Huntington Health
An Affiliate of Cedars Sinai

Fair Oaks Women's Health

625 S. Fair Oaks Ave., Suite 255
Pasadena, CA 91105
P: (626) 304-2626 | F: (626) 585-0695
www.fowh.com

Contents of NEW OB Forms Packet
[This packet should be PRINTED ONE-SIDED. Thank you.]

**FOWH is now affiliated with Huntington Hospital/Cedars-Sinai.**

Starting in April 2023, FOWH is part of the Huntington Hospital-Cedars-Sinai Healthcare system. We are still the same doctors and staff in the same location providing the same ob/gyn medical care that you trust.

**Bold forms require filling out and returning.**

| | | |
|---|---|---|
| 1. | Contents of this New OB Forms Packet | 1 page |
| 2. | Welcome Letter | 1 page |
| **3.** | **Patient Information Form<br>please fill out, sign and return** | **1 page** |
| **4.** | **Insurance Information Form<br>fill out, sign and return** | **1 page** |
| **5.** | **New OB Pt History Form<br>fill out and return** | **6 pages** |
| 6. | FOWH CS HIPAA Privacy Notice<br>for your information | 5 pages |
| **7.** | **FOWH CS Receipt of Privacy Notice<br>fill out, sign and return** | **2 pages** |
| **8.** | **FOWH CS Communicate PHI<br>fill out, sign and return** | **1 page** |
| 9. | **FOWH CS Conditions of Treatment<br>fill out, sign (x3) and return** | **5 pages** |
| 10. | Planned Non-Hospital Birth<br>for your information | 1 page |
| | TOTAL | 24 pages (single-sided) |

This is only for NEW OB patients to our practice. Thank you very much for your time.

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# WELCOME TO OUR PRACTICE

Thank you for choosing Fair Oaks Women's Health for your ob/gyn medical care! In preparation for your upcoming appointment, we would like you to get a head start with some of the paperwork and also tell you a bit about our practice.

Fair Oaks Women's Health is Pasadena's Premier Ob/Gyn group practice, right next door to Huntington Hospital. We offer comprehensive and convenient women's healthcare. Our obstetrical services include everything from routine prenatal care to high-risk pregnancy care. We have our own ultrasound department, fetal non-stress testing (NST's) and lab collection station on the premises.

Our wide range of gynecology services includes well-woman exams, pap smears with HPV testing, minimally invasive gyn surgery (such as laparoscopic hysterectomy), abnormal pap smear evaluation and management, birth control including IUD's and Nexplanon, STI (sexually transmitted infection) evaluations, menopause and hormone evaluations and treatments, fertility testing and much more.

**FOWH is now affiliated with Huntington Hospital/Cedars-Sinai**

Starting in April 2023, FOWH is part of the Huntington Hospital-Cedars-Sinai Healthcare system. We are still the same doctors and staff in the same location providing the same ob/gyn medical care that you trust. But there are some changes:

- Bills and statements will now come from Cedars-Sinai. If you have any questions regarding your Cedars-Sinai bill, please call Cedars Patient and Financial Services at 866-803-1777.
- Our forms have changed. Some are new and some are modified.
- Our office workflow, systems, hardware and software are being upgraded.

We apolgize for any inconveniences or disruptions that might arise from our new affiliation. Please share your concerns with us at any time. Call (626) 304-2626 and ask for the Office Manager.

**EMR (electronic medical record)**

Our practice uses a computerized health record, called an EMR. It takes time to enter your information into the computer. It would be very helpful if you would complete your New Patient forms and then mail (or fax or e-mail) them to us before your appointment. If you do not send these forms, your visit could be delayed while we update the computer before you see the doctor. Email your forms to: obgyn@fowh.com.

**Please arrive early for your FIRST appointment**

It takes time time to enter or update your personal, insurance and health information. At your first visit we scan your driver's license and insurance card for entry into our EMR. *We guarantee to keep all of your personal information private.* This is the law (a Federal law called HIPAA).

**Parking – we do not validate**

Please note that you pay the cashier BEFORE returning to your car. To save money (but with a little more walking) some patients park in the Huntington Hospital EAST Parking structure, a building just south of ours. The entrance is off Fairmount Ave. across from the Emergency Dept.

**Lab – IHD (Innovative Health Diagnostics – www.ihdlab.com)**

For your convenience, we have an on-site lab, called IHD. This lab runs most of our standard lab tests. IHD is a separate entity, is not affiliated with our practice, and we do not profit from their testing. Not all insurance plans contract with IHD. You should know which lab your insurance is contracted with.

***If your insurance requires you to use a different lab than IHD please let us know.***

**Marina's Oasis and Pasadena Pellet Therapy are both separate medical practices, and are not in any way affiliated with Cedars-Sinai Medical Care Foundation.**

Feel free to call us at any time if you have any questions. Call (626) 304-2626.

