New Patient Demographics - Website Form

Patient Demographic Information

Patient Name (Last, First, Middle) _____ **Nickname** _____

SSN _____ **Birth Date** _____ **Age** _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address _____

Emergency Contact Name _____ **Emergency Contact Phone** _____

Marital Status _____ **Race** _____ **Ethnicity** _____

Preferred Language _____ **Employer** _____

Primary Care Physician (Name, Address, Phone Number) _____

How did you hear about us: *Select one*

☐ Patient Referral ☐ Provider referral:_____ ☐ Insurance referral ☐ Web search

☐ Social Media ☐ Event ☐ Direct Mail or Magazine ☐ Radio/TV ☐ Billboard ☐ Other:_____

Responsible Party Information (if different than above or if patient is a minor)

Guarantor Name (Last, First) _____ **Relationship** _____

SSN _____ **Birth Date** _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address

Insurance Information

Primary Insurance	_____	**Secondary Insurance**	_____
Policy Holder Name	_____	**Policy Holder Name**	_____
Relationship to Patient	_____	**Relationship to Patient**	_____
Policy Holder DOB	_____	**Policy Holder DOB**	_____
Policy # / Member ID	_____	**Policy # / Member ID**	_____
Group #	_____	**Group #**	_____

Patient / Guarantor Signature _____ **Date** _____

CONFIDENTIAL HEALTH HISTORY

Name: _____ DOB: _____ Age: _____ Date: _____

Are you currently pregnant? ☐ Yes ☐ No Are you trying to get pregnant? ☐ Yes ☐ No

# of pregnancies: _____ # of miscarriages: _____ # of abortions: _____ # of live births: _____

First day of last menstrual period: _____ Days between periods: _____ Days of flow: _____

Current method of birth control: _____ Date of last mammogram: _____

Date of last pap smear: _____ History of abnormal paps? ☐ Yes ☐ No

Reason for visit: _____

FAMILY HISTORY (Check if your blood relatives had any of the following:)

	RELATIONSHIP		RELATIONSHIP
☐ Arthritis	_____	☐ Heart disease, strokes	_____
☐ Asthma, hay fever	_____	☐ High blood pressure	_____
☐ Cancer	_____	☐ Kidney disease	_____
☐ Chemical dependency	_____	☐ Tuberculosis	_____
☐ Diabetes	_____	☐ Other	_____

HOSPITALIZATIONS / SURGERIES

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION & OUTCOME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS (List medications you currently take, including vitamins, herbs and over-the-counter drugs.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES (List medications or substances to which you are allergic and the reaction you have to them.)

MEDICATIONS	SUBSTANCES
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

HEALTH HABITS (Check which substances you use and describe how much you use.)

	HOW MUCH
☐ Caffeine	
☐ Tobacco	
☐ Drugs	
☐ Alcohol/Beer/Wine	
☐ Other	

CONDITIONS (Check conditions you have or have had in the past; C-Current, P-Past)

C	P		C	P		C	P	
☐	☐	Skipping periods	☐	☐	Heavy periods	☐	☐	Painful periods
☐	☐	Pelvic pain	☐	☐	Pain with intercourse	☐	☐	Vaginal discharge
☐	☐	Exposure to STD	☐	☐	Excessive hair growth	☐	☐	Hot flashes
☐	☐	Pain with urination	☐	☐	Frequent urination	☐	☐	Involuntary loss of urination
☐	☐	Sexual assault or abuse	☐	☐	Breast mass	☐	☐	Painful breasts
☐	☐	Nipple discharge	☐	☐	Fever	☐	☐	Weight loss
☐	☐	Dizziness	☐	☐	Fatigue	☐	☐	Appetite loss
☐	☐	Sore throat	☐	☐	Nosebleeds	☐	☐	Runny nose
☐	☐	Eye pain	☐	☐	Visual changes	☐	☐	Hearing loss
☐	☐	Shortness of breath	☐	☐	Cough	☐	☐	Pain with breathing
☐	☐	Nausea	☐	☐	Diarrhea	☐	☐	Painful bowel movements
☐	☐	Vomiting	☐	☐	Constipation	☐	☐	Bloating
☐	☐	Skin rash	☐	☐	Swelling	☐	☐	Bruising
☐	☐	Cuts	☐	☐	Headaches	☐	☐	Numbness
☐	☐	Weakness	☐	☐	Agitation	☐	☐	Confusion
☐	☐	Depression	☐	☐	Hostility	☐	☐	Suicidal thoughts
☐	☐	Excessive bleeding	☐	☐	Swollen lymph nodes	☐	☐	Asthma
☐	☐	Seasonal allergies	☐	☐	Bronchitis	☐	☐	Chest pain
☐	☐	Irregular heart beat	☐	☐	Leg swelling	☐	☐	Muscle pain
☐	☐	Arthritis	☐	☐	Swollen joints			

