



Offices at Cranbrook ■ 10111 East 21st Street North ■ Suite 301 ■ Wichita, KS 67206

316-634-0060 ■ 316-634-0050 (fax) ■ cwhwichita.com

Center For Women's Health

PATIENT INFORMATION

Last Name:		First Name:	
Address:	City:	State:	Zip Code:
Phone Number:	Marital Status:	Social Security Number:	
Primary Care Provider:	DOB:	Preferred Name:	
Email Address:		Significant Other's Name:	
Place of employment:			
Please circle: Female		Male	Non-Binary
Primary Language:			
Preferred Pharmacy:			

INSURANCE INFORMATION:

Primary Carrier:	Policy Holder's Name/D.O.B.: <input type="checkbox"/> Self
Member ID:	Group Number:
Medical Claims PO Box:	

CONSENT TO TREATMENT:

I hereby grant consent for treatment or services to be provided by the providers of Center for Women's Health. I also certify that no guarantee or assurance has been made regarding the result that may be obtained.

QUEST DIAGNOSTICS:

Center for Women's Health uses Quest Diagnostics as our in-office laboratory vendor. Laboratory services including blood draw, pap smears, cultures or biopsies done in our office will be sent to Quest Diagnostics.

It is your responsibility to know if Quest Diagnostics is your in-network laboratory vendor.

If you do not want your laboratory services to be sent to Quest Diagnostics, please write your preferred laboratory vendor name below. We may be able to schedule a pick up for this specimen, otherwise you will need to take the lab order to your designated laboratory vendor.

Preferred Laboratory Vendor:

By signing this form, you acknowledge that you have consented to treatment as stated above as well as to using Quest Diagnostics as your laboratory vendor, unless you listed an alternative vendor.

Patient Signature:	Date:
<input type="checkbox"/> Updated. Signature:	Date:
<input type="checkbox"/> Updated. Signature:	Date:
<input type="checkbox"/> Updated. Signature:	Date:
<input type="checkbox"/> Updated. Signature:	Date:



Center For Women's Health

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end.

AGREEMENT:

- The patient is responsible for payment of all medical treatment and other related services covered by the treating provider at Center for Women's Health.
- As a service and out of consideration to our patients, this office will file insurance claims for all covered services. We will file up to two insurance companies. If you have additional coverage, you must file those yourself. We will not do 3rd party billing. This preparation is not a guarantee that we have a contractual relationship with your insurance plan, nor can we guarantee that your specific insurance policy covers the services that we have provided. It is a courtesy of CWH to provide an estimate of charges for procedures, surgeries, etc. but it is the patient responsibility to deal with insurance company.
- Self pay patients are responsible for all medical treatment and other related services covered by the treating provider at Center for Women's Health. While CWH will try to estimate services in advance, the patient agrees in advance to pay for all services, tests and fees the providers feel are necessary for the patient's care.
- We do not have a way to access the terms and conditions of your insurance policy and therefore are unable to speak on your behalf to your insurance company about contract disputes that you might have. If you believe that your insurance company has not paid your medical costs correctly, you should contact your company directly to negotiate a solution.
- This office will accept your insurance company's maximum allowable reimbursement. The patient will be responsible for any deductible, co-insurance and co-payment amount. The patient is 100% responsible for payment of any non-covered services at the time of service.
- Patient is responsible for all charges during their care; including laboratory charges, sonograms, and referrals to outside clinics for advanced testing and screening if necessary.
- Patients with insurance, which require a referral, must have a referral prior to receiving treatment. It is the patient responsibility to obtain all necessary referrals from the primary care physicians. Patients without proper referrals and electing to receive service from the office will be required to make full payments in advance of the time of service.
- Patients normally receive a statement from our clinic after the insurance company has processed the claims. This will include all charges that the insurance company has not paid. **Payment is due upon receipt.**
- **An 18% APR will accrue on balances not paid within the specified billing cycle, with a \$10 minimum charge. Rates are subject to change without notice.**
- An account is considered past due if not paid by due date listed on billing statement, unless prior arrangements have been made with our billing office. If no attempts at payment have been made, the account may be referred to a collection agency.
- Patients may be discharged from care due to nonpayment of account.
- Patients who reserve an appointment with a provider and fail to keep that appointment will be subject to a \$50 no-show fee; \$100 no show fee for a scheduled procedure. To avoid this charge, patients must cancel appointments 24 hours prior to their reserved time. Fees are subject to change without notice.
- We accept cash, check, Visa, MasterCard, Discover, and debit cards. There is a \$50 returned check fee.
- CWH may send you a refund check for services rendered; if this check is lost, stolen, or not received there is a \$35 stop payment fee to reissue the check. We will not reissue checks for services later than one year.
- A copy of this form is available upon request.

