

W *falany & hulse* WOMEN'S CENTER

Administrative Patient Information

Name (Last, First, Middle)			SSN#		
Date of Birth:		Age	Marital Status	Maiden Name	
Address			City, State		Zip Code
Patient Home Phone		Patient Cell Phone		Patient E-mail	
Patient Business Phone			Patient Occupation		
Business Address			City, State		Zip Code
Spouse/Parent/Guardian Name (If under age 18):				Employer	
Address			City, State		Zip Code
Business Phone		Alternative Phone		Relationship (Parent, Spouse, Guardian)	
In case of Emergency:				Phone:	
Do you have a living will? Y N		Who referred you to our practice?			
Primary Insurance Company:			Secondary Insurance:		
Address:			Address:		
City, State, Zip Code:			City, State, Zip Code:		
Phone:		Co-Pay:	Phone:		Co-Pay:
Insured Party ID#			Insured Party ID#		
Group ID#			Group ID#		
Name of Insured:			Name of Insured:		
Sex:	Date of Birth:		Sex:	Date of Birth:	
SSN of Subscriber:			SSN of Subscriber:		
Relationship to Patient:			Relationship to Patient:		
<p>*** Payment is due at time of service. ***</p> <p>Assignment and Release; I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign to Falany & Hulse Women's Center, P.C., all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am fully responsible for all charges not paid by my insurance company. I hereby authorize this practice to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all submissions. I fully understand that any outside lab work performed will be billed by that lab, independently.</p>					
Patient's Signature:				Date:	

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HIPPA - Patient Consent Form

PATIENT CONSENT FOR USE / DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____ Previous / Other Name (s): _____

I understand that the patient's health information is private and confidential. I understand that Falany & Hulse Women's Center, P.C. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Falany & Hulse Women's Center, P.C. may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

Falany & Hulse Women's Center, P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I will have a right to read the "Notice" before signing this agreement.

Falany & Hulse Women's Center, P.C. may update this "Notice of Privacy Practices". If I ask Falany & Hulse Women's Center, P.C. will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Falany & Hulse Women's Center, P.C. to limit how the patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Falany & Hulse Women's Center, P.C. does not have to agree to my request. If Falany & Hulse Women's Center, P.C. does agree to my request, I understand that Falany & Hulse Women's Center, P.C. would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

- 1) Signing and dating a form that Falany & Hulse Women's Center, P.C. can give me called "Revocation of consent for Use and Disclosure of Health Care Information", or
- 2) Writing, signing, and dating a letter to Falany & Hulse Women's Center, P.C.. If I write a letter, it must say that I want to revoke my consent to authorize and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Falany & Hulse Women's Center, P.C. does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Falany & Hulse Women's Center, P.C. "Notice of Privacy Practices". My signature means that I agree to allow Falany & Hulse Women's Center, P.C. to use and disclose the patients personal health information to carry out treatment, payment, and health care operations.

Patient / Legally-Authorized Signature: _____ Date: _____

Relationship to patient if signed by anyone other than patient: _____

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Notice To All Patients

Patient Name: _____ Account Number: _____

To enhance our communication capabilities with our patients, we are now collecting e-mail addresses and alternate phone numbers for each patient. Please list these numbers and addresses below. As with all records, this will be kept in the strictest confidence under HIPPA guidelines.

Please note, for the benefit of our patients, we will contact you with your test results by phone if there is a reason for you to come back for a follow-up appointment. You will be called with these results as soon as they arrive back at our office.

Thank you for your cooperation.

Home Phone Number: _____ Best time to call: _____

Work Phone Number: _____ Best time to call: _____

Cell Phone Number: _____ Best time to call: _____

Preferred Pharmacy Name: _____ Number: _____

Address: _____

E-Mail Address: _____

Alternate E-Mail: _____

Please allow our office to notify you of appointment changes and test results according to office policy.

Date Updated: _____

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We welcome you to our office as a new gynecological patient:

Please read the following information below very carefully before you sign at the bottom. We will be happy to answer any questions you may have.

