Suburban Women's Specialists, LLC

PATIENT INFORMATION			
NAME (Last, First, Middle)	BIRTHDATE	AGE	SSN
MAILING ADDRESS, CITY, STATE, ZIP CODE	BILLING ADDRESS (IF DIFFERENT FROM MAILING)		
HOME PHONE / CELL PHONE	EMAIL	CIRCLE PRIMARY CONTACT HOME CELL WORK	
MARITAL STATUS / PRIMAY CARE PHYSICIAN	PHARMACY NAME AND PHONE NUMBER		
EMPLOYER(NAME AND ADDRESS)	WORK PHONE NUMBER	MAY WE USE AS A CONTACT? YES NO	

RESPONSIBLE PARTY INFORMATION (FOR PATIENTS UNDER THE AGE OF 18 OR DISABLED)			
NAME (Last, First, Middle)	BIRTHDATE	SSN	EMAIL ADDRESS
MAILING ADDRESS,CITY, STATE, ZIP CODE	BILLING ADDRESS (IF DIFFERENT FROM MAILING)		
HOME PHONE / CELL PHONE	REALTIONSHIP TO PATIENT		

PRIMARY INSURANCE		SECONDARY INSURANCE(IF APPLICABLE)	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
NAME OF POLICY HOLDER	DOB	NAME OF POLICY HOLDER	DOB

Person(s) Suburban Women's Specialists representative may relate your health information to:		
NAME(s)	RELATIONSHIP	PHONE NUMBER(s)

May we leave normal lab/radiology reports or billing issues on your answering machine, or to whom answers the phone? Y/N
If YES, which phone number may we use? HOME CELL WORK (Circle if applicable)

Who may we thank for referring you to our practice?

I request that payment of Medicare or other insurance company benefits be made to Suburban Women's Specialists, LLC for services provided. I authorize the release of any information needed for processing of this or a related claim. I will permit a copy of the authorization to be used in place of the original , and request payment of medical insurance benefits to the party who accepts assignment. I understand that laboratory studies, pathology studies and cultures sent out will be billed by the specific laoratories to myself and/or my insurance. I accept payment responsibilities if my insurance refuses to pay. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatice dialing device, as applicable. **Our office provides estimates which allow you to better understand how much you will need to pay for a specific health service(s). It is only an estimate and it is not a guarantee of coverage or payment. The final amount that you will owe may change for a variety of reasons including: (1) the benefits change, (2) the coverage ends, (3) there are other claims processed before these services are received, (4) fewer, more, or different services are received, or (5) the out of pocket maximum (when the plan begins to pay 100% for covered services), has been met.** ***Please note we DO NOT accept Medicaid and cannot bill Medicaid for any services rendered.***

I UNDERSTAND THAT MY SIGNATURE IS MY AUTHORIZATION

SIGNATURE OF PATIENT/GUARDIAN DATE

Suburban Women's Specialists

Betty L. Anthony, MD., PhD., FACOG
Suiza C. Chua, MD., FACOG

Patient Name: _____

Financial Responsibility

Co-Payments _____ (Initial)
All office visits require a co-payment from your insurance company. Exceptions may include pre/post-operative visits for a determined period for some surgical procedures. Some insurance plans require co-payments for pre/post -operative visits.

Deductible_____ (Initial)
A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a co-payment is required for the visit. In addition, some services and **ALL procedures** performed in the office require the patient to meet their deductible before insurance pays the benefits. If you have not met your deductible, you will be responsible for the full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as a surgery to the insurance company, and are billed as surgery.

Diagnostic Procedure Consent _____ (Initial)
Your office visit today may include an ultrasound or Non-Stress Test (for pregnant patients). This is considered a diagnostic procedure, which will be billed to your insurance company as performed today. Depending on the specifics of your particular policy, your insurance carrier will pay all, part of none of the cost. **It is the responsibility of you, the insured, to be aware of the limits of coverage of your policy prior to the procedure**. Any charges not covered by the insurance carrier will be the responsibility of the patient. By initialing this section you are acknowledging these terms.

No Show_____ (Initial)
Patient who fails to show for their scheduled appointment, procedure, surgery, or did not notify the office **within 24 HOURS PRIOR** to the appointment, shall be subject to a NO SHOW Penalty of $25.00.

Guarantee of Payment for Services & Assignment of Benefits _____ (Initial)
It is the policy of the office that you must pay for services when rendered. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. If you have any questions, please ask before leaving the office.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus 28% before being able to be seen by our physicians.

I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release my medical information in the processing of the claim.

Insurance Coverage_____ (Initial)
I understand that my eligibility for coverage by _____ has been verified at the time of my appointment.
I am aware that when the insurance is verified, there is a disclaimer which states my insurance does not guarantee payment, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver_____ (Initial)
I understand that if my insurance requires a referral for my visit, I am responsible for making sure that the referral is obtained from my primary care physician. I also understand that if the referral from the primary care physician's office is not received before/on the day of my appointment, I agree to pay for all services rendered on the day of the visit.

