SWOR WOMEN'S CARE

Annual Exam Update Form

Swor Women's Care
1900 S. Tuttle Ave.
Sarasota, FL 3423

Name: _____ DOB: _____ Date: _____

Family Doctor/Internist: _____

Please Describe Reason for Appointment:

_____

_____

Prescription Medications: □ Check if none

_____

_____

_____

_____

Supplements & Non-prescriptions: □ Check if none

_____

_____

_____

_____

Allergies: □ Check if none

_____

Gynecological History:
Age:_____ Height: _____ Weight:_____
Marital Status: _____
Cultural Identity: _____
Have you ever been pregnant? Yes No
If "**Yes**" please answer the following:
Number of times you have been pregnant? _____
Number of live-born children _____
Number of miscarriages/abortions _____
Number of tubal pregnancies _____
History of infertility? Yes No
Method of birth control: □ Check if none

_____

Date of last menstrual period _____
Age when periods started _____
Age when menopause occurred _____
How many days apart are your periods _____
How long do your periods last _____
Describe your periods:

_____

Date of last pap smear (mm/yy) _____
Date of last mammogram (mm/yy) _____
Date of last bone density (mm/yy) _____
Date of last colonoscopy (mm/yy) _____
Date of last fecal occult (mm/yy) _____

Tobacco Use: □ Yes □ No □ Quit If "yes" or "quit" Amount_____How long? _____

Alcohol Use: □ Yes □ No How much?_____How often? _____

In the last 12 months have you been involved in an abusive relationship? □ Yes □ No

Medical History Update: □ Check if nothing new since last annual exam

_____

Surgical History Update: □ Check if nothing new since last annual exam

_____

Family History Update: □ Check if nothing new since last annual exam

_____

Please check if experiencing at this time: □ Check if nothing

□ Abdominal pain or pelvic pain
□ Hot Flashes/Night Sweats
□ Vaginal discharge
□ Unpleasant vaginal odor
□ Vaginal itching
□ Vaginal Burning
□ Vaginal dryness
□ Pain with intercourse
□ Bleeding with intercourse
□ Mood swings
□ Depression
□ Memory loss
□ Difficulty concentrating
□ Sleeping problems
□ Decrease in sexual desire
□ Decrease in energy level
□ Digestion problems
□ Acne
□ Urinary leakage
□ Urinary incontinence
□ Burning with urination
□ Breast pain
□ Painful periods
□ Menopausal symptoms
□ PMS
□ Bleeding post menopause
□ Abnormal weight gain
□ Abnormal weight loss
□ Migraines
□ Bloating
□ Other _____

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Financial and Office Policies

We would like to thank you for choosing Swor Women's Care as your women's health care provider. This document explains our current office and financial policies. It is important that you read and agree to these policies.

Financial Responsibility: Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.

Payment Form: Swor Women's Care accepts Cash, Personal Checks, MasterCard, Visa, and Discover Cards as payment for services rendered.

Insured Patients: Please bring your insurance card with you to your appointment. If your insurance plan requires an office visit co-pay, this will be collected at the time of service. The co-pay cannot be waived by our office; it is a requirement placed on us by your insurance carrier. You are financially responsible for any co-insurance, deductible or non-covered service. If you are a member of a health plan that Swor Women's Care participates with, we will submit a claim to your primary insurance company on your behalf. If you have an insurance plan that we are not providers of, payment is due at the time of service and we will assist you in submitting your claim for reimbursement to your insurance company.

Authorizations: If your insurance requires authorization for office visits, then it is your responsibility to obtain this from your primary care physician.

Balance Due: Once we have received payment along with an Explanation of Benefits (EOB) from your insurance plan, you will receive a statement from our office indicating what your insurance has paid. Any remaining balance will then be due and payable. Patients with large deductibles will be asked to pre-pay a portion of their known medical expenses (for example: GYN surgery patients)

Non Insured Patients: Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager prior to your visit.

Medicare Patients: You are personally responsible for your deductible, co-insurance and any service that Medicare deems as "Medically Unnecessary". Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for certain services.

In Office Labs/Testing: Please verify your benefits with your insurance company prior to having any lab or diagnostic testing performed. If your insurance company does not cover screening lab tests, we do offer certain tests at a reduced cost to you if performed in our office on a cash-pay basis.

No Show: Please be aware that our office charges $25 if you no show for your appointment or if you do not give a 24-hour notice of cancellation. Also, there is a $250 charge if you cancel or no show for a surgery with our office.

Returned Checks: A $25 fee will be assessed for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

Collection Accounts: Swor Women's Care reserves the right to turn an account over to collections if it is deemed that the account is in default of payment or compliance with this policy and you will be discharged from the practice. You can avoid collections and discharge from the practice by arranging a payment plan with the office.

Financial Hardship: We understand that sometimes it is a hardship to pay your medical bills timely. Please discuss with our Office Manger so we can work out a payment plan. Ignoring medical bills is not advisable. Let us know your situation so we can work with you.

I hereby authorize Swor Women's Care as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Swor Women's Care and authorize Swor Women's Care to submit claims on my behalf for any bills or services furnished to me during the next 12 month period(year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

I have read and understand the handout, Financial and Office Policies. By signing below, I am stating that I understand and agree to the above policies. I also understand that at any time our financial policy may be updated.

Signature: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change the notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or other health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I,_____, give Swor Women's Care permission to release private health information and test results to the person(s) listed below, in the event that I am unreachable.

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Name (please print) _____
Patient Signature_____
Date _____
****

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date _____
Initials _____
Reason _____

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Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination. Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____ ____/____/_____ ____/____/_____
Signature DOB Date

I understand that my provider is involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

_____ ____/____/_____
Signature Date

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LABORATORY TESTING

Swor Women's Care will be sending all in house specimen collections to Florida Woman Care Laboratory, LLC for interpretation. If they are not contracted with your insurance, they will forward to correct lab facility.

Florida Women Care Laboratory, LLC is a laboratory dedicated solely to women's healthcare, which we believe will provide our patients with a high level of specialized care for laboratory testing. The group's laboratory employs only Pathologists with specialty expertise in Gynecological Pathology and/or Cytopathology to ensure high quality, specialized testing and analysis. In addition, our physicians will have a direct line of communication with these pathologists to discuss your care.

We believe these factors will contribute to our ability to provide our patients with increased continuity of care and more timely results. As with any laboratory and its services, we cannot guarantee that all services will be covered at 100% under each patient's insurance plan. If the labs ordered are subject to your deductible, co-pay, co-insurance, and in some cases not covered by insurance you will receive a separate lab bill for any/or all tests that were ordered by the provider.

Self-pay patients, any extra charges, such as labs, tests and or/procedures need to be paid prior to leaving the office to take advantage of the discount. All self-pay rates are discounted from our billed charges and not included with our office fees.

We do appreciate the opportunity in taking care of you and your family.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient Signature Date