Ted E. Fogwell, M.D., P.A.
Margot Perot Women's & Children's Hospital
8160 Walnut Hill Lane, Suite 220
Dallas, Texas 75231
(214) 750-0980

Diplomate of the American
Board of Obstetrics & Gynecology

Obstetrics & Gynecology

Dear New Patient:

It is important to me that I give the best possible care to each of my patients. Part of that care depends upon having as much information as possible about your medical history and current problems.

Please review the following:

(1) "Patient Information" form,
(2) "Insurance Information" form,
(3) "HIPAA Notice of Privacy Practices" form.
(4) "Fees, Financial Arrangements, & Insurance coverage" form,
(5) "Health History" form,
(6) And, if appropriate, the "Obstetric History" form for pregnant patients.

The "Health History" is a necessary part of the evaluation. By completing the form as your schedule allows, you will have time to obtain information pertaining to your history that might be impossible to recall while in the office. Also, if I am able to reflect upon your history in an unhurried manner before your appointment, our discussion in the office may focus on the areas of concern to you. For these reasons, please return your completed "**Health History**", "**Patient Information**", and "**Insurance Information**" forms as soon as possible prior to you appointment.

If you feel that your previous medical records would be helpful to me in caring for you, please print out the "Medical Records Release" form for as many physicians necessary. If you feel your records would be beneficial for your continued care, you may mail or fax these requests directly to those physicians or hospitals in order to facilitate a speedier receipt of your records. You may also bring the completed requests with you and Dr. Fogwell will help you decide if your records would be helpful.

Thank you for returning the information to me in a timely manner prior to your appointment. I am looking forward to meeting you.

Sincerely,

Ted E. Fogwell, M.D.

TEF/mj

TED E. FOGWELL, M.D., P.A. APPOINTMENT DATE: ___________________________

PHONE: HM: ____________________ CELL: ____________________ WK: ____________________
IN WHAT ORDER WOULD YOU PREFER TO BE NOTIFIED IF WE NEED TO CONTACT YOU?
PLEASE NUMBER 1-4 IN BLANKS - HOME: _____ CELL: _____ WORK: _____ OTHER: ____________________

LAST NAME: ______________________________ FIRST NAME: ___________________ M.I. ______
ADDRESS: _________________________________CITY: ___________STATE: ___ ZIP: ________
DATE OF BIRTH: ___________ AGE: ___ MARITAL STATUS: M☐ S☐ D☐ W☐ SEP ☐
NEAREST RELATIVE NOT LIVING WITH YOU:
NAME: ___________________________________ RELATIONSHIP: ___________________________
ADDRESS: ____ PHONE #: _________________

DRIVER'S LIC. #: ____________ STATE:______ SOCIAL SECURITY #: _______________________

REFERRED BY: _________________________ PRIMARY CARE MD: ____________________________

OTHER PHYSICIANS PROVIDING CARE

____
NAME SPECIALTY

____
NAME SPECIALTY

____
NAME SPECIALTY

____
NAME SPECIALTY

____
NAME SPECIALTY

EMPLOYMENT INFORMATION

EMPLOYER: ______________________________ ADDRESS: ___________________________________
CITY: _______________ STATE:____ ZIP: ___________ E-MAIL (WK)__________________________
PHONE #: ________________________________ FAX #: ___________________________________
WORK POSITION HELD: ____

HUSBAND'S INFORMATION ☐ N/A

LAST NAME: ________________________________ FIRST NAME: ___________________ M.I. ____
SOCIAL SECURITY #: _________________ D.O.B. __________ E-MAIL _______________________
EMPLOYER: ____________________________ ADDRESS: ____________________________________
WORK POSITION HELD ____
CITY: ___________________________ STATE: ____ ZIP: _______
PHONE #: __________________ FAX #: ____________________ PAGER #: __________________

MISCELLANEOUS INFORMATION

E-MAIL ADDRESS: ________________________ PAGER NUMBER: ____________________________
EMERGENCY- NOTIFY: ____
ADDRESS: _______________________________________PHONE #: ____________________________

TED E. FOGWELL, M.D., P.A.

