**Name ___________________________Date of Birth ______Todays Date ________**

# Past Medical History ©2002

**(Please provide details of your personal medical history, & indicate Dates & Treatment)**

**Asthma**
**Cancer**
**Diabetes**
**Hypothyroid or Thyroid Dysfunction**
**Heart Disease / Stroke**
**Heart Murmur / Valve Prolapse**
**Deep Venous Thrombosis/ Pulmonary Emboli**
**Varicosities / Phlebitis**

**Epilepsy / Seizures**
**Tuberculosis and/or PPD +**
**Kidney Disease**
**Liver Disease / Hepatitis**
**Anxiety / Depression**
**Abuse**
**Mental Health Problem**
**Stomach Ulcers**
**Major Accidents**
**History of Blood Transfusion**
**Rh Sensitized / Rh Isoimmunization**
**Sexually Transmitted Disease**
**Herpes**
**Gonorrhea / Chlamydia**
**HIV / AIDS or Syphilis**
**Human Papilloma Virus / HPV**
**Abnormal Pap smear**
**Genital Warts**
**Endometriosis**
**Incontinence**
**Infertility / PCOS**
**Abnormal Uterus / Fibroids**
**Hypertension**

**List all prior SURGERIES, major and minor:**

**List all hospital stays:**

**Tobacco use / Cigarettes:**
**Age started smoking:**
**Age stopped smoking:**
**Number of cigarettes/day**

**Alcohol Use:**
**Number of Drinks / Week**

**Do you use or have you used Recreational Drugs?**
**If yes, what drugs and when?**
______________________________________________________________________________
_________________________________________________________________

**List ALL presently used MEDICATIONS along with their DOSAGE and FREQUENCY (including over the counter meds):** ____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**List ALL medications to which you are ALLERGIC:** ______________________________________________
______________________________________________________________________________

## Past pregnancies

| Year of Delivery | Length of Labor | Birth Weight | Type of Delivery | Male/Female & Name(s) | Place of Delivery | Comments / Complications |
|---|---|---|---|---|---|---|
| | | | | | | |

**Please list all miscarriages (years occurred and # of weeks pregnant):**
__________________________________
______________________________________________________________________________

**Age at first period ______Date last menstrual period began _________ how long did it last?** ________

**Flow of periods are: normal ______heavier ______lighter ______ Are your periods regular?** ________

**How often? ______Do you have pain with periods? _____Does pain require medication?** ___________

**If so what medications? _________________________ Date of last pap smear/result?** ______________

**Present type of birth control used _________________If oral contraception, name of pill___________**

## Family History

**Breast Cancer___________ If yes, what relationship? ______________________________Age @ diagnosis_______**
**Ovarian Cancer__________ If yes, what relationship? _____________________________ Age @ diagnosis_______**
**Colon Cancer ___________ If yes, what relationship? ______________________________Age @ diagnosis_______**
**Other**
______________________________________________________________________________
______

## PATIENT DEMOGRAPHIC INFO

DATE ______/______/______ REFERRED BY:__________________________________________ DRIVER'S LIC #: ______________________________

LAST NAME____________________________________________ FIRST_______________________________________ MIDDLE INITIAL___________

SOC SEC #__________-______-__________ DOB________/_________/_________ MARRIED( ) SINGLE( ) WIDOWED( ) DIVORCED( )

ADDRESS________________________________________________________________________________ APT # ______________________________

CITY____________________________________STATE_____ ZIP CODE___________________

HOME PHONE # __________________________ WORK PHONE # __________________________ CELL PHONE # _____________________________

STUDENT? NO( ) YES( ) FULL TIME( ) PART TIME ( ) EMPLOYMENT STATUS: FULL TIME( ) PART TIME ( )

OCCUPATION/EMPLOYER__________________________________________________________________________________________________

PHARMACY NAME **(Required)**______________________________________________________________________ PHONE # (____) _______________

