

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Health Operations

I understand that as part of my health and medical care, Lisa Wasemiller-Smith, M.D., Inc. originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

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

I further understand and agree that this authorization to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review that PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Lisa Wasemiller-Smith, M.D. reserves the right to change this notice and practice. I understand that any changes to the PATIENT PRIVACY NOTICE will be posted at the office of Lisa Wasemiller-Smith, M.D. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Lisa Wasemiller-Smith, M.D., Inc. is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you.....that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

_____ Yes, I do consent for my medical information to be sent to parties directly involved (insurance companies, laboratories, pathology and other medical professionals and facilities).

_____ No, I do not consent for my medical information to be sent to parties directly involved. By checking this box, I understand that I will have to pay for my visit today up front even if I have insurance, and hand carry my lab/pathology to be processed. I also understand that the physicians and employees of Lisa Wasemiller-Smith, M.D., Inc. cannot send or discuss my medical records with other medical professionals and facilities.

Signature of patient or legal representative

Date notice effective

FOR OFFICE USE ONLY

Lisa Wasemiller-Smith, M.D., Inc. _____ accepts _____ denies
_____ accepts conditionally the restrictions imposed on release of information as stated above.

Reasons why Lisa Wasemiller-Smith, M.D., Inc. accepts restrictions imposed conditionally:

Signature/Title

Lisa Wasmiller-Smith, M.D.
11200 North Portland
Oklahoma City, Oklahoma 73120
(405) 936-1100

ATTENTION: IMPORTANT INFORMATION

- 1) It is the patient's responsibility to have a referral or authorization for each visit, if **YOUR** insurance requires one. If an authorization is required and the office does not have one at the time of your appointment, then the patient is responsible for **FULL PAYMENT** of visit or rescheduling the appointment.
- 2) The patient must make sure the office staff is aware of any name, address, phone and/or insurance information changes before appointment.
- 3) It is the patient's responsibility to know which laboratory is in their network, otherwise all lab work will be sent to LabCorp or Diagnostic Labs of Oklahoma. If the patient does not provide the office staff with correct lab information and a lab outside of the patient's insurance network is used, then the patient is responsible for any additional charges.

Additionally, if there are any questions, please ask the office staff to explain.

Patient's Signature: _____

Date: _____

PATIENT INFORMATION

(Please Print)

Name _____ Today's Date _____

Address _____ City/St _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Social Security # _____ Marital Status _____

Referred By _____ Personal Physician _____

Your Employer _____ Position _____

Spouse's Name _____ Date of Birth _____ Spouse's SS# _____

Spouse's Employer _____ Position _____

**PERSON RESPONSIBLE FOR BILL
(If other than above)**

Name _____ Relationship _____

Address(if other than above) _____ Home Phone _____

Employer _____ Position _____

CONTACT / EMERGENCY RELATIVE OR FRIEND (not living with you)

Name _____ Relationship _____

Address _____ Home Phone _____

Employer _____ Position _____ Work Phone _____

Lisa Wasemiller-Smith, M.D. is an owner of Lakeside Women's Hospital. I refer patients there because it is convenient and efficient for patients, and the quality of care is excellent. We believe that patients have a choice in the selection of health care facilities. If you wish to use another facility, please let us know.

AUTHORIZATIONS

BENEFITS TO PHYSICIAN

I authorize my insurance company to make payments directly to Dr. Lisa Wasemiller-Smith.
I understand I am responsible for any portion of the bill not covered by my insurance company.

RELEASE INFORMATION

I authorize release of my medical information for insurance claim purposes.
PHOTOSTAT OF THE ABOVE IS VALID AS THE ORIGINAL.

I understand the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

Patient Signature _____ Date _____

Parent Signature if Minor _____ Date _____

PAST MEDICAL HISTORY <input type="checkbox"/> None		
<input type="checkbox"/> AIDS/ HIV	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Anemia/Blood Disorder	<input type="checkbox"/> Endometriosis	
<input type="checkbox"/> Anesthesia complications	<input type="checkbox"/> Female/Sexual Problems	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Headaches or Migraines	<input type="checkbox"/> Psychiatric Illness
<input type="checkbox"/> Arthritis/Lupus	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Birth Defects or Inherited Disease	<input type="checkbox"/> Herpes (HSV)	<input type="checkbox"/> Sexual Abuse/Domestic Violence
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach/Bowel/Gall Bladder Problems
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Breast Problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney or Bladder Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chlamydia/Gonorrhea	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Varicosities
<input type="checkbox"/> Depression	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Other:

SOCIAL HISTORY/LIFESTYLE	
Occupation:	Is sexual intercourse painful? (Y/N):
Religion:	History of sexually transmitted infection:
General Stress Level (Low/Medium/High):	Current Birth Control Method:
Diet (Regular/Vegetarian/etc.):	Smoking Status (Never/Former/etc.):
Exercise Level (Occasional/Moderate/Heavy):	Smoking (How much per day/week?):
Marital Status: (S / M / D / W)	Alcohol Intake (None/Occasional/Moderate/Heavy):
Sexual Orientation: (Heterosexual/ Homosexual/ Bisexual)	Caffeine Intake (None/Occasional/Moderate/Heavy):
Sexually Active (Y/N):	Illicit Drugs:
How many years have you been sexually active?	Other/Notes:

HOSPITALIZATIONS/SURGICAL PROCEDURES <input type="checkbox"/> None		
Month/Year	Illness/Operation	Complication (Y/N)

VACCINE HISTORY: LIST RECENT VACCINATIONS	
Name of vaccine:	Date:
Tdap/Tetanus (Last 10 years?) Y/N	
Pneumonia: Y/N	
Gardasil (HPV): Y/N	
Shingles: Y/N	
Flu: Y/N	

FAMILY HISTORY: (IF YOU CHECK YES PLEASE LIST RELATION) <input type="checkbox"/> None		
<input type="checkbox"/> AIDS (HIV)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia/Blood Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Anesthesia complications	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis/Lupus
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Uterine Cancer
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Other: