

Patient Satisfaction Survey



Don't bother travelling to New York. Now, the high quality treatments which are a routine part of women's health internationally have come to you. Whether you need a simple check-up or 21st Century technologies, both are as close as your next appointment.

- Intrauterine Insemination
- Treatment of Polycystic Ovaries
- Evaluation of Pelvic pain
- Office Hysteroscopy
- Permanently Treat Heavy Bleeding with Endometrial Cryoablation
- Birth Control
- Prenatal Care
- Prevention of Preterm Birth with 17-alpha-hydroxy-progesterone
- Prevention Cervical Cancer & Warts with Gardasil HPV Vaccine
- Colposcopy, LEEP and more

252 Glynn; RR1 #6196

Kingshill, VI 00850

appointments@drmamourette.com

(800) 516-4090

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age: _____ Your Sex: (M) (F)

Please circle how well you think we are doing in the following areas:

	GREAT	GOOD	OK	FAIR	POOR
Ease of getting care:					
Ability to get in to be seen	5	4	3	2	1
Hours Center is open	5	4	3	2	1
Convenience of location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
Waiting:					
Time in waiting room	5	4	3	2	1
Time in exam room	5	4	3	2	1
Waiting to have tests	5	4	3	2	1
Waiting for test results	5	4	3	2	1
Staff:					
Provider: (Physician, Dentist, Physician Assistant, Nurse Practitioner)					
Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives good advice/treatment	5	4	3	2	1
Nurses and Medical Assistants:					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
All Others:					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
Payment :					
What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
Collection of payment	5	4	3	2	1
Facility:					
Neat and clean building	5	4	3	2	1
Ease of finding where to go	5	4	3	2	1
Comfort and Safety waiting	5	4	3	2	1
Privacy	5	4	3	2	1
Confidentiality:					
Keeping information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us:	5	4	3	2	1

What do you like best? _____

What do you like least about our center? _____

Suggestions for improvement? _____

Thank you for completing our Survey!

Dr. Mamourette.com

Ob-Gyn & Infertility

Patient Privacy Notice

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. If you have any questions about this notice, please contact : Moise Mamourette at (340)692-6263. This notice describes the privacy practices at our office. We are required by law to:

- * Maintain the privacy of protected health information
- * Give you this notice of our legal duties and privacy practices regarding your health information
- * Follow the terms of the notice currently in effect.

How we may use and disclose your health information Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Moise Mamourette. Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance. National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to Moise Mamourette.

Right to Amend. You have the right to request an amendment to your records by written request to Moise Mamourette.

Right to an Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Moise Mamourette.

Right to Request Restrictions. You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Moise Mamourette. We are not required to agree with your request, but we will try to comply. Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Moise Mamourette. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to privacy@drmmamourette.com, or,

Moise Mamourette, MD
252 Glynn; RRI #6196
Kingshill, VI 00850 (340)692-626

Patient Bill of Rights



Don't bother travelling to

New York. Now, the high quality treatments which are a routine part of women's health internationally have come to you. Whether you need a simple check-up or 21st Century technologies, both are as close as your next appointment.

Essure® Permanent Birth Control

Intrauterine Insemination

Treatment of Polycystic Ovaries

Evaluation of Pelvic pain

Office Hysteroscopy

Permanently Treat Heavy Bleeding with Endometrial Cryoablation

Prenatal Care

Prevention of Preterm Birth with 17-alpha-hydroxy-progesterone

Prevention Cervical Cancer & Warts with Gardasil HPV Vaccine

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A patient has the right to:

- Be treated with courtesy, respect, and with appreciation of his/her dignity, and with protection of his/her need for privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his/her care.
- Know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- Know what rules and regulations apply to his/her conduct.
- Be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges of care.
- Receive a copy of a reasonably clear and understandable, itemized bill and upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- To access any treatment that is in his/her own judgment and the judgment of his/her health care practitioner in the best interests of the patient including complimentary or alternative health care treatments, designed to provide an effective option to conventional treatments.
- Treatment for any emergency condition that will deteriorate without treatment.
- Have his/her reports of pain addressed promptly.
- Know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such experimental research.
- Express grievances regarding any violation of his/her rights, as stated in Virgin Islands law, through the grievance procedure of the health care provider or health care facility which served him/her and to the appropriate state licensing agency.

