GYNECOLOGY & LAPAROSCOPIC SURGEONS, PC
Improving Your Life

Date: ____/____/_____

Name: ____ **Date of Birth**: ____/____/_____
(first) (middle/maiden) (last)

Address: ____
Street City State Zip

Marital Status: ☐ M ☐ S ☐ W ☐ D **Spouse's Name**: ______________________

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black or African American ☐ White ☐ More than 1 race

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Preferred Language**: ☐ English ☐ Spanish ☐ French ☐ Other

E-Mail Address:____

Home Phone: _________________ **Work Phone**:______ ___________ **Cell Phone**: ______________________

Emergency Contact: Name:______________________________ Relationship: __________________________

Phone: _____________________ Address: ____

Occupation: ____ **Employer:** _____________________________

Employer's Address: ____

Driver's License Number: ________________ **State**:_____

Who is your primary care physician (First & Last name) ?____

Preferred pharmacy name and phone number: ____

Preferred Contact Method: ☐ Patient Portal (please set up account) ☐ Phone or Voicemail

May we leave messages with lab results, etc. on your voicemail? ☐ No ☐ Yes: ☐ Home ☐ Work ☐ Cell (check applicable)

Person to Receive Bills (If different from above-Parent, Spouse, Other):

Name: ____ Home Phone: ________________

Address:____
Street City State Zip

Employer: ____Work Phone: _______________________

Address: ____
Street City State Zip

INSURANCE INFORMATION:

Primary Carrier: _________________________________ Group #_______________ Policy # _______________

Copay amount: $________________

In whose name is the policy?____________________________________ Policy Holder's Birthdate:____________

Secondary Carrier___________________________________ Group #______________ Policy #_______________

In whose name is the policy? ______________________________ Policy Holder's Birthdate:____________

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

AUTHORIZATION TO RELEASE INSURANCE INFORMATION AND TO PAY BENEFITS TO GYNECOLOGY & LAPAROSCOPIC SURGEONS, PC: I hereby authorize GYNECOLOGY & LAPAROSCOPIC SURGEONS, PC to release any information acquired in the course of my examination or treatment to insurance carriers, third party payors, or others involved in the processing or collection of claims. I hereby assign payment directly to GYNECOLOGY & LAPAROSCOPIC SURGEONS, PC for any medical/surgical procedures performed. This authorization is valid until rescinded in writing or replaced by one of a later date.

SIGNATURE: ____ DATE: ____________

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NAME:		AGE:		DATE:	
How did you hear about us?					
What is the main reason for your visit today?					

PAST MEDICAL HISTORY (Circle if you have or have had this problem in the past)

☐ High Blood Pressure	☐ Abnormal pap smears	☐ Pregnancy-related problems	☐ Breast cancer
☐ Heart attack	☐ Previous blood transfusion	☐ Sexually Transmitted Infections	☐ Ovarian cancer
☐ Diabetes	☐ Anemia	☐ Gonorrhea	☐ Uterine cancer
☐ High Cholesterol	☐ Blood clotting problem	☐ Chlamydia	☐ Colon Cancer
☐ Hypothyroidism	☐ Clots in lungs or legs (PE or DVT)	☐ Syphilis	☐ Other cancer
☐ Hyperthyroidism	☐ Tuberculosis (TB)	☐ Trichamonas	☐ Osteoporosis/bone fractures
☐ Liver problems	☐ Kidney Stones	☐ HPV	☐ Depression
☐ Gallbladder problems	☐ Urinary Tract Infections	☐ Herpes	☐ Seizures/Epilepsy
☐ Asthma	☐ Endometriosis	☐ HIV or AIDS	☐ Eating disorders
☐ Mitral Valve Prolapse	☐ Fibroids	☐ Genital Warts	☐ DES Exposure
☐ Other heart problems	☐ Infertility	☐ Pelvic Infections/PID	☐ Migraines (with/without aura)
☐ Colon polyps	☐ Irritable bowel syndrome	☐ Fibromyalgia	

Please list all hospitalizations and surgeries

DATE	SURGERY/HOSPITALIZATION	REASON

Current Medications (prescription, over-the-counter, herbal, and "alternative" medicines with dosages)

1)	4)
2)	5)
3)	6)

Allergies to Medications or Latex (please describe allergic reaction, i.e. rash, difficulty breathing, nausea

1)	3)
2)	4)

Family History: Do any of your family members have any of the **above-listed medical problems/cancers**?

