FARHINA IMTIAZ, MD

NORTH CYPRESS WOMENS CENTER

ROUTINE WELL WOMAN EXAM

An Annual exam is a once-a-year health check up by your gynecologist which includes a breast exam and a pelvic exam. The annual exam DOES NOT include discussion of new problems or detailed review of chronic conditions. Annual exams are also called routine check-ups, yearly exams, annual pap, and preventive visit. **The purpose of this exam is to identify potential health problems in the early stages when they may be easier and less costly to treat. It is not intended to evaluate, diagnose, or treat existing medical conditions.**

What should I expect during my annual exam?

- General physical exam
- Pelvic Exam and Pap Smear if indicated
- Breast Exam
- Review of vital signs including weight and blood pressure
- Update of life and work situations
- Update of family health history including any new serious illnesses in your family
- Review of your individual health history
- Update of current medications, herbs, and supplements you may be taking
- Evaluation for needed health screening tests based on age and personal/ family history. Examples may be routine blood work, mammogram, screening for sexually transmitted diseases, screening for colon cancer, etc.
- Update and recommendations for immunizations

What happens if you have a new health problem when you come in for your annual exam?

- You and Dr. Imtiaz will need to decide whether to use the time on the day of your appointment to address your problem. In that case your annual exam can be rescheduled for a different day. Alternatively, you may decide to do your annual exam and return at a different time to further evaluate your problems.

Why did I get a bill if my routine preventive exam is covered at 100%?

- If you have an existing problem that needs to be addressed during your preventive office visit, such as high blood pressure, diabetes, skin rash, high cholesterol, headaches, vaginal discharge, abnormal vaginal bleeding, etc., your provider may bill **part of the exam as your annual preventive exam, and part of the exam as treatment of your diagnosis.** The part of your exam related to the treatment of existing medical conditions applies towards your copay, deductible or co-insurance, which means you may owe a balance. If your provider feels that the majority of the time was spent discussing existing medical conditions, the entire visit may be considered a medical treatment visit and would not be billed as a routine preventive exam. In addition, some lab tests may not fall under preventive care if they are performed for specific problems or existing conditions that require ongoing oversight. For example, once you have been diagnosed with high cholesterol, a lipid panel is no longer considered screening. Instead, it is considered oversight and management of the disease. If you have a discharge your cultures are no longer considered routine and billed as a problem.

What can I do to make sure I receive 100% coverage of my routine preventive exam?

You can take the following steps to help ensure your routine exam is billed correctly:

- When scheduling your routine preventive exam, please use the terms "routine preventive exam", "complete physical exam" or "annual physical". Do not use terms such as "check-up", "med check", or "establish care". These all imply that the visit is to evaluate a known medical condition.
- When you talk with your provider, let them know you are there for your routine preventive exam.
- If you bring up health problems during your routine preventive exam, understand that you may have a charge related to the treatment of that problem, or the provider may ask that you schedule a separate appointment for evaluation of that problem.

- Do not save up all of your health concerns for your routine preventive exam. If you have a current chronic condition, you may need other diagnostic visits and services during the year.

Do I need an annual (routine) exam every year?

- Yes! That is the short answer. You may not need a pap smear every year, however, a general health check-up including a digital pelvic exam and breast exam are recommended for all women. These exams including review of your vitial signs are important in the early detection of disease. Preventative care means early diagnosis and treatment of health problems and is extremely important to your general health and well-being.

Please schedule a separate appointment for the following:

- A list of health concerns and questions
- New health concerns or problems found at the time of your annual exam
- Ongoing health problems that need more attention

Our policy regarding test results from your appointment:

- You may schedule an additional appointment in 1-2 weeks after your routine exam to discuss your test results if you would like. Our office will contact you with any abnormal test results. If your test results are normal you will not be contacted.

