Woman's

Breast Specialty Clinic Patient Information

PERSONAL INFORMATION - *Please Print*

Last Name	First Name	Middle or Maiden	Age	Date of Birth	Social Security No.

Address	City	State	Zip Code

Home Phone ☐	Cell Phone ☐	Work Phone ☐ *Please check your preferred number*

Name, Address and Phone of Employer or School

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other:________________ ☐ Would rather not report

Ethnicity ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Would rather not report

Preferred Language	Do you need a translator? ☐ Yes ☐ No

Referring Physician or how you found us	Primary Care Physician	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	If Married, Spouse's Name

- To provide continuity of care, do we have your consent to send your clinic notes to your referring and primary physicians listed above? ☐ Yes ☐ No
- Would you like to be set up for our online portal? It is a secure way to access your medical information. ☐ Yes *(please provide your email address)* ☐ No

Email address:____

RESPONSIBLE PARTY - *PLEASE PRINT (Parent if patient is a minor OR the insurance policy holder)*

☐ Check if same as above

Last Name	First Name	Middle or Maiden	Social Security No.

Address	City, State, Zip Code	Phone

Relationship to Patient

Please list one (1) Emergency Contacts:

Name	Address	Phone	Relationship
1)			

Preferred Pharmacy

Name and location of pharmacy: Pharmacy Phone:

INSURANCE INFORMATION - *PLEASE PRINT*

***** NOTE *****

Due to HIPPA requirements, we are required to obtain the subscriber's date of birth and social security number in order to file claims. Failure to submit this information will result in a denied claim for which you will be responsible.

Primary Insurance Name	Subscriber	Subscriber's Date of Birth (See above NOTE)
**Subscriber's Social Security Number	Relationship to Subscriber	Employer

SECONDARY INSURANCE INFORMATION - *PLEASE PRINT*

Primary Insurance Name	Subscriber	Subscriber's Date of Birth (See above NOTE)
**Subscriber's Social Security Number	Relationship to Subscriber	Employer

SOCIAL HISTORY - *PLEASE PRINT*

Do you smoke? ☐ No ☐ Former Smoker ☐ Yes:___ cigarettes/day Do you drink? ☐ No ☐ Monthly or less ☐ Weekly ☐ 2-3 times/week ☐ Daily:___ drinks/day

ALLERGIES - *PLEASE PRINT*

Do you have a history of latex allergy? ☐ No ☐ Yes

Signature of patient or legal guardian______________________________ Date____________

100 Woman's Way
Baton Rouge, Louisiana 70817
(225) 927-1300
www.womans.org

Woman's Physician Practices Patient Documents

Welcome to Woman's Physician Practices. As our patient, your rights and responsibilities are important to us, and we ask you to read and sign this policy that guarantees them. We believe in your privacy, and our Notice of Health Information Privacy Practice explains how we ensure confidentiality. Also, providing you with a clear understanding of our financial policy is important to our professional relationship.

For services performed in the clinic, you may receive *two separate bills*, one for professional services and one for technical services.

1. **Woman's Hospital** will bill the technical portion of your visit (i.e. use of the facility, labs and ultrasounds).
2. **Woman's Physician Practices** will bill for your *professional* visit which includes your visit with the physician and their interpretation of any procedures performed during your office visit.

Patient Payments: Patients with no insurance coverage that do not qualify for charity care or have not completed the screening process will be required to pay at the time services are rendered. If other services within the hospital are ordered, (i.e., laboratory, radiology, etc.) you will be required to pay at the point of service. We are unable to determine the exact amount you will be charged for the visit. We will provide you information outlining the approximate cost. Any amount paid in excess of the actual charges will be promptly refunded. If charges are more than estimated then you will be billed for the remaining balance.

Insurance Payments: We will automatically file claims on your behalf with your primary insurance carrier. Because insurance coverage varies from plan to plan, please understand that you are ultimately responsible for payment of your account. As a courtesy, we will file secondary insurance, but follow-up on any secondary benefits is your responsibility. If Medicare or Medicaid is the secondary carrier, we will assume responsibility for the follow-up until payment is received. As your insurance company pays your claims, you are expected to pay all deductible and co-insurance amounts within 30 days of payment by your insurance company.