INSURANCE/PAYMENT INFORMATION

LAST NAME:____ **FIRST:** _____________________________ **MI:**_____

DATE OF BIRTH: ____

MY INSURANCE CLASSIFICATION IS (PLEASE CHECK ONE OF THE FOLLOWING):

☐ **P.P.O.** ☐ **EPO** ☐ **POS** ☐ **HMO** ☐ **SELF PAY** ☐ **OTHER** ____

PRIMARY INSURANCE CARRIER

COMPANY NAME:______________________________________

CLAIMS ADDRESS:_____________________________________

CITY: ____________________**STATE:** ________**ZIP:**________

PHONE: _________________**FAX:**_______________________

POLICY #:_________________**GROUP #:**____________________

INSURED'S LAST NAME: _______________**FIRST:**___________

ADDRESS:____

CITY:_________________**STATE:**_____________**ZIP:**__________

PHONE: ___________________**DOB:** ____________**SEX:**_____

INSURED'S EMPLOYER___________________________________

PHONE #: __________________**FAX #:**______________________

PATIENT'S RELATION TO INSURED:________________________

THIS PLAN IS: ☐ **MY POLICY** ☐ **MY HUSBAND'S POLICY**

☐ **MY MOTHER'S POLICY** ☐ **MY FATHER'S POLICY**

☐ **OTHER:**____

SECONDARY INSURANCE CARRIER

COMPANY NAME:_________________________________

CLAIMS ADDRESS:________________________________

CITY: _________________**STATE:** ________**ZIP:**______

PHONE: _________________**FAX:**__________________

POLICY #:________________**GROUP #:**______________

INSURED'S LAST NAME: ____________**FIRST:**_________

ADDRESS:______________________________________

CITY: ________________**STATE:** ________**ZIP:**_______

PHONE: ________________**DOB:** _________**SEX:**_____

INSURED'S EMPLOYER:___________________________

PHONE #:__________________**FAX #:**_______________

PATIENT'S RELATION TO INSURED:_________________

THIS PLAN IS: ☐ **MY POLICY** ☐ **MY HUSBAND'S POLICY**

☐ **MY MOTHER'S POLICY** ☐ **MY FATHER'S POLICY**

☐ **OTHER:**_____________________________________

I UNDERSTAND THAT IT IS <u>MY RESPONSIBILITY</u> TO DETERMINE IF DR. FOGWELL IS IN NETWORK WITH MY INSURANCE PLAN. I ALSO UNDERSTAND THAT IF DR. FOGWELL IS NOT IN NETWORK WITH MY INSURANCE PLAN, I MAY BE RESPONSIBLE FOR A HIGHER DEDUCTIBLE OR COINSURANCE PAYMENT THAN I WOULD BE IF I HAD CHOSEN A PHYSICIAN IN NETWORK. I AGREE TO PAY ANY CHARGES INCURRED DURING MY CARE AND TREATMENT BY DR. TED FOGWELL.

I HAVE DETERMINED THAT DR. FOGWELL IS: ☐ **IN NETWORK** ☐ **OUT OF NETWORK**

I AUTHORIZE TED E. FOGWELL, M.D., P.A. TO RELEASE MEDICAL INFORMATION THAT MAY BE NECESSARY TO REQUEST REIMBURSEMENT FROM INSURANCE COMPANIES TO WHOM I HAVE SUBMITTED A CLAIM. I UNDERSTAND I AM RESPONSIBLE FOR ALL MEDICAL FEES DURING MY TREATMENT. I ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, TO TED E. FOGWELL, M.D., P.A..

