

BRENDA P. JACOBS, M.D.

3550 Linden Avenue Ste #1  
Long Beach, California, 90807  
Telephone (562) 595-7889  
Fax (562) 595-1335

We are honored that you have chosen our practice to receive your obstetrics and/or gynecological care. We would like to simplify the processing of paperwork on the day of your visit by enclosing our patient information forms. Please complete these forms and bring them with you at the time of your visit.

If you have insurance, please bring your card with you on the day of your appointment as well as a picture ID. If you do not have insurance or you have a co-pay/cost share, we accept cash, Mastercard, Visa, Discover, and checks.

If you have any questions at any time, please feel free to contact our office.

Thank you for the opportunity to provide you with excellent medical care.

Sincerely,

Dr. Brenda P. Jacobs and Staff

**PATIENT INFORMATION (please print)****Appointment Date:**

Name: \_\_\_\_\_ Sex: ☐ Female ☐ Male  
Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Marital Status: ☐ Married ☐ Single ☐ Divorced Driver's License #: \_\_\_\_\_  
Race: ☐ American/Alaskan Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Declined Email Address: \_\_\_\_\_  
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined: \_\_\_\_\_ Language: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Who referred you to us/How did you hear about us? \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer/Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

**GUARANTOR RESPONSIBLE PARTY ☐ Patient ☐ Other Relationship:**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**INSURANCE Insured Party: ☐ Patient ☐ Guarantor ☐ Other:**

Primary Ins Co: \_\_\_\_\_ Name of insured: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Date of birth of insured: \_\_\_\_\_  
Insured ID/Cert#: \_\_\_\_\_  
Secondary Ins Co: \_\_\_\_\_ Name of insured: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Date of birth of insured: \_\_\_\_\_  
Insured ID/Cert#: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Durable Power of Attorney for Health Care** (California Civil code section 2500): Do you have or wish to have an appointed representative to carry out your wishes concerning your healthcare/treatment in the event of an emergency rendering you unable to make such decisions? ☐ Yes, I have a representative. Name of representative \_\_\_\_\_  
Phone #: \_\_\_\_\_

Please provide copy of certificate.

☐ No, I do not have a representative. ☐ Please give me the information on how to appoint myself a representative.

I hereby **assign the insurance benefits** to which I am entitled, directly to Brenda P. Jacobs, M.D. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as the original.

I **consent to treatment** as necessary or desirable including but not restricted to whatever drugs, medicine, performance of operations or procedures and conduct of laboratory, x-rays or other studies that may be used by the attending physician or his/her nurse or qualified designate.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

Signature of patient/guardian

Date

## PAYMENT POLICY

As a courtesy to our patients who have proof of medical insurance, we offer up to a 3 month delay of payment. This allows enough time for your insurance company to pay (or deny payment) for services. I hereby authorize payment directly to my physician of all medical and surgical benefits.

Co-payment must be paid at the time services are provided, or in case of surgery or obstetric delivery. We expect that the patient responsibility portion will be paid prior to the hospitalization. We accept Mastercard, Visa, debit card, personal check, money order or cash.

If your insurance requires authorization by your Primary Care Provider (PCP), it is your responsibility to obtain the authorization prior to your visit.

Full payment is expected at the time services are provided.

In the event your insurance company does not pay for services provided, you are responsible for your bill. If your account exceeds 60 days I understand I may be subject to a \$25.00 late fee.

All balances due to your physician need to be paid, or resolved, in 4 months from the time you are first billed. If full payment is not made after 4 months, a 10% annual fee will be applied to the remaining balance. Payments can be no less than 10% of your total balance, paid monthly, interest may be charged.

For services related to infertility, full payment is due at the time of your visit. If your insurance carrier covers infertility related services your physician will reimburse you once the company furnishes payment.

A \$20 charge will be applied for all returned checks.

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## COLLECTIONS

We take every measure to avoid sending our patients to collections, in the event we must do so and we cannot locate you by mail or phone, is there anyone you want us to notify before we refer your account to formal collection?

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

There is a \$50 fee that will be applied when your account is sent to a collection agency.