Authorization for Release of Medical Information: I give permission to Woman's Physician Practices or any authorized member of the clinic staff to give, tell or show all medical information to any health plan, Social Security Administration, or its intermediary/carrier, or any other agency which may pay for services I receive and as described in Woman's Hospital Notice of Privacy Practices. This authorization extends to any review agency selected by any health plan, or any other agency that may par for services I receive. A photocopy of this form shall serve as the original.

Authorization to Access External Prescription History: I give permission to Woman's Physician Practices or any authorized member of the clinic staff to access my external prescription history.

Assignment of Insurance Benefits: I assign Woman's Physician Practices to the any and all benefits due me for services under any applicable health plan or the Social Security Administration or its intermediary/carrier due to an admission or treatment by the clinic. I certify that the information I have given in applying for payment under Title XVII of the Social Security Act is correct. I authorize and request that payment of the benefits be made on my behalf to the clinic.

My Signature Below Indicates That:

- I understand the information contained herein and agree that the information I provided is true and correct to best of my knowledge. I have had the chance to ask any questions that I might have.
- I received/was offered Your Responsibilities and Rights booklet.
- I received/was offered the Woman's Hospital Notice of Health Information Privacy Practices. ________ (Initials)

Patient Signature/Parent/Guardian Signature:________________________ Date:__________

Person responsible for bill (if different from above signature):________________________

Relationship:________________________

Patient is not able to consent because:________________________

Witness:________________________ Date:__________

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Woman's Physician eHealth Collaborative

- Permission to Create an eHealth Summary and Share Medical Information

We are taking part in an exciting program to improve your health care and make office visits easier and more convenient. To do this, your doctor would like your permission to enroll you in our eHealth Summary program. This means sharing important parts of your medical information with other providers (doctors, nurses, and health professionals) through an electronic medical chart. The eHealth Summary will allow your providers to access your health information more quickly and accurately than with paper charts.

The eHealth Summary is an overview of vital medical information. For instance, the eHealth Summary may include a list of your current medications, allergies, recent diagnoses (problems), prenatal record, or any surgery you may have had. It may also include information about such "sensitive" issues as mental health, substance abuse, sexually transmitted disease, and sexual abuse information. It will not include detailed confidential notes from your office visits.

The eHealth Summary has a secure system to protect your healthcare information. All authorized healthcare professionals with access to the eHealth summary agree to follow strict privacy and security policies. The technology will encrypt (scramble) the information and track who and when someone has accessed your summary.

Your doctor is asking permission to share your vital medical information through the eHealth Summary for all legally permitted uses and disclosures. These include but are not limited to:

- Clinical care
- Billing and financial management
- Administrative management
- Reports to public health agencies and other governmental requirements
- Reports to protect the security of your medical information
- Reports to evaluate the use of the eHealth Summary
- Reports to track and evaluate the quality of your healthcare services

Only authorized healthcare professionals, their agents and others whose job it is to secure, monitor and evaluate the operation of the information system and quality of care would be able to access your information through this program.

☐ **YES, I want my health information included in the Woman's Physicians eHealth Collaborative eHealth Summary as described above. By my signature below:**

1. I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the eHealth Summary.
2. I give permission to those described above to use and disclose my information, as described above.
3. I understand that I have the option to withdraw permission and can do so by giving written notice to my doctor's office. Should I withdraw my permission, this request will be effective within one (1) business day of my written notice.

_______________________________ _______________________

Signature of Patient/Representative Date

☐ **NO, I do not want my information included in the Woman's Physicians eHealth Collaborative eHealth Summary.**

I understand that my information will still be stored electronically for my provider's records, but an eHealth Summary will not be available to other providers (including Woman's Hospital). I also understand that, without the eHealth Summary, it may be more difficult for doctors and healthcare providers to coordinate my care. This could have an adverse effect on the quality and efficiency of my health care services.

_______________________________ _______________________

Signature of Patient/Representative Date

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Involvement of Care and Notification Purposes

Patient Name:____

Date of Birth:______________________________

Woman's Physician Practices may disclose protected health information to a family member, close personal friend, or any other person identified by the patient below, if the information is relevant to that person's involvement with the patient's care or payment of the patient's health care services.

