHT TO INSPECT AND COPY

You have the right to inspect and/or obtain a copy of your medical information, including lab test results. You can ask for an electronic or paper copy of your medical information.

We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

RIGHT TO AMEND

If you feel that medical information we have about you 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 Palomar Health Medical Group. Your request must be made in writing, and you must provide a reason that supports your request. We may deny your request as authorized by law.

Even if we deny your request for amendment, you have the right to submit a statement of disagreement.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, and with other exceptions pursuant to law. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. 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.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations; for use in a facility directory; or to family members and others involved in your care. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full.

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. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice upon request. 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 website: **PalomarHealth.org**.

Changes to this Notice – We reserve the right to change this notice at any time, and to make the new notice effective for all medical information we maintain, including medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in all of our departments and clinic sites.

Complaints – If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by contacting the Privacy Officer by telephone at **1.877.376.3930** or in writing to Palomar Health Medical Group, Privacy Officer, 15611 Pomerado Road, Suite 400, Poway, CA 92064. You will not be penalized or retaliated against for filing a complaint.

Complaints – Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PALOMAR HEALTH
MEDICAL GROUP®
Reimagining Healthcare™

Notice Of Privacy Practices

Patient Label Here

Patient Name: _____

DOB: _____ MRN: _____

Acknowledgement of Receipt

PATIENT INFORMATION

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Patient / Guardian Signature Date

_____ _____
Patient Phone XXX-XXX-XXXX Name of Physician

By signing this form, the patient acknowledges receipt of the "Notice of Privacy Practices" of Palomar Health Medical Group. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information. We encourage you to read it in full.

I acknowledge receipt of the "Notice of Privacy Practices" of Palomar Health Medical Group.

_____ _____
Patient / Guardian Signature Date

_____
If legal representative, state relationship to patient

☐ I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is: _____

PHMG Advance Directive Information

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Patient Label Here

Patient Name: _____

DOB: _____ MRN: _____

Your Rights as an Palomar Medical Group Patient

You have a legal right to make known your wishes about your medical care, including the right to accept or refuse treatment. The document "Advance Health Care Directive" is a means to specify your wishes and to make them legally binding.

What is an Advance Health Care Directive?

This is a legal document that enables you to specify your desires about life-sustaining treatment. It also allows you to name someone you trust to speak for you when you are incapacitated. This document replaces "Living Wills" and the "Durable Power of Attorney for Health Care". You can identify your primary care physician and specify your wishes about CPR, feeding tubes, breathing machines, pain medication, organ donation and other desires.

How do I find out more?

- **Internet Resources**
  http://ag.ca.gov/consumers/general/adv_hc_dir.php
  http://www.cmanet.org/about/patient-resources/end-of-life-issues/advance-directives
  http://www.coalitionccc.org/
- **The booklet "Finding Your Way"** is a useful guide to thinking about and discussing these issues. To order a copy, send $1.50 check (payable to "CHCD") to Center for Healthcare Decisions, 3400 Data Drive, Rancho Cordova, CA 95670 or order it through their website, **www.chcd.org**.

How do I obtain an Advance Healthcare Directive form?

The California Medical Association – Kit available for nominal fee (currently $6)

1201 J St. STE 200
Sacramento, CA 95814

Phone: **800.786.4262**
Fax: **916.551.2036**

Obtain the form on-line free of charge at:
http://ag.ca.gov/consumers/pdf/AHCDS1.pdf

What other kinds of directives are available?

- Physician Orders for Life-Sustaining Treatment (POLST) – this complements the Advance Directive by having a physician order signed and ready-to-go in the event you need life-sustaining treatment. Specific instructions may be made about CPR and medical interventions like assisted breathing and artificial feeding.

Palomar Health Medical Group has a written policy on Advance Directives. Check the box below if you wish more information.

Patients: Please check the appropriate box(es):

☐ I have an Advance Directive and/or POLST. I will provide Palomar Health Medical Group with a copy. [Give the copy to one of our staff or mail to AHMG, 15611 Pomerado Road, Poway, CA 92064, ATTN: Medical Records.]

☐ I have an Advance Directive/POLST but do not wish to provide AHMG with a copy.

☐ I do not have an Advance Directive/POLST.

☐ I would like more information on Palomar Health Medical Group policy on Advance Directives.

