☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**

☐ **Jennifer R. Gulick, M.D., P.L.L.C.**

3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

NAME: ____

LAST FIRST DATE OF BIRTH

ADDRESS: ____

STREET CITY STATE ZIP

PHONE (PLACE CHECK WHERE WE MAY LEAVE A MESSAGE, YOU CAN PICK MORE THAN ONE)

HOME ☐ WORK ☐ CELL ☐

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐LEGALLY SEPARATED

SOCIAL SECURITY NUMBER: ______-___-______ PHARMACY #: ____

RACE (PLEASE CIRCLE ONE): CAUCASIAN AFRICAN AMERICAN NATIVE AMERICAN CHINESE ASIAN FILIPINO HISPANIC S. AMERICAN JAPANESE PACIFIC ISLANDER RUSSIAN MULTIRACIAL OTHER: ___________

HOW DID YOU HEAR ABOUT OUR PRACTICE? ____

EMPLOYER: ____

ADDRESS: ______________________ CITY: ____________ STATE: ____________ ZIP: ________

____

EMERGENCY CONTACT #1 PHONE # RELATIONSHIP

____

EMERGENCY CONTACT #2 PHONE # RELATIONSHIP

INSURANCE POLICYHOLDER NAME: ____

(If same as patient may leave following blank)

DOB: ____________ SSN #: ____________ RELATION TO PATIENT: ____________

ADDRESS: ______________________ CITY: ____________ STATE: ________ ZIP: ________

HOME PHONE: ______________________ CELL PHONE: ______________________

PRIMARY INSURANCE CARRIER: ____

PLAN TYPE: ☐HMO ☐EPO ☐PPO ☐POS

BILLING ADDRESS: ______________________ CITY: ____________ STATE: ________ ZIP: ________

PHONE NUMBER: ____

POLICY NUMBER: ______________________ GROUP # : ______________________

COPAY/COINSURANCE AMOUNT: ____

SECONDARY INSURANCE? ☐Y ☐N (IF SO, PLEASE PROVIDE A COPY OF ABOVE INFORMATION TO RECEPTIONIST)

Please complete entire form.* ***If something does not apply, please mark N/A**. Thank you!**

Revised 2-15-17

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**

☐ **Jennifer R. Gulick, M.D., P.L.L.C.**

3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

NAME: ____________________ AGE: ______ DATE: ______

REASON FOR VISIT: ____________________

FIRST DAY OF LAST MENSTRUAL CYCLE: ______ AGE OF FIRST MENSTRUATION: ______

ANY PROBLEMS WITH MENSTRUAL CYCLE? ______ AGE OF MENOPAUSE: ______

ARE YOUR CYCLES REGULAR? ☐Y ☐N HOW MANY PADS/TAMPONS ON HEAVIEST DAY: ______

ARE YOU CURRENTLY SEXUALLY ACTIVE? : ☐Y ☐N BIRTH CONTROL METHOD USED: ______

OF PREGNANCIES: _____ # DELIVERIES: _______ # MISCARRIAGES: ______ # ABORTIONS: _________

YEAR	SEX	WEIGHT	VAGINAL OR CESAREAN DELIVERY	COMPLICATIONS

Operations	Year	Other Hospitalizations	Year

***LIST ALL MEDICATIONS AND DOSAGES (INCLUDING OVER THE COUNTER MEDICATION):**

MEDICATION NAME	DOSAGE	DIRECTIONS

***DRUG ALLERGIES:** ____________________

Please check if you have had any of the following:

Heart disease ☐ Hypertension ☐ Cancer (Type) ____________________

Diabetes ☐ Hypothyroid ☐ Hyperthyroid ☐

Migraine Headaches ☐ Blood Clotting Disorder ☐ Asthma ☐or lung disease☐

High cholesterol ☐ Heart murmur ☐ Abnormal Pap ☐

Abnormal Mammogram ☐ Seizure disorder ☐ Liver disease ☐

Infertility ☐ Herpes ☐ Frequent Urinary Infections ☐

HIV ☐ Other STD ☐ Endometriosis ☐

Other: ____________________

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

ARE YOU *CURRENTLY EXPERIENCING* ANY OF THE FOLLOWING?

