Date______________

Dr. Elizabeth Motyka, MD

Personal Health History Form

Name: Last________________________First___________________Middle/Maiden___________
Age_____ Gender Identification_________
Please describe the major reason for this visit:

Please list any other significant concerns that you currently have:

Medical History

Have you had any major illnesses or hospitalizations that have caused you to miss work, school, or change your lifestyle? Yes ____ No ____If yes, please list:

Please list any surgeries you have had:

Describe any past problems or current concerns regarding reproduction or sexual function:

Please list any pregnancies below

TYPE	Number	Associated problems/comments	Age
Vaginal Births			
Caesarian Sections			
Miscarriages			
Terminations			

If you have periods, when was the first day of your last period? ______________
How often do you have a period? ________________How long does each period last? _______________
Do you have any other vaginal discharge that is bothersome? _____ We recommend safe sexual practices.
Are you currently sexually active? ______ Do you practice safe sex? ________Would you like testing for STD's? _______ Do you have a regular partner? ______ Is your partner male or female or both? ________
Are you planning a pregnancy now? ________________ If you have a male partner, what birth control method are you using? ______________Would you like information about other methods? _______

What allergies do you have currently (foods, medications, environmental, or latex)? What type of reaction do you have?

If you are on testosterone, are you having any unwanted side effects? ________________
Are you happy with your level of virilization? _______ What future health goals do you have for your transition? (surgery, etc.) ____

What medications do you currently take and why? (Include over-the-counter medications, vitamins, and herbal remedies)

Medications Dose Frequency Reason for taking

What alternative health remedies do you use? (Massage, acupuncture, etc.)

Family History

Have any of your relatives had the following diagnoses?

	Yes	Which relative
Heart disease		
Stroke		
High blood pressure		
High Cholesterol		
Diabetes		
Thyroid disease		
Breast cancer		
Other Cancer(s)		
Depression		
Mental Health Hospitalization		
Suicide attempt		
Osteoporosis		

Social History

We recommend limiting tobacco use. How much tobacco do you use a day? _________

For how many years______________ How much alcohol do you use a day? ___________________

What recreational drugs do you use? ___________________ How often? ______________________

Please circle your current stress level no stress 1 2 3 4 5 6 7 8 9 10 severe

What is your biggest source of stress right now?

What do you do to relieve stress?

What are the things that bring you your greatest happiness?

Are you currently employed? Yes___ No ___If yes, what is your job and are you concerned about any work-related health hazards?

Do you like your job? Yes _______No __________

Do you have any financial concerns that limit your ability to seek health care? Yes_____ No_____

What is your Marital Status: Single___ Co-habiting ___ Married____ Divorced___ Widowed ___

What cultural, religious, or spiritual issues do you have that might influence your health care?

Preventive Health Care and Screening

When was your last: tetanus shot? _________ pap smear? _________ mammogram? __________ breast self-exam?______ cholesterol screen? ________ Vitamin D test? __________ dental check?______ bone scan? ________ colonoscopy? _______ Would you like a Pap test today? __________

Do you follow a healthy diet? ____________If not, would you like information on nutrition or weight control? ________________________

Consider your physical activity during the last month and circle the statement that best describes your exercise habits:

How often do you exercise aerobically?	How long do you exercise?
Daily or almost daily	Over 45 minutes per session
3 - 5 times a week	30 – 45 minutes per session
1 - 2 times a week	20 – 30 minutes per session
A few times a month	10 -20 minutes per session
Less than once a month	Less than 10 minutes per session

Circle the types of activities that you perform? Strength Training, Walking, Sports, Running, Yoga, Swimming, Cycling, House/Yard work, Hiking, Flexibility Training,
Other: ____

Would you like information on exercise, fitness, strength, or flexibility training? _______________

How many hours do you sleep each night? _____________

We recommend safety belt use in cars and helmets with motorcycles.

Do you wear a safety belt or helmet when driving? ___________

We recommend avoiding alcohol when driving. Do you drink alcohol and drive a car or boat? ______

Have you ever been sexually or physically abused? _____________

Is anyone hurting you now? _______________

Is there a firearm in your house? ____________ We recommend safe storage or removal.

