Legal Name ______________________ Preferred Name ______________________

Date of Birth ______________________ Marital Status: ○ Single ○ Married ○ Separated ○ Divorced

Social Security # ______________________ E-Mail ______________________

Address ______________________ Phone 1 ______________________

City ______________ State ______ Zip ______ Phone 2 ______________________

Employer ______________________ Occupation ______________________

Address ______________________ Work Phone ______________________

City ______________ State ______ Zip ______ Referred By ______________________

Primary Care Physician (PCP) ______________________ PCP Phone ______________________

Spouse / Parent Name ______________________

Date of Birth ______________________ Social Security # ______________________

Employer ______________________ Occupation ______________________

Address ______________________

City ______________ State ______ Zip ______ Work Phone ______________________

Primary Insurance ______________________ Name of Insured ______________________

Insurance Address ______________________ Date of Birth ______________________

City ______________ State ______ Zip ______ Phone ______________________

ID # or Social Security # ______________________ Group ______________________

Secondary Insurance ______________________ Name of Insured ______________________

Insurance Address ______________________ Date of Birth ______________________

City ______________ State ______ Zip ______ Phone ______________________

ID # or Social Security # ______________________ Group ______________________

Emergency Contact ______________________ Relationship ______________________

City ______________ State ______ Zip ______ Phone ______________________

Pharmacy Location ______________________

Phone ______________________ Fax ______________________

I assign all medical/surgical benefits to which I am entitled to the attending physician. I authorize the release of medical information necessary to request reimbursement from insurance companies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether paid by said insurance or not.

Consent to receive treatment: I hereby authorize the physician to treat myself or if a minor, my daughter, as deemed medically necessary.

Patient/Guardian Signature: ______________________ Date: ______________________

Printed Name of Signatory: ______________________ Patient's Name: ______________________

Authorization to Release Patient Information

I authorize Joseph K. Leveno, MD and staff to release and furnish (on a confidential and a strict need to know basis) all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by physicians or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions.

I also give my authorization to have a copy of my medical records delivered to a Primary Care Physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

I also give my authorization for Joseph K. Leveno, MD and staff to discuss my financial data and all medical information with the following people:

Name:	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

These authorizations will remain in effect permanently or until written notice, otherwise.

Patient/Guardian Signature: ______________________________ Date: ____________________

Printed Name of Signatory: ____________________________ Patient's Name: ____________________

Patient's Responsibility

Signing of this form in no way implies that your insurance company will cover your visits with this office. Joseph K. Leveno, MD and their employees cannot guarantee any information given to us by your insurance carrier regarding your benefits.

1. If you are not part of an HMO, PPO, Medicare/Medicaid, Managed Choice plan that your physician participates in, you will be responsible for your bill at the time of service.
2. If you are part of a PPO plan and you have a deductible for services other than your regular office copay, you will be responsible for payment of said deductible.
3. If you are part of a Managed Choice plan, HMO plan, or Tricare Prime failure to obtain a valid referral from your Primary Care Physician/Manager (PCP or PCM) may result in no benefits being paid, you will be responsible for any non-payment from your insurance carrier.

Patient/Guardian Signature: ______________________________ Date: ____________________

Printed Name of Signatory: ____________________________ Patient's Name: ____________________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA, privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

Home Telephone ________________________________

____ Okay to leave message with detailed info
____ Leave message with call back number only

Work Telephone ________________________________

____ Okay to leave message with detailed info
____ Leave message with call back number only

Written Communication

____
____
____ Okay to mail to my home address
____ Okay to mail to my business address

Other ____

Patient/Guardian Signature: ____ Date: __________________________________

Printed Name of Signatory: ___________________________________ Patient's Name: ___________________________________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for Treatment, Payment, and Healthcare operations (TPO) may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

(For in-office use only, where we will record disclosures made by our office per signed release)

Date	Disclosed To Whom Address and/or Fax	(1)	Description of Disclosure/Purpose	By whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized –
(2) Type key: **T**=Treatment; **P**=Payment Information; **O**=Other
(3) Enter how disclosure was made: **F**=fax; **P**=Phone; **E**=Email; **M**=Mail; **O**=Other

Medical History

Patient's Name ______________________ Today's Date ______________________

Date of Birth ______________________ Age ______________________

Menstrual History:

Age at First Period ______________________ Usual Period Duration (days) ______________________

Usual Cycle Length (days) ______________________ Pain with Periods? Y | N
(Start of period to the start of your next period)

First Day of Last Menstrual Period ______________________ Date of Last Pap Smear ______________________

Results ______________________

Contraception ______________________
(i.e. Birth Control, Condoms, Pull Out, Surgery, etc.)

