PATIENT HISTORY

Name _____ DOB ___/___/____

Occupation: _____

Medication Allergies: _____

Daily Prescription Medications: _____

_____

Current Medical Conditions: _____

Surgeries

Operation	Date	Operation	Date
_____	_____	_____	_____
_____	_____	_____	_____

Other Hospitalizations (excluding childbirth)

Reason	Date	Reason	Date
_____	_____	_____	_____
_____	_____	_____	_____

Please circle your answer below and explain as needed

Pregnancies: None Number of Pregnancies ____ Number of Live Births _____

Abnormal Pap Smear: no yes (if YES, have you had a colposcopy? Surgery?)

Cigarettes: Never Smoked Currently Smoke ____packs per day Quit/date _____
Have you smoked MORE than 100 cigarettes in your lifetime? _____
Are you exposed to second hand smoke? _____
How many years have you smoked? _____
Alcohol Consumption: never occasional weekly daily: # per day: _____
Last Colonoscopy_____Where_____
Last Bone Density _____Where_____
Last Mammogram_____ Where _____

Past Medical History Name: _____

- ❑ Acid Reflux (GERD)_____
- ❑ Allergies (Food, seasonal, environmental)_____
- ❑ Anemia _____
- ❑ Anesthesia Complications _____
- ❑ Anxiety Disorder _____
- ❑ Arthritis _____
- ❑ Autoimmune disease _____
- ❑ Cancer _____
- ❑ Depression/Postpartum depression _____
- ❑ Dermatologic Disorders _____
- ❑ Diabetes _____
- ❑ Dyslipidemia _____
- ❑ Eating Disorder _____
- ❑ Fibromyalgia _____
- ❑ GI Problems _____
- ❑ Headaches _____
- ❑ Heart Disease _____
- ❑ Hematologic disorders _____
- ❑ Hepatitis/Liver Disease _____
- ❑ High Cholesterol _____
- ❑ Hypertension_____
- ❑ Infertility_____
- ❑ Kidney Disease _____
- ❑ Kidney or Bladder Problems_____
- ❑ Lung Disease _____
- ❑ Neurologic/Epilepsy _____
- ❑ Psychiatric Illness _____
- ❑ Pulmonary (TB, Asthma) _____
- ❑ Stroke _____
- ❑ Thyroid Problems _____
- ❑ Trauma/Violence _____
- ❑ Other_____
- ❑ Have you ever been sexually assaulted? Yes No
  - ❑ If yes, would you like to talk about it with the provider? Yes No

Have you had: Ablation Tubal Ligation Hysterectomy
Are you: Postmenopausal Perimenopausal
Have you ever been pregnant? Yes No How many? _____
Have you had an ectopic pregnancy? Yes No How many? _____
Have you had a cesarean? Yes No How Many ?_____

Primary Physician: _____
Pharmacy: _____

Marital status: Married Single Divorced Widowed Domestic Partner Separated

Patient Authorizations and Consent:

Assignment of benefits: I hereby authorize payment of medical benefits to Artemis Inspired Medicine, PC on my behalf for any services furnished to me by their providers. I understand I am financially responsible for any amount not covered by my insurance policy. I also, hereby authorize Artemis Inspired Medicine, PC to release to my insurer, referring physician and other consultants on my case information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Consent to Photograph: I hereby authorize, Artemis Inspired Medicine, PC to take my photograph for inclusion in my medical chart retained by the office. I understand this photograph is solely for the purpose of identification and familiarization by the office staff.

Patient Relationship Termination: I understand that I will be terminated if I repeatedly no show for scheduled appointments, non-compliant with recommended medical care and with paying bills in a timely manner, become hostile or display abusive behavior toward/with the staff.

Communication Notification: With my consent, Artemis Inspired Medicine, PC, personnel may call my home, cell, or emergency contact listed, leave a message on answering machine, voicemail, or send an email in reference to appointment reminders, insurance issues, information pertaining to my clinical care, and any collection of debt owed to the office. Below you will find the numbers you may call, I will update as needed:

Phone #1: _____ **Phone #2:** _____

Email Address: _____

Emergency Contact: _____ **Phone#:** _____

Payment Arrangement/Credit Card on File: I authorize the use of my credit card on file for any payment arrangement that has been set up in regards to outstanding balances/past debt. I agree to keep credit card information current.

