PATIENT HISTORY QUESTIONNAIRE

Patient Name: ________________________ Age:__________ Today's Date: ___________________
Reason for this visit: ____
Referring Physician: ______________________ Preferred Pharmacy:___________________________
Email: ____
Mailing Address: ____
Marital Status: Single Married Long term Relationship Divorced Widowed

DRUG ALLERGIES: NO YES, List Name and Type of Reaction:

____ _____________________________________
____ _____________________________________
____ _____________________________________
____ _____________________________________
____ _____________________________________

MEDICATIONS/SUPPLEMENTS:

Name of Medication/Supplement	Dose	Frequency
______________________________	________________	__________________
______________________________	________________	__________________
______________________________	________________	__________________
______________________________	________________	__________________
______________________________	________________	__________________

FAMILY HISTORY: (Please put what family member and what side of family) **NONE**

Diabetes: ______________________________ Breast Cancer: ______________________________
High Blood Pressure:______________________ Ovarian Cancer: ____________________________
Heart Disease: ___________________________ Cervical Cancer: ____________________________
Stroke: _________________________________ Colon Cancer: _______________________________
Other: __________________________________ Other Cancer: _______________________________

SOCIAL HISTORY- DO YOU CURRENTLY?

Smoke Never Yes, _____ packs/day Former, Years smoked _____________
Use alcohol No Yes How often: ____
Use illicit drugs and/or Marijuana No Yes Type/frequency: ____________________
Exercise: Type: ________________________ How often _______________________
Employed: No Yes Occupation: ____

PAST SURGICAL HISTORY (List all surgeries and month/year performed) **NONE**

_______________________________________ ____
_______________________________________ ____
_______________________________________ ____
_______________________________________ ____
_______________________________________ ____

_____ Please initial here ONLY if you would like a chaperone present during your exam.

Review of Systems: Have you experienced any of the following in the **past 6 months?**

___Depression	___Anxiety	___Vomiting	___Nausea
___Diarrhea	___Constipation	___Rectal bleeding	___Hemorrhoids
___Vaginal discharge	___Vaginal odor	___Vaginal itching	___Appetite changes
___Changes in hair/nails	___Weight gain or loss	___Excessive thirst	___Abdominal pain
___Heart palpitations	___Tremors	___Hot flashes	___Fatigue
___Stiffness/joint pain	___Dizziness	___Urinary frequency	___Cough
___Difficulty swallowing	___Shortness of breath	___Chest pain	___Cold intolerance
___Bleeding w/ intercourse	___Painful intercourse	___Insomnia	___Change in moles
___Breast tenderness	___Breast lump	___Nipple discharge	___Painful urination
___ Blood in urine	___Leakage of urine	___Urinary frequency	

SCREENING HISTORY

Date of last pap smear: ______________________

Have you had abnormal pap smears? No Yes

Have you had treatment for abnormal smears? No Yes If yes, what type(s) of treatment have you had? Monitoring w/ Paps Laser Cone biopsy Colposcopy Loop Excision (LEEP) Cyrosurgery/freezing

Date of last mammogram: ________________

Have you had an abnormal mammogram? No Yes, when___________________________

Do you perform monthly self breast exams? No Yes

Date of last bone density scan (DEXA): __________________

Date of last colonoscopy: ________________________

GYN HISTORY:

Are you sexually active? No Yes

What birth control method(s) do you currently use? _________________________________

History of Sexually Transmitted Infections- Circle any that apply:

None Genital Warts/ HPV Herpes– genital or oral Syphilis Chlamydia Gonorrhea Pelvic Inflammatory Disease (PID) Other: ____

Have you been immunized for Human Papillomavirus (HPV)? No Yes

MENSTRUAL HISTORY(complete even if post-menopausal or no longer having periods)

Age at first period: __________

First day of last menstrual period: ______/_____/______

Do you have monthly periods? No Yes

Duration of bleeding: ________ days

Flow: Spotting Light Moderate Heavy Clots

If your menstrual periods are regular; periods start every: ____________ days

If your menstrual periods are irregular; periods start every:____ to ____ days (e.g. 12 to 60)

