



El Camino Women's Medical Group

Obstetrics, Gynecology, Infertility & Minimally Invasive Surgery

Registration Form

Personal information

First name:

MI:

Last name:

SSN:

DOB:

Driver's license:

Address:

City:

State:

Zip code:

Phone (H):

Phone (Cell):

Email:

Educational level:

Marital status:

Preferred language:

Ethnicity (may list multiple):

Preferred pharmacy:

Pharmacy Address/Phone:

Primary care physician:

May we send them your visit summaries?

Referred by:

☐ Yes ☐ No

Employment information

Employer:

Occupation:

Emergency contact

Name:

Relationship:

Phone:

Insurance information

Insurance company:

Insurance type: ☐ PPO/EPO ☐ POS ☐ HMO

Insured person's name:

Insured person's DOB:

Group number:

Subscriber ID number:

Privacy preferences

I request the following restrictions to the use or disclosure of my health information:

Medical information can only be discussed with:

☐ Patient only

☐ Family member/friend: _____

☐ Physician

☐ Other _____

Detailed messages regarding test results can be left on voicemail:

☐ No

☐ Yes, at this number: _____

Any updated/amended copies of this office's notice of Privacy Practices will be sent to your listed email address, unless otherwise requested. The most updated policies will always be available in the office and on the website: www.ElCaminoWomen.com.



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Medical history

General information:

Name:

DOB:

Age:

Primary doctor:

Past medical history:

Please list all allergies and your reaction:

☐

None

Please list all medications, including birth control, supplements, herbs, vitamins, and over-the-counter drugs:

☐

None

Please list any medical conditions, including mental health conditions:

☐

None

Please list all major injuries, surgeries, and/or hospitalizations you have had:

☐

None

Date of last physical exam:

Date of last mammogram:

Date of last colonoscopy:

Family history:

Please list any medical problems affecting close relatives, including cancer:

Father:

Paternal uncle:

Mother:

Paternal aunt:

Paternal grandfather:

Maternal uncle:

Paternal grandmother:

Maternal aunt:

Maternal grandfather:

Siblings:

Maternal grandmother:

Children:

Spouse:



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Medical history, Page 2

Social History:

Do you use tobacco products? ☐ No Used to, but quit ☐ Yes

If yes, how many per day?

And for how many years?

Do you drink alcohol?

If so, how often?

Do you use recreational or illegal drugs?

How many servings of dairy products do you eat in an average day?

How many times a week do you exercise?

What activities?

Do you have pets?

With whom do you live?

Has anyone threatened or hurt you in the last year?

What is your occupation?

Past gynecological history:

At what age did you experience your first menstrual period?

How often is it and for how many days?

If menopausal, when was your last period?

Date of last Pap smear:

Have you ever had an abnormal Pap smear?

If so, what date was the most recent abnormal pap?

How old were you the first time you engaged in sexual intercourse?

How many sexual partners have you had in your life? _____ Male _____ Female

Are you currently sexually active? If so, how long have you been with your current partner?

Have you ever had a sexually transmitted infection?

If so, what kind and when?

Do you have concerns about your sex life that you wish to discuss?

Do you experience urinary leakage?

Have you ever been told you have fibroids or ovarian cysts?

Past obstetrical history:

Number of pregnancies:

Number of term births:

Number of preterm births:

Number of miscarriages:

Number of abortions:

Number of living children:

For each pregnancy:

Date of delivery	Weight of baby	Gender	Type of delivery	Epidural?	Complications?



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 Shar@elcaminowomen.com.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

How this Medical Practice May Use or Disclose Health Information

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

1.Treatment. We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them-when they are sick or injured or following the patient's death.

2.Payment. We use and disclose PHI to obtain payment for the services we provide. For example, we give health plans the information they require for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

3.Health Care Operations. We may use and disclose PHI to operate this medical practice e. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get health plans to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs, and business planning and management. We may also share PHI with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of health care information from further disclosing it except as specifically required or permitted by law.

a. We may also share PHI with other health care providers, health care clearinghouses, or health plans that have a relationship with our patients when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their



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accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

b. We may also share PHI with the other health care providers, health care clearinghouses, and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities that collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Check in. We may use and disclose medical information about our patients by having them check in when they arrive at our office. We may also call out their names when we are ready to see them.