A patient is responsible for:

- Providing the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- His or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

Dr. Mamouzette.com

Ob-Gyn & Infertility

Moise Mamouzette, MD

252 Glynn RR1 6196
Kingshill, VI 00850
Phone 800-516-4090
FAX 340-692-6263

Patient's Name: _____
DOB: _____

DEMOGRAPHIC INFORMATION

Patient Name: _____ Age: _____ Date of Birth: _____

Mailing Address: _____
(STREET) (CITY) (STATE) (ZIP)

Social Security Number: _____

Patient's Sex: Female Married Single Widowed Divorced

Employed: F/T P/T Retired Student

Patient Employer: _____ Work Telephone: _____

Home Telephone: _____ Cell phone: _____

Email Address _____

May we contact you at work if necessary? _____

Another number where you could be reached in case of emergency? _____

Primary Care Physician: _____ Pharmacy: _____

Primary Insurance Co. Name: _____ Telephone: _____

Address: _____

ID No.: _____

Group No.: _____ CoPayment amount: _____

Guarantor's Name: _____ Insured's Date of Birth: _____

Patient's relationship to guarantor? self spouse child other

Secondary Insurance Co. Name: _____ Telephone: _____

Address: _____

ID No.: _____

Group No.: _____ CoPayment amount: _____

Guarantor's Name: _____ Insured's Date of Birth: _____

Patient's relationship to guarantor? self spouse child other

AUTHORIZATION

I authorize release of any information necessary to process my Insurance claims and assign and request payment directly to my physicians. I understand that I am financially responsible for all charges incurred for services rendered to me. I agree to accept full responsibility for payment to include the balance remaining after the payment of possible Insurance benefits.

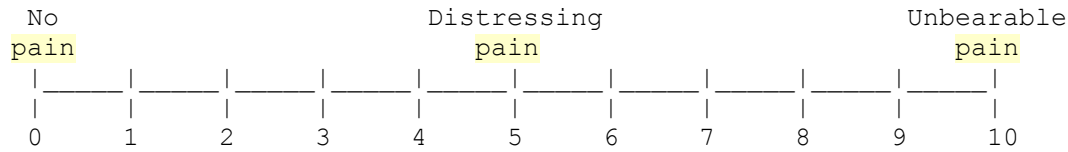
X _____ Date: _____
Signature of Patients or Responsible Party

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Patient's Name: _____
DOB: _____

0-10 Numeric Pain Distress Scale [1]



Flowsheet for Pain Management Documentation

DATE	PAIN RATING	ANALGESIC	HR	BP	LEVEL OF AROUSAL	OTHER	PLAN & COMMENTS

Moise Mamouzette, MD

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Patient's Name: _____
DOB: _____

Current Date: _____

Reason for visit: (Required for all visits) Annual GYN^{V72.3} Pain^{789.03, 4} Bleeding^{626.8} Swelling Discharge^{616.11}

Other: _____

On or about: _____ date, this patient began having pain bleeding of _____ (location).

Pain is sharp dull, constant intermittent, which occurs during _____ (context)

made worse by _____ better by _____.