We recommend use of smoke detectors in the home. Do you have a smoke detector? _______

We recommend limiting sun exposure. Do you have recreational or occupational sun exposure? _____________

If you are of child-bearing age we recommend 0.4 mg of folic acid/day. If you are <18 years old or post-menopausal, we recommend 1200 mg of calcium /day.

Risk Factor Assessment

Please check any of the following risk factors to **cervical cancer** that apply to you:

___Prior history of abnormal pap
___Exposure to any sexually transmitted diseases- including herpes, HIV, HPV, gonorrhea, syphilis, or chlamydia
____ History of a blood transfusion
____ Onset of first sexual activity prior to age 16
____ Smoking ____DES
____ > 5 sexual partners in a lifetime

Please check any risk factors for **osteoporosis** that apply to you:

____Use of steroids current or past
____Family history
____Smoking
____Underweight ____ Caucasian

Please check any of the risk factors for **diabetes** that apply to you:

____Family history
____History of diabetes in a pregnancy or delivery of a baby >9 lbs.
____Overweight
____High Blood pressure

Please check any of the following risk factors for **breast cancer** that apply to you:

____Family history
____History of menopause after age 52
____History of menstruation prior to age 12
____History of a biopsy showing hyperplasia

727 Eastowne Dr. Suite 200 A Chapel Hill, NC 27514 Phone: 919.401.4515

Please check any of the following risk factors for **heart disease** that apply to you:

____Smoking

____History of heart attack in a family member especially, if <55 years of age

____History of high cholesterol in you or a family member

____Diabetes

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. Thank you. If it was in the past mark with a "P"

Cardiovascular

____Blood pressure

____Chest pain-angina

____Heart

____ Failure

____Heart attack

____Blood vessels

____Murmur-valve problem

Respiratory

____ Lungs (Breathing prob, Asthma, TB)

____ Cough

____ Wheezing

____ Shortness of breath

____ Seasonal allergies

Gastrointestinal

____ Abdomen (constipation, ulcers)

____ Rectum (hemorrhoids, incontinence)

____ Liver (hepatitis)

_____Bloating

____ Diarrhea

Endocrine

____ Diabetes

____ Thyroid

Eyes, Ear, Nose, Throat

____ Eyes

____ Mouth

____ Ears

____ Throat

____ Nose and Sinuses

Psychiatric

____ Schizophrenia

____ Anxiety

____ Depression

_____Eating DO

____ Bipolar

_____ PTSD

Musculoskeletal

____ Joints (arthritis)

____ Muscles

____ Bones

Dermatologic

____ Rashes, moles, ulcers

____ Lymph nodes

____ Hair loss/Excess hair

General

____ Insomnia

____ Fatigue

Neurological

____ Loss of sensation

____ Loss of strength

____ Memory loss

____ Dizziness/fainting

____ Migraines or headaches

____Seizures

Hematologic

____ Anemia

____ Blood clots

____ Easy Bleeding

____ HIV

____ Blood transfusion

Genitourinary

____ Breast

_____ Vagina

____ Uterus

_____ Tubes

____ Ovaries

_____ Cervix

____ Pelvic Infection

_____ Incontinence

____ Kidney

_____ UTI

Sexual/hormonal Health

_____ Bothersome low libido

_____ Hot flashes/night sweats

_____ PMS

_____ Pain w/ sex

_____Satisfaction w/ partner

_____ Trouble w/ orgasm

_____ Vaginal dryness

Other problems/risks

_____Lack of care-giver or support ____Need for case management ____Inadequate housing or food

_____Language barrier to care ____ Financial barriers to care ____ Needing help with self-care

Would you like us to share a summary of your care today with your Primary care provider

Yes___ No_____ Name of provider ____________________________________

Signature ____ Date _______________

Elizabeth G. Motyka, MD
OFFICE POLICIES

Contact and Appointment info: We are open for scheduled appointments, prescription refills and general questions.

- Monday from 9:00 a.m. to 12:30 p.m. and 1:30 p.m. to 5 p.m.
- Tuesday and Wednesday 8:30 am to 12:30 pm and 1:30 pm to 5:00 pm
- Thursday 9:00 am to 12:30 pm and 1:30 pm to 6:00 pm and
- Friday 8:30 to 12:30 and 1:30 to 3:00.

