KOTZEN CENTER FOR WOMEN'S HEALTH

NEW PATIENT INFORMATION

Welcome to our Office!

We are so pleased you made the decision to join other health conscious women who want personalized and exceptional medical care. Women like yourself who want the most advanced medical services, knowledge and technological tools available to maintain optimal health.

It is important to complete the enclosed **Confidential Patient Information Form** before your appointment. We need your medical history to ensure you receive the most personalized medical treatment available. Please bring the completed forms to your appointment. And please be aware that Dr. Kotzen, like most physicians, cannot assume responsibility for your medical care or treatment **until you have your medical exam.**

Please note that **all your information is confidential.** That means your medical history and current information will not be discussed with anyone, including your relatives, other doctors, and/or insurance companies, without your specific expressed permission.

Our office staff is happy to answer any questions about billings, methods of payment and/or appointment availability. To ensure you understand our service payment guidelines, please note that our office:

- **Does not participate in any HMO insurance plans.**
- **Does not participate in PPO or other insurance plans** but we will complete and file your claim form(s) upon request. Any reimbursements will be sent to the patient.
-
- Accepts American Express, Discover and Visa/MasterCard.
- Payment is due at the time services are rendered.

Our office is conveniently located off Flagler Drive at 200 Butler Street, Suite 303, in West Palm Beach, Florida. There are two parking lots, one in the front and side of the building and one across the street. A map can be found at www.kotzencenter.com.

Again, we appreciate your decision to choose Dr. Kotzen for your medical and preventative health care needs. **Our goal is to provide you with the most conscientious and caring medical services possible, in a relaxed and warm atmosphere.** Please know that we are here and available for your special requests or needs.

Most of all, we look forward to meeting you in our office.

Jeffrey H. Kotzen, M.D. • 200 Butler Street, Suite 303 • West Palm Beach, Florida 33407 • (561) 837-9880 • Fax (561) 837-9884

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Patient Registration

Today's Date ____/ ____ / 20____

Patient's Name *Last*	*First*	*M.I.*
Soc. Sec. #	Date of Birth	
Local Address		Apt/Unit #
City	State	Zip
Local Home Phone #	Cell/Pager Phone #	Email Address
Northern Address *(if applicable)*		Apt/Unit #
City	State	Zip
Northern Home Phone #	Other Northern phone #'s	
Marital Status	Spouse's Name *(if applicable)*	
Employer	Work phone #	
Primary Insurance Company		
Insurance Subscriber's Name	Relationship to Patient	
Subscriber's Soc. Sec #	Subscriber's Date of Birth	
Emergency Contact	Relationship	Phone #
Pharmacy Name	Phone #	
Other Physicians & Specialists		
Referred by	How did you hear about us?	

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Patient's Name	Today's Date
Date of Birth	Marital Status
Reason for Today's Visit	

GYNECOLOGY HISTORY

Menopausal? *Yes* *No*	First Day Of Last Period
Regular? *Yes* *No*	If No, Please Explain.
Are You Sexually Active? *Yes* *No*	Birth Control Method
Do You Have Any Sexual Concerns You Would Like To Discuss? *Yes* *No*	
Do You Lose Urine? *Yes* *No*	When You Cough Or Sneeze? *Yes* *No*
Date Of Last Pap Smear	Have You Ever Had An Abnormal Pap Smear? *Yes* *No*
Date Of Last Mammogram	Have You Ever Had An Abnormal Mammogram? *Yes* *No*
Date Of Last STD Screen	Date Of Last Bone Density

PREGNANCY HISTORY

Date	Vaginal/Cesarean	Weeks	Baby Weight/Name	Complications

SURGICAL HISTORY

Date	Surgery	Complications

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MEDICAL HISTORY

High Blood Pressure? *Yes* *No* DVT ? *Yes* *No* If Yes What Year?

Heart Attack? *Yes* *No* Stroke? *Yes* *No* If Yes What Year?

Sexually Transmitted Diseases ? *Yes* *No* If Yes, Please Explain.

Cancer? *Yes* *No* If Yes What Kind?

Other?

Allergies To Medications? *Yes* *No* If Yes, Please List.

Current Medications

____

____

____

Who Is Your Regular Medical Doctor?

SOCIAL HISTORY

Do You Smoke? *Yes* Packs Per Day? *In The Past* Last Year Smoked? *Never*

Do You Drink Alcoholic Beverages? *Yes* *No* If Yes, How Many Drinks Per Week?

FAMILY HISTORY

	Age	Medical Conditions	Age At Death	Cause Of Death
Mother				
Father				
Brother				
Brother				
Sister				
Sister				

Any History Of Breast Cancer In Your Family? *Yes* *No* If Yes, Who?

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Dear Patient,

Under Florida Law, physicians are generally required to carry medical malpractice insurance or other otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **Your doctor has decided not to carry medical malpractice insurance.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Regretfully, we have made the decision of going uninsured because the malpractice insurance premiums have become too expensive and simply, we cannot afford the coverage any longer.

If this action which we have taken makes you uncomfortable to initiate or continue under our care, we suggest that you search the community for a physician who is insured.

This document **must be signed** before you initiate or continue under our care.

Thank you,

Jeffrey H. Kotzen, M.D.

I, ____________________________, have read this document and acknowledge and understand its contents.

____________________________ ________________
Signature *Date*

____________________________ ________________
Witness *Date*

Would you like a copy of this letter? *Yes* *No*

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KOTZEN CENTER FOR WOMEN'S HEALTH

NOTICE OF PRIVACY PRACTICES

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

Please review it carefully.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Jeffrey H. Kotzen, M.D. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to receive a printed copy of this notice
- the right to request restrictions on the use and disclosure of your protected heath information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed

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Jeffrey H. Kotzen, M.D. Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Jeffrey H. Kotzen, M.D. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Jeffrey H. Kotzen, M.D.
200 Butler Street, #303
West Palm Beach, FL 33407

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Jeffrey H. Kotzen, M.D.
200 Butler Street, #303
West Palm Beach, FL 33407

Effective Date
This Notice is effective on or after April 15, 2003.

I have been offered and/or received a copy of the "Notice of Privacy Practices" for Dr. Kotzen's office.

_______________________________ Signature

_______________ Date