_____ _____

Signature of Patient or Patient's Legal Representative Date

PALOMAR HEALTH MEDICAL GROUP
Reimagining Healthcare™

This information is confidential and will not be revealed to anyone without your permission

Name:_____ **Date of Birth:**_____ **Age:**___ **Date:**_____
Height:__ft___in Weight:____lbs Preferred Language:_____Ethnicity:_____Marital Status:_____

A WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? ☐ Pregnancy ☐ Annual GYN Exam ☐ GYN Health Issue

Please describe GYN issue: ***How long have you had this GYN issue:***_____

B GYNECOLOGIC HISTORY

Age at first period:_____ **Date of *beginning* of last menstrual period**:_____ **Age at menopause**:_____
Frequency: ☐ Regular ☐ Irregular **Cycle Length** (#days between periods):_____ **Cycle Duration** (#days of bleeding):_____
Flow: ☐ Light ☐ Moderate ☐ Heavy ☐ Clots **Cramping**: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Sexually Active: ☐ Yes ☐ No ☐ Previously **Partners**: ☐ Men ☐ Women ☐ Both **Types of sex**: ☐ Vaginal ☐ Oral ☐ Anal
Contraceptive method: ☐Pills☐ Patch☐ Ring ☐ Shot☐ IUD ☐ Implant ☐ Tubal Ligation☐ Condoms ☐ None ☐ Other
Date of last Pap:_____Was it Normal: ☐ Yes ☐ No *What abnormality:*_____
Have you ever had an *abnormal* pap: ☐ Yes ☐ No *When:*_____*What abnormality:*_____
Have you ever had *treatment* for an abnormal pap: ☐ Yes ☐ No *When:*_____*What treatment:*_____
Date of last mammogram: ☐ N/A_____Was it normal: ☐ Yes ☐ No

C OBSTETRICAL HISTORY ☐ Have never been pregnant

(Please list all pregnancies in order, including miscarriages, premature births, abortions, ectopic (tubal), etc.)

	No.		No.		No.		No.		No.
Pregnancies (# times pregnant)		**Term Births** (>37weeks)		**Premature Births** (20-36weeks)		**Abortions**		**Living Children**	
						Miscarriages			
						Ectopic/Tubal			

Mon/Day/Yr	Duration of Pregnancy (i.e. 40weeks)	Hours in Labor	Birth weight (pounds)	Sex M/F	Type of Delivery (vaginal, C-section, forceps, vacuum, miscarriage, etc.)	Epidural Y/N	Place of delivery or abortion	Comments/ Complications

Pregnancy Complications: **Diabetes** ☐ Yes ☐ No **Hypertension** ☐ Yes ☐ No **Pre-eclampsia** ☐ Yes ☐ No

D CURRENT MEDICATIONS (List all including hormones, vitamins, herbs, nonprescription medications, etc.)

Drug Name	Dose	Frequency (i.e. twice daily)	Drug Name	Dose	Frequency (i.e. twice daily)

E ALLERGIES **Food:** ☐Yes ☐No **Latex:** ☐Yes ☐No **Medications:** ☐Yes ☐No (If *Yes*, list all and reaction):

_____

_____

_____

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This information is confidential and will not be revealed to anyone without your permission

Name:_____ **Date of Birth:**_____ **Age:**____ **Date:**_____

F PAST MEDICAL AND FAMILY HISTORY *Please ☒check if you **or** a blood relative has had any of the following*

Indicate family member M=Mother; F=Father; B=Brother; S=Sister; GM= Grandmother; GF= Grandfather; O = Other (i.e. Aunt or Uncle)

		No	Yes	Self	*Family*			No	Yes	Self	*Family*
1.	alcohol or drug problems	☐	☐	☐		23.	fibroids	☐	☐	☐	
2.	anemia	☐	☐	☐		24.	gallbladder disease	☐	☐	☐	
3.	arthritis/joint pain/back problems	☐	☐	☐		25.	genital herpes	☐	☐	☐	
4.	asthma	☐	☐	☐		26.	headaches/migraines	☐	☐	☐	
5.	autoimmune disease (lupus)	☐	☐	☐		27.	heart attack/disease	☐	☐	☐	
6.	birth defects	☐	☐	☐		28.	hepatitis/liver disease	☐	☐	☐	
7.	bladder infections	☐	☐	☐		29.	hereditary disease	☐	☐	☐	
8.	bleeding problems	☐	☐	☐		30.	high blood pressure	☐	☐	☐	
9.	blood clots in lungs/legs (DVT/PE)	☐	☐	☐		31.	high cholesterol	☐	☐	☐	
10.	blood transfusions	☐	☐	☐		32.	HIV/AIDS	☐	☐	☐	
11.	bowel problems	☐	☐	☐		33.	kidney infections/ stones	☐	☐	☐	
12.	cancer - **breast**	☐	☐	☐		34.	mitral valve prolapse	☐	☐	☐	
13.	cancer - **cervical**	☐	☐	☐		35.	pelvic infection	☐	☐	☐	
14.	cancer - **colon**	☐	☐	☐		36.	pneumonia/lung disease	☐	☐	☐	
15.	cancer - **ovarian**	☐	☐	☐		37.	reflux/digestive problems	☐	☐	☐	
16.	cancer - **uterine**	☐	☐	☐		38.	rheumatic fever	☐	☐	☐	
17.	cancer - **other**	☐	☐	☐		39.	sickle cell anemia	☐	☐	☐	
18.	chickenpox	☐	☐	☐		40.	stroke	☐	☐	☐	
19.	chlamydia/gonorrhea/syphilis	☐	☐	☐		41.	thyroid problems	☐	☐	☐	
20.	depression/anxiety	☐	☐	☐		42.	tuberculosis	☐	☐	☐	
21.	diabetes	☐	☐	☐		43.	other	☐	☐	☐	
22.	epilepsy/seizure disorder	☐	☐	☐		44.	other	☐	☐	☐	