Does bleeding or spotting occur between periods? No Yes

Does bleeding or spotting occur after intercourse? No Yes

Is pain associated with periods? No Yes Occasionally

Age of menopause: __________ Have you had postmenopausal bleeding? No Yes

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PREGNANCY HISTORY:

Total # of pregnancies: _______ # of Living Children: _______ # of Abortions: _______
# of Miscarriages _______ # of Ectopic ________ # of Premature Births (37 weeks or less): _______
# of Full Term Births: _______ # of Multiple Births: ________
# of Vaginal Deliveries: ________ # of C/S (cesarean sections): ________
Birth weights: ____

PERSONAL PAST MEDICAL HISTORY (Check any that apply): **None**

	AIDS/HIV		Cancer Type:________________		Kidney Disease
	Abuse/Domestic violence		Depression		Bladder Problems
	Acid Reflux/GERD		Dermatologic Disorders		Liver Disease
	Acne		Diabetes		Neurologic/ Epilepsy
	Anesthesia Complications		Endometriosis		Osteoporosis
	Anxiety		GI Problems		Other
	Arthritis		Headaches		Ovarian Cancer
	Asthma		Heart Attack		Polycystic Ovaries
	Autoimmune disease Type: _________________		Heart Disease		Polyps
	Bleeding disorder		Hepatitis/Liver Disease		Stroke
	Hx of blood transfusion		High Cholesterol		Thyroid Problems Type:_____________________
	Breast cancer		Hypertension		Uterine Fibroids
	Breast Problem		Hx of Infertility		Varicosities

INTERESTED IN AESTHETIC LABIAL AND/OR VAGINAL SURGERY

___ I want aesthetic vaginal surgery
___ I have had difficult births
___ My labia are larger/looser than what I want
___ My vagina feels too loose inside
___ I do not like the way my labia looks
___ I have decreased sensations
___ My labia rub, tug, and pull on my clothing
___ I feel pelvic heaviness/pressure
___ I am unable to wear type of clothing I want
___ Sex is uncomfortable/unpleasant
___ I have had unflattering comments about my genital region
___ I am interested in G-spot treatment

INTERESTED IN NON-SURGICAL THERMIVA

___ To tighten the labia majora
___ To improve vulvar and vaginal moisture
___ To tighten the vagina
___ To improve sensitivity of tissues
___ To treat a leaky bladder
___ To improve or achieve orgasms
___ To reduce urinary urgency and frequency
___ Reduce painful intercourse

INTERESTED IN BIOIDENTICAL HORMONES

___ I want information on bio-identical hormones

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BHRT Checklist For Women

Name: ____________________ **Date:** ____________________

E-Mail:____________________

Symptom (please check mark)		Never	Mild	Moderate	Severe
1. Depressive mood	1.				
2. Fatigue	2.				
3. Memory Loss	3.				
4. Mental confusion	4.				
5. Decreased sex drive/libido	5.				
6. Sleep problems	6.				
7. Mood changes/Irritability	7.				
8. Tension	8.				
9. Migraine/severe headaches	9.				
10. Difficult to climax sexually	10.				
11. Bloating	11.				
12. Weight gain	12.				
13. Breast tenderness	13.				
14. Vaginal dryness	14.				
15. Hot flashes	15.				
16. Night sweats	16.				
17. Dry and Wrinkled Skin	17.				
18. Hair is Falling Out	18.				
19. Cold all the time	19.				
20. Swelling all over the body	20.				
21. Joint pain	21.				

Family History		NO	YES
1. Heart Disease	1.		
2. Diabetes	2.		
3. Osteoporosis	3.		
4. Alzheimer's Disease	4.		
5. Breast Cancer	5.		