5. Notification and Communication with Family. We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about their location or general condition in the event of their death, unless a patient had instructed us otherwise. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family.

6. Marketing. Provided we do not receive any payment for making these communications, we may contact our patients to encourage them to purchase or use products or services related to their treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to them. We may similarly describe products or services provided by this practice and tell our patients which health plans we participate in. We may receive financial compensation to talk with our patients face-to-face, to provide them with small promotional gifts, or to cover our cost of reminding them.

7. Sale of Health Information. We will not sell our patients' health information without their prior written authorization. The authorization will disclose that we will receive compensation for PHI if the patient authorizes us to sell it, and we will stop any future sales of information to the extent that the patient revokes that authorization.

8. Required by Law. As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose our patients' health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose our patients' health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a



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subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose our patients' health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose our patients' health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose our patients' health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if the patient has agreed to the disclosure on behalf of themselves or their dependent.

17. Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in lawful custody.

18. Workers' Compensation. We may disclose our patients' health information as necessary to comply with workers' compensation laws. For example, to the extent our patients' care is covered by workers' compensation, we will make periodic reports to their employer about their conditions. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, our patients' health information/record will become the property of the new owner, although our patients will maintain the right to request that copies of their health information be transferred to another physician or medical group.

20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify our patients as required by law. If they have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

21. Other disclosures specified in our Notice of Privacy Practices. We may disclose our patients' health information as otherwise described in our Notice of Privacy Practices.

22. Psychotherapy Notes. We will not use or disclose our patients' psychotherapy notes without their prior written authorization except for the following: (1) treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if the patient sues us or brings some other legal proceeding, (4) if the law requires us to disclose the information to the patient or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning the patient's psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner following the patient's death. To the extent the patient revokes an authorization to use or disclose their psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose our patients' health information to researchers conducting research with respect to which their written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.



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When this Medical Practice May Not Use or Disclose Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

Our Patients' Health Information Rights

- 1. Right to Request Special Privacy Protections.** Our patients have the right to request restrictions on certain uses and disclosures of their health information by a written request specifying what information they want to limit, and what limitations on our use or disclosure of that information they wish to have imposed. If our patients tell us not to disclose information to their commercial health plan concerning health care items or services for which they paid for in full out-of-pocket, we will abide by their request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify our patients of our decision.
- 2. Right to Request Confidential Communications.** Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to a particular email account or to their work address. We will comply with all reasonable requests submitted in writing which specify how or where our patients wish to receive these communications.
- 3. Right to Inspect and Copy.** Our patients have the right to inspect and copy their health information, with limited exceptions. To access their medical information, our patients must submit a written request detailing what information they want access to, whether they want to inspect it or get a copy of it, and if they want a copy, their preferred form and format. We will provide copies in the requested form and format if it is readily producible, or we will provide our patients with an alternative format they find acceptable, or if we can't agree and we maintain the record in an electronic format, their choice of a readable electronic or hardcopy format. We will also send a copy to any other person our patients designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny our patients' request under limited circumstances. If we deny a request to access a child's records or the records of an incapacitated adult because we believe allowing access would be reasonably likely to cause substantial harm to the patient, the guardian or legal representative will have a right to appeal our decision. If we deny a patient's request to access their psychotherapy notes, our patients will have the right to have them transferred to another mental health professional.
- 4. Right to Amend or Supplement** Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete. Our patients must make a request to amend in writing and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information and will provide them with information about this medical practice's denial and how they can disagree with the denial. We may deny their request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if they would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny a request, our patients may submit a written statement of their disagreement with that decision, and we may, in turn, prepare a written rebuttal. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning anything in the record they believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
- 5. Right to an Accounting of Disclosures.** Our patients have a right to receive an accounting of disclosures of their health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to them or pursuant to their written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18



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(specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to Impede their activities.

6.Right to Paper Copy of Notice of Privacy Practices. Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email. If we have a website, we must post our current Notice of Privacy Practices on our website.

Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles our patients' health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If our patients are not satisfied with the way this office handles a complaint, they may submit a formal complaint to:

Region IX

Office for Civil Rights

U.S. Department of Health & Human Services

90 7th Street, Suite 4-100

San Francisco, CA 94103

(800) 368-1019; (800) 537-7697 (TDD)

(202) 619-3818 (fax)

OCRMail@hhs.gov



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Patient Portal

El Camino Women's Medical Group uses eClinicalWorks as our electronic medical record.

You should receive an email from eClinicalWorks on how to set one up. If you don't get an email, please confirm with our staff that we have your correct email address (info@elcaminowomen.com).

The Patient Portal:

You can access the [Patient Portal](#) from our website or through a phone app called [Healow](#).

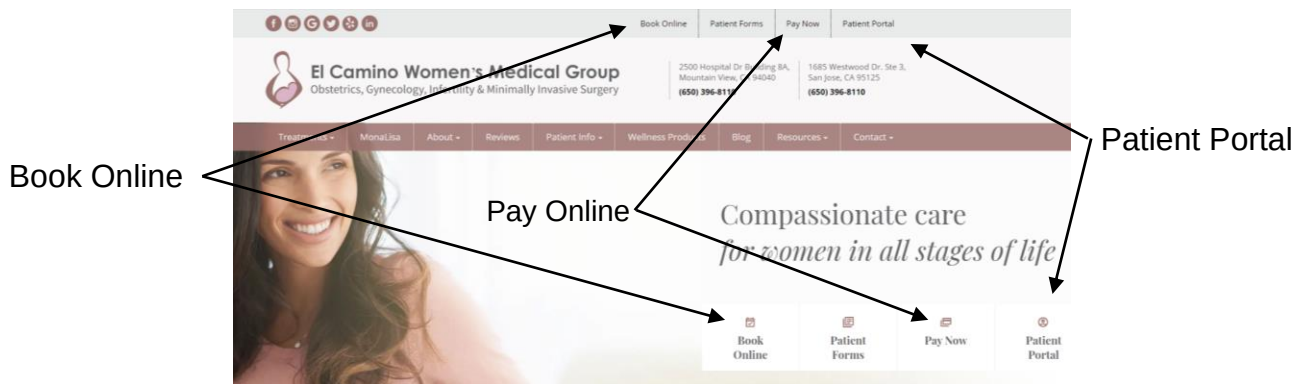
From the Patient Portal and Healow you can:

- See all upcoming appointments, information from past appointments, labs and test results
- Update your demographics, pharmacy information, medications and allergies
- Request refills on medications
- Send eMessages to the staff or your doctor and get replies (only for non-urgent issues)
 - You should call for all urgent issues, even after hours: 650-396-8110
- Attend your televisits, as long as your camera and sound settings allow
- For Healow, our practice code is: DGFCBA

Paying your bills

When you receive a statement for your care, you can send in payment with check or credit card.

You can also pay online through our website (www.ElCaminoWomen.com)



Financial Policies

As part of registration for care with our practice, you agree to responsibility for the cost of your care. We do our best to understand your plan, properly bill your insurance and direct you to providers and lab services in network for your insurance. However, the final responsibility lies with you. Please remember to:

- Update our office with any change of name, address or insurance inform
- Pay your bills on time, we assess a \$20 fee if we need to send out an additional invoice
- If you need to reschedule (or cancel) your appointments, give us a full business days' notice or you will be subject to a \$45 cancellation fee.

Visit: <https://elcaminowomen.com/office-info/office-policies.html> to access our office policies



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Consents (to be signed electronically)

Consent for medical services and treatment

I voluntarily consent to receive routine evaluation and treatment, including non-invasive procedures and minor office procedures, as ordered by the clinicians of El Camino Women's Medical Group, which may include physicians, physician assistants, therapists, and other licensed health professionals who work with or under the supervision of our physicians.

I understand that multiple licensed professionals may participate in my care as part of the El Camino Women's Medical Group team, and that each will act within their scope of practice. This consent covers routine evaluation and treatment, including physical examinations, diagnostic testing, and non-invasive procedures. Separate consent will be obtained for any procedures or treatments that require it.

I understand I may withdraw this consent at any time.