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# PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY _____

LAST NAME _____ FIRST NAME _____ M.I. ____

PREFERRED FIRST NAME _____ DATE OF BIRTH _____ SSN#_____

ADDRESS _____ (PO Boxes Not Allowed)

CITY_____ STATE_____ ZIP_____

HOME PH# _____ MOBILE PH# _____ WORK PH#_____

PREFERRED Ph# WEEKDAYS (**CIRCLE** ONE): **HOME** **MOBILE** **WORK**

EMAIL _____ PREFERRED CONTACT METHOD: _____

MARITAL STATUS _____ DRIV LIC. # _____

**Optional** - We invite you to share your race, ethnicity, sexual orientation, and gender identity information:

RACE_____ ETHNICITY _____

SEXUAL ORIENTATION _____ GENDER IDENTITY _____

SEX AT BIRTH _____ PRONOUN ___she/her ___they/them ___he/him

Are you employed? _____ If yes, YOUR OCCUPATION _____

EMPLOYER NAME _____ PH.# _____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

**(If you are married/committed, may we have your spouse/sig other information)**

SPOUSE/PARTNER NAME _____ DATE OF BIRTH_____

EMPLOYER_____ OCCUPATION _____

MOBILE PH# _____ WORK PH#_____

**HOW DID YOU HEAR OF US?** _____

PRIMARY CARE PROVIDER (PCP – FIRST AND LAST NAME) _____

**PHARMACY NAME AND ADDRESS**_____

PHARMACY CITY,STATE,ZIP _____ PH# _____

**EMERGENCY CONTACT NAME** _____ RELN _____

MOBILE PH# _____ OTHER PH# _____

Please sign below if you give us permission to message you (such as test results) via voice mail or e-mail:

SIGNED _____ DATE _____

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# INSURANCE INFORMATION FORM

Please take a few minutes to complete this form. All information provided is completely confidential. Thank you. We use this information only for medical insurance verification and billing.

PATIENT NAME _____ DATE OF BIRTH _____

_____ I am insured under my own plan _____ I am insured under someone else's plan

INSURANCE COMPANY NAME _____

CLAIM FILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

BILLING PH# _____

NAME OF POLICY HOLDER (GUARANTOR): ☐ MYSELF or _____

MEMBER ID NUMBER of POLICY HOLDER _____

POLICY GROUP NUMBER _____

DATE POLICY ISSUED _____

DATE POLICY EXPIRES _____

CO-PAY AMOUNT (SPECIALISTS) _____

CO-INSURANCE PERCENTAGE _____

PRIMARY CARE PROVIDER _____

TYPE OF INSURANCE: ☐ INDEMNITY ☐ PPO ☐ POS ☐ EPO ☐ MEDICARE

## RELEASE OF INFORMATION

By signing below, I authorize Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment.

NAME _____ DATE _____

SIGNATURE _____

Insurance Verification

_____

_____

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**This form is for our pregnant patients. If you are NOT pregnant, please fill out the GYN History Form. Thank you for answering the following questions. Your health is important to us. Congratulations!**

## *OBSTETRICS PATIENT HISTORY FORM*

TODAY'S DATE _____ Your age_____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First)_____ (M.I.) _____

Your spouse/partner's full name _____

Your Ethnicity_____ REFERRED HERE BY _____

## CURRENT PREGNANCY

What was the FIRST day of the last menstrual period? _____ Is this date definite? (Y/N) _____

Cycles regular? (Y/N) _____ Cycle length (avg=28 days) _____ Date of first pos. preg. test _____

Conception (check one): _____normal Date of conception? _____ ____ IUI (date_____)

_____IVF frozen embryo (transfer date _____), what day # was embryo? (e.g. day 5, day 6… )

Was this pregnancy from an egg donor? YES NO If yes, please enter the age of the donor: _____

What was your weight just before becoming pregnant? _____ What is your height? _____

When was your last pap smear? _____By whom? _____ Was it normal? YES NO

## PAST PREGNANCY DETAILS

| Total Number of Pregnancies | Full Term Births (> 37 wks) | Premature Births (< 37 wks) | Terminations | Miscarriages | Ectopic pregnancies | Multiple Gestation (Y/N) | Number of Living Children |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Date | Term Preterm or Miscarriage | M / F | Birth Weight | Type of Delivery | Weeks Gestation | Length of Labor | Anesthesia | Complications/ Problems | Location |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Notes: _____

