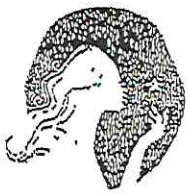


Venus Gynecology, LLC

Patient Registration

Date:_____

Patient Name:_____

Sex:_____ Date of Birth:_____ Social Security #:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ None

May we contact you at work: ☐ Yes ☐ No Phone:_____

Email Address:_____

Primary contact method: ☐ Home ☐ Cell ☐ Work

Emergency Contact:

Name:_____

Relationship:_____Phone:_____

Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ Asian ☐ Black/African American ☐ White ☐ Other ☐ Prefer not to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to Answer

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Pharmacy:_____

How did you hear about our practice:_____

Insurance Information:

Primary Ins Name:_____

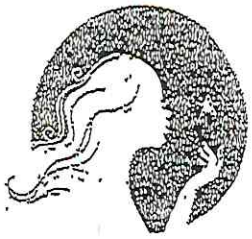
Policy #:_____ Group #:_____

Relation to Policy Holder:

☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Policy Holder:_____ Social Security #:_____

Date of Birth:_____ Phone:_____



Venus Gynecology, LLC

Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Venus Gynecology, LLC is authorized to release information about the above named patient.

☐ Spouse (Name):_____

Authorized to receive information regarding:

☐ Medical Information (may include test results, diagnosis information, etc)

☐ Financial Information (may include balance, payments)

☐ Parent/Other (Name):_____

Authorized to receive information regarding:

☐ Medical Information (may include test results, diagnosis information, etc)

☐ Financial Information (may include balance, payments)

☐ Employer/School:_____

Authorized to receive information regarding:

☐ Medical Information (may include test results, diagnosis information, etc)

☐ Financial Information (may include balance, payments)

I authorize Venus Gynecology to contact me by:

☐ Text message (SMS may be subject to carrier fees. Fees are the responsibility of the patient)

☐ Email

☐ Voice Message

Authorized to leave information regarding:

☐ Brief: Appointment information only

☐ Extended: Any/all test results, prescription information, financial information, general information.

Patient/Legal Guardian Signature:_____ Date:_____

Venus Gynecology, LLC

Financial Responsibility

It is the policy of Venus Gynecology, LLC that payment in full is due at the time of service unless other financial arrangements are made in advance. As a courtesy, Venus Gynecology, LLC will make every effort to verify your insurance eligibility and benefits prior to your visit. Verification of eligibility and benefits ***does not*** guarantee payment from your insurance provider. If Venus Gynecology, LLC is a participating provider with your health insurance, you will be responsible for the ***estimated*** portion at the time of service. It is your responsibility to know your insurance coverage, authorization requirements, copay, deductible and co-insurance amounts. ***Not all services recommended by your physician are covered by your insurance. In the event your insurance plan does not cover a provided service, you will be responsible for the complete charge. ANNUAL EXAMS: If you discuss anything outside of your annual wellness visit you could be billed an office visit.***

It is your responsibility to notify Venus Gynecology, LLC of any insurance changes. Failure to do so may result in unpaid balances being assigned to you for payment. If your insurance does not pay in a timely manner, or fails to pay, you will be responsible for payment. **Balances over 120 days old may be subject to collections. If your balance is sent to collections, you will be responsible for any fees charged by agencies, attorneys or court costs.**

Medicare Patients: Medicare only covers screening pap & pelvic exams every 24 months. If you are on your off year, you may be responsible for payment in full for those services. In addition, standard Medicare no longer covers the full Well Woman exam. If you are a new patient, you will be responsible for the difference paid by medicare and the full Well Woman exam, the estimated patient responsibility is $45. ***Some Medicare Advantage plans will cover the Well Woman exam, but standard Medicare will not.***

Venus Gynecology, LLC requires 12 hour notice for all appointment cancellations. There will be a $50 fee for all no show/missed appointments. **Repeated no show/missed appointments may result in dismissal from the practice.**

If you are covered by an out of network provider, we will, as a courtesy to you, file your insurance for out of network benefits. You will be responsible for payment in full at the time of service. If we later receive payment from your insurance company, you may be refunded the amount of the payment.