I hereby authorize my physician to release any and all medical information to my insurance carrier (or to a designated attorney) for the purpose of claims administration and evaluation, utilization review and financial audit. I hereby assign to my physician all monies for medial and/or surgical expenses related to services rendered. I also understand that there is a charge for the copying of my medical records to be sent to other providers (at my request) and/or for personal access. I also understand I am financially responsible for charges not covered by insurance assignment. I further agree in the event of non-payment, to bear the cost of my indebtedness along with any cost of collection, and or court cost and reasonable legal fees should this be required.

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Patient, Parent or Guardian signature

Date

**BRENDA P. JACOBS, M.D.**

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LONG BEACH, CA 90807  
(562) 595-7889  
FAX (562) 595-1335**

Please complete this form prior to your visit. In order for us to complete our paperwork process, we ask that you arrive 15 minutes prior to your scheduled appointment. Thank you.

Date of visit \_\_\_\_\_

Patient's name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Spouse's name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

**OBSTETRICAL HISTORY**

|                           |       |                                |       |
|---------------------------|-------|--------------------------------|-------|
| Number of pregnancies     | _____ | Number of full term deliveries | _____ |
| Number of abortions       | _____ | Number of premature deliveries | _____ |
| Number of living children | _____ | Number of miscarriages         | _____ |

| DOB | Sex | Name | Anesthesia | type & length of delivery | complications |
|-----|-----|------|------------|---------------------------|---------------|
|-----|-----|------|------------|---------------------------|---------------|

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**GYNECOLOGICAL HISTORY**

Age onset of periods \_\_\_\_\_ ☐ Regular ☐ Irregular Every \_\_\_\_\_ days ☐ heavy ☐ medium ☐ light  
Length in days of periods \_\_\_\_\_ Clots: \_\_\_\_\_ Cramps: \_\_\_\_\_  
Age of menopause \_\_\_\_\_ ☐ Hot flashes ☐ Dryness  
When was the first day of your last period? \_\_\_\_\_ Are you pregnant \_\_\_\_\_  
Date of last pap smear \_\_\_\_\_ Normal? \_\_\_\_\_ Ever abnormal? \_\_\_\_\_ When? \_\_\_\_\_  
Date of last mammogram \_\_\_\_\_ Normal? \_\_\_\_\_ Ever abnormal? \_\_\_\_\_ When? \_\_\_\_\_  
Do you perform breast self-exams? ☐ yes ☐ no If so, how often? \_\_\_\_\_  
Do you currently have any vaginal or urinary problems? \_\_\_\_\_

**BIRTH CONTROL METHODS**

Do you currently have a need for contraception? If so, what method are you (or your partner) using:

|                                    |                                        |                                                                       |
|------------------------------------|----------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> pill      | <input type="checkbox"/> condom        | <input type="checkbox"/> rhythm                                       |
| <input type="checkbox"/> IUD       | <input type="checkbox"/> foam or cream | <input type="checkbox"/> vasectomy or tubal ligation                  |
| <input type="checkbox"/> diaphragm | <input type="checkbox"/> withdrawal    | <input type="checkbox"/> Depo-provera injection                       |
| <input type="checkbox"/> Norplant  | <input type="checkbox"/> none          | <input type="checkbox"/> no need <input type="checkbox"/> other _____ |

Do you practice "safer" sex? (if applicable) \_\_\_\_\_

Do you plan to continue with your present method of birth control? ☐ yes ☐ no

### ALLERGIES & MEDICATIONS

Do you have any allergies to medication? ☐ yes ☐ no If so, check any of the following to which you are allergic to:

- |                                              |                                       |                                                  |
|----------------------------------------------|---------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Penicillin          | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Codeine                 |
| <input type="checkbox"/> Contraception cream | <input type="checkbox"/> Sulfa        | <input type="checkbox"/> Latex                   |
| <input type="checkbox"/> Other _____         |                                       | <input type="checkbox"/> No known drug allergies |

Type of reaction? \_\_\_\_\_

List all medications which you are presently taking (include birth control pills and vitamins)

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### SURGICAL & MEDICAL HISTORY

Have you ever had any surgeries? If so, please state type and date: \_\_\_\_\_

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Have you had any serious or chronic medical illnesses? If so, please explain: \_\_\_\_\_

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Have you ever had any of the following:

- |                                       |                                                |                                                  |
|---------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> mumps        | <input type="checkbox"/> German measles        | <input type="checkbox"/> measles                 |
| <input type="checkbox"/> chicken pox  | <input type="checkbox"/> rheumatic fever       | <input type="checkbox"/> blood clots (phlebitis) |
| <input type="checkbox"/> DES exposure | <input type="checkbox"/> mitral valve prolapse |                                                  |

Have you or your partner ever had any of the following?