For any Yes, please indicate #, and explain: Clear Explanation

G SURGERIES/HOSPITALIZATIONS (not including hospitalization for childbirth)

Year	Procedure or Reason for Hospitalization	Year	Procedure or Reason for Hospitalization

H SOCIAL HISTORY

Do you smoke/have ever smoked?	☐ Yes ☐ No	*# packs/day*	*# years smoked*	*Quit when?*	*Do you want to Quit?* ☐ *Yes* ☐ *No* ☐ *N/A*
Do you drink alcohol?	☐ Yes ☐ No	*What do you drink?*	*How often do you drink?*	*How much do you drink?*	
Do you use/have ever used drugs?	☐ Yes ☐ No	*What substance?*	*How often?*	*Quit when?*	*Do you want to Quit?* ☐ *Yes* ☐ *No* ☐ *N/A*

I **In case of an emergency, do you consent to ***transfusion of blood or blood products***?* ☐ Yes ☐ No

J PHARMACY INFORMATION

Name:_____ Street:_____ City:_____ Phone:_____

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CONGRATULATIONS

As part of your prenatal care, please read and complete the attached *Prenatal Screening and Testing Consent* and other related consent and prenatal forms. *Please remember these need to be completed and returned 1 week prior to your appointment*.

For your convenience, we have provided space below for you to write any questions you may have. You will be able to discuss these and any other questions, at your next visit.

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Obstetrical Worksheet

1. Have you had any children born with a birth defect? ☐YES ☐NO
2. Does anyone on either side of the family have birth defects? ☐YES ☐NO
3. Is there any disease the runs in your family? ☐YES ☐NO
4. Is anyone on either side of the family mentally challenged? ☐YES[1] ☐NO
5. Does anyone on either side of the family have Fragile-X, Autism, Premature Ovarian Failure, or Spinal Muscular Atrophy? ☐YES[1] ☐NO
6. Are and you and the father of your baby of Ashkenazi Jewish, French-Canadian, or Cajun descent? ☐YES[2,3] ☐NO
7. Is there any possibility that you and the father of your baby are related? ☐YES ☐NO
8. If you or the baby's father is African American, have you ever been tested for sickle cell trait or disease? ☐*N/A* ☐YES[4] ☐NO
9. Are you of any of the following descent? ☐YES ☐NO

☐ African[4,5,6] ☐ Mediterranean[4,5,6,7] ☐ Asian[6,7] ☐ Southeast Asian[4,5,6] ☐West Indian[5,6,7] ☐ Middle Eastern[5,7] ☐ Hispanic[7]

10. Have you ever had chicken pox or had the vaccination against the chicken pox? ☐YES ☐NO
11. If your baby is a boy, would you like him to have a circumcision? ☐YES ☐NO
12. Are you interested in further information about cord blood banking? ☐YES ☐NO
13. Are you interested in getting permanently sterilized after the birth of your baby? ☐YES ☐NO
14. Have you been exposed to any toxic chemical(s) during this pregnancy? ☐YES ☐NO
15. Have you had any type of illness during this pregnancy? ☐YES ☐NO
16. Are you under the care for any medical issues by any other provider? ☐YES ☐NO

[1] Consider Fragile X testing, [2] Consider Tay-Sachs testing
[3] If both parents are Ashkenazi Jewish then consider **Ashkenazi Panel** (Canavan disease, Familial dysautonomia, Tay-Sachs), or **Comprehensive Ashkenazi Panel** (Bloom Syndrome, Familial hyperinsulinism, Fanconi anemia, Gaucher disease, Glycogen storage disease type I (Gierke disease), Joubert syndrome, Maple syrup urine disease, Mucolipidosis type IV, Niemann-Pick disease, Usher Syndrome)
[4] Consider Sickle Cell Anemia testing, [5] Consider Hemoglobin Electrophoresis, [6] Consider Alpha-Thalassemia testing, [7] Consider beta-Thalassemia testing

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____

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Prenatal Screening and Testing Consent

____(initial) I understand there are multiple *optional* **screening and diagnostic tests** available to me. I have read the information in the "**California Prenatal Screening Program**" booklet (or have had it read to me) and have been given the opportunity to ask questions pertaining to these as well as carrier screening tests.