## PATIENT MEDICAL HISTORY

*(If YOU have EVER had any of these conditions, please indicate)*

| X if YES | Condition | Comments |
|---|---|---|
| | **Diabetes** (type 1, type 2 or previous gestational diabetes). Any medication taken? | |
| | **High Blood Pressure** (hypertension now or in the past or with a prior pregnancy): | |
| | **Heart Disease** (fainting, heart murmurs, abnormal rate or rhythm, prior heart attack, abnormal valves): | |
| | **Autoimmune Disorder** (Lupus, Rheumatoid Arthritis, Sjogren's or other related conditions): | |
| | **Kidney Disease or Urinary Tract Infections (UTI)** (recurrent UTI, kidney stones): | |
| | **Seizure Disorder or Neurologic Disease** (migraines, epilepsy, history of TIA or stroke): | |
| | **Mental Health Condition** (includes anxiety or panic attacks, OCD, bipolar disorder, eating disorder): | |
| | **History of Depression or Postpartum Depression** (mild or severe, suicide attempts, hospitalization | |
| | **Gastrointestinal or Liver Disease** (irritable bowel syndrome [IBS], Crohn's Disease, Ulcerative Colitis, | |
| | **Varicose Veins or Blood Clots in Veins** (pulmonary embolism, DVT – deep vein thrombosis): | |
| | **Thyroid Disease** (under or over active thyroid, thyroid cancer or radiation): | |
| | **Domestic Violence** (now or ever in the past): | |
| | **History of Blood Disorders or Transfusion** (anemia, blood clotting problem, transfusion ever): | |
| | **Smoking History** (current or former smoker): | |
| | **Alcohol Use History** (current or past use or abuse of alcohol): | |
| | **Illicit or Recreational Drug Use History** (current or past use or abuse): | |
| | **Rh Disease or Rh Negative** | |
| | **Lung Disease** (asthma, chronic bronchitis, TB): | |
| | **Seasonal Allergies** (hay fever, asthma): | |
| | **Breast Disease or Breast Surgery** (implants above the muscle, under the muscle, breast reduction): | |
| | **Complications of Anesthesia** (describe): | |
| | **History of Abnormal Pap Smear** (any treatments such as freezing, LEEP or cone biopsy and when): | |
| | **History of Uterine Abnormality** (double uterus, unicornuate uterus): | |
| | **History of Infertility or IVF, IUI, inseminations?** | |
| | **Low Back Problems or Back Surgery?** | |

ADDITIONAL PAST MEDICAL HISTORY DETAILS:

_____

_____

_____

_____

## SURGERY or HOSPITAL ADMISSIONS

| Surgery or Hospital Admission - Details | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |

## SYMPTOMS SINCE BECOMING PREGNANT

*(Are you currently experiencing any of the following symptoms?)*
*(If so, please indicate with an X)*

**General**
_____ Fatigue or Weakness
_____ Fever, Chills or Sweats
_____ Excess Weight Gain or Loss

**Eyes, Ears, Nose and Throat (HEENT)**
_____ Nose Bleeds
_____ Sore Throat
_____ Trouble swallowing

**Breasts**
_____ Breast Lump
_____ Breast Pain or Tenderness
_____ Nipple Discharge (other than white)

**Cardiovascular**
_____ Chest Pain
_____ Irregular Heartbeat or Palpitations

**Respiratory**
_____ Chronic Cough
_____ Shortness of Breath or Wheezing

**Gastrointestinal**
_____ Diarrhea (watery stool)
_____ Heartburn
_____ Nausea or Vomiting
_____ Severe Constipation
_____ Abdominal Pain

**Urinary**
_____ Burning with Urination
_____ Blood in Urine
_____ Leakage of Urine
_____ Waking at night 2 or more times

**Gyn**
_____ Vaginal Discharge
_____ Vaginal Itching or Burning
_____ External Vulvar Pain
_____ External Vulvar Rash, Sores or Bumps

**Musculoskeletal**
_____ Joint Pain (Back, Knee, Wrist, Hip)
_____ Muscle Cramping or Pain
_____ Joint Swelling

**Neurologic**
_____ Dizziness
_____ Headaches or Migraines
_____ Numbness

**Psychological**
_____ Anxiety, Worries, Stress (Excessive)
_____ Depressed
_____ Insomnia

**Skin**
_____ Itching
_____ Moles or Sores
_____ Rash

**Comments or Additional Symptoms Not Listed Above?**

_____

_____

_____

## GENETIC SCREENING QUESTIONS

(If you or **ANY** close relative of yours - such as brothers, sisters, parents, other children - has EVER HAD or CURRENTLY HAS any of the problems listed below, please CIRCLE YES)

_____Check Here if All are No

| | | |
|---|---|---|
| IS PATIENT GOING TO BE AGE 35 BY THE DUE DATE? | YES | NO |
| HISTORY of THALASSEMIA or HEMOGLOBIN (BLOOD) DISORDER | YES | NO |
| HISTORY of NEURAL TUBE DEFECT (spina bifida) | YES | NO |
| HISTORY of CONGENITAL HEART DEFECT | YES | NO |
| HISTORY of DOWN SYNDROME (or any known chromosomal condition) | YES | NO |
| IS THE MOTHER OR FATHER OF THE BABY ASHKENAZI JEWISH or CAJUN?<br>If yes, has any genetic testing been done? | YES<br>Yes | NO<br>No |
| HISTORY of SICKLE-CELL ANEMIA or SICKLE-TRAIT | YES | NO |
| HISTORY of HEMOPHILIA | YES | NO |
| HISTORY of MUSCULAR DYSTROPHY | YES | NO |
| A. HISTORY of CYSTIC FIBROSIS<br>B. IS THE MOTHER or THE FATHER OF THE BABY CAUCASIAN/EUROPEAN? | YES<br>YES | NO<br>NO |
| HISTORY of HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA) | YES | NO |
| HISTORY of INTELLECTUAL DISABILITY OR AUTISM<br>If yes, has testing for Fragile X chromosome been done? | YES<br>Yes | NO<br>No |
| HISTORY of ANY INHERITABLE GENETIC CONDITION or ANY BIRTH DEFECTS | YES | NO |
| HISTORY of MATERNAL PKU OR OTHER METABOLIC SYNDROME | YES | NO |
| PATIENT OR BABY'S FATHER HAD A CHILD WITH ANY BIRTH DEFECTS | YES | NO |
| HISTORY OF STILLBIRTH OR 2 OR MORE MISCARRIAGES | YES | NO |
| HISTORY OF ILLICIT SUBSTANCE USE SINCE LAST MENSTRUAL PERIOD | YES | NO |
| HAVE YOU PREVIOUSLY DONE ANY GENETIC TESTING? | YES | NO |

