MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

Case No					Today's Date			Birth Date			
Last Name	First Name	Middle				Daytime Phone			Evening Phone		
Address	City	State	Zip			Marital Status			Occupation		
Emergency Contact		Phone Number				Relationship			Last Physical Exam Date		
By Doctor:		Phone Number				Family/Referring Doctor			Phone Number		
May I Contact either of these records? No	Yes Doctors for your past health	What are your present medical symptoms?									

Family History		IF LIVING		IF DECEASED		Any blood Relatives who have or have had any of the listed conditions							
		HEALTH		Death			Yes	No	Relationship		Yes	No	Relationship
	Age	Good	Fair Poor	Age	Death Cause								
Father						Asthma				Hay Fever			
Mother						Arthritis				Insanity			
Brothers Sisters						Allergies				Kidney Disease			
1 M F						Anemia				Leukemia			
2. M F						Alcoholism				Migraine			
3. M F						Bleeding Tend.				Nervous Break'n			
4. M F						Cancer				Obesity			
5. M F						Colitis				Rheumatism			
Husband						Congenital Heart				Rheumatic Fever			
Sons Daughters						Diabetes				Stroke			
1 M F						Epilepsy				Suicide			
2. M F						Goiter				Stomach Ulcers			
3. M F						High Bl. Press.				Turberculosis			
4. M F						Heart Disease							
5. M F													
6. M F													

HABITS

Do you	Yes	No	Daily Consuption
Smoke	☐	☐	_____ Pkgs.
Drink Coffee	☐	☐	_____ Cups
Drink Alcohol	☐	☐	_____ ozs.
Drink Beer	☐	☐	_____ ozs
Awaken Early	☐	☐	

MEDICATIONS

Check if taken:

Antacids	☐	Blood Thinning Pills	☐	Iron or Poor Blood Med	☐	Vitamins	☐
Antibiotics	☐	Cortisone	☐	Laxatives	☐	Water Pills	☐
Aspirin, Bufferin, Anacin	☐	Cough Medicine	☐	Phenobarbital	☐	Weight Reducing Pills	☐
Barbiturates	☐	Digitalis	☐	Shots	☐	Other(List)	
Birth Control Pills	☐	Dilantin	☐	Sleeping Pills	☐	☐	
Blood Pressure Pills	☐	Hormones	☐	Thyroid Med	☐	☐	
		Insulin, Diabetic Pills	☐	Tranquilizers	☐	☐	

Operations you have had: Year	Diseases you have had requiring hospitalization Year	Serious illnes not requiring hospitalization: Year

Drugs you are allergic to:	Describe any serious injuries or accidents you have had:

	Yes	No	
Are you still having your monthly menstrual periods?	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When?
Do you have very heavy bleeding with your periods?	☐	☐	When?
Do you feel bloated and irritable before your period?	☐	☐	
Are you now or have you ever taken birht control?	☐	☐	When?
Have you ever had a miscarriage?	☐	☐	When?
Do you regularly have the cervix cancer screenings?	☐	☐	Date of last screening?

How many children born alive? _____
How many stillbirths? _____
How many premature births? _____
Date of last menstrual period _____
How many miscarriages? _____
How many cesarean operations? _____

Additional information to make the doctor aware of:

Dignity Women's Center

Steven G. Pilkington, MD, PLLC

Board Certified Obstetrician & Gynecologist

PATIENT INFORMATIOM:

Patient's Last Name: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____-_____-_____ Age: _____ Patients Social Security #: _____

Hm Phone: _____ Cell Phone: _____ Wk Phone: _____

Marital Status: _____ Race:_____ Ethnicity:_____ Language:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance: _____ ID Number: _____ Group: _____

Name of Policy Holder: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ ID Number: _____ Group: _____

Name of Policy Holder: _____ SSN: _____ DOB: _____

Person Responsible for Bill: _____ Phone: _____

Relationship to the insured: ____ Self ____ Spouse ____Child ____ Other: (please describe) _____

Street Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ Address: _____ Phone #: _____

How did you hear about us? _____

WILL YOU ACCECPT BLOOD IF REQUIRED FOR HOSPITAL EMERGENCY TREATMENT? YES ( ) NO ( )
INITIALS____ (If your answer is "NO" please notify the receptionist immediately.) As your physician I must practice medicine in the manner that I feel is most beneficial and safe for my patients. Therefore, I cannot accept a patient who will not accept blood for necessary emergency care.
PLEASE BE INFORMED THAT DR. PILKINGTON RECOMMENDS NATURAL METHODS OF FAMILY PLANNING (HE DOESN'T PRESCRIBE ARTIFICIAL METHODS OF FAMILY PLANNING). DR. PILKINGTON DOES NOT PERFORM ABORTIONS. DR. PILKIGNTON DOES NOT PERFORM TUBAL LIGATIONS.

Payment for service is due at the time of service- this includes all PPO/HMO copayments required by the member's contract. PPO/HMO patients will be billed for any "Patient Share" balances not collected after insurance payment. There will be a $30.00 charge for returned checks and these checks will be represented electronically to your account. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I have read all the information on this form and have completed the above answers. I have no further questions about these issues and I am requesting medical advice and treatment by Dr. Pilkington. I certify this information is true and correct. I will notify you of any changes in the above information.

