Women's Care Associates

Marian Zinnante, M.D., F.A.C.O.G.
Sara Northrop, D.O., F.A.C.O.O.G.
Jessica Pearce, D.O.
Obstetrics & Gynecology

Dear Patient,

Thank you for you recently scheduled appointment. In preparation for your appointment please complete the attached health questionnaire and patient information form and either fax them to us or bring them with you to your appointment. This will help ensure you can be seen on a timely basis.

We also request that you please provide your insurance card and driver's license upon registration on the day of your visit.

We look forward to seeing you soon, and thank you for choosing us to care for you!

Sincerely,

The Medical Staff of Women's Care Associates

Fax: 817-473-4329

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Whom may we thank for referring you to our office? ______________________

PCP Name: ______________________

PATIENT DEMOGRAPHICS FORM

ALL ITEMS **HIGHLIGHTED IN BOLD MUST BE FILLED IN COMPLETELY

PATIENT'S NAME: ______________________ **MARITAL STATUS:** S M D W SEP

ADDRESS: ______________________ **CITY:** ______________ **ZIP:** ______

DATE OF BIRTH: _____ / _____ / _____ **SOC. SEC. #** _____ / _____ /_______ **RACE:** ______________

HOME # ______________ WORK PH # ______________ **CELL #** ______________

PREFERRED CONTACT: HOME WORK CELL **EMAIL:** ______________________

PHARMACY NAME: ______________ **ADDRESS/NUMBER:** ______________________

EMPLOYER: ______________________ **OCCUPATION:** ______________________

EMPLOYER ADDRESS: ______________________ CITY/ZIP: ______________________

SPOUSE/GUARDIAN: ______________________ RELATIONSHIP: ______________

EMERGENCY CONTACT NAME: ______________________ **RELATONSHIP:** ______________

ADDRESS: ______________________ **PHONE #** ______________________

PRIMARY INSURANCE CO.: ______________________ **INSURED'S ID #** ______________

NAME OF POLICYHOLDER: ______________________ **DATE OF BIRTH:** _____ / _____ /_____

RELATIONSHIP TO PATIENT: ______________________ **GROUP #** ______________

SECONDARY INSURANCE CO.: ______________ INSURED'S ID # ______________________

NAME OF POLICYHOLDER: ______________________ DATE OF BIRTH: _____ / _____ /_____

RELATIONSHIP TO PATIENT: ______________________ GROUP# ______________

We will need to make a copy of your Insurance Card (s) and Driver's License. Please have available upon request.

I verify that all the above information is correct. I also authorize the release of any pertinent private health information to Marian Zinnante, M.D and Sara Northrop, D.O. If you have an HMO, EPO, POS or PPO plan we will file your claim for you with assignment of benefits to this office. You may be responsible for co-insurance and/or deductible (when not met). It is the policy of this office to collect payment at the time of service for uninsured patients. I have read the above and accept the terms as written.

______________________________ ______________________

Signature of Responsible Party Date

Women's Care Associates

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AUTHORIZATION, CONSENTS, AND AGREEMENTS

Please initial next to each item

______ CONSENT TO TREATMENT: I the undersigned, as the patient, or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of physician on duty. I understand that no guarantee or assurances have been made as to the results, which may be obtained.

______ FINANCIAL AGREEMENT: I hereby guarantee payment for services to **Women's Care Associates.** I understand that I will be held responsible for court cost, legal fees, or agency fees, which may be incurred in the collection of the account.

______ ASSIGNMENT OF BENEFITS: I hereby authorize all insurance companies to pay direct to **Women's Care Associates** and any ancillary providers, any benefits and fees under my insurance policy or policies. I understand that this order does not relieve me of any obligation to pay the account. Also, any balance that is not covered by the insurance company is my responsibility.

______ RELEASE OF MEDICAL INFORMATION: I hereby consent and authorize **Women's Care Associates** to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefits from my health insurance carrier.

______ PAPERWORK COMPLETION REQUEST: I hereby consent to understanding that I will be held responsible for a $25.00 paperwork completion fee in the event that I must have Family and Medical Leave Act (FMLA) paperwork, Disability paperwork, or other similar forms completed by the office staff.

______ CANCELLATION POLICY: I hereby consent to understanding that all missed appointments will incur a $25.00 no show fee. To avoid this charge, I agree to provide **Women's Care Associates** with a minimum of **24-hour cancellation** notice prior to my appointment time.

______ MEDICAL RECORD REQUESTS: I hereby consent to understanding that should I request to have my medical records transferred to another physician's office, I will incur a fee in accordance with the Texas Statute as follows: $25.00 for the first 20 pages transferred and additional costs per page thereafter. I am aware that payment must be received prior to records being released from the office. Please allow a minimum of 7-10 business days for the request to be processed via fax or patient pickup in the office.

______ PRESCRIPTIONS: I hereby consent to understanding that should I need a prescription refilled, I will leave a message with the office or have my pharmacy fax/call in a prescription. Please allow 24-48 hours to complete the request.

______ ANNUAL EXAMINATION RESTRICTION: I hereby consent to understanding that an annual examination, as defined by insurance companies, consists of routine, preventative services including my annual pap smear and breast examination. Any additional services or treatments provided by the physician including but not limited to, prescription monitoring, infections, injections, and referrals, will not be considered as within the annual guidelines provided by my insurance company and I may be responsible for the additional charges after insurance has been filed.

I HAVE READ AND I ACCEPT THE TERMS DESCRIBED ABOVE.