Woman's Physician Practices may also use or disclose protected health information to notify a family member, close personal friend, or any other person identified below by the patient of the patient's location, general condition, or death.

I have read and agree with the above statements, and hereby identify the following persons:

Name	*Relationship to the Patient*	*Date of Birth*	*Phone Number*

I have had the opportunity to object to this disclosure and do not have any objections at this time. In the event that I do have an objection to this disclosure in the future, I will express that objection in writing to the Physician Office Practice Manager.

______________________________ ______________________

Signature of Patient Date

Medication / Problem List

Date Originated: ____________

Revised: ____________

Name (Last, First, M.I.): ☐ M ☐ F D.O.B.: AGE:

Date: ____________

Allergies: ____________

MEDICATIONS

(Include all over-the-counter drugs, vitamins and inhalers)

Name of Drug	Strength	Frequency Taken	Review Date	Update Initials

Primary Physician: ____________ GYN Physician: ____________

What desires do you have from our clinic? ____________

Questions for providers: ____________

☐ Copy given to the patient - Initials ____________ Date: ____________

Drug Allergies: ____________

Smoke ☐ Yes ☐ No Frequency ____________ Alcohol ☐ Yes ☐ No Frequency ____________

MEDICAL PROBLEMS: *FOR PROVIDER USE*			
MEDICAL PROBLEMS	Date of onset	Past Surgeries	Date on onset

Screening for Risk of Hereditary Cancer

(please complete if not previously done or changes since last completed)

Date: ________________ Patient Name: ____ D.O.B. ________________

PATIENT INFORMATION

Height (ft/in):____________ Weight (lbs.):___________ Age at time of first menstrual period:____________

Are you: ☐ Pre-menopausal ☐ Peri-menopausal ☐ Post-menosausal: Age of onset:__________

Have you had a live birth?: ☐ No ☐ Yes: Age at first child's birth____________

Have you ever used Hormone Replacement Therapy? ☐ No ☐ Yes

If Yes, Treatment Type: ☐ Combined ☐ Estrogen only ☐ Progesterone only

If Yes, is patient a: ☐Current User: Started ________ yrs ago Intended use for ________ more yrs

☐Past User: Stopped________yrs ago

Have you ever had a breast biopsy? ☐Yes ☐No

INFORMATION ABOUT PATIENT'S FEMALE RELATIVES

Number of daughters:__________ Number of sisters:__________

Number of maternal aunts (mother's sisters):_________ Number of paternal aunts (father's sisters):__________

Please check the appropriate boxes:

Any males in the family with breast cancer? ☐ No ☐ Yes

Any Ashkenazl Jewish ancestry? ☐ No ☐ Yes

Any previous genetic testing for inherited cancer? ☐ No ☐ Yes

Cancer Type	Self	Your Children	Siblings	Mother	Mother's Side	Father	Father's Side
Breast (before age 50)	☐	☐	☐	☐	☐	☐	☐
Breast (after age 50)	☐	☐	☐	☐	☐	☐	☐
Ovarian (any age)	☐	☐	☐	☐	☐	☐	☐
Colon/rectal (before age 50)	☐	☐	☐	☐	☐	☐	☐
Colon/rectal (after age 50)	☐	☐	☐	☐	☐	☐	☐
Colon Polyps (not cancer)	☐	☐	☐	☐	☐	☐	☐
Other Intestine/Stomach	☐	☐	☐	☐	☐	☐	☐
Endometrial (before age 50)	☐	☐	☐	☐	☐	☐	☐
Endometrial (after age 50)	☐	☐	☐	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐	☐	☐	☐
Pancreatic (any age)	☐	☐	☐	☐	☐	☐	☐

Other Cancers please list:							
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

For Office Use Only:

A) Risk of Hereditary Cancer ☐ No ☐ Yes ☐ Uncertain 10 year risk____________________

B) Discussed with Patient ☐ No ☐ Yes

C) Referred to Genetics ☐ No ☐ Yes Lifetime Risk____________________

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