Father (If deceased, age and cause of death)	
Mother (If deceased, age and cause of death)	
Siblings	
Grandparents/Aunts/Uncles	

Obstetrical History: Please list all pregnancies including normal, miscarriages, abortions, & ectopic pregnancies:

Mo/Yr	Weeks Pregnant	Normal, Cesarean, Miscarry, Abortion	Sex M/F	Problems: pre-term, bleeding, pre-eclampsia, high blood pressure, diabetes, hospitalization, other

NAME: ______________________________________ **AGE:** _________ **DATE:**__________________

Last Menstrual Period: _____/_____/_____
Last Pap: _____/_____/_____
Last Mammogram:_____/_____/_____
Last Colon Cancer Screening: _____/_____/_____
Last Bone Density Study (DEXA): _____/_____/_____
Last Cholesterol Screening: _____/_____/_____
Primary Care Physician: ________________________

Regarding your periods:
Age at first period _______
Days from start to finish: _____
Days between periods: _______
Flow is light/ medium/ heavy ?
Do you have to change a tampon/pad hourly? _____
Does your bleeding ever soak through clothing? ___
Do you bleed between periods? _______
Do you have cramping that requires medication? ____
Is PMS a problem you would like to address today?__
Age at menopause (if applicable)? ________

Social History:

Are you ☐ single ☐ married ☐ widowed ☐ divorced ☐ separated?
Do you currently work? ☐ Yes ☐ No If yes, where? ____
Who lives in your home with you? ____
Do you have a religious preference you would like to share with us? ______________________________________
Do you smoke? ☐ No If No, did you smoke in the past? ____ If yes, for how long? _____ When did you quit? ___
☐ Yes If yes, how much and for how long? ____________
Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per week? __________
Do you use any illicit drugs, even occasionally? ☐ No ☐ Yes If yes, which ones? __________________________
Are you sexually active? ☐ Yes ☐ No If yes, do you use birth control? ☐ Y ☐ N Which one?__________
Age at first intercourse? ________ Number of sexual partners in your lifetime:______
Do your partners include ☐ men, ☐ women, or ☐ both?
Have you ever been in an abusive situation (physically, sexually, verbally, or emotionally)? ☐ No ☐ Yes
Do you exercise regularly? ☐ Yes ☐ No If yes, number of times per week?____________
Do you take calcium regularly? ☐ Yes ☐ No If yes, how many mg per day? ___________

REVIEW OF SYSTEMS Please CHECK if you CURRENTLY have any of the following:

1. ***General Symptoms:*** ☐ Fatigue, ☐ unexplained fever, ☐ night sweats
2. ***Skin:*** ☐ Hair growth, ☐ rash, or ☐ skin color changes
4. ***Respiratory System:*** ☐ Unexplained cough, ☐ wheezing, ☐ coughing up blood
5. ***Breasts:*** ☐ Lump, ☐ pain, ☐ discharge, ☐ skin changes
6. ***Cardiovascular System***: ☐ Chest pain, ☐ irregular heart beats, ☐ shortness of breath
7. ***Gastrointestinal Tract:*** ☐ Abdominal pain, ☐ change in bowel habits (constipation, diarrhea), ☐ nausea, ☐ vomiting
8. ***Genitourinary Tract:*** ☐ Menstrual cramps, ☐ burning with urination, ☐ frequent urination, ☐ irregular periods, ☐ pelvic pain, ☐ vaginal discharge, ☐ urinary urgency, ☐ blood in urine, ☐ uncontrollable loss of urine, ☐ pain with intercourse
9. ***Musculoskeletal System:*** ☐ Joint pain, ☐ swelling, or ☐ stiffness
10. ***Nervous System:*** ☐ Headaches, ☐ numbness, ☐ seizures
11. ***Psychiatric***: ☐ Anxiety, ☐ change in sleep pattern, ☐ depression
12. ***Endocrine:*** ☐ Appetite changes, ☐ hotter than others in a room, ☐ colder than others, hair changes, ☐ decreased sex drive
13. ***Hematology***: ☐ Easy bruising, ☐ enlarged lymph nodes, ☐ prolonged bleeding

Hereditary Cancer Risk Assessment

Patient Name: ____ Today's Date: ___________________________________

Your Physician: _______________________________________ Date Of Birth: __________________________________

INSTRUCTIONS: Please circle YES (Y) to any statement below if it applies to YOU or YOUR FAMILY MEMBERS.
Next to each statement, please list the AGE of the person when they were DIAGNOSED with cancer and your relation.
1st Degree Relatives = Mother / Father / Sister / Brother / Children
AND 2nd Degree Relatives = Aunt / Uncle / Grandparent / Niece / Nephew
AND 3rd Degree Relatives = Great Grandparents / 1st Cousins

1. Have YOU had Genetic Testing for Hereditary Cancer Previously (BRCA/MyRisk)?

☐ **YES**	**Approximate year you were tested?**___________ **Result:** ☐ Positive ☐ Negative ☐ Unknown
☐ **NO**	Proceed to Section 2 – Cancer Family History