____(initial) I understand that not all testing may be covered by insurances and if I choose to have testing that is not covered*; I am accountable for the costs of those tests*.

- **Carrier Screening test(s):** (if you have already had these tests, they do not need to be repeated as the results do NOT change)
  - a. *Cystic Fibrosis (CF) (offered to all women)* ☐YES ☐NO
  - b. *Spinal Muscular Atrophy (SMA) (offered to all women)* ☐YES ☐NO
  - c. Fragile X Syndrome ☐YES ☐NO
    - (Recommended for women with a family history of fragile x-related disorders, unexplained intellectual disability or developmental delay, autism with intellectual disability, or women who have unexplained ovarian insufficiency)
  - d. Tay-Sachs (recommended for Ashkenazi Jewish, French-Canadian, or Cajun descent) ☐YES ☐NO
  - e. Sickle Cell Anemia (recommended for African, Mediterranean, or Southeast Asian descent) ☐YES ☐NO
  - f. Alpha-Thalassemia (recommended for African, Mediterranean, Asian, or West Indian descent) ☐YES ☐NO
  - g. Beta-Thalassemia (recommended for Mediterranean, Asian, Middle Eastern, Hispanic, or West Indian descent) ☐YES ☐NO
- **Prenatal Screening test(s):** *(select only one)*
  - ☐ a. **Sequential Integrated Screening** [Green section of booklet]
    (Combines specialized early ultrasound for nuchal translucency (NT) with first and second trimester blood test results)
  - ☐ b. **Serum Integrated Screening** [Blue section of booklet]
    (Combines first and second trimester blood tests)
  - ☐ c. **Quad Marker Screening** [Yellow section of booklet]
    (One blood test drawn in the second trimester)
  - ☐ d. **NONE** of the prenatal screening tests
- **Prenatal Diagnostic test(s):**
  - a. **Invasive Diagnostic testing** (CVS, Amniocentesis) instead of screening ☐YES ☐NO
  - b. **Non-Invasive Prenatal Testing (NIPT) (cell-free fetal DNA)** ☐YES ☐NO

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____

Acknowledge of Receipt of Cord Blood Banking Information

California state law requires healthcare providers to inform expecting parents of their options regarding preserving umbilical **cord blood stem cells**.

"Cord blood is the blood from the baby that is left in the ***umbilical cord*** and ***placenta*** after birth. It contains cells called hematopoietic (blood-forming) stem cells that can be used to treat some diseases. It is now possible to donate cord blood to a public bank or store it in a private bank for future use." (ACOG AP172)

I have read the information in the "California Prenatal Screening Program" booklet (or have had it read to me) regarding umbilical **cord blood banking**. *I fully understand, should I wish to obtain additional information about umbilical cord blood stem cell preservation, that this responsibility will be solely and completely my own.* _____(initial)

Note: Some of our providers may have a contractual relationship with some of the cord blood companies and may receive payment for collection services.

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____

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Drug Screening Notice

I understand, in order to ensure the health of my baby, my urine and/or blood may be **screened for drugs** at the discretion of my provider._____(initial)

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____

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Pulmonary TB Questionnaire

1. Have you ever had a positive TB (Tuberculosis) skin test or TB blood test? ☐YES ☐NO ☐Don't Know
2. Have you ever had a severe reaction to a TB skin test? ☐YES ☐NO ☐Don't Know
3. Have you ever been told NOT to have the TB skin test? ☐YES ☐NO ☐Don't Know
4. Have you ever had a chest X-ray for a positive TB test? ☐YES ☐NO ☐Don't Know
5. Have you ever taken medications for tuberculosis? ☐YES ☐NO ☐Don't Know
6. *If you were not born in the US, have you had the BCG vaccine?* ☐*N/A* ☐YES ☐NO ☐Don't Know
7. Have you lived with or been in contact with someone who has TB disease? ☐YES ☐NO ☐Don't Know
8. Have you had any of the following symptoms for the ***last 2 weeks***?

Cough	☐YES ☐NO
Coughing up blood	☐YES ☐NO
Spitting up blood	☐YES ☐NO
Loss of appetite	☐YES ☐NO
Night sweats	☐YES ☐NO
Fevers	☐YES ☐NO

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____