PATIENT REGISTRATION FORM

ADVANCED GYNECOLOGY PROF, LLC

(Print clearly & press firmly in black ink)

Today's Date: _____

Patient Name: _____
Last First MI Nickname

Date of Birth: _____ SSN _____ Gender F M

Address: _____
Street Apt City State Zip

E-Mail (please print legibly): _____

Primary Phone ( )_____ May we leave a message? **YES** **NO**

Secondary Phone ( )_____ May we leave a message? **YES** **NO**

Work Phone ( )_____ OK to call work? **YES** **NO**

Primary Care Physician_____ **Referring Physician**_____
Last First Last First

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Secondary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone ( ) _____ Secondary Phone ( )_____

Preferred Language: **EN-English** **FR French** **VI-Vietnamese** **Other**_____
ES-Spanish **ZH-Chinese** **KO-Korean**

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____ Phone ( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?

Name _____ Relationship _____ Phone ( )_____
Last First

Patient Signature: _____

FINANCIAL POLICY ADVANCED GYNECOLOGY PROF LLC

(Print clearly & press firmly in black ink
Each line has to be initialed)

Today's Date_____

Patient Name_____
Last First MI

Date of Birth_____

Please carefully review this information and sign/initial where indicated. **<u>Please note: The following policies are non-negotiable and failure to agree to all policies gives our practice the right to refuse service:</u>**

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to Advanced Gynecology, LLC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Advanced Gynecology, LLC to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ ***(Initial) I have read and agree to the above statement.***

COPAYS/DEDUCTIBLE: Insurance co- payments are mandated by your insurance company and **MUST** be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied.
I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided. I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____ ***(Initial) I have read and agree to the above statement.***

SELF-PAY: Self-pay and previous balance amounts are **<u>due and payable at the time of service</u>**. Unless prior arrangements have been made.

_____ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

PRIVACY POLICY: I have been made aware of the privacy policy of Advanced Gynecology, LLC and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

_____ ***(Initial) I have read and agree to the above statement.***

Outstanding Patient Balance Interest and Service Charges:
All Patient balances over 60 days past due on statements may be charged a $20 per month service charge and 12% annual interest rate. If you are on a payment plan and stay current, no service charge or interest will be accrued.

_____ ***(Initial) I have read and agree to the above statement.***

Please read the following 3 policies:

******NO SHOW POLICY: I understand and agree that a $75.00 charge will apply for appointments that I do not honor or do not cancel within 24 hours prior to the scheduled appointment. I also understand that the practice reserves the right to terminate me as a patient for non-compliance with our NO-SHOW policy.**

I understand and agree that there will be a $250.00 charge for scheduled surgery or procedures that I do not honor or do not cancel within 5 days prior to the scheduled appointment.

_____***(Initial) I have read and agree to the above statement.***

******LAB POLICY There are times when your insurance may decide that a specific lab test or procedure is required or may decide not to pay for a test or procedure. ADV will not change its medical practices to meet your insurance requirement but, will ensure quality medical care based on community and American College of Obstetrics & Gynecology (ACOG) standard requirements. It is your responsibility to either accept these recommendations and proceed with the care and make the appropriate payments OR DECLINE the recommendations and testing before it is provided, or you will be charged and held responsible for those services in full by the corporation providing those services (e.g. outside labs or facilities).*******
_____***(Initial) I have read and agree to the above statement.***

*****WELL WOMAN POLICY It is your responsibility to understand what your insurance does or does not pay for. Annual well woman examinations are typically a 30 minute visits and NO specific problems. Some insurance plans only pay for this type of visit exactly one year and one day past the last routine well woman exam, or possibly every two years. In the case of Medicare, certain portions of your well woman visit are not covered at all; and other portions only every two years unless you have a high risk reason for annual coverage. Some Medicare supplement plans cover the difference, but not all. Should you have medical issues during your well woman exam, they may be re-scheduled for a problem follow up appointment at another time. If it is medically necessary for those problems to be addressed in today's visit, your visit will not be able to be billed as a routine well woman exam. Some insurance plans, require more out-of-pocket expense to the patient for non-routine problem gynecological exams *****

_____***(Initial) I have read and agree to the above statement.***

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

Patient / (Legal Guardian) Signature: _____ **Date:** _____

Advanced Gynecology Prof. LLC.

265 S. Parkside Dr. Suite 100 Colorado Springs CO 80910 (719)-633-8773 Ph. (719)-633-1905 Fax

Patient Name: _____

Patient Date of Birth: _____

Both Advanced Gynecology and myself, firmly desire to resolve all disputes arising hereunder without resorting to litigation in order to protect their respective personal and business reputations and the confidential nature of certain aspects of our relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, Association, or such other arbitration association as select by Advanced Gynecology, in its sole discretion. In accordance with its Commercial Arbitration Rules, and judgement on the award rendered by the arbitrator or arbitrators, their rulings and judgements shall be binding and conclusive on the parties, and shall be kept confidential by the parties to the greatest extent possible. The parties shall make no disclosure of the award except as required by law or as necessary or appropriate to effectuate the terms thereof.

The Party being adjudicated as winning the arbitration ruling shall also be entitled to all reasonable legal costs including travel and expenses.

This agreement does not reduce or relinquish either party from being represented by legal counsel or others at their discretion.