Pregnancy History:

Year				
Length of Pregnancy				
Length of Labor				
Type of Delivery				
Anesthesia				
Hospital				
Birth Weight				
Gender				
Complications				
Child's Name				

Problem List

Problem	Current	Past
Head Injury		
Severe Headaches		
Migraine Headaches		
Seizures		
Vision		
Ear, Nose, Throat		
Thyroid		
Asthma		
Shortness of Breath		
Coughing Blood		
Chest Pain		
Abnormal Heartbeat		
Heart Murmur		
Mitral Valve Prolapse		
Rheumatic Fever		
Other Heart Disease		
Breast Disease		
Intestinal Tract Disease		
Hepatitis		
Mononucleosis		
Blood in Stool		
Vulvar Disease		
DES Exposure		
Abnormal Pap Smear		
Uterine Disease		
Fallopian Tube Disease		
Ovarian Disease		
Endometriosis		
Pelvic Inflammatory Disease		
Infertility		
Venereal Disease		
Genital Herpes		
Loss of Urine		
Urinary Tract Infection		
Pain with Intercourse		
Varicose Veins		
Bleeding Disorder		
Unusual Bleeding		
Birth Defect		
Genetic Disease		
Rubella		
Chicken Pox, Measles, Mumps		
Cancer		
Excessive Weight Loss/Gain		
Hypertension		
Diabetes		
Anemia		
Psychiatric		
Alcohol or Drug Abuse		
Blood Transfusion		
Other:		

Patient's Name: ____ Date: _____________________

Please list all **Previous Hospital Admissions** (except those related to pregnancy):

Year:	Hospital:	Diagnosis:	Treatment:

Family History:

	Living?	Medical Issues:
Father:	Y | N	
Mother:	Y | N	
Siblings:	Y | N	

Please give details if any family member has/had:

Cancer	
Leukemia	
Hypertension	
Heart Disease	
Diabetes	
Kidney Disease	
Tuberculosis	
Hepatitis	
Epilepsy	
Bleeding Disorders	
Twins	
Birth Defect	
Genetic Defect	
Three or more miscarriages	
Anemia other than Iron Deficiency	

Personal History:

Drug Allergies or Reactions: ______________________________

Height: ______________________ Usual Weight: ______________________

Smoking History: ______________________________

Alcohol Consumption: ______________________________

Reason(s) for Today's Visit: ______________________________

Patient's Name: ______________________________ Date: ______________

Joseph K. Leveno, MD PA

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

Our Legal Duty

We are obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. This notice takes effect April 14th, 2003 and will remain in effect until we replace it.

You may request a copy of our notice at any time. For more information about your privacy practices or for additional copies of this notice, please contact us at:

Joseph Leveno, M.D., P.A.
1600 Coit Road Ste. 102
Plano, Texas 75075

or telephone 972-596-5821

Uses and Disclosures of Medical Information

We use disclosed medical information about you for your treatment, payment, and health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now, or in the future, to facilitate payment by third parities for services rendered by us, or to assist with, aid in, or facilitate the collection of data for the purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs manage care organizations, IPAs, CMS, other governmental, third-party payors, or any organization contracting with any of the above entities to perform such functions.

Copies of your medical information may be delivered to a primary care physician, or any other physician who is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues.

Individual Rights

This office will not use or disclose any of your medical and financial information for any purposes not stated above without your specific authorization; you may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We may charge a cost-based fee for copying of records and for postage.

Questions and Complaints

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

Patient/Guardian Signature: ____ Date: _____________________

Printed Name of Signatory: ____________________________ Patient's Name: ____________________________

JOSEPH K. LEVENO, M.D., P.A.
1600 Coit Road, Suite 102
Plano, Texas 75002
Phone: (972) 596-5281 | Fax: (972) 596-5634

Late Cancellation, No-Show, & Late Arrival Policies

We understand that you may sometimes need to reschedule appointments. When we make your appointment, please understand we are reserving time for you to see Dr. Leveno as well as an appointment for a sonogram if required. We sincerely appreciate your assistance and cooperation as this allows for a smooth office flow and more efficiently uses your time.

Our Cancellation and No-Show Policy is as follows:

We request that you please give our office at least a 24-hour notice if you need to reschedule your appointment. If you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, you will be charged a rescheduling fee as shown below.

- **Dr. Leveno - $50**
- **Sonogram - $50 additional fee** (All sonograms will be followed by a visit with Dr. Leveno on the same day.)

Note: A patient, who is a no-show three times or more, may be dismissed from the practice.

Our Late Arrival Policy is as follows:

If a patient is more than 15 minutes late to their appointment, the appointment may be cancelled and need to be rescheduled. Patients arriving late may also be asked to wait to be seen until the provider has an opening in their schedule.

If you have any questions regarding these policies, please let our staff know and we will be glad to speak with you in more detail.

I have read and understand the **Late Cancellation, No-Show, and Late Arrival Policies** for the office Dr. Joseph K. Leveno, MD and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice, and that I will be notified of the change at my next visit.

I ______________________________________ (print name) have read and understand the **Late Cancellation, No-Show, and Late Arrival Policies** for the office of Dr. Joseph K. Leveno, MD.

_______________________________________   ______________________

Patient/Legal Representative Signature   Date