Michael J. Christie, M.D., F.A.C.O.G.
The Center for OB/GYN, P.L.L.C.

PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY AND READ CAREFULLY

DATE_____ YOUR SSN#_____-_____-_____

YOUR NAME_____MIDDLE INITIAL_____YOUR DATE OF BIRTH_____
Last First

YOUR MAILING ADDRESS
STREET_____CITY_____STATE_____ZIP CODE_____

YOUR HOME PHONE # (or where you can be reached) 1)_____
2) OTHER PHONE # WHERE YOU CAN BE REACHED_____

YOUR CELL PHONE #_____ **EMAIL**_____

YOUR EMPLOYER_____POSITION_____YOUR EMPLOYER PHONE #_____(EXTENSION)_____

EMPLOYER ADDRESS_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____RELATION TO PATIENT_____PHONE#_____

NEAREST RELATIVE NOT LIVING WITH YOU – NAME_____PHONE #_____

PARTNER/SPOUSE/PARENT - - PERSON RESPONSIBLE FOR BILL (GUARANTOR)

NAME_____DATE OF BIRTH_____S.S.#_____-_____-_____

PARTNER/SPOUSE/PARENT – EMPLOYER_____PARTNER/SPOUSE/PARENT - EMPLOYER PHONE #_____

RELATIONSHIP TO PATIENT (please circle) HUSBAND PARTNER PARENT LEGAL GUARDIAN

PLEASE CIRCLE ONE OF THE FOLLOWING METHODS OF PAYMENT-
CASH PRIVATE INSURANCE MEDICARE MEDICAID - - MEDICAID #_____
CREDIT CARD: VISA MASTERCARD
#1)INSURANCE CARRIER NAME _____ #2)INSURANCE CARRIER NAME_____

I authorize the treatment of the person named above and agree to promptly pay all fees and unpaid balances for treatment rendered. I understand that I must report all insurance coverage even though more than one company may be involved. I understand that payment is due at the time services are rendered. I am responsible for payment of all charges/fees regardless of insurance coverage (including any fee that is not covered by my insurance policy), and all proceeds of insurance are assigned to this office where applicable. I understand that if, for any reason, my insurance company should fail to cover my medical expenses, I will be held responsible for full compensation for medical services. This payment includes deductibles, coinsurance, copay, and any fee that is not covered by my insurance policy. I authorize payment to Dr. Christie benefits payable to me for any services rendered by Dr. Christie subsequent to this date and for such other charges as may be made by The Center for OB/GYN, P.L.L.C. I authorize Dr. Christie to disclose all or part of this patient's medical record to any insurance company or association, the Federal or State Government, such information as may be necessary for the completion of all claims for payment. I understand that should I fail to pay any or all of the debt incurred for medical services, all attorney fees, collection fees, and court costs will be added to my outstanding debt at the time of default. The rate for those fees will be calculated at up to 40% of the outstanding debt in addition to the balance due at the time of default.
Prior authorization for services to be rendered may be required by my insurance. If this authorization has not been obtained by myself, I understand my insurance may either deny or reduce the payment for these services. I understand that without prior authorization from my insurance company, I would be financially responsible for any denial or reduction in payment of services received.
I certify that I have read the above, understand the above, and as the patient or the patient's general agent, accept the terms as described above.

_____ _____ _____
PRINTED NAME OF PERSON RESPONSIBLE FOR BILL/GUARDIAN SIGNATURE DATE

Michael J. Christie, M.D., F.A.C.O.G
Board Certified OB/GYN

I understand that an ultrasound is a screening technique that may be of use in managing my medical care, both in relation to obstetrics (babies) and gynecology (uterus and ovaries). However, as with any clinical test or procedure, I understand that there is no guarantee of the results and there is a margin of error in the results as no test is 100% accurate. Therefore, while a particular positive or negative (normal) ultrasound finding may be of value, it is not a guarantee regarding the outcome of my medical care or pregnancy. Ultrasound, as with all technology used in medicine, has limitations. Some fetal anomalies (abnormalities) can be undetectable (not seen) on ultrasound examination.

I have read and understand that it is expected and normal that a certain percentage of abnormalities can be undetected (not seen) on ultrasound, both in obstetrics (babies) and gynecology (uterus and ovaries).

Printed name	Date	Time

Signature

Michael J. Christie, M.D., F.A.C.O.G.
The Center for OB/GYN

I understand that during the course of my care with Dr. Christie, I will likely have blood work, mammograms, pap smears, etc. performed. **I will call the office to get the results of my tests.**

If I do not hear from Dr. Christie's office regarding the results of any of these tests, I will call Dr. Christies' office to discuss the results of my tests. I will **NOT** assume "no news is good news". These tests are mine; I will take responsibility for checking with the office for these results.

Pap results and some cultures of the cervix, may take 10-14 business days before the results are sent to our office. Mammograms, blood test and urine results will generally take 2-3 business days to return.