Financial and Insurance Authorization

I understand that I am financially responsible for my account regardless of my insurance and for any charges that are for medical care not covered by my policy or because of not following the required procedures of my health plan. All charges are due within 60 days from the time of service. I authorize the release of any medical information necessary to process this claim and request that payment of medical benefits be made directly to this office.

It is my responsibility to know and understand my insurance policy and benefits. This includes referrals, copayments, covered lab and X-ray benefits, and prior authorizations for procedures. I further understand that if I enroll in another insurance plan, it is my responsibility to notify the office; otherwise, I will be responsible for non-covered payments due to inaccurate billing.

I understand that this financial authorization applies to all services provided by the clinicians at El Camino Women's Medical Group.

I understand there are fees related to failing to reschedule appointments or pay invoices in a timely manner.



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Prescription history

By signing this consent form, I agree that the office of El Camino Women's Medical Group can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

HIPAA Acknowledgement

I hereby acknowledge that I have received a copy of the El Camino Women's Medical Group's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available at each appointment.

Telemedicine Consent

I hereby acknowledge that I have received a copy of the El Camino Women's Medical Group Telemedicine Consent Form. By signing this form, I am confirming that I have read and understand the listed rights and information with respect to telemedicine.

Notice to consumers regarding your physicians:

Physicians are licensed and regulated by the Medical Board of California or the Osteopathic Medical Board of California: (800) 633-2322, www.mbc.ca.gov, www.ombc.ca.gov.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

Signature of patient / parent / guardian

Date

Print Name



Health Exchange Consent Form

What is a health information exchange?

A health information exchange is a network that enables our office's electronic health record systems to communicate with outside systems to share your health information.

El Camino Women's Medical Group has joined the **Carequality Network** which allows us—with your permission—to access your records from places like Stanford, the Palo Alto Medical Foundation, Sutter, and Kaiser hospitals and clinics.

What are the benefits of health information exchanges?

Allowing a physician to access your health information from other systems may improve the care we are able to provide you:

- We will have quicker access to a more complete picture of your medical history (diagnoses, prescriptions, labs and imaging) and make better informed and safer decisions about your care.
- You may not need to take the same medical tests over again.
- Your healthcare costs may be lowered.

What are my choices? (please initial one choice with each section) Your

records with our practice:

_____ I CONSENT to sharing my records from the office of El Camino Women's Medical Group with any outside systems via the health information exchange

_____ I do NOT CONSENT to sharing my records from the office of El Camino Women's Medical Group with any outside systems via the health information exchange

Your records with other offices:

_____ I CONSENT to the office of El Camino Women's Medical Group accessing my outside records

_____ I do NOT CONSENT to the office of El Camino Women's Medical Group accessing my outside records

Signature

Date



Telemedicine Consent Form

I hereby authorize El Camino Women's Medical Group, and its employees, to use telemedicine in the course of my diagnosis and treatment. I understand that telemedicine involves the communication of my medical information, both orally and visually, to physicians and other health care practitioners located in other parts of the state or outside of the state.

I understand I have all the following rights with respect to telemedicine:

Patient Choice of Care. I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.

Access to Information. I have the right to inspect all medical information transmitted during a telemedicine consultation; and may receive copies of this information for a reasonable fee.

Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telemedicine; and that no information or images from the telemedicine interaction will be disclosed to researchers or other entities without my consent.

Potential Risks. I understand that there are risks from telemedicine, including the possibility, despite reasonable and appropriate efforts, that the transmission of medical information could be disrupted or distorted by technical failures in transmission; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage or medical information generated by this telemedicine consultation in one or more databases could be accessed by unauthorized persons. In addition, I understand that telemedical examinations or care may not be as complete as face-to-face examinations or care and that telemedicine does not negate or minimize the risks that may be inherent in a medical illness or condition. Finally, I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse.

Consequences. I understand that by consenting to telemedicine my physician will communicate medical information concerning me to physicians and other health care practitioners located in other parts of the state or outside the state.

Benefits. I understand that I can expect benefits from telemedicine, but that no results can be guaranteed or assured.

I have read and understand the information provided above, I have discussed it with my physician or my physician's designee, and all my questions have been answered to my satisfaction.

Signature of patient / parent / guardian

Date

Print Name