



PATIENT INFORMATION

Patient Name: Last: _____ First: _____ Middle: _____
 Address: _____ Home Phone: _____
 City: _____ State: _____ Zip: _____ Cell Phone: _____
 Date of Birth: _____ Social Security#: _____ Other Phone: _____
 Check one: Single Married Divorced Widowed Separated
 Patient's Employer: _____ Occupation: _____
 Employer Address: _____ Work Phone: _____
 City: _____ State: _____ Zip: _____
 Worked-related Injury: Yes No Automobile Accident: Yes No Date of Injury/Accident: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____
 Advanced Directive: Yes No Copy on File: Yes No Retired: Yes No
 Referred by: _____

POLICY HOLDER/INSURED INFORMATION - Primary Insurance

Relationship to Patient: Self Spouse Mother Father Other: _____
 Insured Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Social Security#: _____
 Employer: _____ Employer Address: _____
 City: _____ State: _____ Zip: _____ Work Phone: _____
 Primary Insurance: _____ Phone: _____
 Group#: _____ Policy#: _____

INSURANCE COMPANY INFORMATION- Secondary Insurance

Relationship to Patient: Self Spouse Mother Father Other: _____
 Insured Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Social Security#: _____
 Secondary Insurance: _____ Phone: _____
 Group#: _____ Policy#: _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Deepali Kashyap M.D. PLLC (d/b/a Galleria Women's Health). I understand that payment for copays and deductibles are required at the time services are rendered. I further understand that I am responsible for the payment of services rendered by Galleria Women's Health. In the event that my insurance company denies a claim, I will become responsible for all amounts not covered payable to Galleria Women's Health. As a parent/guardian, I am financially responsible for services rendered to a minor. If my account is turned over for outside collections, I will be responsible for all costs of the outside collection agency. I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

SIGNATURE: _____ Date: _____



Patient Contact Information

Patient Name: _____ Date of Birth: _____

To be HIPPA compliant we need you to tell us how to contact you with your health information. You need to be very specific regarding how you prefer to be contacted and where we can leave clinical messages and tests or lab results.

How do you prefer to be contacted? (ONLY INDICATE YOUR PREFERENCE)

Cell Phone: _____ Patient Portal: _____

Work Phone: _____ Home Phone: _____

Are we able to leave personal clinical, medical or lab results messages? _____ Yes _____ No

(YES) I hereby give Deepali Kashyap, M.D. PLLC (d/b/a Galleria Women's Health) permission to leave clinical/medical messages, which may include personal and sensitive information on the media source(s) that I have indicated above. I understand that is my responsibility to keep my contact information updated.

Signature: _____ Date: _____

(NO) I only consent for Galleria Women's Health to leave a general call back message for me. **I understand that it is fully my responsibility to return all calls in a timely manner.** I understand that is my responsibility to keep my contact information updated.

Signature: _____ Date: _____

If you are unavailable, is there anyone that you give us permission to leave such messages with?
_____ Yes _____ No

If yes, provide their name, relationship to you and contact information.

Name: _____ Relationship: _____ Phone: _____

Pharmacy of Choice: _____ Pharmacy Phone: _____

Pharmacy Cross Streets: _____

MEDICAL HISTORY FORM

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Primary Care Physician: _____

Medication Allergies: _____

Please List the reason(s) for your appointment today: _____

Duration: _____

Obstetrical History

Total pregnancies: _____ Vaginal: _____ Cesarean: _____

Total Children: _____ Full Term: _____ Pre-Term: _____

Abortions: _____ Miscarriages: _____ Ectopic: _____

Gynecology History

When was your last Pap Smear? _____ History of Abnormal Pap: Yes No

When was your last mammogram? _____ History of Abnormal Mammogram: Yes No

When was you last Dexa Scan? _____ History of Abnormal Dexa: Yes No

When was your last colonoscopy? _____ History of Abnormal Colonoscopy: Yes No

Menstrual History

When was your last menstrual period? _____

Your age at first menstrual period? _____

Are your menstrual periods regular or irregular? _____

How often are your periods? _____

How many days do your periods last? _____

Menstrual flow: Light Moderate Heavy

Do you have cramps with your periods? Yes No

If yes, do you need medication for relief? Yes No. If yes, what medication? _____

If you are not having menstrual periods, at what age did you have your last one? _____

Since menopause, any vaginal bleeding? Yes No

Do you have hot flashes or vaginal dryness? Yes No

Sexual History

How many lifetime sexual partners have you had? _____

Are you sexual active at the present time? _____

Do you usually have pain with Intercourse? _____

What do you use for birth control? _____

Have you been physically or sexually abused? _____

History of any of the following sexually transmitted diseases?

Trichomonas Gonorrhea Herpes PID Chlamydia Syphilis HIV



Past Medical History

Have you ever had any of the following problems?