The pain does not travel travels to _____ (location). Severity is _____ out of ten(10)

and is associated with: (circle) nausea vomiting diarrhea constipation frequency urgency nocturia dysuria

Other features: _____

Are you experiencing any of these symptoms:

Symptom	yes	no	Symptom	yes	no	If yes please provide more details.
No period ^{626.8}	<input type="checkbox"/>	<input type="checkbox"/>	Change in mood, crying, sleeping disturbances, insomnia)	<input type="checkbox"/>	<input type="checkbox"/>	
Mid-Cycle bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Belly getting bigger	<input type="checkbox"/>	<input type="checkbox"/>	
Clots with periods	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding after menopause	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding with urination	<input type="checkbox"/>	<input type="checkbox"/>	Leaking urine with cough, laughing sneezing, or jumping ^{625.6}	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse (sex) ^{625.0}	<input type="checkbox"/>	<input type="checkbox"/>	
Painful Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes ^{627.2}	<input type="checkbox"/>	<input type="checkbox"/>	OTHER			

Menstrual Profile:

Age of first period: _____ .I am irregular-or- regular, bleed for _____ days, pass Clots^{626.2}, have PMS^{625.4}

Any and all STDs?: _____

Last PAP date: _____ Normal? yes no^{795.0} Ever Abnormal? yes no Ever any LEEP/Cryo/Cone yes no

Last Mammogram date: _____ Normal? yes no Ever Abnormal? yes no Ever any GYN Cancer yes no

Last colorectal screening date: _____ Last DEXA: _____

Obstetrical History:

G		T		P		A		L		Comments Infertility, GDM, PIH, PTL, DVT/PTE, ABR, PPH ^{V13.7}
No	Mon/ Yr	Sex	Wt	Wks Gestation	Hours in Labor	Del. Type	Anesthesia			
1.										
2.										
3.										
4.										
5.										

Medical History: (check if applicable)

Obstetrical	yes	no	Gynecology	yes	no	Comments
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	DES exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Fetal Death ^{V25.2}	<input type="checkbox"/>	<input type="checkbox"/>	Incompetent Cervix	<input type="checkbox"/>	<input type="checkbox"/>	
Gestational Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low weight baby	<input type="checkbox"/>	<input type="checkbox"/>	
Hypermesis	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	
Preterm labor/birth ^{V25.41}	<input type="checkbox"/>	<input type="checkbox"/>	Isoimmunization	<input type="checkbox"/>	<input type="checkbox"/>	
Post Partum Depression	<input type="checkbox"/>	<input type="checkbox"/>	RH negative	<input type="checkbox"/>	<input type="checkbox"/>	

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Patient's Name: _____
 DOB: _____

Please tell us if you have or have had any of the following illnesses:

Check all that apply:		yes	no	(comment)			yes	no	(comment)
Accidents or Trauma	<input type="checkbox"/>	<input type="checkbox"/>			Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>		
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>			Cancer of any kind	<input type="checkbox"/>	<input type="checkbox"/>		
Hyperthyroidism or Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>			Seizures/Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		
Anemia/low platelets ^{V12.3}	<input type="checkbox"/>	<input type="checkbox"/>			Bowel Trouble	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>			Liver or Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			GERD or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>			Fractures	<input type="checkbox"/>	<input type="checkbox"/>		
Heart trouble/ Murmur	<input type="checkbox"/>	<input type="checkbox"/>			Blood Clots in Legs	<input type="checkbox"/>	<input type="checkbox"/>		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			HIV+ or AIDS	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			Other:				
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>							
Lupus	<input type="checkbox"/>	<input type="checkbox"/>							

Have you been hospitalized for any medical conditions? No _____ If yes explain: _____

Have you had any operations or biopsies? No _____ If yes explain: _____

Social History: Occupation: _____ Abuse/Stress _____

Did you ever have sex when you really did not want to? _____ Does anyone hit you? No _____ Who: _____

Sleep: _____ hrs/day restful -or- poor _____ Exercise _____ x/week _____ gym _____ walking _____ other: _____

Are you on a special diet? No _____ Which? _____

Smoke? *yes no* x _____ years _____ Drink Alcohol? _____ x/week Use Street Drugs? _____ x/week

Have Sex: _____ x/week Orientation: Lesbian, Straight, Bisexual, Birth Control Method? = _____