I have read and agree to the above terms and conditions. I authorize the release of any medical and/or other information necessary to process insurance claims. I authorize payment of medical benefits directly to Venus Gynecology, LLC for services rendered.

Patient/Legal Guardian Signature_____Date:_____

Venus Gynecology, LLC

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name & Address:_____

_____

_____

I have received a copy of the Notice of Privacy Practices of the above named Practice.

_____ _____

Signature Date

_____

For Office Use Only

_____

We were unable to obtain a written acknowledgment of the receipt of the Notice of Privacy Practices because:

☐ An emergency existed & a signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason:_____

_____

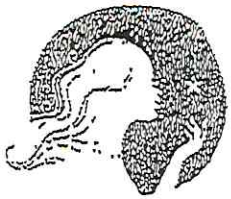
☐ Other:_____

_____

Prepared by:_____

Signature:_____

Date:_____



Venus Gynecology, LLC

Helena P. Kirkpatrick, MD
8203 Nigels Dr, Ste 203
Myrtle Beach, SC 29572
Phone (843) 268-2525
Fax (843) 628-0744

Medical Records Request to Our Office

Patient Name:_____

Address:_____

Date of Birth:_____ Phone:_____

Release From:

Physician Name:_____

Address:_____

Phone:_____ Fax:_____

I authorize the custodian of my medical records or other person/entity to disclose/release the following medical records – check all that apply:

- ☐ All Records
- ☐ Laboratory and/or Pathology
- ☐ Radiology Records/Reports
- ☐ Abstract and/or Summary Report
- ☐ Medical Records 1 year
- ☐ Medical Records 2 years
- ☐ Medication List/Pharmacy Records
- ☐ Other:_____

Purpose of Release:

☐ Continuing Care ☐ Legal ☐ Personal ☐ Other:_____

I understand the information released may include history or reference to psychiatric/psychological care, drug/substance abuse, sexual assault, results of tests for all infectious diseases including HIV/AIDS.

I understand that I may cancel or revoke this authorization at any time by submitting a written request to Venus Gynecology, LLC. I understand that the cancellation/revocation will not apply to information that has already been released in response to this authorization. Unless canceled/revoked, this authorization will expire 1 year from the date signed.

Printed Name:_____

Signature:_____ Date:_____

Venus Gynecology, LLC

Gynecology Questionnaire

Patient Name:_____ DOB:_____ Date:_____

Reason for today's visit? ◻ Annual Exam ◻ Problem:_____

Primary Care Provider:_____ Phone:_____

Gynecological History

1. First day of last period:_____
2. At what age did you start your periods?:_____ (If you do not have periods, skip to question 5)
3. How often do you have your periods?:_____ How long do they last?:_____
4. How is your flow? ◻ Heavy ◻ Light ◻Moderate Do you have pain with your period? ◻ Yes ◻ No
5. What is your current method of birth control?_____
6. What age did your period stop?_____ Are you taking hormone replacement? ◻ Yes ◻ No
7. Do you have any spotting? ◻ Yes ◻ No Do you leak urine? ◻ Yes ◻ No
8. Have you ever had any of the following:

   ◻ Gonorrhea ◻ Chlamydia ◻ Genital Herpes ◻ Genital Warts ◻ Syphilis
9. Date of last PAP smear?_____ Have you ever had an abnormal PAP? ◻ Yes ◻ No
10. Date of last mammogram?_____ Have you been evaluated for infertility? ◻ Yes ◻ No
11. Do you have a history of:

    ◻ Uterine Fibroids ◻ Uterine Polyps ◻ Endometriosis ◻ Ovarian Cysts

If so, how were you treated?_____

12. Have you ever had a colonoscopy? ◻ Yes ◻ No If yes, date of last colonoscopy:_____
13. Have you ever had a bone density scan? ◻ Yes ◻ No If yes, date of last scan:_____
14. Have you ever had the Gardasil vaccines (2 or 3 shot series) ◻ Yes ◻ No