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MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, **ovarian**, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of **other cancers**?	☐ Y ☐ N	**List them here:**		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	**Who?**	**What gene(s)?**	**What was the result?**

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature ______________________ Date __________

Healthcare Provider Signature ______________________ Date __________

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk®
☐ COLARIS®PLUS with Myriad myRisk® ☐ COLARIS *AP*®PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update
☐ Other: ______________________

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: ______________________

Financial Policy

Patient Name:_______________________________

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care, and we will be pleased to discuss our personal fees with you. Your clear understanding of our Financial Policy is important to our professional relationship. All patients must review and sign this form before seeing the doctor for the first time. Please ask if you have any questions about fees, our Financial Policy or your responsibility.

Our practice is In-Network with most major insurance companies. (BCBS, Cigna, United health, Multiplan, Aetna, Tricare, and Medicaid and Medicare) All patients must complete our patient registration form and give us necessary information before seeing a provider. **You are responsible for any portion of your bill that your insurance carrier denies or does not cover**. If your deductible is not met, we will require payment in full at time of service. If your deductible has been met, any co-payment will be collected at time of service. We accept personal checks, Mastercard, Visa and Debit cards.

If your insurance has not paid your account in full within 45 days, the balance will become your responsibility. If we do not receive your payment in full within 90 days from the date of the first statement, your account may be turned over to a third-party collection agency. *Your Insurance coverage is a contract between you and your insurance carrier*; however, we are available to assist you in maximizing your insurance benefits.

Please be aware that few insurance companies attempt to cover all medical costs. Some pay fixed allowances for each procedure while others pay only a percentage of the cost. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If your carrier requires a pre-authorization prior to certain procedures, our office will assist in obtaining it prior to your treatment. Preauthorization is not a guarantee of payment.

Patients without insurance

Patients being seen for a medical reason who do not have health insurance will be expected to pay for their first consultation in full at the time of service. If further testing or procedures are necessary, each case will be addressed individually at the time to work out a payment plan.

Charges may also be made for no-show appointments and appointments cancelled without 24 hours' advance notice. N0-shows and repeated cancellations may limit your ability to make future appointments.

If you have any questions concerning our Financial Policy; or if this creates an undue hardship, please contact our practice immediately to discuss special arrangements. You may reach our Office Manager through our main number (907-339-0363)

- By signing below, I verify that I have read and understand this Financial Policy:
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Modern Gynecology to release pertinent information to my insurance company when requested in order to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Modern Gynecology.
- I understand that should this debt become delinquent by 90 days after the first statement is sent out, the balance may be referred to a collection agency. I will be held responsible for all fees associated with the collection of my debt

______________________________________ ______________________

Signature of patient or responsible party Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.
Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot obtain, use or disclose your health information for any reason except for obtaining, using or disclosing information from or to other providers, radiology facilities and hospitals to aid in your treatment.

Security: You will be notified as soon as possible if the security of your personal health information is breached.

Uses and Disclosures of Health Information

We may use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may use and disclose your health information to a physician, pharmacist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interests that may be involved with your treatment.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails or letters).

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.
It is important for you to understand email is not a secure form of communication and content communicated in emails may be intercepted by unauthorized third parties (e.g. computer hackers). Additionally, email can accidentally be sent to individuals or groups for whom the email was not intended. It is important for you to understand these risks if you choose to communicate with Alaska Center for Pain Relief via email.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Non-disclosure to insurance company: If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.

Electronic Notice: You may receive a paper copy of this notice upon request.

Questions and Complaints

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I, ____ acknowledge that I was provided a copy of the Notice of Privacy Practices for **Modern Gynecology**.

Signature of Patient: ________________________________ Date: _____________

Signature of Guardian:_______________________________ Date: ______________

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I ________________________authorize Modern Gynecology to use and/or disclose certain protected health information (PHI) about me to: ________________________________ (Name of entity to receive this information).

Relationship to the patient:_______________________.

This authorization permits Modern Gynecology to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, origin of information, etc.

The information will be used or disclosed for the following purpose:

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on [date]: ______________, or defined event.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy and Security Officer at: 3851 Piper St – Suite U464, Anchorage, AK 99508.

