PositiveSteps
Fertility

New Patient Paperwork

POSITIVE STEPS FERTILITY

Patient:

Last Name:_____ First:_____

Middle Initial_____Preferred Name:_____

DOB_____ SS #: _____

Address:_____

City:_____ ST_____ ZIP_____

Preferred Phone:(_____)_____

Alt Phone(_____) _____

Email:_____

Current Employer:_____

Type Work:_____Previous:_____

Emergency Contact:

Name:_____ Relation:_____

Phone Number:(_____)_____

To whom may we discuss your health information:

Name_____Relation:_____

Name_____Relation:_____

Consent signature:_____

Partner:

Last Name:_____ First:_____

Middle Initial_____Preferred Name:_____

DOB_____ SS #: _____

Address:_____

City:_____ ST_____ ZIP_____

Preferred Phone:(_____)_____

Alt Phone(_____)_____

Email:_____

Current Employer:_____

Type Work:_____Previous:_____

Emergency Contact:

Name:_____ Relation:_____

Phone Number:(_____)_____

To whom may we discuss your health information:

Name_____Relation:_____

Name_____Relation:_____

Consent signature:_____

Reason for consult:_____

_____

Who referred you to our clinic?

_____

Is there a provider you would like us to send a letter?_

_____

Pharmacy Name and #_____

REVIEW OF SYSTEMS

Do you currently have symptoms related to any of the following? If yes please explain

1. Eyes YES NO
_____
_____
_____

2. Ear/nose/throat/mouth YES NO

(Hoarseness,Hearing,Sinusitus,nose bleeds)

_____
_____
_____

3. Cardiovascular YES NO
(Chest pain, palpitations, shortness of breath lying flat)
_____
_____
_____

4. Respiratory YES NO
(Cough, shortness of breath, wheezing)
_____
_____
_____

5. Gastrointestinal YES NO
Nause,vomiting,acid reflux,blood in stool, abdominal pain,diarrhea, constipation)
_____
_____
_____

6. Heme/Lymph YES NO
(Swollen lymph nodes, easy bruising, easy bleeding)
_____
_____
_____

7. Endocrine YES NO
(increased thirst, Heat or cold intolerance)_____
_____
_____

8. Neuro Psych YES NO
(Depression, mood changes, headache, dizziness)
_____
_____
_____

9. Musculoskeletal YES NO
(Joint pains, joint swelling, muscle weakness)
_____
_____
_____

10 Skin YES NO

(Rashes, changes in mole, change in nevi)_____
_____
_____

11.Breast YES NO

(Lumps in breast, Breast pain, nipple discharge, nipple bleeding)_____
_____
_____

12. Genitourinary YES NO

(Painful or frequent urination, blood in urine, urinary or fecal incontinence, urinary urgency)_____
_____
_____

13. GYN YES NO

(Irregular or painful menses, painful intercourse, decreased sex drive, vaginal discharge, vaginal odor)_____
_____
_____

14. Mammogram History YES NO
(Normal or abnormal)
_____
_____

15. Pap History- NORMAL ABNORMAL

DATE:_____

_____
_____
_____

Dr. John Preston Parry

149 Fountains Blvd | Madison MS, 39110
Phone: 833-767-7837| Fax: 601-202-4685 | vicki@parryscope.com | Parryscope.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name: Social Security #:

I request and authorize _____ to release healthcare information of the patient named above to:

Dr J Preston Parry
149 Fountains Blvd
Madison, MS 39110

This request and authorization applies to:

○ All healthcare information ◉ Other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

PositiveSteps
Fertility

Privacy acknowledgement and Medical Information Release Form (HIPAA Release Form)

Name: _____

Date of Birth: _____/____/_____

_____I received a copy of Positive Steps Fertility's Privacy document.

Medical Information Release Form (HIPAA Release Form)

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call [ ] _____

The best time to reach me is (day)_____ between (time)_____

[ ] you may send message/records to my email:_____

Signed: _____ **Date: ____/____/_____**

Witness: _____ Date: ___/____/_____

Telemedicine Session
Patient Authorization and Consent Form

Telemedicine lets a doctor or other healthcare provider care for you, even when you cannot see him or her in person. The doctor uses the Internet or other technology to:

- give you advice,
- give you an exam, or
- do a procedure through online communications.

Telemedicine can also be used to:

- get prescription refills,
- book an appointment, or
- let your doctor talk with other providers about your health problem or treatment.

Telemedicine is more than a phone call, an email, a fax, or an online questionnaire. Sometimes you may need to come to a healthcare facility to use their equipment (TV screen, camera, or Internet). A provider may use need to use technology tools or medical devices to check on your health remotely. If you agree, part of your health record may be sent to the telemedicine provider before your session.