Patient Signature: _____ Date: _____

Medical History

Patient name: _____ **Patient date of birth:** _____

Current medications and doses/frequency:

_____
_____
_____
_____

Drug Allergies:

_____
_____
_____
_____

Previous surgeries with dates:

_____
_____
_____
_____

Past Medical history

_____
_____
_____
_____

Date of last Mammogram: **Date:** _____ **Results:** _____
Date of last DEXA: **Date:** _____ **Results:** _____
Date of last Colonoscopy: **Date:** _____ **Results:** _____
Date of Last PAP **Date:** _____ **Results:** _____

Have you had any of the following?

	Yes	No		Yes	No		Yes	No
Anesthesia or lung prob	___	___	Bleeding disorders	___	___	Hepatitis	___	___
Breathing difficulty	___	___	Heart Problems	___	___	Diabetes	___	___
Blood clots	___	___	Hypertension	___	___	Ulcers	___	___
Liver disease	___	___	Thyroid Disease	___	___	Smoker	___	___
Blood Transfusion	___	___	Pelvic Infection	___	___	Migraines	___	___
MRSA/VRE	___	___	Psychiatric disorder	___	___	with aura		
						Addictions	___	___

Have you had any sexually transmitted disease? If so please describe _____
Have you had the Human papillomavirus vaccine (HPV)? YES ___ NO ___
Have you had the Hepatitis B vaccine? YES___ NO ___

Family History of:	Yes	No		Yes	No
Diabetes	___	___	Fever with anesthesia	___	___
Heart disease	___	___	Cancer of bowel, uterus, ovaries, or breast	___	___
DVT	___	___	Pulmonary Embolism	___	___

Ashkenazi Jewish or French Canadian descent Yes_____ No_____

Other inherited diseases: _____
Number of Pregnancies _____
Other: _____

Please sign: _____ **Date:** _____

Advanced Gynecology

Review of Systems

Name: _____ DOB: _____ Date: _____

PLEASE REVIEW ALL OF THESE SYMPTOMS—CIRCLE ANY RECENT PROBLEM AREAS (LAST TWO WEEKS)

****DO NOT CIRCLE UNDERLINED BOLD TITLES****

Eyes: blurred vision, eye pain, loss of part of visual fields, eye discharge, dry eyes, double vision

Ears/Nose/Mouth/Throat: sore throat, hoarseness, ear pain, hearing loss, nosebleeds, ringing in your ears, sinus problems, neck mass or enlargement, difficulty swallowing

Cardiovascular: chest pain, difficulty breathing with exertion, swelling of lower legs or hands, sudden difficulty breathing at night, shortness of breath, irregular heartbeat, rapid heart rate

Respiratory: cough, coughing up blood, shortness of breath, difficulty breathing, wheezing, exposure to tuberculosis, need to sleep propped up to breath

Gastrointestinal: abdominal pain, abdominal bloating, constipation, diarrhea, blood in stool or black/tarry stools, reflux or heartburn, loss of appetite, nausea, vomiting, feeling full early, blood in vomit, yellowing/jaundice of skin, alcoholism, stool incontinence

Genitourinary: excessive menstrual bleeding, bleeding between periods, irregular frequency of periods, disruptively painful periods, passing clots with periods, vaginal bleeding after menopause, abnormal vaginal discharge, new sexual contacts or STD exposure, frequent urination, leak of urine with cough/sneeze/exercise, leak of urine after sudden urge, frequent kidney or bladder infections, incomplete emptying of bladder, difficulty getting pregnant, pressure in vaginal area, push things into vagina for BM/urine, painful urination, painful intercourse, blood in urine, breast lump or skin changes, nipple discharge or bleeding, breast swelling or pain

Musculoskeletal: back pain, joint pain, joint swelling, muscle weakness, muscle pain, loss of height

Integumentary: rash, concerning or changing skin lesion, excessive acne

Neurological: seizures, headaches, migraines, numbness, dizziness, sensation of room spinning, weakness, difficulty with speech

Psychiatric: depressed mood, trouble sleeping, easily irritated, decreased interest in activities, suicidal thoughts, suicidal planning, anxious mood, panic attacks, alcohol or drug dependence

Endocrine: heat intolerance, cold intolerance, excessive thirst, change in hair or skin texture, excessive sweating, hair growth on face, bulging of eyes, hot flashes, mood swings

Hematologic/Lymphatic: easy bruising, enlarged lymph nodes, tendency toward prolonged/excessive bleeding

Allergic/Immunologic: frequent infections, fever, chills

Constitutional Symptoms: fatigue, unintentional weight loss or gain, night sweats

Other: _____

_____

Patient signature: _____

Personal Information

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

Today's Date: _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents or great grandchildren

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	OTHER CANCER(S) (SPECIFY):							

☐ Y ☐ N Are you of Jewish descent?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If yes, please explain and include a copy of the result:

Testing Criteria (Check all that apply to you or your family)

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at or under age 45*
- ☐ Ovarian cancer at any age*
- ☐ Two primary breast cancers in the same person with one diagnosed at or under age 50*
- ☐ Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
- ☐ Three relatives on the same side of the family with breast and/or ovarian cancer at any age
- ☐ Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
- ☐ Male breast cancer
- ☐ Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer**

Lynch Syndrome

- ☐ A personal history of colon/rectal cancer or endometrial cancer diagnosed at or under age 50
- ☐ A personal history of two or more Lynch syndrome cancers***
- ☐ Two or more relatives with a Lynch syndrome cancer***, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer*** at any age

☐ A previously identified BRCA1 or BRCA2 mutation, or Lynch syndrome mutation in the family

* In self, first or second degree family members
**HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*
***Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Cancer Risk Assessment Review and Counseling

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only:

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Appointment: _____

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____

Print Name

_____ _____

Patient (or Patient Representative*) Signature Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. **This form must be maintained for 6 years.**