

ROD J. TURNER, M.D., P.A. - **PROB. GYNECOLOGY EXAM FORM**
402 BLOSSOM STREET WEBSTER, TX 77598 PHONE 281-554-3107 FAX 281-557-0372

PRINT NAME: _____ DATE ___/___/20___

Date of birth: ___/___/___ (MM/DD/YYYY) Age: _____ Race: _____

1. **Marital Status:** Single Married Separated Divorced Widow
2. Who is your **PRIMARY CARE PHYSICIAN (PCP)**? _____
3. When was your **LAST MENSTRUAL PERIOD**? (The start date): _____
4. When was your **LAST MAMMOGRAM**: _____ (Normal, Abnormal, or Not Applicable)
5. When was your **LAST PAP SMEAR**: _____ (Normal or Abnormal)
6. Have you had your **UTERUS** and/or **TUBES & OVARIES REMOVED**? YES or NO
7. **Smoker**? YES / NO _____ packs per day? **Alcohol**? YES / NO _____ per day. **Street Drug**? YES / NO
8. Any **DRUG ALLERGIES**? No Know Drug Allergies (NKDA) or YES (Please list them) _____

9. **MEDICAL HISTORY:**

- A. Any **MEDICAL ILLNESS**? (I.E. High Blood Pressure, Diabetes, Asthma, Thyroid Disease, etc?) _____
- B. Any **SURGICAL PROCEDURES**? (I.E. Tonsils, Wisdom teeth, Appendix, Gallbladder, Eye, Head, Limb, Body surgeries, etc.?) _____
- C. And **SOCIAL HISTORY** problems? (I.E. Alcohol, Drugs, etc?) _____

10. What **MEDICATIONS** are you currently taking? (I.E. Including supplements, Vitamins, Herbs, or Over the counter (OTC) drugs): _____

11. What **BIRTH CONTROL METHOD** are you using? (Please circle) :

No Need, Oral Contraceptive Pills, Condoms, IUD, Diaphragm, Tubal Ligation, Vasectomy, Depo-Provera

Other: _____

12. **WHAT DID YOU SCHEDULE THIS APPOINTMENT WITH DR. TURNER FOR TODAY?**

1. _____
2. _____

13. Will you need a **REFILL** on any **MEDICATION**? YES / NO (Please list): _____

14. Will you need an **ULTRASOUND** or **MAMMOGRAM**? YES / NO (Please list): _____

15. Will you need any **LABS** requested? YES / NO (Please list): _____

16. Will you need to be screened for any **Sexually Transmitted Diseases**? YES / NO : _____

Signature Please

ROD J. TURNER, M.D., P.A.



PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

RELEASE RECORDS TO:

ROD J. TURNER, MD, PA

402 Blossom Street ◆

Webster, Texas 77598-4208 ◆ U.S.A.

Phone 281 / 554-3107 ◆ Fax 281 / 557-0372

REQUESTED RECORDS FROM:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT INFORMATION :

Patient Name: _____

Address: _____

City: _____ State: _____ Zip _____

Primary Phone# _____ Secondary Phone# _____

Date of Birth: _____ Social Security Number _____

I, AS ABOVE, authorize the above listed person/s, physician/s, firm or entity (or its agents, representatives, or employees) to release for inspection and copying, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from date/s of: _____ to **PRESENT**.

- Entire Record - Inpatient Radiology/X-Ray Reports Operative Reports Pathology Reports
- Entire Record - Outpatient Newborn/Neonatal Records Laboratory Reports ER Records
- Labor & Delivery Records Discharge Summary Anesthesia Records Other: _____

If requested by patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on LAST DAY OF THIS YEAR. The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from MY PROVIDER. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Office at the Office in which records are released.

REASON FOR REQUESTING RECORDS: *CONTINUITY OF CARE.*

Signature of Patient or Legal Representative: _____

Date: _____, 20 _____.

*****CONFIDENTIALITY NOTICE*****

The document(s) accompanying this facsimile transmission contain Confidential Information, belonging to the sender that is legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this facsimile information is strictly prohibited. If you have received this facsimile in error. Please notify us by telephone 281-554-3107 immediately and return the original document(s) to us at the above address via the U.S. Postal Service. Thank You.

Rod J. Turner, M.D., P.A.

