Female Patient Questionnaire & History

Name:_____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth:_____ Age:_____ Weight: ____ Occupation: _____

Home Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work: _____

E-Mail Address:_____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Primary Care Physician's Name:_____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex has suffered.
( ) I haven't been able to have an orgasm.

Habits:

( ) I smoke cigarettes or cigars_____ per day.
( ) I drink alcoholic beverages_____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine_____ a day.

BHRT Checklist For Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes, please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

( ) Medical/GYN exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:

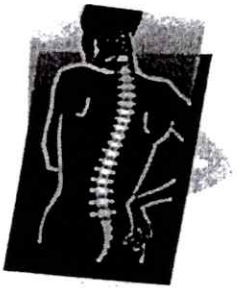
( ) Breast cancer.
( ) Uterine cancer:
( ) Ovarian cancer.
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy removal of ovaries.

Birth Control Method:

( ) Menopause.
( ) Hysterectomy.
( ) Tubal ligation.
( ) Birth control pills.
( ) Vasectomy.
( ) Other: _____

Medical Illnesses:

( ) Polycystic Ovary Syndrome (PCOS)
( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric disorder.
( ) Cancer (type): _____
Year: _____



Ernesto R. Padron, M.D.
Interventional Pain Management Specialists
3213 S. 24th Street, Suite 101-B
Omaha, Nebraska 68108
Office: 402-933-8375 / Fax: 402-933-9964

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information use or disclosed by us in any form, whether electronically, paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new right to understand and control now much health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

We respect patient confidentiality and only release medical information about you in accordance with the Nebraska federal law. This notice describes our policies related to the use of the records or your care generated by ERNESTO R. PADRON, M.D., LLC.

We may use and disclose your medical records only for the following reasons:

1. **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers. For example: A physical exam
2. **Payment:** obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example: Sending a bill for your visit to insurance company for payment.
3. **Health Care Operations:** the business aspects of running a practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. For example: Internal quality assessment.

Information Disclosed Without your consent

Under Nebraska federal law, information about you may be disclosed without your consent for the following reasons:

1. **Emergency:** sufficient information may be shared to address the immediate emergency are facing.
2. **Follow-Up Appointments:** we will be contacting you to remind you of future appointments or Information about your treatment alternatives or other health -related benefits and services that may be interest to you.

3. **Required by Law:** includes situations where we have a subpoena, court order, or are mandated to provided public health information, such as communicable disease or suspected abuse and neglect such as child abuse, elder abuse or institutional abuse.
4. **Coroners, Funeral Director, and Organ Donation:** medical information is disclosed to coroner or medical examiner and funeral directors for the purpose of carrying out their duties. When organs are donated sufficient information will be provided to the program as necessary to facilitate the organ o tissue donation.
5. **Governmental Requirements:** information to health oversight for activities authorization by law: such as audits, investigation, or licensure, there may also to be need to share information with the Food and Drug Administration related to adverse events or product defects as well with the Department of Health and Human Services to determine our compliance with the federal laws related to health care upon request:
6. **Criminal activity or Danger to others:** if a crime is committed on our premises or against our personnel we may share the information wit the law enforcement to apprehend the criminal. We have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Any others use, or disclosure will e made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to extent that we have already taken actions relying on your authorization.

You have the following rights with respect to protect health information:

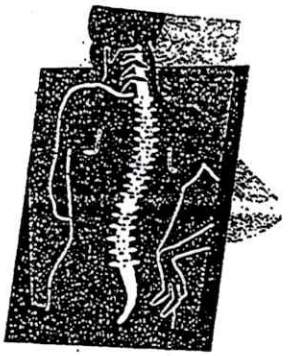
1. The right request restrictions on certain uses and disclosures or protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other identified by you. We are not required to agree to a request restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable request to receive confidential communication of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information at the cost of a reasonable fee copying and mailing your records.
4. The right to amend your protected information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice form us upon request.

This notice is effective as of April 14,2003 and we are required to abide by terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, the Department of Health & Human Services, or Office of civil rights, about violations of the provision of this notice or the policies and procedures of our office.