Urinary incontinence (leakage) ☐
Abnormal vaginal discharge ☐
Genital warts or lesions ☐
Hot flashes ☐
Abnormal vaginal bleeding ☐
Pain with intercourse ☐
Vaginal dryness ☐
Breast discharge or lumps ☐
Pelvic or abdominal pain ☐
Fever ☐

***OTHER SYMPTOMS YOU WOULD LIKE ADDRESSED AT YOUR VISIT TODAY** ______________________

____

LAST PAP SMEAR DATE: ______________ NORMAL? ☐Y ☐ N

LAST MAMMOGRAM DATE: ______________ NORMAL? ☐Y ☐ N

LAST ANNUAL LABS DATE: ______________ NORMAL? ☐Y ☐ N

IF YOU ARE OVER THE AGE OF 50:
COLONOSCOPY DATE: ______________ NORMAL? ☐Y ☐N

BONE DENSITY SCAN DATE: ______________ NORMAL? ☐Y ☐ N

FAMILY HISTORY:

MOTHER: LIVING? ☐Y ☐N AGE: ILLNESS: ______________

FATHER: LIVING? ☐Y ☐N AGE: ILLNESS: ______________

OF BROTHERS: ILLNESS ______ # OF SISTERS: ILLNESS: ______

OTHER FAMILY ILLNESS: ______________

SOCIAL HISTORY:

OCCUPATION: ______ ARE YOU: ☐SINGLE ☐LIVING WITH PARTNER ☐MARRIED ☐DIVORCED ☐WIDOWED

TOBACCO USE? ☐Y ☐N CIGARETTES PER DAY: ______ HOW LONG? ______

ILLICIT DRUG USE? ☐Y ☐N ______________

ALCOHOL USE? ☐Y ☐N DRINKS/WEEK: ______________

EXERCISE REGULARLY? ☐Y ☐N TYPE: ______ DAYS/WEEK: ______

SPECIAL DIET?: ______________

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

Appointment Policy

We value our patients and the time we spend with each of you and we would like to set aside appointments that work well for your schedule. If there is a conflict with your scheduled appointment time, we ask that you call the office 24 hours in advance to cancel or reschedule your appointment. ***Appointments cancelled without a 24 hours advance notice will be charged $25. If you miss more than 3 scheduled appointments, you may be dismissed from the practice.***

______________________________ ________________
Signature of Patient/Guardian Date

____
Printed Name of Patient/Guardian

Clarification of Medical Visits

In our office, we want to put the patient first by providing outstanding medical care. In order for us to do this, we want to make sure our patients understand our policy for billing your medical visits. If you are scheduled to come in for your annual well woman exam, the doctors will only discuss details or perform services regarding that visit. If there are other medical issues that you would like to discuss that is not considered part of an annual well woman exam, we ask that you schedule another appointment.

If you have an emergent problem, we will address that problem and you will need to reschedule your annual well woman exam. If the problem visit and annual well woman exam is done on the same day, you will be billed for each service separately. Depending on your insurance benefits, you may be held responsible for any out of pocket expenses associated with both services.

If you have any questions or concerns regarding these policies, please ask our staff.

Thank you.

______________________________ ________________
Signature of Patient/Guardian Date

____
Printed Name of Patient/Guardian

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

INSURANCE COVERAGE *NOTIFICATIONS*

IF YOU HAVE **MORE THAN ONE** INSURANCE POLICY, YOU ARE RESPONSIBLE FOR PROVIDING INFORMATION FOR BOTH AND STATING WHICH ONE IS YOUR **PRIMARY** AND **SECONDARY**.

IF YOU **CHANGE INSURANCE POLICY** DURING YOUR **PREGNANCY**, YOU MUST INFORM OUR OFFICE AS SOON AS POSSIBLE

FAILURE TO NOTIFY US OF CORRECT INSURANCE INFORMATION WILL RESULT IN YOU BEING FULLY RESPONSIBLE FOR THE FULL AMOUNT OF YOUR VISIT(S).

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**

☐ **Jennifer R. Gulick, M.D., P.L.L.C.**

3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

Policy on Insurance Coverage

We are enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each one has different stipulations and restrictions. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Your medical insurance is a benefit that your employer provides for you or you purchase for yourself.

During the course of treatment, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, such as, copays, deductibles and co-insurance will be your responsibility and are due at the time of service.