- | Patient                  | Partner                  |                       | Patient                  | Partner                                                           |
|--------------------------|--------------------------|-----------------------|--------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia             | <input type="checkbox"/> | <input type="checkbox"/> Syphilis                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital herpes        | <input type="checkbox"/> | <input type="checkbox"/> Genital warts                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea             | <input type="checkbox"/> | <input type="checkbox"/> Frequent yeast infections                |
| <input type="checkbox"/> | <input type="checkbox"/> | Tube infections (PID) | <input type="checkbox"/> | <input type="checkbox"/> Bacterial/trichomonas vaginal infections |

Father: ☐ living ☐ deceased age \_\_\_\_\_ health problems: \_\_\_\_\_  
 Mother: ☐ living ☐ deceased age \_\_\_\_\_ health problems: \_\_\_\_\_  
 Brothers: how many? \_\_\_\_\_ Health problems: \_\_\_\_\_  
 Sisters: how many? \_\_\_\_\_ Health problems: \_\_\_\_\_

Have you or any family member ever had the following?

| Patient                  | Family                                               | Patient                  | Family                                                 |
|--------------------------|------------------------------------------------------|--------------------------|--------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Benign breast tumor or mass | <input type="checkbox"/> | <input type="checkbox"/> Nephritis (kidney disease)    |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis (liver disease)     |
| <input type="checkbox"/> | <input type="checkbox"/> Epilepsy or convulsions     | <input type="checkbox"/> | <input type="checkbox"/> Severe varicose veins         |
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> | <input type="checkbox"/> Alzheimer disease             |
| <input type="checkbox"/> | <input type="checkbox"/> Migraine headaches          | <input type="checkbox"/> | <input type="checkbox"/> Pulmonary embolus (lung clot) |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma/Visual difficulty  | <input type="checkbox"/> | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> | <input type="checkbox"/> Heart attack                | <input type="checkbox"/> | <input type="checkbox"/> Thyroid disease               |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> | <input type="checkbox"/> Fibroids (benign growths)     |
| <input type="checkbox"/> | <input type="checkbox"/> Mental disorder             | <input type="checkbox"/> | <input type="checkbox"/> Bleeding disorder             |
| <input type="checkbox"/> | <input type="checkbox"/> Alcoholism                  | <input type="checkbox"/> | <input type="checkbox"/> Cancer (specify)              |
| <input type="checkbox"/> | <input type="checkbox"/> Gastrointestinal disorder   | <input type="checkbox"/> | <input type="checkbox"/> Breast cancer                 |

### SOCIAL HISTORY

Have there been any recent changes in your relationship with your partner? ☐ yes ☐ no  
 Do you have any problems at home? ☐ yes ☐ no  
 Do you feel "safe" at home? ☐ yes ☐ no  
 Are there any questions about your sexual relationship you'd like to discuss? ☐ yes ☐ no

Do you smoke cigarettes ☐ yes ☐ no How many per day? \_\_\_\_\_  
 Do you drink alcohol? ☐ yes ☐ no Do you feel the need to cut down? ☐ yes ☐ no  
 Do you use street drugs? ☐ yes ☐ no

Are you exercising? ☐ yes ☐ no How often? \_\_\_\_\_ What type? \_\_\_\_\_  
 Have you had a recent cholesterol test? ☐ yes ☐ no Results: \_\_\_\_\_

### REASON FOR YOUR VISIT TODAY:

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# **HIPAA NOTICE OF PRIVACY PRACTICES**

**BRENDA P. JACOBS, M.D.**

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, communicable diseases; health oversight; abuse or neglect. Food and Drug Administration requirements: Legal Proceedings: law enforcement; coroners, funeral directors and organ donation; criminal activity, military activity, national security; workers' compensation: Inmates: required uses and disclosures: Under the law, we must make disclosures to you and when by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:**

Print name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Revised Oct 2011