PRINT NAME: _____________________________ **SIGNATURE:** _______________________________ **DATE:** ___________

MEDICAL RECORDS RELEASE FORM

PHYSICIAN/FACILITY IN POSSESSION OF RECORDS

____
Physician Name

____
Street Address

____
City, State, and Zip Code

____
Phone #: Fax #

RELEASE RECORDS TO:

TED E. FOGWELL, M.D., P.A.

8160 WALNUT HILL LANE #220

DALLAS, TEXAS 75231

Phone: 214-750-0980 Fax: 214-361-1927

My signature below authorizes you to provide a copy, summary, or narrative of my medical records {as indicated by the checkmark(s) below} or otherwise release confidential information.

☐ Complete record:

☐ Records of care during the following dates: ____________________ to: ____________________

☐ Records concerning the following condition(s) ____

☐ Other (please specify): ____

☐ Confer orally with Dr. Fogwell or his staff about my medical information:

Name at time of treatment: ______________________________________ BIRTHDATE: ____________
(PLEASE PRINT CLEARLY)

The reasons or purposes for this release are as follows:

☐ For continuing patient care, diagnosis, evaluation and treatment.

☐ For emergent care of this patient.

☐ Other: ____

After completion of this form, you may:

1. Print, sign, and date it prior to mailing to the designated physician or institution – OR –
2. You may submit it to our office for further discussion with Dr. Fogwell at the time of your appointment.

Patient Signature: ____ Date: ______________

Ted E. Fogwell, M.D.

April 14, 2003

HIPAA 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 our privacy officer. When you arrive for your appointment, you will be asked to sign a statement acknowledging you have read, understand, and agree to this privacy practice notice.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How we may use and disclose health information. Described as follows are the ways we may use and disclose health information that identifies you ("health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We also may use and disclose Health Information to tell you about results of tests and recommendations by mail, electronic media to addresses you provide to us, and telephone recording devices at your residence phone number or your cellular phone recording system (e.g. voice mail).

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify you family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special situations

As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made, if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or the health and safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our privacy officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request and amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our privacy officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our privacy officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment of your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our privacy officer. ***We are not required to agree to your request.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact our only by mail or at work. To request confidential communication, you must make your request, in writing, to our privacy officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.obgyndallas.com. To obtain a paper copy of this notice, please contact our privacy officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page in the heading.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy officer. All complaints must be made in writing.
You will not be penalized for filing a complaint.

FEES, FINANCIAL ARANGEMENTS, & INSURANCE COVERAGE

It is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary will be helpful toward that end.

We will contact your insurance carrier to inquire about benefits available to you and your obligation under the plan. It is suggested that you do the same in order to be aware of your coverage. You may also want to verify if you are required to obtain a referral from your primary care physician prior to this appointment. Each individual plan is different, so please call your insurance company to be sure!

Payment for your visit will be expected at the time of service. This may include your office visit co-payment and any applicable deductible amounts. Acceptable methods of payment are cash, check, Visa, and MasterCard.

We use electronic filing to process insurance claims for payment directly to our office beginning with your first office visit. If your insurance carrier has not paid our claim within the allowed 45 days, we will expect you to take an active part in calling them for immediate remittance. If by mistake payment is made to you, please send it to us along with all paperwork sent to you at that time.

Your health plan may refuse payment of our claim for some of the following reasons:

1. There is pre-existing illness that is not covered by your plan.
2. Your have not met your full calendar deductible.
3. The type of medical service required is not covered by your plan. (i.e. routine exams are not covered by Medicare)
4. The health plan was not in effect at the time of service.
5. You have other insurance which must be filed first.
6. You have any medical service more frequently than your plan allows.

Financial obligation for medical services rests between you and your health plan carrier. While we are pleased to be of service by filing your medical insurance claim for you, we are not liable for any limitations in coverage that may be included in your plan. If your health plan denies payment for any reason, it is your responsibility, as a patient, to pay the denied amounts in full.

I have read and understand my obligations and I acknowledge that I am fully responsible for any services not covered by my health insurance carrier.

____ ________________

Patient Signature Date

____

Printed Name of Patient