- If you have any questions or need more information, please contact our office

Patient Signature: _____ Date: _____

PAIN MANAGEMENT SPECIALISTS
ERNESTO PADRON, M.D., L.L.C.



SOUTH OMAHA SURGICAL CENTER
3201 S. 24TH ST.
OMAHA, NE 68108
P: 844-365-6766/F: 847 696 7040

ASSIGNMENT OF BENEFITS

Patient Name: _____ SSN: _____

In consideration of your undertaking to render care, I agree to the following:
En consideración por darme tratamiento médico yo acepto lo siguiente:

- Release of Information: I authorize the release of any information I deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for me to process any claim for reimbursement of charges insured by me at Ernesto Padron M.D, LLC.

  Ud. está autorizado a proveer cualquier información Ud. considere propia y en referencia a mi condición médica a cualquier compañía de seguros, abogados, represéntate u otra persona necesaria para el proceso de cargos debido a mi tratamiento médico en Ernesto Padron M.D, LLC.

- Right to Receive Payment: I authorize and assign you, the medical provider and treating facility, Ernesto Padron M.D, LLC, the right to receive direct payment from my attorney, insurance company, or any other party who may become obligated to pay me any sums. I further authorize endorsement of my name to any draft which you are legally entitled.

  Yo autorizo y asigno, al médico en Ernesto Padron M.D, LLC, el derecho de recibir directamente pago de mi abogado, compañía de seguros, y otro médico, quien esta obligado a pagarme cierta cantidad. Yo además autorizo al centro que firme mi nombre a cualquier forma de pago que contenga mi nombre y por lo cual le pertenece legal mente.

- Assignment of Right to Sue: In the event any insurance company, attorney, or other person obligated to contractual agreement refuses to make a payment upon your demand for your services; I hereby assign and transfer Ernesto Padron M.D, LLC, the cause of action that exists in my favor against such parties and authorize you to prosecute said action either in my name or your name for you to resolve said claims as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account. I also understand that a 33% collection fee, in addition to attorney fees will be collected upon demand.

  En el caso que la compañía de seguros, o abogados, o otra persona encargada debido a un contrato no pagar a Ernesto Padron M.D, LLC, bajo la demanda, yo autorizo que se haga acción legal para procesar mi cuenta. Yo entiendo que seguiré responsable por todos los cargos por los servicios médicos. Yo también entiendo que en 33% será agregado por costos de colección y además de los gastos de abogados.

- Attorney Direction: I hereby direct my attorney not to interfere with my claim on any lien upon, any medical payment benefits to which I may be entitled for my health insurance, medical, workmen's compensation, or other payment sources. If there are any said medical payment checks which include my attorney's name, I

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direct my attorney to sign his/her name to these checks for the benefit of the medical provider and Ernesto Padron M.D, LLC.

Yo indicare a mi abogado que no interfiera con "lien" presentada y cualquier benefició por el cual a mi pertenece ya sea de mi seguro du salud, compensación de trabajo o otra forma. Y si alguno de esos pagos induye el nombre de mi abogado, Yo indicare a mi abogado para que endorse su nombre y pague al médico y a Ernesto Padron M.D, LLC, que me proveyó de los servicios.

Patient Signature	Date	Witness

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PATIENT CONSENT FORM

CONSENT TO THE USE AND DISCLOSURE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I understand, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

I, _____ consent to the use of disclosure of my medical information by Ernesto Padron M.D, LLC, for the purpose of diagnosing or providing treatment to me, obtain payment for my treatment, or to conduct healthcare operation of the practice. I understand treatment by the practice may be denied if I do not sign this consent.

I have been informed by Ernesto Padron M.D, LLC, of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand Ernesto Padron M.D, LLC has the right to change the Notice of Privacy Practices from time to time and I may contact Ernesto Padron M.D, LLC, at any time at above address to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing Ernesto Padron M.D, LLC, restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Ernesto Padron M.D, LLC, is not required to agree to my requested restrictions, but if agreed upon, Ernesto Padron M.D, LLC, must abide by such restrictions.

I understand I may revoke this consent in writing at any time, except where Ernesto Padron M.D, LLC, has already made disclosure in reliance on prior consent.

_____ _____ _____

Patient Signature Date Witness