_____

Patient or Guardian Signature

_____ _____

Patient Name (Guardian Name) Date

FARHINA IMTIAZ, MD

NORTH CYPRESS WOMENS CENTER

REGISTRATION AND ANNUAL UPDATE FORM

Patient Last Name: _____ Patient First Name: _____

Street Address: _____ Apt #: _____

City, State: _____ Zip Code: _____

Phone (Home): _____ (Mobile / Cell): _____

Email: _____@_____

Date of Birth: _____ Social Security: _____

Relationship Status: S: _____ M: _____ SEP: _____ D: _____ W: _____

Ethnicity: _____ Race: _____ Language: _____

Emergency Contact: Name: _____ Phone: _____

Relationship: _____

Insurance Policy Company (Primary): _____

Member ID: _____ Group Number: _____

Insured Last Name: _____ First Name: _____

Please Inform us if you have a secondary Insurance Policy

Pharmacy Information Must Be Completed

Pharmacy Name: _____ Phone Number: _____

Address: _____ City / State: _____

Street Intersection: _____ Zip code: _____

Patient (Guardian) Signature: _____ **Date:** _____

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CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY AUTHORIZATIONS

Patient Name Printed: _____ **Date of Birth:** _____

Guardian (if applicable): _____ **Relationship:** _____

- I hereby and voluntarily consent to authorize North Cypress Women's Center and its providers to provide healthcare to me. The health care services may include without limitation, routine physical and mental assessment, diagnostic and monitoring tests and procedures, examinations and medical treatment, routine laboratory procedures, and tests (blood, urine and other studies), imaging services, administration of medications and other procedures and treatment prescribed by the medical staff. These services may also include counseling necessary to receive appropriate services including family planning.
- I understand that I will be asked to sign a separate informed consent for treatment of specific conditions.
- I understand that there are no guarantees, implied, or otherwise proffered, being made to me concerning the results of treatment, or the effectiveness of any birth control methods prescribed to me.
- I understand that this consent is valid and remains in effect as long as I am a patient of Dr. Farhina Imtiaz.
- I understand that I may refuse any treatment suggested by the staff of North Cypress Women's Center or Dr. Imtiaz and if I do so, I am solely responsible for my medical outcomes.
- I understand that when I do not "show-up" for my appointment I am in essence refusing treatment and am solely responsible for the outcomes and progression of my conditions.

Assignment of Insurance Benefits:

- I authorize payment of insurance medical benefits to **Farhina Imtiaz, MD, PA**

Authorization to Release Information:

- I authorize Farhina Imtiaz, MD to release any medical information as may be necessary for the completion of my insurance claims to any insurance carrier, health care facility, or hospital.

Acceptance of Financial Responsibility:

- I accept financial responsibility for any services not covered by my insurance company. I further understand that benefits obtained at the time of services are only a summary of benefits and not a guarantee of payment. I will be solely responsible for any sums or amounts the insurance company does not pay.

Complaint Policy:

- If you believe that you have a complaint against this establishment you may file a complaint by phone or in writting to Office Manager at the office address.

By signing below you acknowledge that you have read all of the information provided and agree to the above. . You also agree that you have had an opportunity to ask questions and Dr. Imtiaz or her staff has answered all of your questions satisfactorily.

_____

Patient Signature

_____ _____

Patient Name Date

FARHINA IMTIAZ, MD

NORTH CYPRESS WOMENS CENTER

HIPPA ACKNOWLEDGEMENT AND HIPPA RELEASE

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

I hereby give consent for the individuals named below to access and to obtain releases of my medical records and other personal information that may be in the medical records of North Cypress Women's Center. This consent is unlimited and does not expire unless rescinded by me in writing. I understand that this consent is for information that is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The persons named below have my permission to use and disseminate the information received at their sole discretion.

Name of person who may obtain your information: _____

Patient Name: _____ **Patient Date of Birth**: _____

(Please Print Name)

Signature of Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

CONSENT FOR ROUTINE, RANDOM OR REASONABLE SUSPICION DRUG SCREEN

I hereby consent to allow North Cypress Women's Center to allow a urine specimen given by me and submit it for random, routine, and reasonable suspicion drug test screen. I further consent to allow the laboratory testing service to make results of such screen available to North Cypress Women's Center.

I have read, accepted and understand the above waiver and agree to the terms set herein.