All visits are by appointment only. We are not able to accommodate walk in problems or life-threatening emergencies, as we are a solo practice Please give us at least 24 business hours' advance notice for a cancellation or reschedule. A fee of up to $50 will be charged for missed appointments and for cancellations without 24 business hours' notice. ***All cancellations and rescheduling must be by phone during business hours.*** There is no online facility for appointment changes. I reserve the right to discontinue my services after three missed appointments without notice. Refills cannot be filled after hours.

Emergencies: We can be reached by calling our office at 919 401-4515 during business hours. For emergencies after hours, please call our office number and you will be directed on how best to reach the doctor on call. For hospital emergencies, our on-call group uses Wake Med North Hospital. For less urgent situations, you may leave a message at the office number 919 401-4515 or on the patient portal. Every effort will be made to return calls promptly by the next business day. If the situation warrants or there is a delay in returning a message, please seek help at the nearest emergency room or urgent care center.

Phone/ Portal Policy: To best manage patient needs and the large volume of patient communications that come in each day for Dr. Motyka, phone calls and portal messages from patients with questions that can be handled in 5 min or less of Dr Motyka's time will be accommodated free of charge. For complicated or multi-issue questions which need greater time and attention, patients will be asked to either schedule an in office, telehealth visit, portal visit, or a phone consultation appt. Phone consultations are not usually covered by insurance. Payment for phone consultations can be made by personal credit card at the time of the visit. ($420.00/hour)

Communication: We will communicate with you about test results and care management primarily through the patient portal. You will receive an email or text from the practice when your results come in. Log into the portal to see the results and clinical advice. Please sign up for the portal so we can communicate effectively. If the advice is critical or complicated, our medical assistant may call you or ask you to set up an appt.

Confidentiality: Our work together is completely confidential, as are your records. Your social security number is required for billing and financial responsibility, this information is protected under the same confidentiality laws as your personal medical records. Your explicit written permission is required to release information about your treatment to other providers, family members or others. You may have access to your medical records for review if you wish. You will be asked to sign a HIPPA form at your first visit. If you would like to see the full privacy policy it is available at our office or on our website: www.forwomengyn.com

About Financial Arrangements and Insurance: We participate in many insurance plans including Blue Cross/Blue Shield, United Healthcare, Cigna and others. We do not participate with Medicare or Medicaid patients. You may want to check with your insurance company about your specific benefits. Payment of any copay and or coinsurance is due at the time services are rendered. We accept cash, checks, MasterCard, or Visa. Returned checks are subject to an additional collection fee of $30. By signing below, you acknowledge responsibility for payment of charges incurred for services rendered to you by the practice and its provider.

Policy on Supplements and Product for Sale and Off label Use of medications and supplements: We offer various nutritional/ herbal products, informational supplies, and medical equipment for sale which may be offered at various other locations, possibly including local stores. We are aware that many potential sources of purchase have excellent products including the very ones we sell, and we encourage you to shop around and compare. When one of the items that we recommend to you is available elsewhere we want you to feel no pressure to buy these products from us. These products are offered by our office for three reasons, 1) your convenience, 2) to provide you access to products that are sold only through doctor's offices, and 3) because we think the products are especially good ones. Some therapies may not be

considered conventional medical treatment. We offer such off label or alternative treatments because we believe they are of potential benefit. There is no guarantee of benefit. Refunds will be made only for products returned within 60 days, unopened, and accompanied by the detailed (not the credit card) receipt which identifies the specific product purchased. Supplement sales are not part of the medical record; you will need to keep your original receipt for tax or HSA purposes.

Physician Responsibilities: Dr Motyka is a solo practitioner sharing the building with other practitioners. We are not in partnership with each other. We maintain a separate practice with separate records, billing, and responsibilities for your care.

Discrimination: We do not tolerate discrimination against age, color, religion, sex, sexual preference, gender identity, or reproductive choices. We do however maintain the right to terminate care in the setting of violence, abusive or threatening behavior, noncompliance with care and or office policies, and failure to make payment arrangements.

Coordination of care: If you have a primary care provider and you would like us to send updates to them please let the front desk coordinators know. If you see other outside providers, please share our practice information with them so we can keep up to date on your health status and plan of care. If you are referred to our practice by another provider, we will notify them of your plan of care.