Print Patient's name or legal guardian: ____

Signed by: ____Date:__________________

NO SHOW/MISSED APPOINTMENT POLICY

We, at Modern Gynecology, understand that sometimes you need to cancel or reschedule your appointment and there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24 hour notice). You can cancel appointments by calling the following number: 907-339-0363.
To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted 1 business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

- Please cancel your appointment with at least 24 hours notice: There is a waiting list to see the clinician's at Modern Gynecology and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
- If less than a 24 hour cancellation is given this will be documented as a "No-Show" appointment.
- If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
- If you have "No-Show/Missed" appointment documented, you will receive a $75.00 No-Show fee.
- If you have 3 "No-Show/Missed" appointments within a one year time period, dismissal from the practice will be considered. You will be notified by letter if the dismissal was approved.

I have read and understand Modern Gynecology No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Modern Gynecology appropriately if I have difficulty keeping my scheduled appointments.

_______________________________ _________________ ___________

Patient Signature Relationship to Patient Date

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AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR PATIENTS

PATIENT NAME:___________________________________ DOB:____________

I hereby authorize and direct my insurance benefits to be paid directly to my personal physician or Modern Gynecology.

I also authorize Modern Gynecology to release any information necessary to process this claim. I understand that information will be released to:

Billing department of the physician and/or practice
Insurance carrier to process claim

I understand that my information, under certain circumstances may be released for on of the following reasons:

- Other Healthcare professionals in order to coordinate my care or treatment
- Insurance adjuster - if my claim is a work or motor vehicle injury
- Employer - if my claim is related to a work injury
- Attorney - if my claim is in a litigation process
- Health insurance carrier, for chart audit reason, and for claim payment

I understand that Modern Gynecology and/or their staff and billing office will not release and information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that Modern Gynecology and/or their staff and billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and others errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to outside sources such as your insurance carrier from the clinical or billing office.

This office is not responsible for any disclosure of your confidential medical information once we provide this information, AT YOUR request, to your insurer, employer, family member or otherwise.

With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physicians, their staff and/ or their billing office control.

By my signature, I state that I have read, understanding, and agree to this Authorization and Release.

____
Patient or Guardian Signature

____
Date

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Explanation of Fees for Gynecological Visits

We are required by our contract with your chosen insurance carrier to file your claims according to the services that we provide. There are two basic types of visits:

1)Routine, Well Women, Preventative, or Yearly Visit: These are visits to prevent health problems and to review any recommended age-appropriate screening tests such as mammograms, pap smears, and bone density analysis. Weight, smoking, diet, constipation, vaccinations, sterilization, contraception, STD screenings and lipid screening might be addressed. This is not a visit to discuss current problems that you might be having that need to be addressed or to prescribe new medications. Current prescriptions may be refilled if there are no changes to your health since you were last seen. Insurance only covers these types of visits once a year. If your claim is denied for this reason, we will bill you for this visit as non-covered.

2) Problem/ Follow Up Visits: These are visits to address symptoms or complaints that might signify the need for diagnosis and treatment or require the ordering of further testing for evaluation. They may be for illness or follow up of a medical condition. These types of visits may be for menopause symptoms, period problems, infertility, headaches, insomnia, sexual dysfunction, fatigue, depression, pain, etc. These visits will focus on the problems that you want to discuss. The visit may or may not include an examination.

Your coverage for these two types of office visits is determined by your particular insurance contract. It is your responsibility to know what is covered at 100%, what is covered with a deductible and/or a copayment, and what services are not covered.

If you want to have your visit limited to a Preventative/Annual Visit it is your responsibility to make that known prior to seeing Dr. Jill. If your visit expands to a Problem Visit as described above, the visit will be billed accordingly and additional deductibles and copayments will be applied.

We will make every effort to help you maximize your insurance coverage but we will bill according to national billing guidelines. We will not be able to honor requests to change what was billed at any time unless there was a billing/coding error.

At either type of visit, laboratory testing may be ordered. We will code the reason for the testing appropriately but the laboratory is responsible for billing your insurance. For lab work, you may still be responsible for deductible and copayment even if the visit is covered at 100%. It is important to know what lab is preferred for your insurance and to let the office staff know at the time of your visit. All labs drawn in the office are sent to and billed by Labcorp.

____ ________________________
Signature of patient or responsible party Date