INSURANCE RELEASE:

I authorize payment of medical benefits to the treating provider at Center for Women's Health to release any information requested by my insurance carrier.

I have read and understood the above agreement and by my signature here below, agree to the terms.

Patient Signature

Patient Printed Name

Date of Birth

Responsible Party Signature

Responsible Party Printed Name

Relationship to Patient

Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____ / ____ / ____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____ / ____ / ____



ANNUAL GYNECOLOGICAL UPDATE

Name: _____ DOB: _____ Today's Date: _____

Welcome Back! Please take a few minutes to fill out this form to help us update your records.

Please check the reason for your visit: Annual Exam Problem

Would you like to be tested for sexually transmitted infections? *Y/N*

Who is your primary care physician? _____

What was the first day of your last period? _____

Are your periods regular: *Y/N* How many days in a cycle? _____

How heavy is the bleeding? _____ How many days of bleeding: _____

Are you sexually active? *Y/N* (if yes) Do you have pain with intercourse: *Y/N*

Please list any new medical problems: _____

Please list any surgeries you had since your last visit: _____

Any new medical problems in your family? _____

Prescription Medications / dosages: check if none Supplements & over the counter meds: check if none

Please list any allergies you have: _____

Do you smoke: *Y/N* How much: _____ Do you drink alcohol: *Y/N* How much per week? _____

Do you use street drugs: *Y/N* _____ Do you have problems with violence at home: *Y/N*

Do you exercise regularly? *Y/N*

Do you wear sunscreen? *Always / Usually / Sometimes / Never*

Are you exposed to occupational or recreational hazards? *Y/N*

Do you wear your seatbelt while riding or driving in a car? *Always / Usually / Sometimes / Never*

Do you perform monthly self breast examinations? *Y/N*

What is your birth Control Method: (please circle) none, condoms, spermicidal, foam, Depo-Provera, IUD(Mirena), IUD(Paraguard), IUD(Skyla), IUD(Liletta), Nexplanon, birth control pills, birth control patch, birth control ring, tubal ligation, vasectomy Other _____ Are you satisfied with this method? *Y/N*

If not done in our office: _____

Date of last pap smear: _____ Normal: *Y/N* if no, results _____

Date of last Mammogram: _____ Normal: *Y/N* if no, results _____

Date of bone density: _____ Normal: *Y/N* if no, results _____

Have you had any blood work, labs or x-rays in the past year? *Y/N* If so, please list: _____

When was your last Tetanus vaccine? _____ Have you had the HPV vaccine? _____

For those over 45, when did you have your last sigmoidoscopy / colonoscopy: _____

PATIENT NAME: _____ DATE: _____

REASON FOR TODAY'S VISIT: _____ LMP: _____

<p>General</p> <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fever / Chills <input type="checkbox"/> Fatigue / Weakness	<p>Breast</p> <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Lumps/ Nodules <input type="checkbox"/> Pain/ Tenderness <input type="checkbox"/> Breast Masses <input type="checkbox"/> Nipple Bleeding	<p>Gynecologic</p> <input type="checkbox"/> Break through Bleeding <input type="checkbox"/> Labial Sores <input type="checkbox"/> Labial lumps/nodules <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Itching <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Pain between periods <input type="checkbox"/> Postmenopausal Bleeding <input type="checkbox"/> Irregular menses <input type="checkbox"/> Loss of Sexual Desire <input type="checkbox"/> Night Sweats <input type="checkbox"/> Vaginal Odor <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Infertility Problems
<p>Skin</p> <input type="checkbox"/> Nail Changes <input type="checkbox"/> Hair Changes <input type="checkbox"/> Mole Changes <input type="checkbox"/> Skin Rashes <input type="checkbox"/> Itchy Skin	<p>LUNGS</p> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing	<p>Musculoskeletal</p> <input type="checkbox"/> Muscle Pain/ Cramps <input type="checkbox"/> Weakness <input type="checkbox"/> Joint Pain/Swelling
<p>Eyes</p> <input type="checkbox"/> Blurred / Double Vision <input type="checkbox"/> Glaucoma / Cataracts <input type="checkbox"/> Dry or itchy eyes <input type="checkbox"/> Eye glasses or contacts	<p>HEART</p> <input type="checkbox"/> Murmur <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain	<p>Neurological</p> <input type="checkbox"/> Seizures <input type="checkbox"/> Vertigo <input type="checkbox"/> Paralysis <input type="checkbox"/> Tingling/Numbness
<p>Ears</p> <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Hearing changes / Deafness <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Earache <input type="checkbox"/> Dizziness	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Change in appetite <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bloating/Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal Bleeding	<p>Psychiatric</p> <input type="checkbox"/> Depression <input type="checkbox"/> Irritability <input type="checkbox"/> Anxiousness <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Panic Attack <input type="checkbox"/> Drug Addition <input type="checkbox"/> Physical Abuse
<p>Nose</p> <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Runny Nose <input type="checkbox"/> Post Nasal Drip	<p>Genitourinary</p> <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Pain with urination <input type="checkbox"/> Bloody urine <input type="checkbox"/> Urination at night	<p>Endocrine</p> <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Extreme Thirst <input type="checkbox"/> Excessive Hair Growth <input type="checkbox"/> Hypoglycemia/Low Blood Sugar
<p>Mouth</p> <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Oral sores/ulcers <input type="checkbox"/> Dental Problems <input type="checkbox"/> Loss of Taste	<p>Blood</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Painful Lymph Nodes	
<p>Throat</p> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Throat pain <input type="checkbox"/> Hoarseness		
<p>Neck</p> <input type="checkbox"/> Stiffness <input type="checkbox"/> Soreness <input type="checkbox"/> Pain <input type="checkbox"/> Masses		