## INFECTION HISTORY QUESTIONS

_____Check Here if All are No

| | | |
|---|---|---|
| HAVE YOU EVER TESTED POSITIVE FOR HEPATITIS B OR C ? | YES | NO |
| DO YOU LIVE WITH SOMEONE WHO MIGHT HAVE TUBERCULOSIS? | YES | NO |
| DO YOU or YOUR PARTNER HAVE A HISTORY OF **GENITAL** HERPES? | YES | NO |
| HAVE YOU HAD A SKIN RASH or VIRAL ILLNESS SINCE YOUR LAST PERIOD? | YES | NO |
| HAVE YOU EVER HAD HIV, GONORRHEA, CHLAMYDIA, HPV, SYPHYLLIS or VENEREAL WARTS? (circle any that apply) | YES | NO |
| HAVE YOU EVER TESTED POSITIVE FOR VAGINAL STREP B (GROUP B STREP)? | YES | NO |
| ARE THERE ANY OTHER INFECTIONS YOU HAVE BEEN TREATED FOR? | YES | NO |
| HAVE YOU TRAVELED OUTSIDE THE U.S. SINCE BECOMING PREGNANT? | YES | NO |

## PRESCRIPTION MEDICATIONS YOU ARE TAKING

| List name of medication, dose taken, how often and reason |
|---|
| |
| |
| |

## DRUG STORE MEDICATION, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

| List name of product and dose taken |
|---|
| |
| |
| |
| |

## ALLERGIES (circle choices)

Do you have any known allergies? NO ALLERGIES Allergic to Latex? YES NO

***If yes, please list all allergies and your allergic reaction***

| **Allergic to** | **Reaction** |
|---|---|
| | |
| | |

## FAMILY MEDICAL HISTORY

*(If **ANY** close relative of yours - such as maternal and/or paternal grandparents, parents, brothers, and sisters – has EVER HAD or CURRENTLY HAS any of the problems listed below.*

| CONDITION | Please CIRCLE CONDITION and indicate who has that specific condition. |
|---|---|
| 1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE | |
| 2. HIGH BLOOD PRESSURE, HEART ATTACK, STROKE | |
| 3. TUBERCULOSIS, ASTHMA, OTHER LUNG DISEASE | |
| 4. BREAST DISEASE, BREAST CANCER | |
| 5. STOMACH, GI or COLON DISEASE or CANCER | |
| 6. KIDNEY DISEASE, KIDNEY STONES | |
| 7. GYN DISEASES, OVARIAN CANCER, UTERINE FIBROIDS | |
| 8. MUSCULOSKELETAL DISEASE, OSTEOPOROSIS | |
| 9. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES | |
| 10. SEVERE DEPRESSION or OTHER PSYCHIATRIC CONDITION | |
| 11. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND | |
| 12. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE | |
| 13. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT | |
| 14. ANY TYPE of CANCER or MALIGNANT TUMORS | |

## ADDITIONAL PREGNANCY ISSUES

| | | | |
|---|---|---|---|
| 1. Was this pregnancy a result of fertility treatment? If yes, please have copies of recent blood tests and ultrasounds sent to us. | YES | NO | |
| 2. Have you ever had your blood drawn to test for any genetic conditions?<br>If yes, please provide a copy of those test results | YES | NO | MAYBE |
| 3. Have you been vaccinated against Whooping Cough (TDaP)? | YES | NO | MAYBE |
| 4. Do you plan to have NIPT (non-invasive prenatal testing)?<br>This allows us to test for fetal DNA in the mother's bloodstream about 9-10 weeks. | YES | NO | MAYBE |
| 5. Have you heard about Nuchal Translucency testing?<br>(We will discuss this during your first visits.) | YES | NO | MAYBE |
| 6. Do you get 3 servings per day of dairy products (milk, yogurt, cheese)?<br>If not, we advise a daily Calcium Supplement (like CitraCal) with Vit D<br>usually about 500 mg calcium and about 500 to 1,000 units of Vitamin D. | YES | NO | MAYBE |
| 7. Do you own any cats?<br>If so, it is advised that pregnant women not change the cat litter | YES | NO | |
| 8. Are there any known or suspected hazards in your workplace? | YES | NO | MAYBE |
| 9. Do you have plane travel planned during this pregnancy?<br>If so, we generally advise not flying after 32 weeks gestational age. | YES | NO | MAYBE |
| 10. In the past year, have you been threatened or injured by someone you know? | YES | NO | TALK TO ME |
| 11. Do you use a seat belt 100% of the time while driving? We strongly urge all pregnant women (and everyone!) to wear seat belts all the time. | YES | NO | |
| 12. Are you considering having a tubal ligation (permanent sterilization)? | YES | NO | MAYBE |
| 13. If you have a boy, do you want him circumcised? | YES | NO | MAYBE |
| 14. Do you plan to save the baby's umbilical cord blood at the time of delivery or would you like more information about this? | YES | NO | MAYBE |
| 15. If you already have a Pediatrician, please enter their name.<br>Is this doctor on staff at Huntington Hospital? | Dr. _____<br>YES | NO | MAYBE |
| 16. Please see our OB guide on the web at: www.pasadenapregnancy.com | | | |