Understanding your benefits can be confusing and we will do our best to assist you in this area, but keep in mind we have limited access to your medical benefits. Your employer or you have chosen this plan and benefits, not your physician. If YOU do not inform us of any special requirements in your contract, and we subsequently order services, such as labs, pathology or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill YOU directly for those charges.

Your insurance company will never guarantee your benefits to you or to this office. That is why we can only estimate your portion. Regardless of what we calculate as your medical plan benefit, ultimately ***YOU are responsible for the TOTAL cost of your medical treatment.*** If you are unable to pay the estimated portion for your appointment today we will be happy to reschedule it to a later date.

If your insurance company requires a “referral” from your primary care physician, you will be responsible for contacting your primary care physician for the referral (this is the patient’s responsibility NOT the responsibility of this office).Treatment rendered by this office without the required referral will serve as your consent for treatment not covered by insurance, and will be payable by you. If we are contracted with your insurance company, your appointment will be rescheduled until a referral can be obtained.

Please check the appropriate boxes:

- ☐ I certify that I have **no insurance** and will be solely responsible for payment in full. (Payment is expected at the time of service)
- ☐ I certify that the insurance reported to this office is a complete and current listing. I understand the office will not submit a claim for any insurance not reported at the time of service.
- ☐ I **DO NOT** have any other insurance coverage other than that which has been provided upon submission of this authorization.

***** You’re responsible for providing the correct information regarding which insurance is PRIMARY and SECONDARY. *****

I have read and understood the office policy stated above and agree to accept responsibility as described.

______________________________ __________________

Signature of Patient/Guardian Date

____

Printed Name of Patient/Guardian

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**

☐ **Jennifer R. Gulick, M.D., P.L.L.C.**

3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

Consent to Treat Patient

I, __________________________ (name of patient) have an appointment for an examination and treatment and I give permission to be examined and treated by the following physician.

☐ Kristen N. Innes, M.D., P.A. ☐ Christine V. Ku, M.D., P.L.L.C. ☐ Jennifer R. Gulick, M.D., P.L.L.C.

Consent to Treat a Minor

____________________________ (name of minor) has an appointment for examination and treatment.
I,____________________________ (parent/legal guardian) give permission for ____________________(name of minor) to be examined & treated by the following physician. I have accompanied ________________ (name of minor) for her visit today.

☐ Kristen N. Innes, M.D., P.A. ☐ Christine V. Ku, M.D., P.L.L.C. ☐ Jennifer R. Gulick, M.D., P.L.LC.

PLEASE INITIAL EACH OF THE FOLLOWING SECTIONS TO ACKNOWLDEGE YOU HAVE READ THE INFORMATION AND SIGN BELOW:

_______ **Assignment of Benefits:**

By signing this form, you authorize payment of medical benefits, including private insurance benefits, directly to Kristen N. Innes, M.D., P.A., Christine V. Ku, M.D., P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete your insurance claim. The duration of this consent is definite and continues until revoked in writing

_______ **Acknowledgement of Receipt of Notice of Health Information Practices**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Kristen N. Innes, M.D., P.A., Christine V. Ku, M.D., P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information about how our office may use and/or disclose protected health information about your for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of this office's notice of Health Information Practices.

_______ **Acknowledgement of Receipt of Notice of Office Policies and Procedures**

Kristen N. Innes, M.D., P.A., Christine V. Ku, P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information regarding our office protocols and policies which we have developed in order to optimize our ability to deliver you care. By signing this form, you acknowledge that you have received a copy of our office policies.

_______ **Acknowledgement of ownership interest**

To further our commitment to the quality of surgical care for our patients, Both Dr. Innes and Dr. Gulick have chosen to participate in ownership at Baylor Medical Center at Frisco. Their ownership enhances their ability to direct the manner in which your care is delivered at the facilities. If this is of concern to you, Dr. Innes and Dr. Gulick will be happy to answer any questions. They are on the medical staff at other healthcare facilities and will be happy to discuss your options of choosing an alternative location. By signing this form, you acknowledge that you have read and understand this disclosure.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: ________________________ **Date:**____________

Thank you for taking the time to fill out this form

Revised 2-15-17

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

GENERAL OFFICE POLICIES AND PROCEDURES

Thank you for selecting our office for your healthcare needs. We respect your decision to choose your healthcare provider and want you to have a satisfying experience in our office. We have developed the following policies and procedures to optimize our ability to deliver your care.