You and your healthcare team must decide if your health problem can be helped with telemedicine. The team and others involved in your care (e.g., medical home or hospital teams) will make a plan for your care using telemedicine. This will also include a plan in case you have an emergency during the telemedicine session.
If the patient is a minor child, the telemedicine provider will explain to the parent how a telemedicine exam is different from an in-person exam. He or she will also explain if a complete exam of the child is possible.

Your Telemedicine Session

During your telemedicine session:

- The provider and the staff will introduce themselves.
- When starting a session, you may be asked to confirm the state you are in and the state where you live.
- The provider may talk to you about your health history, exams, x-rays, and other tests. Other providers may take part in this discussion.
- A visual and/or partial physical exam may take place. This may happen by video, audio, and/or with other technology tools. A nurse or other healthcare staff may be in the room with you to help with the exam.
- Non-medical staff may be in the room to help with the technology.
- Video and/or photo records may be taken, and audio recordings may be made.
- A report of the session will be placed in your medical record. You can get a copy from your provider.

All laws about the privacy of your health information and medical records apply to telemedicine. These laws also apply to the video, photo, and audio files that are made and stored.

Risks and Common Problems

Many patients like telemedicine because they do not have to spend time and money on travel to see a certain healthcare provider in person. Also, they can see a provider who they might not be able to see otherwise.
Technology can make getting health care easy, **but there can also be problems:**

- If there is an equipment or Internet problem, your diagnosis or treatment could be delayed.
- Records or images that are taken and sent may be poor quality. This can delay or cause problems with your diagnosis or treatment.
- The records sent for review before the session may not be complete. If this happens, then it may be hard for the telemedicine provider to use his or her best judgment about your health problem. For instance, you could react to a drug or have an allergic response if the provider does not have all of the facts about your health.

- There could be problems with Internet security and privacy. For instance, hackers may access or view your health information. If this happens, then your medical records may not stay private.
- If there is a technology problem, the information from your session may be lost. This would be outside the control of your doctor and the telemedicine provider.
- Without a hands-on exam, it may be hard to diagnosis your problem.

More Facts

A main goal of telemedicine is to make sure that you get good, personal health care, even though you are not seeing a provider in person.

Some states may require you to have a face to face visit first and a yearly visit with your doctor before telemedicine treatment can happen.

Telemedicine providers must follow the same rules for prescribing drugs just as they would for an office visit. Before your session, you will learn about which drugs telemedicine providers can and cannot prescribe.
Having a telemedicine session is your choice. Even if you have agreed to the session, you can stop your medical records from being sent – if this has not happened yet. You can stop the session at any time. You can limit the physical exam.

You will be told about all the staff who will take part in the session. You can ask that any of these people leave the room to stop them from seeing or hearing the session. It is up to you to make sure the setting for your session is private. It should only include people who you are willing to share health information with. Your telemedicine provider can ask that people with you leave the room to make sure your session is private.

Your session may end before all problems are known or treated. It is up to you to get more care if your health problem does not go away.

You will be told how long it might take to respond to your emails, phone calls, or other types of messages.

Before your session, you may want to ask how much of the cost will be covered by your insurance and how much you may owe.

Patient Acknowledgment

This form gives you facts about and risks of telemedicine sessions. By signing this form, you agree that you have read, understand, and agree with these terms.
I also confirm by my signature below that:

- I have been told the name and credentials of my telemedicine provider,
- I have been able to ask questions about telemedicine sessions,
- All of my questions have been answered,
- I understand no guarantees have been made about success or outcome, and
- I agree to take part in a telemedicine session.

_____ _____

Signature of Patient, Parent/Guardian, or Responsible Party **Date and Time**

_____

Relationship to Patient (if Responsible Party is not Patient or if Patient is a Minor)

_____ _____

Witness **Date and Time**

SIGN BELOW ONLY IF YOU ARE CHOOSING TO USE SKYPE OR FACTIME FOR YOUR VIDEO CONSULT

We use Zoom, WhatsApp, Skype, and Facetime for our telemedicine video consults. Though Zoom can be HIPPA compliant the others don't meet the highest standards for HIPAA, just as talking on one's cell to a physician is not compliant. By signing below, I acknowledge that I'm choosing to use WhatsApp, Skype or Facetime for my video despite them not being fully HIPPA compliant.

_____ _____

Signature of Patient **Date and Time**

_____ _____

Witness **Date and Time**

POSITIVE STEPS FERTILITY
PARRYSCOPE.COM

Dr J Preston Parry
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Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena. - We can not share any mental health evaluation.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Parryscope.com

This Notice of Privacy Practices applies to the following organizations.

Positive Steps Fertility, LLC
Parryscope Fertility

Positive Steps Fertility- Dr John Preston Parry
fertility@parryscope.com 601-202-4779