It is not necessary to have made all the above decisions yet.
We will discuss all pregnancy issues and your concerns at your consultation and throughout your pregnancy.
The above list is to help you as you begin to explore some of these issues

**Notes or Questions for the Doctor:** _____

_____

_____

_____

_____

_____

_____

Revised April 2023

# JOINT NOTICE OF PRIVACY PRACTICES OF CEDARS-SINAI MEDICAL CENTER AND CEDARS-SINAI MEDICAL CARE FOUNDATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

## WHAT IS THIS NOTICE AND WHO WILL FOLLOW IT?

Cedars-Sinai understands that information about you and your health is confidential. We are committed to protecting the privacy of this information. We use and share your health information only as permitted by federal and state laws.

We are required by law to maintain the privacy of your protected health information, to provide you with this Notice of our legal duties and privacy practices with respect to your health information, to notify affected individuals following a breach of unsecured protected health information, and to follow the terms of the Notice currently in effect.

This Notice describes the privacy practices of Cedars-Sinai Health System, including Cedars-Sinai Medical Center[1] ("the Hospital") and Cedars-Sinai Medical Foundation and its affiliated physicians and medical groups ("the Foundation"), and that of all Cedars-Sinai facilities, offices, and personnel, including non-employees such as volunteers, who have a need to use your health information to perform their job, and physicians and allied health professionals while they are caring for you in Cedars-Sinai facilities and offices.

In addition, these entities may share health information with each other for treatment, payment, or health care operations purposes as described in this Notice. This Notice applies to all of the records of your care generated at Cedars-Sinai, whether made by Cedars-Sinai personnel or your personal doctor when caring for you in the Hospital or Foundation. Your personal doctor may have different policies regarding his or her use and disclosure of your health information.

## HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories are different ways that we may use and disclose health information. Not every possible use or disclosure in a category is described below.

### Treatment

We may use and share health information about you to provide, coordinate, or manage your medical treatment and related services.

We may share health information about you with doctors, nurses, technicians, students in health care training programs, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes might slow the healing process. Additionally, different departments of Cedars-Sinai may share health information about you in order to coordinate the services you need, such as prescriptions, lab work, and x-rays. We may also disclose your health information to health care providers outside of Cedars-Sinai for the purpose of coordinating your care.

[1]All departments, units, and programs of the Hospital except the Voluntary Blood Donor Program and Research Institute (except clinical research-related activities involving protected health information).

## Payment

We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain preauthorization or payment for treatment.

## Health Care Operations

We may use and disclose information about you for the purpose of our business operations. These business uses and disclosures are necessary to make sure that our patients receive quality care and cost effective services. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Cedars-Sinai patients to decide what additional services Cedars-Sinai should offer, what services are not needed, and whether certain new treatments are effective.

## Business Associates

Some of our functions are accomplished by individuals or companies with whom we contract, called "business associates," to perform certain specialized work for us. We may disclose your health information to our business associates so they can perform the tasks we have asked them to do.

## Electronic Records

Currently, some or all of your health information may be stored in an electronic format. When permissible for valid purposes (e.g., providing treatment or billing for services), your health care providers may access your health information from their offices or other locations outside of Cedars-Sinai facilities. Additionally, Cedars-Sinai may provide access for certain affiliated physicians or other health care providers to store your health information that they create outside of Cedars-Sinai in Cedars-Sinai's electronic systems. All access to your health information will be permitted only in a manner consistent with applicable law.

## Other Uses or Disclosures

We may also use or disclose your information for certain other purposes allowed by applicable state or federal laws and regulations, including the following:

- For public health activities such as reporting communicable diseases, reactions to medications, problems with products or other adverse events, or for vital statistics such as reporting a baby's birth.
- As required by state or federal law such as reporting abuse, neglect, or certain other events.
- For certain health oversight activities such as audits, investigations, or licensure actions.
- If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 (which may include written notice to you) or to obtain an order protecting the information requested.
- When requested by law enforcement, but only as authorized by law, such as to identify or locate a suspect, fugitive, material witness, or missing person.
- To coroners, medical examiners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

- For research purposes if certain conditions are satisfied. All research projects are subject to a special approval process that evaluates a proposed research project and its use of health information to ensure appropriate safeguards. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave Cedars-Sinai. If you do not want to participate in research efforts, you may notify us using the contact information provided later in this Notice.
- To avoid a serious threat to your health or safety or the health or safety of others.
- As allowed by workers compensation laws for use in workers compensation programs.
- If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- For certain specialized government functions such as intelligence and national security activities.
- We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.
- We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management, or treatment of an abused child and the child's parents, or elder abuse and neglect.
- In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this Notice. For example, there are special restrictions on the use or disclosure of certain categories of information — e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

## Disclosures We May Make Unless You Object

Unless you instruct us otherwise, we may disclose your information as described below:

- To a member of your family, relative, friend, or other person who is involved in your health care or payment for your health care. We will limit the disclosure to the information relevant to that person's involvement in your health care or payment. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition (e.g., serious, fair, good, etc.), and location in our facility. The facility directory allows the Hospital to help visitors find your room or talk to you by phone and generally know how you are doing.