List all your current Meds: _____ Over The Counter?, _____ Vitamins, _____ OCP: _____ HRT: _____

List any drug or food Allergies: _____

Family Health History

	Name(s)	Age(s)	High blood Pressure V17.4	Diabetes V18.0	Stroke V17.1	Heart Attack V17.3	Cancer V16.9	Alcoholism
Mother								
Father								
Sisters								
Brothers								

BY MY SIGNATURE BELOW, I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE. IF I HAVE OMITTED ANY INFORMATION I hereby release Dr Moise Mamouzette and all his representatives and staff from liability for acts performed in good faith and without malice in connection with evaluating and treating me on the basis of the information I have provided or omitted

Signature of Patient _____ Date: _____

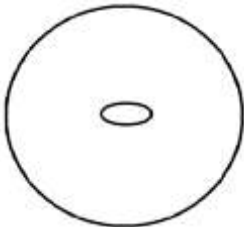
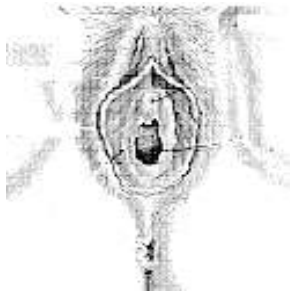
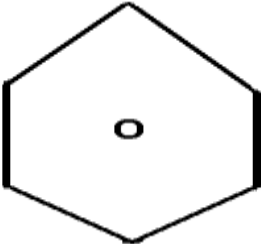
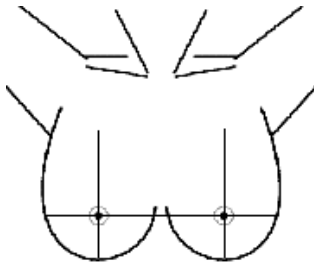
<http://www.drmmamouzette.com>

drm@drmmamouzette.com

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Patient's Name: _____
 DOB: _____



PE: GEN: _____ **BMI:** _____
 VS: BP _____ T _____ P _____ ir-reg, R _____ Weight _____ Height _____

Neck: erythema adenopathy thyromegaly

Breasts: Skin Normal BSE TAUGHT

Tumors None multiple, diffuse, bilat, nontender, mobile, ≤5mm

D/C None

Nodes Normal

Back Normal

Abdomen: Normal Scars _____

Genitalia Normal

Vagina: Normal

Cervix: Normal **PAP** Yes No

CT/NG Yes No

Uterus: Normal Bulky ^{621.2}

Adnexa: Normal Mass ^{789,33, 4}

Rectovaginal: Normal Guaiac: + / - ⁸²²⁷⁰

Groin nodes Normal

Extremities: Normal Varicosities _____ Edema _____

SKIN: Normal Vesicles _____ Macules _____ Papules _____

Blood _____
 Urobili _____
 Bili _____
 Prot _____
 Nitr _____
 Ket _____
 Glu _____
 pH _____
 SG _____
 Leuk ⁸¹⁰⁰² _____
 Urine Culture ⁸⁷⁰⁸⁸ _____
 Yes No ⁸¹⁰²⁵
UHCG: + / - ⁸²¹²⁰ _____
Whiff: + / - ⁸³⁹⁸⁶ _____
 Nitrite: _____
 () Acidic () Basic ⁸⁷²¹⁰
 Wet Mount _____

ASSESSMENT AND PLAN:

- US/TVS
- Colposcopy
- EMB
- Dx Surgery
- Rx Surgery
- Consult: _____ GI GU
- Psy _____
- F/U _____
- REI W/U
- URO W/U

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____

COUNSELED RE: Smoking ^{V65.42} Weight ^{278.00} Diet ^{V65.3} Exercise ^{V65.41} FP & BCM ^{V25.09} HIV ^{V65.44} BSE ^{V65.49}

Counseled ^{9940X} [_____] x15:00min Total Encounter [_____] min Signature: _____ Date: _____