THE PURPOSE OF HAVING YOU CALL OUR OFFICE IS TO MAKE CERTAIN THAT WE RECEIVE THE RESULTS FROM THE HOSPITAL, AND TO MAKE CERTAIN THAT YOU RECEIVE AND UNDERSTAND YOUR TEST RESULTS AS WELL. WE MAKE EVERY EFFORT TO CALL YOU WITH YOUR TEST RESULTS, BUT IF YOU DO NOT HEAR FROM US, CALL US.

Also, please do not lose your prescriptions. Dr. Christie will not re-write "lost" prescriptions.

I have read and understand the above, and I understand that I must call Dr. Christie's office for my test results if I have not been called within the above stated time.

_____ _____ _____

Printed name Date Time

_____

Signature

PLEASE KEEP ALL OF YOUR RECEIPTS FROM OUR OFFICE

Dr. Christie cares for patients with many different insurance plans and is a member of many different insurance networks. Sometimes it is not possible to determine whether or not Dr. Christie is a preferred provider with every patient's insurance. In the same respect, the services rendered by Dr. Christie may not be covered by your insurance. Therefore, it is ultimately your responsibility to make sure that Dr. Christie is "in network" with your insurance plan. If your insurance plan does not pay for the services provided by Dr. Christie, then you will be responsible for any charges not covered by your insurance plan.

I have read and understand the above statement. I agree to pay for any allowable charges that are my responsibility that are not covered by my insurance if Dr. Christie is not a preferred provider with my insurance plan.

_____ _____ _____

Printed name Date Time

_____

Signature

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐Home Telephone_____
☐ O.K. to leave message with detailed communication
☐Leave message with call-back number only

☐Written Communication
☐O.K. to mail to home address
☐O.K. to mail to work/office address
☐O.K. to fax to this number

☐Work Telephone_____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number

☐ Other _____
_____

My medical condition and medical information about me, including lab and test results (as well as information regarding my medical records) can be discussed with the following people:

1)_____ _____ _____
Name Relationship to me Phone Number

2)_____ _____ _____
Name Relationship to me Phone Number

_____ _____
Patient Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if complete properly will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom	(1)	Description of Disclosure	By Whom Disclosed	(2)	(3)

(1) check this box if the disclosure is authorized
(2) Type Key: T = treatment records, P = payment records, O = Healthcare Operations
(3) Enter how disclosure was made: F = fax, P = Phone, E = E-mail, M = mail, O = other

HIPAA Notice of Privacy Practices

MICHAEL J. CHRISTIE, MD, FACOG
2113 GOVERNMENT ST., BUILDING I-4
OCEAN SPRINGS, MS 39564
(228) 875-0025

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, employee review 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 at 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: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required 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 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 and 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_____

GYNECOLOGIC INTAKE HISTORY

NAME_____ **BIRTH DATE**___/___/___ **AGE**___ **DATE**___/___/___
RACE____ **HT**____**WT**____ **REASON FOR VISIT**_____
WERE YOUR REFERRED BY SOMEONE?_____**IF YES, WHO?**_____
DATE LAST MENSTRUAL PERIOD___/___/___ **LENGTH OF PERIOD**_____
DAYS BETWEEN PERIODS _____ **BIRTH CONTROL METHOD**_____
LAST PAP_____ **ABNORMAL PAP SMEAR OR MAMMOGRAMS**_____
NUMBER OF PREGNANCIES_____ **MISCARRIAGES**_____ **ABORTIONS**_____
ECTOPIC PREGNANCIES_____ **CESAREAN SECTIONS**_____**TERM BIRTHS**_____
LIVING CHILDREN_____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD AND NOTE THE YEAR:

VAGINAL DISCHARGE	_____	PAIN WITH SEX	_____	BLOOD DISORD.	_____
VAGINAL INFECTION	_____	D&C	_____	BLEEDING DISORD.	_____
PELVIC INFECTION	_____	DIARRHEA	_____	ANEMIA	_____
GONORRHEA	_____	CONSTIPATION	_____	HEPATITIS	_____
CHLAMYDIA	_____	BLACK STOOLS	_____	TUBERCULOSIS	_____
SYPHILIS	_____	BLOOD STOOLS	_____	GENITAL WARTS	_____
BREAST DISCHARGE	_____	PNEUMONIA	_____	ABNORMAL BLEED	_____
DES EXPOSURE	_____	BREAST LUMPS	_____	ASTHMA	_____
CONE BIOPSY/CRYO	_____	BREAST BIOPSY	_____	SHORTNESS BREATH	_____
FEMALE CANCER	_____	WEIGHT LOSS/GAIN	_____	OTHER LUNG DIS.	_____
OVARIAN CYSTS	_____	HIGH BLOOD PRESSURE	_____	BLOOD CLOTS	_____
OVARIAN TUMOR	_____	HOT FLASHES	_____	RHEUMATIC FEVER	_____
FIBROID TUMOR	_____	FEVER/CHILLS	_____	HEART MURMUR	_____
DYSPLASIA	_____	MIGRAINE/HEADACHES	_____	CHEST PAIN	_____
HERPES	_____	NAUSEA/VOMITING	_____	HEART DISEASE	_____
UNCTR URINATION	_____	THYROID	_____	STROKE	_____
PAINFUL URINATION	_____	DIABETES	_____	GALLBLADDER	_____
URINE FREQUENCY	_____	FAINTING SPELLS	_____	ULCERS	_____
KIDNEY STONE	_____	CANCER	_____	PAINFUL PERIODS	_____
KIDNEY INFEC.	_____	SWELLING	_____	CONVULSION	_____
OTHER	_____				