- To contact you to raise funds for Cedars-Sinai programs and operations. You may opt out of receiving such communications at any time by contacting Cedars-Sinai Community Relations and Development at (323) 866-6899.

## Uses and Disclosures With Your Written Authorization

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your identifiable health information. You may revoke your authorization by submitting a written notice to the applicable health information representative or privacy contact using the contact information provided later in this Notice. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

## Your Rights Concerning Your Protected Health Information

You have the following rights concerning your health information. To exercise the rights in this section, except for requesting a copy of this Notice, you must submit a written request. You may obtain additional information and instructions for exercising these rights by contacting the health information representative where services were provided:

**CEDARS-SINAI MEDICAL CENTER**
Release of Information
Health Information Department
8700 Beverly Blvd, Room 2901
Los Angeles, CA 90048
310-423-2259

**CEDARS-SINAI MEDICAL CARE FOUNDATION**
Director, Health Information Management
8501 Wilshire Blvd, Suite 340
Beverly Hills, CA 90211
310-248-7058

- Request additional restrictions on the use or disclosure of information for treatment, payment, or health care operations. We are not required to agree to the requested restriction except in the limited situation in which you request we not send information about a health care service or related item to your health plan for the purposes of payment or health care operations if you or someone else pays in full for that service or item at the time of the request and if you notify us in advance (so we do not automatically bill your health plan).
- Request that we contact you in a certain way or at a certain location. For example, you may ask that we contact you at a work phone number or address. We will accommodate all requests that are reasonable for our system capabilities.
- Inspect and obtain a copy of records that are used to make decisions about your care or payment for your care (including an electronic copy if we maintain the records electronically). We may charge you a reasonable cost-based fee for providing the records. We 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 Cedars-Sinai will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- Request that your protected health information be amended. We 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, we may deny your request if you ask us to amend information that:

a) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

b) Is not part of the medical information kept by or for the entity receiving the amendment request;

c) Is not part of the information which you would be permitted to inspect and copy; or

d) Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- Request an accounting of certain disclosures we have made of your protected health information. The accounting will provide information about disclosures made outside of Cedars-Sinai for purposes other than treatment, payment, health care operations, disclosures excluded by law, or those you have authorized. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We 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.
- Request a paper copy of this Notice, even if you agree to receive it electronically.

## Changes To This Notice

We reserve the right to change our Notice of Privacy Practices from time to time, and to make the new Notice effective for all protected health information that we maintain. If we make a material change to our Notice, we will post the revised Notice in our facilities and offices and on our website. You may obtain a copy of the current Notice by accessing our website at www.cedars-sinai.edu or contacting us as indicated below.

## Complaints

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying us as set forth below. All complaints must be made in writing. We will not retaliate against you for filing a complaint.

## Privacy Contact Information

If you have any questions about this Notice, wish to request a copy of the current Notice, or if you want to file a privacy complaint, please contact the Medical Center or Foundation as applicable at:

**CEDARS-SINAI MEDICAL CENTER**
Privacy Manager
Corporate Integrity Program
8700 Beverly Blvd
Los Angeles, CA 90048
323-866-7877

**CEDARS-SINAI MEDICAL CARE FOUNDATION**
Privacy Officer
8501 Wilshire Blvd, Suite 340
Beverly Hills, CA 90211
310-385-3425

# ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES OF CEDARS-SINAI MEDICAL CENTER AND CEDARS-SINAI MEDICAL CARE FOUNDATION

By signing this form, you acknowledge receipt of our Joint Notice of Privacy Practices. The Notice of Privacy Practices tells you how we may use and disclose your protected health information.

We reserve the right to change our Notice of Privacy Practices from time to time. If we change our Notice, you may obtain a copy of the revised Notice by accessing our website at www.cedars-sinai.edu or contacting us as indicated below. We will keep a copy of the current Notice posted in our facilities and offices. If you have questions, please contact the Medical Center or Foundation as applicable as follows:

**Cedars-Sinai Medical Center**
Privacy Manager
Corporate Compliance Department
8700 Beverly Blvd
Los Angeles, CA 90048
323-866-7877

**Cedars-Sinai Medical Care Foundation**
Privacy Officer
8501 Wilshire Blvd, Suite 340
Beverly Hills, CA 90211
310-385-3425

I hereby acknowledge that I received a copy of the Cedars-Sinai Joint Notice of Privacy Practices and that I am authorized to attest to this as the individual or legal representative (parent/permanent legal guardian/conservator) by my signature recorded electronically on the signature notepad.