Signature: _____ Date: _____

I understand and agree that my signature below provides direct assignment of my insurance policy benefits to the doctor for payment of the total charges for professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company or adjuster involved in my account.

Signature: _____ Date: _____

Dignity Women's Center

Steven G. Pilkington, MD,PLLC
Board Certified Obstetrician & Gynecologist

CONSENT FOR TREATMENT

I, _____, request Steven G. Pilkington, MD to provide treatment for me. This includes, but not limited to: physical examination including pap smear and/or vaginal cultures (for sexually transmitted diseases), injection of medication or vaccines, office procedures, and venipuncture associated with lab tests requested.

Patient Name: _____
Patient Signature: _____
Date of Birth: _____ Date: _____

CONSENT FOR TRETMENT OF A MINOR

I, _____, request Steven G. Pilkington, MD to provide treatment for the minor listed below. I affirm that I am legally authorized to request medical care for her. This includes, but is not limited to: physical examination including pap smear and/or vaginal cultures (for sexually transmitted diseases), injection of medications or vaccines, office procedures, and venipuncture associated with lab tests requested.

Minor Patient's Name: _____ Date of Birth: _____
Legal Parent/Guardian Name (print): _____
Legal Parent/Guardian Signature: _____ Date: _____

Dignity Women's Center

ELECTRONIC APPOINTMENT REMINDER REQUEST & CONSENT

Dignity Women's Center has now made it even easier for you to receive reminders about your Well Woman Exam. We can now email your reminders! This makes the process quick & easy!

☐ YES! I would like to receive reminders about my yearly Well Woman Exam via email.
My email address is: _____.

☐ YES! I would like to receive reminders about my yearly Well Woman Exam via text message.
My cell phone number is: _____.

I understand that it is my responsibility to inform Dignity Women's Center in writing if my preferences change or if my email address and cell phone changes. I understand that failure to do this could result in me not receiving a notice. I also understand that email can be vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. I also understand that reminders for yearly exams are a courtesy of Dignity Women's Center and that failure to receive one is not an indication that one is not needed. It is my responsibility to schedule a Well Woman Exam yearly.

_____ _____
Patient name (Printed) Date of Birth

_____ _____
Patient Signature Date

4499 Medical Drive #151, San Antonio, TX 78229 Office: 210.593-4392 Fax: 210.593-0152 www.dignitywomenscenter.com

Dignity Women's Center

Steven G. Pilkington, MD, PLLC
Board Certified Obstetrician & Gynecologist

****FOR ALL PREGNANT WOMEN AND INTERESTED GYN PATIENTS ****

CONSENT FOR HUMAN IMMUNDODEFIENCY VIRUS (HIV) TESTING

I, _____ understand that a sample of my blood will be taken and tested by ELISA and/or Western Blot methods for the antibodies to the Human Immunodeficiency Virus (HIV).

I understand that the ELISA and Western Blot tests are very accurate. However, a very small percentage of tests (less that 0.5%) may give a false positive or a false negative result. A false positive means that the test has incorrectly indicated that I am infected with HIV when, in fact, I am not. A false negative result means that the test has incorrectly indicated that I am not infected with HIV when, in fact, I am. A small percentage of the test results may be labeled "equivocal", "unsatisfactory", or "inconclusive", and may require additional testing.

I understand that there is a chance that, if I have been infected with the virus recently, my body may not yet have made sufficient antibodies to be detected by the test.

I understand that the performance of and the results of the HIV antibody test are confidential.
I HEREBY CONSENT TO BE TESTED FOR THE HIV ANTIBODY:

_____ _____
SIGNATURE OF PATIENT/ GUARDIAN DATE

4499 Medical Drive #151, San Antonio, Tx 78229 Office: 210.593.4392 FAX: 210. 593.0152
www.dignitywomenscenter.com

Dignity Women's Center

Steven G. Pilkington, MD, PLLC
Board Certified Obstetrician & Gynecologist

APPOINTMENT POLICY

Our goal is to satisfy our patients with exceptional care. Whether you are seeing us for a routine, annual well woman exam or for a problem visit, we take the time to discuss the issues and answer your questions. The current state of managed care has placed severe limits on what can be done in a single visit. An "annual well woman exam visit" only allows time for the discussion of a preventive medicine problem. Please schedule a "problem visit," not an "annual well woman exam" visit for any other problems. These are two very different types of visits (per insurance company requirements). Therefore, if you have a medical problem at the time of your well woman exam, a "problem visit" will need to be scheduled for you on another day. If the medical problem is emergent or if you choose to do so, we will address the problem and reschedule the "well woman exam" for another day.

We have done our best to explain this aspect of the confusing world of managed care. If you have further questions about this, please ask us or your insurance company.

CANCELLATION POLICY

We value our patients and the time we spend with each of you. We would like to set aside appointments that work for your schedule. Therefore see patients before 8 am and at the noon hour. If there is a conflict with your scheduled appointment time, we ask that you call our office at least 24 hours in advanced to cancel or reschedule. When you schedule an appointment we cannot offer that time slot to other patients needing to be seen. For this reason, appointments cancelled without a 24 hour advanced notice incur a $35.00 fee.