_____ _____

Patient Signature (Guardian if patient is a minor) Date

Suburban Women's Specialists, LLC

Name: _____ DOB: _____

GYN HISTORY

Date of last menstrual period? _____

Age of first period _____ How long is your period? _____ How often do you have a period? _____

How would you describe your periods? □ Light □ Mild □ Heavy Do you have pain with periods? □ Yes □ No

Prior History of STD infection? □ No □Yes_____

Prior History of Abnormal Pap Smear? □ No □Yes_____

Date of Last Pap Smear: _____ Result: _____

Contraceptive Method: _____

Urinary Problems: □ Urgency □Frequency □Pain during urination □Loss of urine when coughing, laughing or sneezing

Menopause? □No □Yes (Age: ____) Hormone Replacement? □No □ Yes

Date of Last Mammogram: _____ Result: _____

Prior history of Abnormal Mammogram? □No □ Yes _____

Colonoscopy: □ No □ Yes Date: _____ Bone Density: □ No □ Yes Date: _____

MEDICAL HISTORY

	Do YOU or have you EVER had any of the following conditions?		Does anyone in your family have any of the following conditions?	
	YES	NO	YES	NO
Bleeding/Clotting Disorder				
Cancer				
Diabetes				
Heart Disorder				
Hepatitis/Infectious Disease				
High Blood Pressure/Cholesterol				
Kidney/Renal Disorder				
Lung Disorder				
Musculoskeletal Disorder				
Neurological Disorder				
Psychiatric Disorder				
Stomach/Bowel Disorder				
Thyroid Disorder				

Drug Allergies: _____ Current Medications: _____

Are you a smoker? □ No □ Yes _____ packs/day Do you drink alcohol? □ No □ Yes _____# Drinks/day

Hospitalization/Surgeries

Please list any hospitalizations, surgeries or illness/injuries (requiring a visit to the ER)-Include date/name of hospital

_____

_____

_____

_____

_____

Pregnancy History

No.	Date Mo/Day/Yr.	WEEKS AT DELIVERY	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR?	COMMENTS/COMPLICATIONS
1										
2										
3										
4										

Signature of Patient/Guardian: _____ Date: _____

Revised 08/17/2018

Family History Questionaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____
Provider Name: _____ Date Completed: _____

Instructions: Please circle **Y** to those that apply to **YOU** and/or **YOUR FAMILY** (on both your M**other's (Maternal) or Father's (Paternal)** side. Behind each statement, please list the relationship to you of the individual diagnosed (such as self, maternal aunt) and their age at diagnosis.

PLEASE CONSIDER THE FOLLOWING FAMILY MEMBERS:

Self Mother/Father Sisters/Brothers Children Aunts/Uncles Grandmothers/Grandfathers Nieces/Nephews

			Relationship (Ex. Maternal Aunt)	Age at Diagnosis
Breast Cancer **BEFORE AGE 50**	Y	N	_____	_____
Breast Cancer in **BOTH** Breasts	Y	N	_____	_____
OVARIAN Cancer at any age	Y	N	_____	_____
MALE BREAST Cancer at any age	Y	N	_____	_____
THREE or more Breast Cancers on the **SAME SIDE** of the Family	Y	N	_____	_____
PANCREATIC Cancer at any age	Y	N	_____	_____
METASTATIC PROSTATE Cancer at any age	Y	N	_____	_____
Ashkenazi Jewish Ancestry **AND** Family History of Breast Cancer at any age	Y	N	_____	_____
PERSONAL (YOURSELF) diagnosis of breast cancer at any age	Y	N		_____
Endometrial / Uterine Cancer **BEFORE AGE 50**	Y	N	_____	_____
Colon Cancer **BEFORE AGE 50**	Y	N	_____	_____
3 or More of Any of the Following Cancers at any Age:	Y	N	_____	_____
			_____	_____
			_____	_____
Uterine, Colon, Stomach, Brain, Kidney, Ureter, and/ or Small Bowel			_____	_____

Patient Signature_____ **Date**_____

FOR OFFICE USE ONLY

O Candidate for further risk assesment and /or genetic testing
O **NOT** a candidate for further risk assesment and /or genetic testing

O Patient offfered genetic testing
O Accepted O Declined

Provider Signature _____ **Date**_____

SUBURBAN WOMEN'S SPECIALISTS, LLC

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

Important: **Do not sign this form without reading and understanding its contents.**
I hereby apply for and consent to admission and treatment by this medical practice and authorize all routine activities, treatments, examinations and diagnostic services. During the course of my care and treatment, I understand that various types of tests and diagnostic treatment procedures ("Procedures") may be necessary. The Procedures may be performed by physicians, nurses, technicians, physician assistants or other health care professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but not limited to the following:

(1) **Needle Sticks,** such as shots, injections, intravenous lines or intravenous injections (IV's). The material risks associated with these types of Procedures include, but not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedure include, but not limited to, allergic reactions, infection, severe loss of blood, musculoskeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of Procedure include, but not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as those done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

(5) **Insertion of Internal Tube** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedure include, but not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices and/or refusal of treatment, no practical alternatives exist.

I understand that:

1 The practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any Procedures;
2 The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others who have knowledge of me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions;
3 I may withdraw my consent for any test or procedure at any time.

By signing this form:

1 I consent to Healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;
2 I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures, the material risks of the Procedures and practical alternatives to the Procedures;
3 I consent to the observation and participation of personnel-in-training and students in my care and treatment;
4 I consent to the disposal by staff personnel of any specimens, tissue or parts that may be removed from my body during my care;
5 If I have questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

Patient / Patient's Representative	**Date**
Relationship if other than self	**Reason patient unable to sign**
Witness	**Date**