Consent for treatment I request the physician and other healthcare professionals who care for me at the practice to perform/order appropriate laboratory/diagnostic procedures and provide therapeutic treatments, which in the judgment of my physician or other healthcare professionals are medically necessary in the course of my medical treatment or preventative care. I also understand that it is the policy of this practice to perform urine pregnancy testing on patients when appropriate before procedures (on patients of childbearing age unless they have had a complete hysterectomy.) I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made or will be made to me as to the results of any professional services that may be received by me as a patient of the practice; i.e. treatments, examinations, procedures, etc. I authorize my provider to send for pathological review or dispose of at their convenience, any specimens or tissue taken from my body during a visit.

When appropriate, I consent to telephone, synchronous audio-visual or digital communication with my physician and other healthcare professionals at the practice as an alternative to a face-to-face visit to provide care or treatment. I understand these services will also be billed for and submitted to insurance when applicable.

Thank you for abiding by office policies.
Please sign to indicate that you have read, understood and agree to the office policies and consent to treatment:

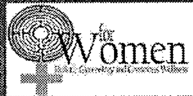
***** Signature**____

Print name______________________________________ Date_______________

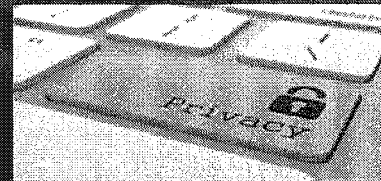
If you would like our office to bill your insurance, please fill in and sign below:
Assignment and release
I, the undersigned, certify that I (or my dependent) have insurance with ____ and assign directly to Dr. Motyka all insurance benefits, if any, otherwise payable to me, for services rendered. I understand that I am financially responsible, for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions,.

Responsible Party Signature/Guardian____ Date_______________

Notice of Privacy Practices



For Women
727 Eastowne Dr. Suite 200A
Chapel Hill, NC 27514



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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnoses, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided or disclose your medical information to our accountant or attorney for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or

information about treatment alternatives or other health related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information:

State Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Electronic Patient Chart Sharing: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment Alternative: We may provide you notice of treatment options or health related services that improve your overall health.

Appointment Reminders: We may contact you as a reminder about upcoming appointments or treatment.

The following uses and disclosure of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are the notes by a mental health professional for the purposes of documenting a conversation during a private session. This session could be with an individual or a group. These notes are kept separate from the rest of the medical record and

do not include; medications and how they affect you, start and stop time of sessions, types of treatments provided, results of test, diagnosis, treatment plan, symptoms, prognosis.

Other uses and disclosures of PHI not covered by this Notice, or by the laws that apply to us, will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Medical Records Department in our office. Specifically, you have the following rights:

- **Right to Request Restrictions** - You have the right to ask that we limit how we use or disclose your medical information. We require that any requests for use or disclosure of medical information be made in writing. Written notice must be sent to the attention of the Office Manager at the practice and address indicated in the header of this Notice. We will consider your request, but in some cases, we are not legally required to agree to these requests. However, if we do agree to them, we will abide by these restrictions. We will always notify you of our decisions regarding restriction requests in writing. We will not ask you the reason for your request. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by alternative means. Your request must specify how or where you wish to be contacted. You have the right to opt out of communications for fundraising purposes.

- **Right to Access, Inspect and Copy** - With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. Consent is required prior to use or disclosure of an individual's psychotherapy notes or the use of the individuals PHI for marketing purposes.

- **Right to Amend** - If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.

- **Right to an Accounting of Disclosures** - In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- Right to a Paper Copy of This Notice - You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time and notify us in writing.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer.

If you have questions about this Notice or any complaints about our privacy practices, please contact:

Office of the HIPAA Privacy and Security Officer

Phone: 1.866.825.1606
1501 Yamato Road
Suite 200 West
Boca Raton, FL 33431

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer.

You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights Region IV office.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Email to OCRComplaint@hhs.gov

We will take no retaliatory action against you if you make complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

VI. Effective Date:

This Notice was effective on January 1, 2019.

New Patient acknowledgement of Receipt:

____

Signature Date

____

Print Name