Office appointments: Our office generally runs on time. Our ability to remain on schedule requires that you arrive for your appointment on time, if not early. Please arrive early for your initial office visit if you have not completed your paperwork. In consideration of other patients, you may be asked to reschedule your appointment if you are more than fifteen (15) minutes late.

Emergencies/Contacting our Office: Our office phone number is 214-618-2802, and is answered 24 hours a day. Please note, we will not recommend a course of treatment or prescribe medication without a physical assessment.

- *Gynecology patients* with after hour's emergencies may contact the physician on call at 214-618-2802. If you are unable to reach the on call physician, proceed to the nearest emergency room or urgent care center for evaluation.
- *Obstetrical patients* with after hour's emergencies may contact the on call physician at 214-618-2802. If you are unable to reach the physician on call, proceed to Labor and Delivery for assessment.

Call Coverage is shared between Dr. Kristen Innes, Dr. Christine V. Ku, Dr. Catherine Holt, Dr. Jordan Mitchell, and Dr. Steven Trostel.

Hospital Affiliates: Dr. Innes is affiliated with Texas Health Resource of Plano and Baylor Medical Center of Frisco. Dr. Ku is affiliated with Texas Health Resource of Plano and Baylor Medical Center of Frisco. Dr. Gulick is affiliated with Texas Health Resource of Plano, Baylor Medical Center of Frisco and Centennial.

Medication Refills: Prescriptions are not refilled after hours. Please call during normal office hours if you require medication refill.

Obtaining your medical record: If you are moving or transferring your care to another physician's office you may submit a written request to receive a copy of your medical records. Your records may be transferred directly to your physician by filling out a records request release form from our office or when we receive a written authorization from your other doctor's office. Just a reminder, state law allows us 15 days to transfer medical records. You may be charged $25 for a copy of your medical records.

Insurance and address change: You are required to notify our office if your insurance terminates or if your insurance changes. You will be held financially responsible for charges incurred if you are without insurance coverage. Please notify us if your address or phone number changes. Our ability to contact you is vital to our ability to provide you care.

Disability and FMLA forms: Please allow adequate time for us to complete Disability and FMLA forms, as they may require up to two weeks to be completed. We will notify you as soon as they are ready to be picked up.

Office visits and children: For the safety of our pregnant patients, we ask that you ***do not*** bring toddlers or school-age children to your office visits. Many pregnant patients lack immunity to viruses responsible for several childhood diseases including chicken pox, measles, and Fifth's disease. We realize that this is not always possible. If you must bring small children to our office, please bring your spouse or other adult who can supervise them during your examination or consultation. A medical office can be an unsafe environment for children, and we are not responsible for unsupervised children.

Refunds: This office refunds credits of $39 and over, due to administrative cost, anything less will remain in your account unless otherwise requested by you.

****Please keep this document for your personal reference****

Revised 2-15-17

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

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 our Privacy Officer who is "Office Manager"

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to

foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described above. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be

involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.]**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, [Office Manager] **at (214) 618-2802 for further information about the complaint process.**

This notice was published and becomes effective on __ September 23, 2013__.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of CMI Rights
200 Independence Avenue, SW Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6175

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

What Women Should Know Before They Get a Pap and HPV Test

- Genital human papillomavirus (HPV) is a very common virus in men and women. It is passed on through genital contact, most often during vaginal and anal sex.
- Most sexually active people will get HPV at some time in their lives, though most will never know it because HPV usually has no signs or symptoms.
- There are about 40 types of genital HPV. In most cases, HPV goes away within two years, without causing any health problems. It is thought that the immune system fights off HPV infection naturally.
- But sometimes, HPV does not go away within two years. Certain HPV types can linger on a woman's cervix and cause cell changes.[1] These changes can lead to cervical cancer over time, if left untreated.
- You can prevent cervical cancer by getting regular Pap tests and following up as recommended by your doctor. The Pap test can find cell changes (caused by HPV) on your cervix. That way, cell changes can be treated before they turn into cancer.
- In some cases, your health professional may use a new HPV test with the Pap test. The HPV test can find out if you have the types of HPV that are linked to cervical cancer. This test can help your doctor decide how soon you should be screened again, and what (if any) other tests you need.
- Take charge of your health by getting screened for cervical cancer, making sure you get your test results, and by following up with appointments and medical care if recommended.