Patient Name: _____ **Patient Date of Birth**: _____

(Please Print Name)

Signature of Patient/Legal Representative: _____ Date:_____

FARHINA IMTIAZ, MD

NORTH CYPRESS WOMENS CENTER

OFFICE POLICIES

North Cypress Women's Center welcomes you to the practice. We strive to make each appointment a pleasant experience. The following policies explain some of the business practices for our organization effective February 11, 2017.

- **Late Arrival:** If you arrive more than 10 minutes late you may have to reschedule. Such an event will result in you incurring the same penalty as a "no-show". In addition, this can also adversely impact timely prescription refills. Please be courteous and arrive on time.
- **Late Cancellation or "No-Show" for Appointments:** A cancellation fee of $40 will be assessed for appointments without a 24-hour notice. Each fee is reviewed on a case by case basis before being assessed. Multiple "No-Show" appointments within a 12-month period may result in termination of our relationship with you. In addition, these fees must be paid in full before you can schedule another appointment.
- **Phone Consultation Fees:** Phone consultation, or frequent phone calls involving the physician are billed at $40 for each 15 minutes.
- **Refund Policy:** All refunds will be made by check, even if the payment was initially made via credit card or cash. If an insurance or personal overpayment is due to you, it will be paid by check. Refund requests are processed on the 15th of the following month of the request. No refunds on accounts with an outstanding balance can be made until the balance is paid in full.
- **Medical Records, Disability, Family Medical Leave Forms, or other forms:** Our office requires 15 business days to process ALL forms. The administrative fee for all forms is $40 and must be paid in advance. All patient and employee portions of the forms must be completed prior to submission to our office for completion.
- **Co-Pays and Prior Balance:** Are due at check-in before services are rendered. You are obligated by your contract with your insurance company to make these payments as services are rendered. We do not bill your co-pay.
- **Laboratory, Minor-Surgery and Ultrasound Diagnostic Services:** These services may be performed in our office and will incur additional fees to the patient and the insurance carrier. Any account balances will be billed to the patient.
- **Patients Without Insurance (Cash Pay Patients):** Cash pay patients will be expected to pay for the services prior to being seen and for any additional services rendered during the office visit.
- **Insurance and Personal Identification Cards:** These must be presented at each office visit in order to prevent delays.
- **Insurance Waiver:** We will bill your insurance carrier for services on your behalf. We are NOT responsible for re-filing claims if we have been given incorrect information. ***You agree to become the liable party for any services not paid for by insurance within 90 days.*** If your policy changes it is YOUR responsibility to inform the office.

By signing below you acknowledge that you have read all of the information provided and agree to the above. . You also agree that you have had an opportunity to ask questions and Dr. Imtiaz or her staff has answered all of your questions satisfactorily.

_____

Patient Signature

_____ _____

Patient Name Date

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

North Cypress Women's Center
Attn: Dr. Farhina Imtiaz
9533 Huffmeister Road, Houston, TX 77095
281-463-9100

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____

Patient History Update

Dr. Farhina Imtiaz, M. D.

Patient Name: _____ Today's Date: _____ DOB: _____ AGE: ___

I can be contacted at: E-mail Address: _____

Cell #: _____ Other #: _____ ( ) OK to leave message

General Health Questions (Please circle those that apply)	
High Blood Pressure, Low Blood Pressure, Rapid Heart Rate, etc.	Y / N
High Cholesterol	Y / N
Difficult Breathing (COPD, Asthma, etc.)	Y / N
Digestive Disturbances (Indigestion, Constipation, Irritable Bowel Syndrome, etc.)	Y / N
Endrocrine (Diabetes, Thyroid, etc.)	Y / N
Chronic Pain Syndromes (Chronic Fatigue Syndrome, Fibromyalgia, etc.)	Y / N
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	
Quality of Sleep	
Do you have difficulty in going to sleep or staying asleep?	Y / N
If awakened, do you find it difficult to go back to sleep?	Y / N
Have you been told that you snore loudly?	Y / N
Do you stop breathing, choke, or gasp for air during sleep?	Y / N
Are you unrested after 6 hrs of sleep and/or do you get fatigued during the day?	Y / N
Do your legs kick at night and interfere with your sleep?	Y / N
Approximately, how many hours of restful sleep do you get most nights?	_____
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	
Bladder Function	
Do you lose urine while coughing, sneezing, laughing, lifting, jumping or running?	Y / N
How often do you urinate; during the day? _____ times, during the night? _____ times	
Do you have to hurry to empty your bladder when full?	Y / N
Do you soil your clothing because you cannot make it to the bathroom in time?	Y / N
Do you use protective undergarments because you cannot hold your urine?	Y / N
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	
Nerve and Muscle Function	
Seizures, Migraines or Other Headaches	Y / N
Have you been told that you have Neuritis or Neuropathy?	Y / N
Do you often have leg cramps?	Y / N
Do you have wounds on your legs that heal very slowly?	Y / N
Do you experience ANY of the following (***please circle those that apply***):	
Radiating Pain, Numbness, Tingling, Burning, Coldness, Sharp or Dull Pain in the :	