402 BLOSSOM ST.
WEBSTER, TX 77589-4208
281-554-3107 OFFICE
281-557-0372 FAX

PATIENT PRESCRIPTION REFILL AGREEMENT

This agreement is to protect your safety when utilizing prescriptions.

For medication refills please contact your pharmacy. Please do not call our office for medication refills. The pharmacy will send us the necessary information to refill your prescription. Allow yourself to have 1 (ONE) week of medication left when you call in a refill. Please allow our office two (2) business days to process the refill request. Some prescriptions may take longer to process due to insurance. All information regarding mail order prescriptions must be brought to our office. We are not responsible for mailing prescriptions. We will notify you when the prescription is ready for pick up. No prescription will be refilled on Weekends or Holidays

ALL CONTROLLED DRUGS WILL NEED A NEW PRESCRIPTION EACH TIME
PLEASE ALLOW ATLEAST 72 HOURS FOR US TO PROCESS THIS REQUEST.

I have read, and understand the office prescription policy.

X _____

Date: _____

Preferred Pharmacy

PHARMACY NAME: _____

PHARMACY NUMBER: _____

PHARMACY ADDRESS: _____ ZIP CODE _____

Rod J. Turner, M.D., P.A.

402 BLOSSOM ST.
WEBSTER, TX 77589-4208
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PATIENT CONSENT FORM

Rod J. Turner, MD, PA requests that each patient sign this consent form which allows us to share protected health information with other physician's offices, your hospital and insurance company. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing.

Name of Patient/Representative _____ Signature _____

Authorization to Release Information

Under the requirements for H.I.P.A.A we are not allowed to give any information to anyone without the consent of the patient. If you wish to have any laboratory or radiology results released to any family members, please indicate their name and relationship to the patient below.

1. _____ Relationship to Patient _____ Date: _____
2. _____ Relationship to Patient _____ Date: _____

Patient Name: _____ Patient Signature: _____

Authorization to Leave Messages with Household Members/ Voice Mails

By signing this consent you give representatives of Dr. Rod J. Turner to leave messages with Household Members or Voicemails. The purpose of these messages is to remind patients that they have or to schedule an appointment, or to notify the patient that the staff would like to discuss an issue or concern. At no time will a representative of our office discuss your medical circumstances or condition with anyone not listed above. The purpose of this consent is to leave messages with members of your household or on your Voicemail.

Patient Name: _____

Patient Signature: _____

Date: _____

TO ALL PATIENTS:

Insurances do not reimburse for Preventative Medicine and Evaluation Management on one date of service. In other words, you cannot be seen for a well woman visit and problem visit at the same visit. If you are having a problem, please notify our office staff, and re-schedule your Preventative Visit.

Thank you ahead of time in your understanding of this Insurance Quandary.

X _____

Date: _____

I have been informed both in writing and orally that the doctors that take call with Dr. Rod J. Turner will no longer go to Methodist St. John Hospital effective July 01, 2006. Should I need any medical care that requires hospitalization, to receive medical care from Dr. Rod J. Turner I must go to Clear Lake Regional Medical Center.

X _____

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____



ROD J. TURNER, M.D., F.S.M.

Please Sign In

Please have your insurance card, photo ID, and credit card ready when you SIGN IN for Service.

Why is Dr. Rod J. Turner asking for a credit card?

At this time, we request your credit card information (this may be a health spending account card, credit card, or account debit card) and authorization to be placed on file for today's service.

- *This preauthorization will allow the office to collect balances due after your insurance has processed today's charges (if applicable).
- *No charges will be applied to your credit card unless your insurance plan indicates that you are responsible for charges under the guidelines of your coverage.
- *We are aware that for some insurance plans there is no additional patient responsibility such as copayments, coinsurance, or deductibles for physician services covered by the insurance plan.
- *Our office secures credit card data and protects it within our network. We follow the payment card industry standards.
- *After your insurance processes your claim for today's services and notifies our office with an Explanation of Benefits (EOB) of your patient responsibility, we will apply the charges to your card up to the amount you authorize today.
- *You can receive an acknowledgement receipt of your credit card authorization today at your request and a letter in the mail confirming the final amount charged.
- *We will destroy your credit card information after the charge is processed.

X _____

Patient LABEL

**Card # :
Exp Date:
CVC:**