If you have questions, please write them down and ask about them during your next doctor's visit.

---

[1]Other types of HPV can cause genital warts in men and women. These types are different from the types that can cause cervical cancer.

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**
☐ **Jennifer R. Gulick, M.D., P.L.L.C.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

- **If both your Pap and HPV tests are normal,** your chances of developing serious cervical cell changes in the next three years are extremely low.
  - Talk to your health professional about when you should come back for your next cervical cancer screening.
  - But remember, you will still need to see your doctor for regular "well-woman" visits. These visits are a chance to check for other possible helath problems and to share any health concerns with your doctor. The well-woman visit is different for each woman, based on age and individual health needs.

- If either your Pap or HPV test is abnormal, you will need to come back for more tests. Be sure to come back for all appointments and tests that your doctor recommends.
  - An abnormal test result does not mean that you have cervical cancer. But you may have HPV or abnormal cell changes.
  - Doctors can treat the cell changes that HPV may cause; they do not treat HPV (a virus).
  - Although HPV is very common, cervical cancer is rare. Most women with HPV will not develop cervical cancer, if the follow up as recommended by their doctor.

The Centers for Disease Control and Prevention (CDC)
1-800-CDC-INFO (1-800-2032-4636; 1-888-232-6348 TTY
Operators can answer your questions in English or Spanish 24 hours a daay, 7 days a week.

The National Cancer Institute's Cancer Information Service (CIS)
1-800-4-CANCER (1-800-422-6237): 1-800-332-8615 TTY
Information specialists can answer your questions in English or Spanish from 9 am to 4:30 pm in your time zone

☐ **Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku, M.D., P.L.L.C.**

☐ **Jennifer R. Gulick, M.D., P.L.L.C.**

3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034
Phone 214-618-2802 Fax 214-618-3208

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name:_________________________ Date of Birth: __________________ Age: __________
Gender (M/F): ______ Today's Date (MM/DD/YY): ________________ Health Care Provider: ________________

Instruction: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. **You and the following close blood relatives should be considered:** You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren.

You and YOUR Family's Cancer History (Please be as thorough and accurate as possible)

	Cancer	YOU Age of Diagnosis	Parents/Siblings/ Children	AGE of Diagnosis	Relatives on your Mother's Side	AGE of Diagnosis	Relatives on your Father's side	AGE of Diagnosis
☒ Y ☐ N	Example: *Breast Cancer*	45			*Aunt* *Cousin*	*45* *61*	*Grandmother*	*53*
☐ Y ☐ N	Breast Cancer							
☐ Y ☐ N	Ovarian Cancer (*Peritoneal/Fallopian Tube*)							
☐ Y ☐ N	Uterine/Endometrial Cancer							
☐ Y ☐ N	Colon/Rectal Cancer							
☐ Y ☐ N	10 or more LIFETIME COLON POLYPS (*Specify #*)							
	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small Bowel, Sarcoma, Thyroid							
☐ Y ☐ N	OTHER CANCERS (Specify cancer type)							

☐Y ☐N Are you of Ashkenazi decent?

☐Y ☐N Are you concerned about your personal and/or family history of cancer?

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

Hereditary Cancer Red Flags (To be competed with your healthcare provider – Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two Primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome** (see cancer list below)

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology***before age 60
- ☐ Abnormal MSI/IHC tumor test results (colon/rectal/endometrial/uterine)
- ☐ Two or more Lynch syndrome cancer**at any age
- ☐ YOU and one or more relatives with Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified BRAC1 or BRAC2 mutation in the family

Lynch Syndrome** (see cancer list below)

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: Breast, ovarian and pancreatic
**Lynch syndrome cancer includes: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas
***MSI High histology includes: Muninous, signet ring, tumor infiltrating lymphocytes, crohn"s-like lymphocytic reaction histology, or medullary growth pattern

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: ____ Date: __________________
Health Care Provider's Signature: __________________________________ Date: __________________

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐YES ☐NO ☐Accepted ☐DECLINED
Follow up appointment scheduled: ☐YES ☐NO Date of Next Appointment: __________________