X _____ _____

Signature: Date:

X _____

Print Name:

## If signed by other than Patient:

_____ _____

Print Name (legal representative): Relationship:

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

## FOR CEDARS-SINAI USE ONLY

Signature of Cedars-Sinai Representative: _____ Date: _____

Title of Cedars-Sinai Representative: _____

Huntington Health | An Affiliate of Cedars Sinai

**Fair Oaks Women's Health**

HEALTH INFORMATION DEPARTMENT

# AUTHORIZATION FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION

PATIENT I.D.

Last name, First name (please print) _____ Today's date _____

Date of birth _____ Medical record number _____

Protected health information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used or disclosed in the course of providing a healthcare service such as diagnosis or treatment. For other than test results, a valid HIPAA-compliant release must be completed. You may further authorize us to release your PHI to answering machines, faxes or electronic mail (email). To ensure your privacy, we will not leave messages containing PHI on answering devices without your permission. You may also authorize us to provide your confidential PHI to another person or persons. Test results related to HIV, hepatitis, substance abuse or malignancy/cancer require your prior authorization be transmitted via electronic means (voicemail, fax, email or My CS-Link™).

When you provide us with your contact information, you authorize us and our agents to use any mailing address, email address or telephone number (landline, wireless, residential or business) for the purpose of communicating with you regarding appointment information, test results, discharge instructions or other clinical information as well as account information or other information pertinent to medical services. You are also agreeing to accept live or autodialed calls and other messages to these numbers or addresses where we may leave recorded messages.

I authorize physicians and/or staff to contact me via the following:

☐ Email address: _____

☐ Phone voicemail: _____

☐ Fax number: _____

Name of alternative person I elect to receive my PHI (please print) _____ Date _____

Signature (patient or individual legally authorized to consent to release) _____

Phone number _____

Address _____ City/State/ZIP _____

This authorization shall remain in effect until you notify us in writing of any requested changes. The Health Information Manager will review your request and respond in writing if your request cannot be honored. If you have any questions or concerns, you may contact the Health Information Manager at 310-248-6674.

Huntington Health | An Affiliate of Cedars Sinai

**Fair Oaks Women's Health**

MEDICAL CARE FOUNDATION

# CONDITIONS OF TREATMENT

PATIENT I.D.

1. **Patient consent for services**
   I hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of the Cedars Sinai Medical Network. These may include but are not limited to: emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, or anesthesia provided to me under the general and special instructions of my physician or surgeon.

2. **Financial responsibility for services**
   I hereby authorize my insurance benefits be paid directly to Cedars-Sinai Medical Care Foundation. I understand that I may have financial responsibility for all or a portion of the charges for the professional services rendered and will remit appropriate payment at the time of service, including specifically copayments and charges for services which are not covered by my insurance.

3. **Copayment policy**
   If applicable, at the time of check-in I will be required to pay a copayment. If I do not pay my copayment, I understand that my visit may be canceled.

4. **Insurance coverage**
   I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have questions.

5. **Referrals/authorization**
   I understand that, depending on my insurance, I may need a referral from my provider to see a specialist. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I will be promptly advised of any requests that are determined not to be appropriate or necessary. I understand that if I choose to access specialty services without prior authorization from my provider, or I elect to use a Point of Service option or fail to notify Cedars-Sinai Medical Care Foundation if my insurance plan requires specific outside vendors such as laboratories to perform referred services, I may be financially responsible for the services rendered and insurance may not cover the relevant services.

6. **Ancillary services**
   I understand that, depending on my insurance, I may receive a separate bill for laboratory, X-ray, anesthesia or other ancillary services.

7. **Release of information**
   I authorize the release of my medical records or other information necessary to provide healthcare, to process my medical claims, and for other purposes relating to the healthcare operations. I understand that Cedars-Sinai Medical Care Foundation is affiliated with Cedars-Sinai Health System, and as such, shares information with Cedars-Sinai Medical Center and its affiliate ancillary departments (e.g., laboratory and imaging). Additional information is provided in our Notice of Privacy Practices.

8. **Fees for patient's health information**
   I hereby understand that I may be charged a cost-based fee when requesting copies of my health information, including the cost of copying (supplies and labor), postage (if information is to be mailed), and preparation for any summary or explanation if agreed to in advance.

9. **Fee for forms**
   I understand, that if I request to have any forms completed by my physician that are not directly related to patient care I will be required to pay a fee. Examples of such forms include, but are not limited to, jury duty excuse, Family and Medical Leave Act application, accident reports, and school and camp forms. There may be other forms with associated fees.

10. **On-time arrival policy**
    I understand that I must arrive at least 15 minutes before the time of my appointment in order to register and provide information prior to the time my physician is scheduled to see me. If I arrive late for my scheduled appointment, I understand that it may be necessary to reschedule my appointment. My physician attempts to maintain an "on-time" schedule, but I understand that urgent or complex needs for patients with prior appointments may cause my physician to be late for my appointment.

11. **No-show policy**
    I understand that if I miss an appointment with less than 3 business hours' prior notice, I may be charged a fee for a missed visit.