We thank you for the opportunity to serve your medical needs. Our office schedules exams by appointment only and we strive to provide care in a timely manner. Likewise, we ask that you arrive promptly for scheduled appointments. If you need to cancel or reschedule, please contact us at least 24 hours in advance - failing to contact us may result in billing you a \$50 "no show" fee. As a courtesy, we will allow you one "no-show" at no cost.

Insurance: We will file your claims for you, however, you are responsible for your co-pay, deductible, or any charges that are not covered by your insurance plan.

Assignment: Please check with the front office and we will be glad to answer questions regarding your insurance plan, but it is the patient's responsibility to check with their insurance company regarding provider/doctor participation. You will be responsible for your deductible and any charges that your insurance does not cover.

All Others: If we are not on your insurance plan, you are expected to pay IN FULL TODAY. We will give you the proper paperwork to file with your insurance.

Self-Pay: You are responsible for your charges and will be expected to make payments in full today, unless you have made previous arrangements with our billing department.

Please provide your signature and today's date for our records verifying that you have read and understand this document.

I authorize the release of any medical information necessary to process insurance claims. I authorize and permit payment directly to the Doctor. I recognize and accept responsibility for any balance remaining after payment of such benefits.

Patient Signature

Date

Name: _____

Reason for Visit: _____

Past Medical History (please check all those that apply)

<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	Date of Last :
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Abnormal Mammogram	<input type="checkbox"/>	Pap :
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Breast cancer	<input type="checkbox"/>	Mammo :
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>		<input type="checkbox"/>	Bone Density :
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Colonoscopy :

Past Surgical History (please list all past surgeries)

Medications (please list all medications you are currently on)

Pharmacy Name and Phone #: _____

Allergies

Do you have drug allergies? No _____ Yes, please list _____

Other allergies: _____

Family History (check all those that apply, if yes, explain)

<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Other	

Reproductive History

Date of Last Menstrual Period: _____

Age at First Menstrual Period: _____

If menstrual period has stopped, age of last period: _____

Sexually Active:

Type of Contraception: _____

Are your periods regular? Yes _____

- No, Please Explain _____

Do you experience clots while menstruating? No _____

- Yes, Please Explain _____

Do you have problems with break through bleeding? No _____

- Yes, Please Explain _____

Are you on Hormone Replacement Therapy? Yes _____ No _____

Total Pregnancy	<input type="checkbox"/>	Full Term Birth	<input type="checkbox"/>	Premature Birth	<input type="checkbox"/>
Abortions	<input type="checkbox"/>	Miscarriages	<input type="checkbox"/>		<input type="checkbox"/>

	First Name	Date of Birth	Birth Weight	Doctor's Name	Delivery Method	Complications
1						
2						
3						
4						
5						
6						
7						

Social History

Do you smoke? If so, packs per day: ____ Drink? ____ Use Drugs? ____ Marital Status: ____
 Have you experienced depression or domestic violence? Please explain (Confidentiality is Guranteed)

Please circle all of the symptoms you are CURRENTLY experiencing.

Constitutional	fatigue	weight loss	weight gain
	loss of appetite		
HENT	headaches	thyroid mass	
Breasts	lumps	tenderness	swelling
	redness	nipple discharge	changes in breast size
Cardiovascular	chest pain	irregular heart beats	limb swelling
Respiratory	shortness of breath	wheezing	cough
Gastrointestinal	nausea	vomiting	diarrhea
	constipation	abdominal pain	hemorrhoids
Genitourinary	urgency	frequency	decreased libido
	vaginal discharge	possible pregnancy	significant PMs
	difficulty voiding	leaking	pain with urination
	menstrual irregularities	menstrual cramping	
Integument/Skin	rash	itching	hair growth change
	changes to existing skin lesions or moles	acne	
Muscoskeletal	joint pain	back pain	hip pain
Endocrine	loss of hair	cold intolerance	night sweats
	hot flashes		
Psychiatric	anxiety	depression	difficulty sleeping
Heme-Lymph	easy bleeding	easy bruising	

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SCREENING QUESTIONNAIRE

Name _____ Date _____

Please circle "Yes" or "No"