______________________________ ______________________
Patient's Name Date

______________________________ ______________________
Signature of Responsible Party Relationship

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CONSENT AGREEMENT

Consent to the Use of Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and evaluation information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures (if requested by the patient). I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation they will mail a copy of any revised notices to the address I provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

No restrictions

I request the following restrictions to the use or disclosure of my health information:

____

(For Office Use) Restrictions are: accepted denied

____

Signature of Patient/Legal Representative Date

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Authorization to release Non-Public Personal Information and receipt of Privacy (HIPAA) Policy

I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize Women's Care Associates to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for evaluation, treatment, consultation or the processing of insurance benefits.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

☐ Telephone; which is ___________________________

- ☐ Leave message with call back number only
- ☐ (It is our policy not to leave a detailed message); however, you may check this box if it is OK to leave a detailed message rather than a "please call back" message.

☐ Written Communication:

- ☐ Ok to mail to my home address (on file)
- ☐ Ok to mail to an alternate address, which is ____________________________________
- ☐ Ok to mail to my workplace address, which is __________________________________

☐ Ok to fax to this number: ____

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name: __________________________ Relationship: _____________ Phone: __________________

Name: __________________________ Relationship: _____________ Phone: __________________

This authorization may be rescinded at any time by the patient as long as this office receives written request at least 10 days before effective date.

____

Patient Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable means to limit the use or disclosure of, and requests for PHI. We will do all in our means to accomplish the intended purpose. The provisions do not apply to notes or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosure information provided below if not notated in the body of the patient's chart notes. Please note: Uses and disclosures may be permitted without prior consent in an emergency.

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Thank you for providing the information below. You can be brief, but please include any information that you feel would be valuable to us. Thank you for choosing us, to care for you!

Name: ______________________________________ Age: _____________ DOB: _______________

Primary Care Physician: ____

Other physicians that care for you: ____

- ☐ I am here for my annual well woman visit.
- ☐ I am here for a problem-oriented visit.
- ☐ I am here for my annual well woman visit, but also have a problem to discuss.
- ☐ I am here to confirm pregnancy.

Please list all current or past **medical problems** you have had (**and when diagnosed/treated**):

____

____

____

Please list any **surgeries or hospitalizations** you have had and **when** they were:

____

____

____

Please list any **medications** (**with doses**) you are on (please include herbal meds/vitamins):

____

____

____

Do you have any drug allergies? None known Yes (**list below, with any reaction you had**)

____

When was your last pap smear? _________ Have you ever had an abnormal pap smear? _____________

If yes, what was done about it? ____

When was your last menstrual period? ____________ When did you start having periods? _____________

How many days are between the 1st day of your period, until the 1st day of your next period? ___________

How many days do your periods last? ____________ Are your periods heavy and/or painful? ___________

Do you use a birth control method? _______________ If so, what is it? _____________________________

Please list any sexually transmitted diseases you have had: ____

List **all pregnancies** you have had with the year and the outcome (including miscarriages or terminations); please also include any complications:

____

____

When was your last mammogram? _________________ Was it abnormal? ___________________________

When was your last DEXA (bone density) scan? ___________ Was it abnormal? ______________________

When was your last colonoscopy? _________ Was it abnormal? ____________________________________

Family History

(for Gynecologic and Other Cancers, please specify the type in the last column)

	Birth Defects	Osteoporosis	High Blood Pressure	Diabetes	Stroke	Heart Disease	Heart Attack	Blood Clotting Prob	Breast Cancer	Gynecologic Cancer	Other Cancer	Thyroid	Epilepsy	Other (please specify)
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Cousin	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Cousin	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Do you drink alcohol? _________ How much? _______________ Do you use illicit drugs? _____________

Do you smoke tobacco or use nicotine products? ___________ How much? _________________________

If no, have you ever used nicotine products? ____

Thank you for supplying this information. Please feel free to write in any other information you think would be helpful to us. Bring this completed form with you on the day of your visit. If possible, please bring any information from previous medical evaluations that would be pertinent to your visit.

I understand that all charges are due at the time of the visit. I understand that prenatal fees (if applicable) are due by the 32 weeks of gestation.

Signature: ____ Date: ________________________

Any other pertinent information or anything that requires more space than was given above:

____

____

____

____

____

____

____

NAME: ____ **DATE:** ______/______/______

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

(please check "YES" or "NO" and specify what it is on the lines below)

EYES (poor vision, pain, tearing, redness, light sensitivity, etc)	**YES**	**NO**
EARS, NOSE, THROAT (hard of hearing, ear ache, cough, stuffy/runny nose, etc.)	**YES**	**NO**
CARDIOVASCULAR (high blood pressure, heart, racing pulse, etc.)	**YES**	**NO**
RESPIRATORY (asthma, breathing problems, shortness of breath, etc.)	**YES**	**NO**
GASTROINTESTINAL (upset stomach, hernia, ulcer, etc.)	**YES**	**NO**
GENITOURINARY (kidney problems, bladder problems, etc.)	**YES**	**NO**
MUSCULOSKELETAL (joint pain, arthritis, muscle pain, etc.)	**YES**	**NO**
INTEGUMENTARY(acne, warts, skin growths, rash, etc.)	**YES**	**NO**
NEUROLOGICAL (numbness, seizures, paralysis, etc.)	**YES**	**NO**
PSYCHIATRIC (depression, anxiety, insomnia, etc.)	**YES**	**NO**
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)	**YES**	**NO**
IMMUNOLOGIC (multiple sclerosis, lupus, HIV, rheumatoid arthritis, etc.)	**YES**	**NO**

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ **Physician:** ______________________

Date Completed: ______________________ **Date of Birth:** ______________________

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For exaple: Colorectal cancer	none	—	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
______________________								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: ______________________

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer Syndrome
- ☐ COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis Syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: ______________________

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