General

Cancer Yes
 Weight gain Yes
 Weight loss Yes
 Fatigue Yes

Eyes

Glaucoma Yes

ENT/Mouth

Hearing loss Yes
 Sinus Problem Yes
 Dental Problems Yes

Cardiovascular

Hypertension Yes
 Heart Attack Yes
 Heart Palpitation Yes
 Heart Murmur Yes

Musculoskeletal

Arthritis Yes
 Osteoporosis Yes

Any other medical condition not listed: _____

Respiratory

Asthma Yes
 Emphysema Yes
 Bronchitis Yes
 Tuberculosis Yes
 Valley Fever Yes
 Pneumonia Yes

Gastrointestinal

Diarrhea, frequent Yes
 Ulcers Yes
 Jaundice/hepatitis Yes
 Constipation Yes
 Diverticulosis/itis Yes

Breast

Tumor/cyst (benign) Yes
 Nipple Discharge Yes

Psychiatric

Anxiety Yes
 Depression Yes

Urinary

Incontinence Yes
 Kidney Stone Yes
 Blood in urine Yes
 Urgency Yes
 Infections, frequent Yes

Neurological

Seizures Yes
 Stroke Yes
 Headaches Yes

Endocrine

Thyroid Disease Yes
 Diabetes Yes
 Hair Growth Yes

Hematological

Bleeding/bruising Yes
 Anemia Yes
 Blood transfusion Yes

Medications: Include dosages and any over the counter medications.

Past Surgical History: List ALL operations:

Year: _____ Type of Operations: _____

Social History:

Marital Status: _____ Occupation: _____ Previous Occupation: _____
 Tobacco: _____ Alcohol: _____ Drug Abuse: _____ Exercise: _____ # in household _____

Family History: Do you have any close relatives with the following problems?

Breast Cancer: Yes. Who? _____
 Ovarian Cancer: Yes. Who? _____
 Colon Cancer: Yes. Who? _____
 Diabetes: Yes. Who? _____
 Heart Disease: Yes. Who? _____
 High Blood Pressure: Yes. Who? _____
 Stroke: Yes. Who? _____

Patient Signature: _____ Date: _____



SERVICE AGREEMENT

Name of Patient: _____ **Date of Birth:** _____

Consent to Treat:

I, _____ authorize the doctors at
(Printed Name of patient or legal guardian if patient is a minor)
Deepali Kashyap, M.D. PLLC (d/b/a Galleria Women's Health) to provide medical care reasonable by today's standards.

Payment for Services Rendered:

I realize that I am responsible for payment of all medical services rendered to me and/or my dependent regardless of the decisions made by my insurance carrier.

Information Release Form:

I authorize Deepali Kashyap, M.D. PLLC to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company, and thereby authorize insurance payment directly to Deepali Kashyap, M.D. PLLC for any services rendered that are not paid by me.

Patient or Legal Guardian Signature

Date

Authorization to Treat Minors:

As the parent/guardian of _____, I hereby give permission to Deepali Kashyap, M.D. PLLC (d/b/a Galleria Women's Health) to evaluate and treat my child, who is a minor. I also give my permission to evaluate and treat in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to Galleria Women's Health, PLLC for the charges of medical services rendered

Patient or Legal Guardian Signature

Date



FINANCIAL AGREEMENT

Thank you for choosing Deepali Kashyap, MD PLLC (d/b/a Galleria Women's Health). Please recall that your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you. We will submit an insurance claim on your behalf if we have a provider contract with your insurance company. **Please read the following agreement carefully, then sign and date below.**

- **All co-payments and deductibles are due at the time of service.** Payments can be made with cash, debit or credit cards (MasterCard or Visa only). **Personal checks are not accepted.**
- I understand that not all services are covered by my insurance. **Fees for NON-COVERED care; such as the cosmetic vulvo-vaginal surgeries, are due in full at or before the time of service unless prior arrangements have been made.**
- **I understand that if I do not inform my doctor of ALL of my insurances (ex. primary and secondary insurances), I will be responsible for all refunded payments requested from my doctor by my insurances.**
- I understand that my doctor will bill my insurance company if they are contracted providers. If payment is not received from my insurance company 90 days from the date of billing, I am financially responsible for any and all services rendered.
- I understand that there is a **\$45.00** fee to have each of my **Disability or FMLA form(s)** completed.
- I understand that **if I do not cancel my appointment at least 24 hours prior to the scheduled time, I will be charged a \$40.00 fee for office visits and a \$150.00 fee for procedures, including surgeries.**
- I understand that **all labs and radiology services will be charged separately from Deepali Kashyap MD, PLLC.**
- I hereby assign to Deepali Kashyap MD, PLLC any insurance benefits available for health care services provided to me. If these benefits are not assigned to the doctors, I agree to forward all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.
- **If this account is turned over to a collection agency,** I agree to pay the collection and legal fees necessary to collect the balance, including a **fifty percent (50%) charge** for collection services added to the unpaid balance.
- I have read the above statements and have no questions.

Patient's Printed Name

Patient's Signature

Date

Legal Guardian

Relationship

Date

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I, _____, understand that as a part of my health care, Deepali Kashyap M.D., PLLC (d/b/a Galleria Women's Health) originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Deepali Kashyap MD, PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization 's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Deepali Kashyap MD PLLC to disclose my protected healthcare information to the following person and/or people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I fully understand and accept the terms of this consent.

Patient or Legal Guardian Signature

Date



HIPAA NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care of treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve
- Understanding what is in your record and how your health information is used helps you to ensure its accuracy, make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where and why others may access your health information.

Understanding your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your Information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations
- We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.
- If you believe your privacy rights have been violated, **you can file a complaint with the Office of Civil Rights either by calling 800-368-1019 or by writing to U.S. Dept of Health & Human Services 90 70th Street Suite 4-100, San Francisco CA 94103.**

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.



We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with Worker's Compensation or other similar programs established by law.

We will use your health Information for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication. After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to the public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.