1. Do you have heavy periods? Yes No
2. Do you have pain with periods? Yes No
3. Do you have pain with intercourse? Yes No
4. Are you interested in permanent contraception? Yes No
5. Do you have fibroids? Yes No
6. Do you ever leak urine? Yes No
7. Do you leak urine with a strong urge on the way to the bathroom? Y / N
8. Do you leak urine when you cough, sneeze, laugh, lift, exercise? Y / N
9. Do you wear pads to protect your clothes from urine leaking? Y / N
10. Do you urinate frequently during the day? Yes No
11. Do you wake up at night to urinate? Yes No
12. Are you interested in a Diet Program? Yes No

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
 Date of Birth: _____ Date completed: _____

Please circle Y to those that apply to **YOU and/or YOUR FAMILY (BLOOD RELATIVES** on both your mother OR father's side.) Please list your relationship to the individual diagnosed (including: self, mother, father, brother, sister, maternal/paternal aunt, maternal/paternal uncle, children, first cousins, nieces, nephews, paternal/maternal grandfather and paternal/maternal grandmother; **NOTE: brothers and/or sisters should be listed on mother's side**) and the age at cancer diagnosis. If you circled yes to one or more statements, you may be a candidate for a blood test to help determine if you have an inherited risk of cancer

	Self	Mother's Side	Father's Side	Age
<u>BREAST AND OVARIAN CANCER</u>				
Y N - Breast cancer before age 50				
Y N - Breast cancer after age 50				
Y N - Breast cancer in both breasts or multiple primary breast cancers				
Y N - Ovarian Cancer				
Y N - BRCA Mutation carrier				
Y N - Male breast cancer				
Y N - Triple Negative Breast Cancer (Age 50-60)				
Y N - Pancreatic Cancer				
Y N - Ashkenazi Jewish ancestry				

<u>COLON AND ENDOMETRIAL CANCER</u>				
Y N - Endometrial cancer before age 50				
Y N - Endometrial cancer after age 50				
Y N - Colorectal cancer before age 50				
Y N - Colorectal cancer after age 50				
Y N - Ovarian Cancer, any age				
Y N - Brain cancer, any age				
Y N - Gastric Cancer, any age				
Y N - Small Bowel Cancer, any age				
Y N - Pancreas/Biliary Cancer, any age				
Y N - Sebaceous adenoma				
Y N - 10 or more colon polyps found in a lifetime				
Y N - Renal pelvis cancer, any age				
Y N - MSI/ IHC abnormal (colon/endometrial)				
Y N - HNPCC/Lynch Syndrome Mutation Carrier				

<input type="checkbox"/> Patient is a candidate for genetic testing <input type="checkbox"/> Patient offered genetic test <input type="checkbox"/> Information given to patient <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <input type="checkbox"/> Appointment follow up date _____

Patient's Signature _____ Date _____

Healthcare Provider's Signature _____ Date _____

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Human Papillomavirus (HPV) Testing Consent

Please read the following information below very carefully before you sign at the bottom. We will be happy to answer any questions you may have.

HPV is a virus that affects both females and males. There are 30 different types that affect the genital area. Some types can cause abnormal pap tests. The virus can be contracted or transmitted from any type of intimate genital contact. Intercourse is not necessary to contract or transmit HPV.

Please be aware that ACOG recommends anyone over the age of 30 be tested for HPV. However not all insurances will cover this. Please be aware of your insurance coverage, when considering HPV testing. We will file your claim for you; however you are responsible for any service not covered by your plan, your deductible or patient liability.

Please be advised that Falany & Hulse Women's Center. P.C does the HPV testing along with the pap test if you elect to do so.

_____ With this knowledge, I hereby **accept** the HPV testing.

_____ I hereby choose to **refuse** the HPV testing at time, unless my pap is abnormal.

Patient Signature

Date

Witness Signature

Date

10515 Bells Ferry Road • Building B, Suite 200 • Canton, Georgia • 30114
2864 E. Cherokee Dr. • Suite G • Canton, Georgia 30115
60 Highland Court • Suite 201 • East Ellijay, Georgia • 30540
(770) 720-8551 (770)720-2121 (706) 698-6400