Past Pregnancies

Date: MM/YY	Gestational Age	Birth Weight	Sex	Delivery Type	Complications

Do you have recurrent miscarriages or have you had a stillbirth?_____

Past Medical History

1. Do you or have you ever had any of the following medical problems?

☐ Diabetes	☐ Heart disease	☐ Hypertension
☐ Autoimmune disease	☐ Seizure disorder	☐ History of blood clots in your legs or lungs
☐ Hepatitis	☐ AIDS /HIV	☐ Psychiatric disorder
☐ Thyroid dysfunction	☐ Asthma	☐ Involved in a major car accident
☐ Bleeding disorder	☐ MRSA	☐ Frequent urinary tract infections
☐ Kidney disease	☐ Sickle Cell Disease/Trait	☐ Stroke

☐ Cancer:_____

2. What prescription medications are you currently taking?

_____

_____

3. What over the counter medications and/or herbal supplements are you taking?

_____

_____

4. Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:_____ Allergic to latex? ☐ Yes ☐ No

5. Have you ever been hospitalized? ☐ Yes ☐ No If yes, what was the reason?_____

6. Have you ever received a blood transfusion? ☐ Yes ☐ No

Family History

1. What is your race or ethnic background?_____

2. Does anyone in your family (parents, grandparents, aunts, uncles, siblings, children) have:

☐ Diabetes	☐ Hypertension	☐ Heart Disease	☐ Stroke
☐ Thyroid dysfunction	☐ Asthma	☐ Kidney disease	☐ Sickle Cell Disease/Trait
☐ Neurological disorder (including seizures)		☐ Autoimmune Disease	☐ Psychiatric disorder
☐ Any birth defect (even if surgically corrected)		☐ Any inherited problems	
☐ History of blood clots in legs and/or lungs		☐ Blood Disorder	

☐ Cancer (Relative, Type) _____

Social History

1. Do you smoke and/or vape? ☐ Yes ☐ No If yes, how much?_____
2. Are you a former smoker? ☐ Yes ☐ No Age started?_____ Age quit?_____
3. Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____
4. Do you use illegal substances? ☐ Yes ☐ No If yes, please list:_____
5. Do you have problems with violence or abuse? ☐ Yes ☐ No
6. Do you work outside of the home? ☐ Yes ☐ No If yes, what type of work?_____
7. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Other
8. Are you sexually active? ☐ Yes ☐ No

Surgical History

Have you ever had any surgery, including biopsies? ☐ Yes ☐ No

If yes, please list:_____

_____

Review of Systems

Please check if any of the following symptoms apply to you:

General:

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Fatigue
- ☐ Indigestion

Eyes:

- ☐ Double Vision
- ☐ Vision changes

Ears/Nose/Throat:

- ☐ Hearing problems
- ☐ Sore throat

Cardiovascular:

- ☐ Chest pain/pressure
- ☐ Difficulty breathing
- ☐ Swelling of legs

Respiratory:

- ☐ Shortness of breath
- ☐ Spitting up blood
- ☐ Chronic cough

Gastrointestinal:

- ☐ Bloody Stool
- ☐ Nausea/Vomiting
- ☐ Frequent diarrhea
- ☐ Constipation

Urinary:

- ☐ Blood in urine
- ☐ Pain with urination

Musculoskeletal:

- ☐ Muscle/Joint pain

Skin:

- ☐ Rash
- ☐ Change in mole

Neurological/Psychiatric:

- ☐ Trouble with walking
- ☐ Seizures
- ☐ Headaches
- ☐ Depression/Crying spells

Summary

Is there anything else you feel we should know about?

_____

_____

_____

_____

Venus Gynecology, LLC

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 regarding this Notice, please contact the Privacy Officer at (843) 268-2525.

Effective Date: June 6, 2019

We are committed to protecting the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) you PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also described your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.venusgyn.com.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

Example: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of you physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing Companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits.
- Collection agencies

Example: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI>

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations. Examples:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- If 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. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audit, 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.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.

- Coroners, funeral directors: 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.
- Medical 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.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Worker's Compensation: Your protected health information may be disclosed by us as is authorized to comply with worker's compensation laws and other similar legally established programs

Other uses and disclosures of your health information.

- Business Associates: Some services are provided through the use of contracted entities called "business associates." We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.
- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Fundraising Activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
- Treatment Alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment Reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations unless you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- 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.

- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment of plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor of this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]
You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter time frame. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact the privacy officer at Venus Gynecology, LLC by phone (843) 268-2525.

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on June 6, 2019.