( ) Neck, Shoulders, Arms or Hands (i.e. Upper extremities)	Y / N
( ) Low Back, Hips or Legs (i.e. Lower Extremities)	Y / N
Have you experienced loss of motion or weakness in your neck, shoulders, arms or hands?	Y / N
Have you experienced loss of motion or weakness in your low back, hips or legs?	Y / N
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	
Balance & Fall Prevention	
Do you ever lose your balance or feel dizzy or unsteady?	Y / N
Do you feel unsteady when walking or climbing stairs?	Y / N
Do you have any gait abnormalities (stumble or lose balance while walking)?	Y / N
Have you fallen more than once in the past year?	Y / N
Does dizziness or imbalance problems interfere with your job or your household responsibilities?	Y / N
Do you feel dizzy while ( ) sitting down or ( ) rising from a seated or lying position?	Y / N
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	
Cognitive & Brain Function	
Have you ever lost consciousness? Y / N If so, was it due to Trauma? Explain	Y / N
Do You:	
Have feelings of Anxiety and/or Depression	Y / N
Have daily problems with memory or thinking (remembering important dates or assignments)?	Y / N
Have daily problems with making judgment's or decisions?	Y / N
Have less interest in hobbies and activities?	Y / N
Repeat the same things over and over again (questions, stories, statements) ?	Y / N
Have trouble learning how to use a tool, appliance or gadgets?	Y / N
Have trouble handling financial affairs (income taxes, paying bills)?	Y / N
Have trouble completing assignments or tasks?	Y / N
Have difficulty getting organized?	Y / N
Avoid getting started on a challenging task?	Y / N
Fidget or squirm with your hands or feet when you have to sit for a long time?	Y / N
Feel overly active or feel like you have to constantly do something, like you were driven by a motor?	Y / N
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	
Allergy & Immunology	
Do you have any hay fever symptoms, such as sneezing, watery nasal drainage and nasal itching?	Y / N
Do you have persistent nasal congestion and/or post nasal drip?	Y / N
Do you have sinus problems, frequent colds, sinus headaches?	Y / N
Do your eyes itch, water, get red and/or swell?	Y / N
Do you have asthma, tight chest, and or persistent cough?	Y / N
Do you have skin problems such as eczema, hives or itching?	Y / N

Do your symptoms worsen when seasons change?	Y / N
Do your symptoms change when you go from indoors to outdoors?	Y / N
Are you symptoms worse in parks or grassy areas?	Y / N
Are your symptoms worse in the morning and/or after waking?	Y / N
Do your symptoms worsen when in contact with dust, while vacuuming, etc.	Y / N
Are your symptoms worse around animals?	Y / N
Do you have close relatives with allergies?	Y / N
Are you aware of any Food Allergies that you may have?	Y / N
Do you take medications to control your allergies? If so, describe: _____	
Do they help?	Y / N

I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months

Major Accidents/Traumas: _____

Major Surgeries: _____

Medications: _____

Any other General Health Issues: _____

This Patient History Update, which will be part of your medical record, lists symptoms and other factors that may allow your physician to recommend one or more diagnostic studies to better manage your care. Upon review and approval, you may be contacted by our Medical Services Scheduling Company to schedule these tests.

Patient Signature: _____ Date: _____

(rev 1-1-2015, Fax 281-310-6330)