By signing this letter you are stating you have read and understand the appointment/cancellation policies outlined on this page and have no further questions.

Patient Name: (print): _____

Patient Signature: _____ Date: _____

4499 Medical Drive #151 San Antonio, TX 78229 Office: 210.593.4392 Fax: 210.593.0152
www.dignitywomenscenter.com

CREDIT CARD ON FILE POLICY

At Dignity Women's Center, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover for which you are responsible. Without this authorization, a billing fee of $300.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Dignity Women's Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover
Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Dignity Women's Center to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Dignity Women's Center. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Dignity Women's Center in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

Dignity Women's Center

4499 Medical Drive Ste. 151
San Antonio, TX 78229
O: (210)593-4392 F: 1(855)300-3785
****Please note new fax number****

AUTHORIZATION TO RELEASE HEALTHCRE INFORMATION (ONLY NEEDED IF REQUESTIONG RELEASE OF 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:

Dignity Women's Center
4499 Medical Drive Ste. 151
San Antonio, TX 78229

This request and authorization applies to:

____Cervical Cancer Screening test and Gynecology related biopsy reports.
____Mammogram Reports
____Bone Density Reports
____Lab results
____Medical Imaging Reports
____Pathology Reports
____Other:_____
____ALL OF THE ABOVE

Covering the time period of: _____to _____
_____ All treatment events

I realize this authorization includes the release of information about the following: AIDS, HIV related information or testing, psychiatric disorders, drug treatment and genetic testing (unless I request that these not be included). I hereby agree to this authorization and understand that it may contain Personally Identifiable information and PHI as defined in HIPPA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice of writing to you. If I chose to limit the information released, I understand that you inform the requestor that portions of the records have been withheld. Dignity Women's Center is not responsible for any incomplete, illegible or omitted information from another institution. I understand that information should be provided within 15 days from the receipt of request and a fee for preparing and furnishing this information may be charged to me according to the rulings set forth by the state of Texas.

Date: _____**Unless revoked, this authorization will expire 90 days from the date provided**
Printed Name (patient or patient's legal representative):_____
Signature (patient or patient's legal representative):_____

IF RECORDS ARE MORE THAN 10 PAGES, PLEASE MAIL TO THE ADDRESS ABOVE, DO NOT FAX!
THANK YOU

NOTICE OF PRIVACY PRACTICES FOR DIGNITY WOMENS CENTER

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used, "HIPAA" provides penalties for covered entitles that misuse personal health information.

As required by ("HIPAA") we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute, de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You many revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain he privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14th 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of out Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protection has been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health &Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement For
Dignity Women's Center

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers

- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I HEREBY AUTHORIZE THE FOLLOWING INDIVIDUAL(S) TO CONSENT TO TREATMENT OR SERVICES, AND TO VERBALLY GIVE AND RECEIVE PROTECTED HEALTH INFORMATION REGARDING ANY TREATMENT OR SERVICES RENDERED AT DIGNITY WOMEN'S CENTER. IF ANY CHANGES OCCUR TO THIS AUTHORIZATION IT WILL BE MY RESPONSIBILITY TO NOTIFY DIGNITY WOMEN'S CENTER.

NAME DOB RELATIONSHIP TO PATIENT

1._____
2._____
3._____

_____ _____
Signature of Patient or Representative/Guardian Date

_____
Printed Name of Patient or Representative/Guardian

Dignity Women's Center

Steven G. Pilkington, MD,PLLC
Board Certified Obstetrician & Gynecologist
4499 Medical Drive #151, San Antonio, TX 78229 Office: 210.593.4392 Fax: 210.593.0152
www.dignitywomenscenter.com

Dear Patient,

We would like to thank you for choosing Dignity Women's Center of San Antonio as your healthcare provider during this special and critical stage of your life.
In our continued efforts to optimize medical care for you and your unborn child, this office has a form of universal urine screening as recommended by the American College of Obstetrics and Gynecology to provide more thorough and complete obstetric care. The American College of Obstetricians and Gynecologists (ACOG) has recommended urine testing for toxins for all ob patients. ACOG is considered the leading authority in the field of OB/GYN. Physicians who are members of ACOG ("fellows") have achieved the highest level of certification possible in the field and are generally obligated to follow the recommendations of the college. Dr. Pilkington is a fellow of ACOG. This testing is provided for all patients *without discrimination*.
This will assist us in identifying potential harm to you and your child from medications or substances that may be present in your system.
In the continued effort to provide you the highest possible level of care, the office follows the guidelines proposed by the American College for Obstetricians and Gynecologists
(ACOG Number 422)
By signing this consent, you're are acknowledging that you have read this notice and understand the reason for the universal protocol, and agree to Dignity Women's Center's protocol for urine testing.. Please ask if you have any questions.
We would like to thank you for assisting us in our continued efforts to provide you, our patients, with the most thorough and comprehensive medical care possible.

Printed Name	Signature	Date