PLEASE CIRCLE YOUR ANSWER (YES OR NO) & FILL IN THE BLANKS

HAVE YOU EVER HAD PREVIOUS SURGERY? YES or NO IF YES, LIST SURGERY & YEAR

1)_____2)_____3)_____
4)_____5)_____6)_____

DO YOU HAVE ANY REGULAR MEDICAL PROBLEMS OR ILLNESSES? YES or NO IF YES, PLEASE LIST

1)_____2)_____3)_____
4)_____5)_____6)_____

DO YOU TAKE ANY REGULAR MEDICINES? YES or NO IF YES, PLEASE LIST

1)_____2)_____3)_____
4)_____5)_____6)_____

SOCIAL HISTORY

DO YOU SMOKE? _____ PACKS PER DAY _____ YEARS_____
DRINK ALCOHOL? _____ DRINKS PER WEEK_____ DRUG USE_____
MARITAL STATUS_____ OCCUPATION _____

FAMILY HISTORY

PLEASE INDICATE ANY RELATIVE WITH THE FOLLOWING:

ANY WOMEN IN YOUR FAMILY HAVE/HAD CANCER? YES or NO IF YES PLEASE LIST

CANCER/ CERVIX_____CANCER/OVARY_____CANCER/BREAST_____CANCER UTERUS_____
OTHER CANCER_____HIGH BLOOD PRESSURE _____
HEART DISEASE_____

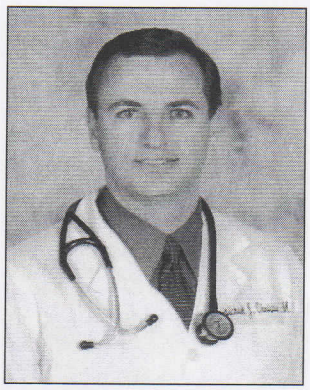
DATE REVIEWED:_____ **PHYSICIAN SIGNATURE:**_____
DATE REVIEWED:_____ **PHYSICIAN SIGNATURE:**_____
DATE REVIEWED:_____ **PHYSICIAN SIGNATURE:**_____
DATE REVIEWED:_____ **PHYSICIAN SIGNATURE:**_____

THE CENTER FOR OB/GYN, P.L.L.C

Michael J. Christie, M.D. F.A.C.O.G.

≈≈Board Certified ≈

Diplomat of the American Board of OB/GYN



147 Reynoir Street
Suite 102
Biloxi, MS 39530
Telephone (228) 374-3749

2113 Government Street
Building I-4
Ocean Springs, MS 39564
Telephone (228) 818-0025
Fax (228) 818-0027

Dr. Michael Christie, board certified obstetrician and gynecologist, opened The Center for OB/GYN in March 2003. The practice has locations in both Ocean Springs and Biloxi.

Dr. Christie believes in the old-fashioned doctor patient relationship with an emphasis on devoting his time and complete attention to his patients' health care needs. His medical philosophy includes building a strong partnership to ensure long-term health happiness.

Dr. Christie has gained a wide range of surgical and medical experience while having the opportunity to train in four different states. In addition to routine gynecological care and surgery, he also performs the latest and most up to date surgical techniques including laser surgery, advanced robotic assisted surgery, advanced laparoscopic surgery ("telescopic" surgery), as well as treat infertility. Many surgical problems that in the past have been treated with large abdominal incisions can now be handled through a laparoscope. This procedure, in which he has had extensive experience, provides the patient with a significantly faster recovery time, as well as much smaller incisions. In addition, Dr. Christie takes care of patients from the basic OB/GYN visit to high-risk pregnancies and complicated gynecological problems.

After completing medical school at The University of Southern California in Los Angeles, Dr. Christie completed his residency training in Virginia. He has been practicing OB/GYN on the gulf coast for over twelve years, and is proud to have opened his own practice, which serves the Biloxi and Ocean Springs areas. Dr. Christie became Board Certified in January 2003, became a Fellow of the American College of Obstetrics and Gynecology in June 2003, and a Diplomat of the American Board of OB/GYN.

Dr. Christie is happily married to his wife Diane and they have one daughter. Therefore, he is familiar with the excitement and fears a family may experience during the pregnancy and birthing process.
The Ocean Springs office (228-818-0025) is located between Oak Park Elementary School and Broome's Grocery on Government St. The Biloxi Office (228-374-3749) is located in the Merit Health Biloxi Suites, which is across from Merit Health Biloxi, Suite 102