Do you have any concerns that this update did not cover? _____

Thank you for taking the time to provide this information.

Family History Screening Form

Patient Name: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____
 Your age at First Period: _____ Your age at First Childbirth (if applicable): _____ Are you Menopausal: Yes or No
 If yes, your age at Menopause: _____ Have you ever used Hormone Replacement Therapy? Yes or No If yes, for how long? _____
 Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please indicate if you have a personal or family history of any of the following cancers. If yes, then write family relationship and AGE at diagnosis. Consider parents, children, brothers, sisters, half- siblings, grandparents, aunts, uncles, nieces, nephews.

BREAST AND OVARIAN CANCER (HBOC)

		You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	EXAMPLE: Breast Cancer		Aunt 53	Grandmother 45
Y	N	Breast Cancer			
Y	N	Breast Cancer in both breasts OR multiple primary breast cancers			
Y	N	Ovarian cancer (Peritoneal/Fallopian Tube)			
Y	N	Male breast cancer			
Y	N	Are you of Ashkenazi Jewish descent?			

COLON AND UTERINE CANCER (LYNCH)

		You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	Endometrial (uterine) cancer			
Y	N	Colon/Rectal cancer			
Y	N	Ovarian, stomach, kidney, brain OR small bowel cancer <i>*Please specify relatives, type of cancer & their age at diagnosis.</i>			
Y	N	10 or more colon polyps in a lifetime (Specify #)			

Y	N	Prostate Cancer (HBOC)			
Y	N	Melanoma (HBOC)			
Y	N	Pancreatic Cancer (HBOC/Lynch)			
Y	N	Other Cancers <i>*Please specify relatives, type of cancer & their age at diagnosis.</i>			

Patient's Signature: _____ Date: _____

<p>For Office Use Only: Patient offered hereditary cancer testing? <input type="checkbox"/> YES ACCEPTED DECLINED <input type="checkbox"/> NO</p> <p><small>1st degree: self, parents, siblings, children. 2nd degree: grandparents, grandchildren aunts/uncles, nieces/nephews, ½ siblings. 3rd degree: great grandparents, great aunts/uncles, 1st cousins.</small></p>	<p>HEALTH CARE PROVIDER SIGNATURE: _____</p>
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HBOC - Personal or Family History

One person with: (out to 2nd degree)
 -Breast (diagnosed <50)
 -Ovarian, ANY age
 -Male breast, ANY age
 -Breast with Ashkenazi Jewish heritage, any age
 -Bilateral breast at ANY age
 -Triple Negative breast (diagnosed ≤60)
 -Metastatic Prostate or Pancreatic at ANY Age
 -Metastatic Breast at ANY age (personal history only)

Two persons with: (out to 3rd degree)
 -Breast cancer (1 diagnosed ≤50)
 -Breast & Ovarian Cancer, any age

Three Persons with: (out to 3rd degree)
 -Breast and/or Pancreatic and/or Prostate, any age

Lynch*- Personal or Family History

One or Two persons with: (out to 2nd degree)
 -Endometrial or Colorectal cancer (1 diagnosed ≤50)
 -Endometrial or CRC cancer (1 ≤50) & another Lynch* cancer, any age

Three persons with: (out to 2nd degree)
 -Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Lynch cancers: endometrial, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/ renal pelvis, biliary tract, sebaceous adenomas