2. Yes/No		**CANCER FAMILY HISTORY**	**YOU SIBLINGS CHILDREN**	**MOTHER'S SIDE**	**FATHER'S SIDE**	**Age at** Diagnosis
Y	**N**	Have **YOU** ever had **Breast Cancer** at any age				
Y	**N**	**Ovarian Cancer** in your family at any age				
Y	N	**Breast Cancer** in your family **before age 50**				
Y	**N**	**Bilateral Breast Cancer** in your family at any age				
Y	**N**	**THREE OR MORE** relatives on one side of your family with **Breast or Prostate Cancer** at any age				
Y	**N**	**Male Breast Cancer** in your family at any age				
Y	**N**	**Pancreatic Cancer** in your family at any age				
Y	**N**	**Ashkenazi Jewish Ancestry** with **Breast or Pancreatic Cancer** in your family at any age				
Y	**N**	**Colon Cancer** in your family **before age 50**				
Y	**N**	**Uterine or Endometrial Cancer** in your family **before age 50**				
Y	**N**	**THREE OR MORE** relatives on one side of your family with **Colon/Rectal**, **Uterine/Endometrial**, or **Gastric/Stomach Cancer** at any age				
Y	**N**	Have **YOU** ever had **Uterine or Endometrial Cancer**				

FOR OFFICE USE ONLY:
Did patient meet criteria for Genetic Education? ▫ **YES** ▫ **NO** ▫ **MORE INFORMATION NEEDED**
If YES, Patient chose to: ▫ **ACCEPT** ▫ **DECLINE High Risk Education**: Reason___________________________________
If ACCEPTED, Patient: ▫ **SUBMITTED** myRisk ▫ **DECLINED Testing**: Reason___________________________________

PATIENT SIGNATURE: ____ **Date:**___________________

PROVIDER SIGNATURE: ____

GYNECOLOGY & LAPAROSCOPIC SURGEONS, PC
Improving Your Life

FINANCIAL POLICY

This is an agreement between Gynecology & Laparoscopic Surgeons, PC, and the Patient named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Gynecology & Laparoscopic Surgeons, PC.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days on the date of the statement.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you have no insurance:

1. You choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees, those charges will be billed directly by the lab.
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

You choose to pay by cash, check, or credit card your co-payment, deductible, and/or any out-of-pocket expenses at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. You agree to pay any portion of the allowed charges not covered by insurance (if we have a contract with your insurance company). If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the monthly statement was sent. The FINANCE CHARGE will be computed at the rate of one and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $.50.

Credit Card Surcharge: NC allows a surcharge on credit card purchases of up to 4%. You may avoid this surcharge by paying with cash or check.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Wake County, North Carolina.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Initials: ________

Returned checks: There is a fee (currently $35) for any checks returned by the bank. After a returned check, all subsequent payments must be in the form of cash, credit card, cashier's check, or money order; checks will no longer be accepted by the patient.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours notice, a $25 fee may be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their care to another physician.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: **Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.**

Patient's name: ______________________
please print

Responsible party (If not the patient):

____

Signature: ___________________________

Co-Signature (if required):____________________________

Date: _______________________________

GYNECOLOGY & LAPAROSCOPIC SURGEONS, PC

Improving Your Life

CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by Gynecology & Laparoscopic Surgeons, PC in order to carry out treatment, payment, or health care operations. The Patient should review the Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Gynecology & Laparoscopic Surgeons, PC reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by contacting our office at 919-847-7475.

Patient retains the right to request that Gynecology & Laparoscopic Surgeons, PC further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Gynecology & Laparoscopic Surgeons, PC is not required to agree to such requested restrictions; however, if the Gynecology & Laparoscopic Surgeons does agree to Patient's requested restriction(s), such restrictions are then binding on Gynecology & Laparoscopic Surgeons.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to Gynecology & Laparoscopic Surgeons in writing. The revocation shall be effective except to the extent that Gynecology & Laparoscopic Surgeons has already taken action in reliance on the Consent. Gynecology & Laparoscopic Surgeons may refuse to treat Patient if she (or an authorized representative) does not sign this Consent Form (except to the extent that we are required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, Gynecology & Laparoscopic Surgeons has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that we are required
by law to treat individuals).

****

Messages containing my confidential health information, including test results, may be left at the following numbers:

_(______)____________________________ This is a ☐ Home ☐ Cell ☐ Work number.

_(______)____________________________ This is a ☐ Home ☐ Cell ☐ Work number.

I authorize the following person to receive healthcare and billing information, including test results:

___________________________________ ___________________________________ **(must present photo ID)**

Full Name (NO Nicknames) Relationship

I authorize the following individual to pick up prescriptions, medication samples, and medical records:

___________________________________ ___________________________________ **(must present photo ID)**

Full Name (NO Nicknames) Relationship

****

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED [SEALED SIGNATURES ARE OPTIONAL] DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____________ Time _____AM/PM

______________________________(SEAL) __________________________(SEAL)

Signature of Patient Person Signing on behalf of Patient *

_________________________________ _________________________________

Please print name Please print name

_________________________________(SEAL) _________________________________

Signature of witness Relationship of person signing on behalf

____

Please print name

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

DATE: ___________________

I acknowledge that I was offered a review of Gynecology & Laparoscopic Surgeons' Notice of Privacy Practices.

_______________________ Patient Name (Print)

_______________________ Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

______________________________ Personal Representative (Print)

___________________________________ Personal Representative's Signature

___________________________________ Relationship