PHARMACY NAME: _____ **LOCATION:** _____

CARE OF THE COMPLETE WOMAN

NAOMI PASCHALL, MD

Patient Agreement

RE: Annual Exam/HPV Testing Policy

Annual Exams:

You scheduled your appointment today for your annual exam. Your insurance plan may have allowed you to schedule this appointment for a well-woman exam without a referral from your Primary Care Physician. If your examination reveals problems that need to be addressed and your insurance company requires a referral from your PCP, it will be necessary to schedule another appointment in order for all referrals, etc. to be in place before additional treatment can be provided.

If your exam involves other aspects of your health, other than a well-woman exam (i.e. annual checkup with pap smear), and you are treated and counseled for problems, then the focus of your exam will change from preventative to a problem visit and your insurance company will be billed accordingly.

Medical benefits are provided to you based on contract that we have negotiated with the insurance carrier. We cannot code your claim just to get paid by the insurance company. It must reflect the actual services rendered and correspond to the documentation in your medical record. And services provided that is not covered by your insurance plan will become your responsibility and payment is expected at the time of service.

HPV TESTING:

We pride ourselves on offering our patients the most advanced preventative car available by following the standard of care set by the American College of Obstetrics and Gynecology. We are offering our patients the only FDA-approved high-risk HPV testing. This test is a highly sensitive viral test performed in conjunction with a Pap smear to screen cervical cancer.

In the best interest of your health, it is our office policy that any Pap smear for patents under the age of sixty-six (66) will be tested for HPV. If you wish to NOT have this test performed, you must sign a waiver before your examination.

STD TESTING:

As the patient, should you desire for STD (sexually transmitted disease) you will need to request that at the time you are with the physician. This testing requires a separate test code so as not to conduct this testing on every patient.

By signing below, you acknowledge that you have read and understand the information provided.

_____ _____

Name Date

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____
Reason for Today's Visit: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. 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 relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	----	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED
Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

NAOMI PASCHALL, MD JULIE PARK, APN

100 COVEY DRIVE, SUITE 204 FRANKLIN, TN 37067

615-790-4140 (P) 615-790-4141 (F)

Financial Policy

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to **you**, not the insurance company. Therefore, payment for treatment is your responsibility.

In order to serve you better and to streamline your time in the office, **payments will now be collected at Check-In**, rather than at Check-Out.

Please read and sign the following:

1. I understand that **payment is due at time of service.**
2. I authorize this office to release or receive any information necessary to expedite insurance claims.
3. I hereby authorize this office to bill my insurance company directly for their services.
4. I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
5. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or if there is no payment made with 60 days, it is my responsibility to pay my doctor's bill directly.

Signature: _____ Date: _____

Witness: _____ Date: _____

Insurance Financial Policy

RETURNED CHECKS

There will be additional charges on all returned checks and additional charges on all delinquent accounts, which must also be paid.

CHANGES OF INSURANCE

As a patient in our office, it is your responsibility to inform us of any changes on your account regarding your insurance or address information. Acceptable insurance identification is required if you change insurance companies. This is defined as a valid insurance card updated when you receive a new insurance card.

COLLECTIONS

If you have not made payments to your account and if there has been no attempt to contact our office with financial arrangements, it may be assigned to a collection agency after 90 days of no payment on account. Please note that after your balance has been forwarded to collections, you may be dismissed as a patient in our office. Your balance will need to be paid at our collection agency or office in full prior to receiving services in our office.

I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any finance charges and all reasonable costs of collection, including filing fees as well as reasonable attorney fees.

IF YOU DO NOT HAVE INSURANCE

If you are paying for your visit out-of-pocket, you will be required to pay in full at the time of service. You will be given a 20% discount.

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

HIPPA ACKOWLEDGEMENT

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 INFORMATIONIS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

PAYMENT: We may use and disclose your health information to obtain payment for services provided to you.

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

YOUR AUTHORIZTION: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law or national security activities.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

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

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

AMENDMENT: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS: 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 may also submit a written complaint to the U.S. Department of Health and Human Services.

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 the U.S. Department of Health and Human Services. A privacy/contact officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak with the Office Manager, who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____ _____

PATIENT'S PRINTED NAME **DATE**

I, _____, acknowledge that I have received

(Signature of Patient, Parent, or Legal Guardian

a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, _____, consent to the use and disclosure of my

(Signature of Patient, Parent, or Legal Guardian)

personal health information by your office for treatment, billing/payment, and healthcare operations as outlined in the NOTICE OF PRIVACY PRACTICES.