## INSURANCE INFORMATION ©2002

PRIMARY INSURANCE CO _________________________________________________________BENEFITS PHONE # ___________________________

ID #______________________________________ GROUP#______________________

NAME OF POLICYHOLDER:____________________________________________________RELATIONSHIP ___________________________________

POLICYHOLDER'S DOB__________/__________/__________ POLICYHOLDER'S SS#_______________-______________- ______________

SECONDARY INSURANCE CO______________________________________________________BENEFITS PHONE # __________________________

ID #______________________________________ GROUP#______________________

NAME OF POLICYHOLDER:____________________________________________________RELATIONSHIP ___________________________________

POLICYHOLDER'S DOB____ ______/__________/__________ POLICYHOLDER'S SS#_______________-______________- ______________

## EMERGENCY CONTACT

NAME__________________________________________PHONE# (_____)__________________RELATIONSHIP _______________________________

## PATIENT PORTAL

Memorial Women's Specialists is pleased to offer a patient portal to our patients. Please read the consent and disclosure information provided by our patient portal provider when you first log on. Your log-in information will be emailed to you.

**EMAIL ADDRESS for use in Patient Portal:** _______________________________________________________________________

**Patient Signature**_________________________________________________________________ **Date:** ________________________

**Parent's/Guardian's Signature (if under 18)** _________________________________________ **Date:** ________________________

**_MEMORIAL WOMEN'S SPECIALISTS_**
**929 Gessner, Suite 2130 ● Houston, Texas 77024**
**Phone: 713-935-9100**

## WELCOME TO OUR PRACTICE

**Consent for Treatment ©2006, ©2013**

I voluntarily give my permission to Memorial Women's Specialists and its medical staff, associates, technical assistants, covering physicians, and other associated and consulting healthcare providers to provide medical services. I am authorizing treatment for as long as I receive medical care, or until I withdraw my consent in writing.

Signature of Patient    Printed Name    Date of Birth    Date

Signature of Legal Guardian (if Minor or Legal Guardianship)    Date

Printed Name of Legal Guardian    Relationship to Minor

**Statement of Financial Responsibility/Assignment of Benefits**

I acknowledge that I am legally and financially responsible for all charges in connection with the medical care and treatment provided by Memorial Women's Specialists and its medical staff, associates, technical assistants, covering physicians, and other associated healthcare providers. I assign and authorize payments from third party payors, such as insurance carriers, to Memorial Women's Specialists. I am responsible to pay for co-payments, finance charges, fees for any check returned by a bank without payment, and any and all costs incurred in attempting to collect payment and past due balances.

**Missed appointments compromise patient care. At least 24 hours notice must be given if you are unable to keep an appointment, or else a fee of $25.00 will be charged to the patient.**

I authorize release of necessary medical and financial information to my insurance carrier for the processing and review of claims related to treatment and payment for that treatment. I also authorize payments of such claims to be made directly to Memorial Women's Specialists. Any surgical and/or medical benefits otherwise payable to me are not to exceed the practice's stated charges. I understand that I am financially responsible for charges not covered by my policy. I acknowledge that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or provisions regarding medical necessity, and I am responsible for payment. I also understand that preverification and precertification of benefits do not guarantee payment and coverage of benefits by my insurance carrier. I accept financial responsibility for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal Law.

Signature of Patient    Printed Name    Date of Birth    Date

Signature of Legal Guardian (if Minor or Legal Guardianship)    Date

Printed Name of Legal Guardian    Relationship to Patient

## NOTICE OF PRIVACY PRACTICES

Effective Date: July 15, 2016

**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:

*Privacy Officer/Office Manager* at *(713) 935-9100*.