12. **Medication refills**
    I understand that refills may take 24-48 hours to complete and that the most efficient way to get a refill is to contact my pharmacy directly. In order to ensure timely medication refills, I agree to notify my physician's office regarding my preferred pharmacy.

13. **Photography for patient identification**
    I understand that Cedars-Sinai Medical Care Foundation is deeply committed to my safety and identity protection. I agree to have my picture taken at check-in for inclusion in my medical record. I understand that my photograph will be used to protect me from identity theft, to ensure patient safety and to further personalize the services I will receive. My picture helps to confirm that all members of the Cedars-Sinai Medical Care Foundation care team are accessing the correct medical record.

14. **Photography for clinical care**
    If clinically indicated, I will be advised if medical photographs need to be taken while receiving medical care through Cedars-Sinai Medical Care Foundation. I consent to medical photography, and I understand that images from such photography may be used for my treatment or for the Cedars-Sinai Medical Care Foundation's own healthcare operations, such as peer review or medical education, as Cedars-Sinai Medical Care Foundation or my treating provider(s) deem appropriate. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images. It has been explained to me that the images will be a permanent part of my medical record. At the time a photograph is recommended, I have the option to revoke this consent.

**15. Open Payments database notice**

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

**16. Notice to Consumers**

Medical doctors are licensed and regulated by the Medical Board of California. For more information, please visit: www.mbc.ca.gov or contact 800-633-2322.

**By signing immediately below, I understand that physicians are licensed and regulated by the Medical Board of California.**

X#1

Patient or legal representative signature

**I certify that I have read the foregoing and received a copy thereof. I am the Patient, the Patient's legal representative, or otherwise duly authorized by the Patient to sign the above and accept its terms on his/her/their behalf.**

X#2

Patient or legal representative name (please print)

Patient or legal representative signature

Date (MM/DD/YYYY) | Time | Relationship to patient

Staff witness name (please print)

Staff witness signature

Date (MM/DD/YYYY) | Time

Huntington Health | An Affiliate of Cedars Sinai

**Fair Oaks Women's Health**

MEDICAL CARE FOUNDATION

## CONDITIONS OF TREATMENT

PATIENT I.D.

**Staff to complete the fields below if the patient/surrogate or legal representative is unable to provide in-person signature.**

Please indicate how consent was obtained:

❑ Telephone ❑ Verbal ❑ Other: _____

_____ _____

Second witness name (please print) Second witness signature

_____ _____

Date (MM/DD/YYYY) Time

Interpreter/Witness for interpreter

❑ This box shall be checked when the following paragraph is applicable:

We have accurately and completely read the foregoing document to the patient/ legal representative in his/her/their primary language identified below. He/She/ They state that he/she/they understood all of the terms and conditions and acknowledged his/her/their agreement by signing the document in my presence.

_____ _____

Interpreter name (please print)/I.D. no. Interpreter signature

_____ _____ _____

Date (MM/DD/YYYY) Time Language

_____ _____

Witness name (please print) Witness signature

_____ _____

Date (MM/DD/YYYY) Time

Huntington Health | An Affiliate of Cedars Sinai

**Fair Oaks Women's Health**

MEDICAL CARE FOUNDATION

## CONDITIONS OF TREATMENT

PATIENT I.D.

**I agree to accept financial responsibility for services rendered to the Patient and to accept the terms of the Financial Agreement, Assignment of Health Plan Benefits and Health Plan provisions above.**

Financial responsible party name (please print)

X#3

Financial responsible party signature

If signed by someone other than the patient, indicate relationship

Date (MM/DD/YYYY) Time

Witness name (please print) Witness signature

Huntington Health
An Affiliate of Cedars Sinai

Fair Oaks Women's Health

625 S. Fair Oaks Ave., Suite 255
Pasadena, CA 91105
**P:** (626) 304-2626 | **F:** (626) 585-0695
www.fowh.com

# PLANNED NON-HOSPITAL BIRTH

At Fair Oaks Women's Health:

- We do not provide OB care for a patient who is planning an out-of-hospital birth.
- We do not provide backup OB care for someone providing out-of-hospital birthing services.
- We do not co-manage OB patients with another prenatal care and/or birthing care provider.

We believe that all pregnant women have the right to choose whatever birth experience they prefer. Additionally, our physicians have the right to limit our care and services to patients who are planning a hospital birth and are trusting us as their sole OB care providers.

During the pregnancy if we learn that you are planning a non-hospital birth and are receiving care from another birthing care provider, we consider this to be a voluntary termination of our OB care services and responsibilities. This also means that you'll be discharged as a patient from our group and will be expected to continue your care with your current alternate birth care provider.

Once a patient has been discharged from our group, we no longer provide any medical care to that patient. If that patient arrives at Huntington Hospital for any reason, they are not considered a patient of our group, even if they have received earlier prenatal care with us during that pregnancy. They most likely would be assigned to the Huntington Hospital Laborist service, called OBHG, who will provide all necessary OB care, including delivery and postpartum.

If your plans change and you wish to commit to an in-hospital birth, we will happily continue to provide all the OB care and medical care that you need. If you have any questions about this policy, please contact our office manager at (626) 304-2626.

January 2023