### WHO WILL FOLLOW THIS NOTICE?

- ✓ MEMORIAL WOMEN'S SPECIALISTS
- ✓ MEMORIAL WOMEN'S SPECIALISTS providers
- ✓ All MEMORIAL WOMEN'S SPECIALISTS employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at MEMORIAL WOMEN'S SPECIALISTS, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

### OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;

- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

## THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician, referring physician, other specialists, nurses, or other health care providers and personnel; to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run MEMORIAL WOMEN'S SPECIALISTS in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, MEMORIAL WOMEN'S SPECIALISTS may provide a written, electronic or telephone reminder that your next appointment with MEMORIAL WOMEN'S SPECIALISTS is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **Quality Assurance.** We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.
- **Utilization Review.** We may need to use or disclose your medical information in perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.
- **Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

- **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect our medical information, however, we require the business to appropriately safeguard your information.
- **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for your to agree or object when required under law), or in accordance with your prior authorization.
- **Treatment Options and Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

**SPECIAL SITUATIONS.**

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities, authorized national security and/or intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:

  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products or supplies;

- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence;
- To report suspected child or elderly abuse or neglect; and
- To assist in public health investigations, surveillance, or interventions.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. 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, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement, National Security and Intelligence Activities.** In certain circumstances, we may disclose your medial information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety or another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Marketing of Related Health Services.** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and address of the sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

- **Fundraising.** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have the right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.
- **Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

**OTHER USES OF MEDICAL INFORMATION.**

- **Authorizations.** There are times we may need or want to disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.
- **Psychotherapy Notes, Marketing and Sale of Medical Information.** Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.
- **Right to Revoke Authorization.** If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for reasons covered by our written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

**Right YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.**

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for MEMORIAL WOMEN'S SPECIALISTS. If you request a copy of the information, MEMORIAL WOMEN'S SPECIALISTS may charge a fee consistent with allowable fees established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

MEMORIAL WOMEN'S SPECIALISTS may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by MEMORIAL WOMEN'S SPECIALISTS will review your request and denial. The person conducting the review will not be the person who denied your request. MEMORIAL WOMEN'S SPECIALISTS will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask MEMORIAL WOMEN'S SPECIALISTS to amend the information. You have the right to request an amendment for as long as the information is kept by MEMORIAL WOMEN'S SPECIALISTS.

  To request an amendment, your request must be made in writing and submitted to MEMORIAL WOMEN'S SPECIALISTS. In addition, you must provide a reason that supports your request.

  MEMORIAL WOMEN'S SPECIALISTS may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, MEMORIAL WOMEN'S SPECIALISTS may deny your request if you ask us to amend information that:

  - Was not created by MEMORIAL WOMEN'S SPECIALISTS, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by MEMORIAL WOMEN'S SPECIALISTS;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to *the Privacy Officer/Office Manager*. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. MEMORIAL WOMEN'S SPECIALISTS will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information MEMORIAL WOMEN'S SPECIALISTS uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information MEMORIAL WOMEN'S SPECIALISTS discloses about you to someone who is involved in your care or the payment for your care.

  MEMORIAL WOMEN'S SPECIALISTS is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which MEMORIAL WOMEN'S SPECIALISTS has been paid out of pocket in full. Should MEMORIAL WOMEN'S SPECIALISTS agree to your request, MEMORIAL WOMEN'S SPECIALISTS will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions you must make your request in writing to MEMORIAL WOMEN'S SPECIALISTS. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit MEMORIAL WOMEN'S SPECIALISTS's use and/or disclosure; and (3) to whom you want the limits to apply. MEMORIAL WOMEN'S SPECIALISTS may notify the receiving party that the records released are incomplete per your request.

- **Right to Request Confidential Communications.** You have the right to request that MEMORIAL WOMEN'S SPECIALISTS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that MEMORIAL WOMEN'S SPECIALISTS contact you only at work or by mail.

  To request that MEMORIAL WOMEN'S SPECIALISTS communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. MEMORIAL WOMEN'S SPECIALISTS will accommodate all reasonable requests. Your request must specify how or where you wish to be request

- **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. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

- **Right to Breach Notification.** In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

## CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the practice's HIPAA Officer at the address listed in Section VI below or asking the office receptionist for a current copy of the Notice.

## COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with MEMORIAL WOMEN'S SPECIALISTS or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with MEMORIAL WOMEN'S SPECIALISTS, contact the Privacy Officer at (713) 935-9100. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred.

All complaints should be submitted in writing. You will not be penalized for filing a complaint.

**Acknowledgment of Review of Notice of Privacy Practices.**

I acknowledge that I have reviewed MEMORIAL WOMEN'S SPECIALISTS' Notice of Privacy Practices, which explains how my medical information will be disclosed. I understand that I am entitled to receive a copy of this document.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

I acknowledge that I have read and was advised of my physician's financial interests including alternatives available to me for treatment, procedures, and laboratory testing services.

Please be advised that Dr. Sinacori has a financial interest in the following company: Assure Fertility Partners of Houston, LLC, which has an interest in Aspire Fertility (Houston, TX). Other reproductive endocrinologists/infertility specialists referrals are available from Memorial Women's Specialists upon request.

Signature of Patient Printed Name Date of Birth Date

Signature of Legal Guardian (if Minor or Legal Guardianship) Date

Printed Name of Legal Guardian Relationship to Patient

I authorize Memorial Women's Specialists to disclose any and all of my health and/or billing information (**including** but not limited to sexually transmitted diseases/HIV and reproductive history information) to the following person(s):

Name ____________________________ Relationship ________________ Phone # ______________

Name ____________________________ Relationship ________________ Phone# _______________

# *MEMORIAL WOMEN'S SPECIALISTS*

**929 Gessner, Suite 2130 ● Houston, Texas 77024**
**Phone: 713-935-9100**

## ADDITIONAL DISCLOSURES

1. **AGREEMENT AS TO GOVERNING LAW AND FORUM**
   The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agrees:
   A. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
   B. In the event of a dispute, any lawsuit, action, or cause of which in any way related to the health care provided to the patient shall be brought only to a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and not permissive.

2. **PROHIBITION OF RECORDING BY PATIENTS AND VISITORS**
   To ensure confidentiality and privacy, I acknowledge any type of photographic, video, audio, electronic, and/or digital recordings is strictly prohibited at any location within this office and/or during the course of patient care, regardless of location, unless otherwise specified and specifically acknowledged by the physician at that time.

3. **LAB RESULTS**
   I acknowledge that if I do not receive my lab/test results in a timely fashion, it is my responsibility to notify the practice and follow up and confirm that I receive them. I will not assume the results are normal just because I haven't received them and/or been notified of them. Additionally, it is my responsibility to provide the practice with updated contact information.

---
Signature of Patient Printed Name Date of Birth Date

---
Signature of Legal Guardian (if Minor or Legal Guardianship) Date

---
Printed Name of Legal Guardian Relationship to Minor

**MEMORIAL WOMEN'S SPECIALISTS**

**929 Gessner Road, Suite 2130, Houston, TX 77024**

**Phone: 713-935-9100 Fax: 713-935-9103**

## Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

- I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit. A telemedicine visit, however, is limited in that the physician cannot examine the patient by hand: palpating, using medical equipment, or performing immediate laboratory studies. This can limit some assessments, and I may be asked to follow up in person or seek emergency medical care.
- I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider and my health care provider staff present in the room.
- I understand that there are potential risks to using technology, including service interruptions, interception and technical difficulties. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I may revoke my consent to future virtual visits at any time.
- I understand that the laws that protect privacy and the confidentiality apply to telemedicine services.
- I understand that my health care information may shared with other individuals for scheduling and billing purposes. I understand that my insurance carrier will have access to my medical records for quality review/audit.
- I understand I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit.
- I understand that health plan payment policies for telemedicine visit may be different from policies for in-person visits.
- I am located in the states of Texas and will be in Texas during my telemedicine visit (s).

I attest that I have personally read this consent (or had it explained to me) and fully understand and agree to its consents.

__________________________________ ____________________

Signature Date

__________________________________ ____________________

Name Date of Birth