Acknowledgement

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outline previously.

Patient Name(s) _____

_____ _____

Responsible party member's name | Relationship

_____ _____

Responsible party member's signature | Date

Artemis Advanced Office Gynecology

Julie A. Madejski, MD, FACOG
5846 Snyder Dr., Lockport, NY 14094
Phone: (716) 433-3053 Fax: (716) 433-3118

Notice of Privacy Practices

In keeping with the Health Insurance Portability and Accountability Act, this notice describes how personal information collected in this office may be used and exchanged.

Personal information includes:

1. Any information that identifies you
2. Any description of your health status
3. Your age
4. Your sex
5. Your ethnicity or demographic characteristics

We must obtain general consent from you to release any of this information for purposes of payment or health care operations. In some cases, permission to share pertinent health information with another healthcare provider will be assumed.

You have the right to:

- Request restrictions on certain disclosures, while we are not obligated to agree to these restrictions we will honor them whenever possible.
- Inspect and copy your protected health information.
- Amend protected health information.
- Obtain an accounting of disclosures of your protected health information, and
- Revoke the permission of disclosure although this would not apply to prior disclosures.

We are obligated to:

- Maintain the privacy of protected health information.
- Provide this notice of our privacy policies.
- Abide by the terms of this notice.
- Make public any changes of this notice.

You have the right to register a complaint concerning any suspected violations of the privacy act with our office and/or with the Secretary of the Department of Health and Human Services (DHHS). There will be no retaliation against you if you file a complaint. If you need to file a complaint, speak to Kayla Schmidt (HIPAA Compliance Officer) or Tricia Spellan (Administrative Manager). They will take down your complaint and follow office procedures to investigate the problem. You will receive a follow up phone call once the complaint has been investigated.

- *If you have any questions, please ask any staff member.*

I have read and understand Artemis Advanced Office Gynecology confidentiality policy.

Signature of patient or responsible party **Date**

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **DOB:** ____/____/____

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_____**Phone#**_____

[ ] Child(ren)_____**Phone#**_____

[ ] Other_____**Phone#**_____

[ ] **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
[ ] you may leave a message with any of the above people

Best time of day to reach me is _____ **between (time)** _____

Signed: _____ **Date:** ____/____/____

Witness: _____ **Date:** ____/____/____

CURRENT MEDICATIONS

NAME:_____ DOB:_____

Medication Name:	*Dosage:*	*How Often Taken:*

Last Colonoscopy_____ Where_____
Last Bone Density_____ Where_____
Last Mammogram_____ Where_____

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Doctor You're Seeing Today:** _____

Instructions: This is a screening tool for cancers that run in families. Please circle (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.

3 **You and the following close blood relatives should be considered:** *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, 3rd degree-cousins, Great-Grandparents and Great Grandchildren*

1 **YOU**

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

	CANCER	AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
X Y N	*EXAMPLE: BREAST CANCER*	45	--- ---	---	*Aunt Cousin*	45 61	*Grandmother*	53
Y N	BREAST CANCER							
Y N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
Y N	UTERINE/ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
Y N	OTHER CANCER(S) ***Circle Cancer Below***							
	Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Prostate							

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)*

Cancer Risk Assessment Review

Patient's Signature: _____ Date: _____

Health Care 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: _____

Ultrasound Guidelines

We normally begin with a transabdominal ultrasound to view the uterus and ovaries. This requires a full bladder. Ideally the patient arrives with a full bladder and having recently eaten a meal. If we can see everything we need, we can avoid the transvaginal exam. Doing just a transvaginal ultrasound has been known to miss massed that rise out of the pelvis. However, transvaginal ultrasounds give a superior view of the uterine lining and the ovaries are particularly useful in cases of:

1. The patient cannot hold a full bladder.
2. The uterus is tipped away from the abdominal wall.
3. The patient's BMI is greater than 30 or there is poor resolution due to peristalsis (small bowel activity).
4. The location of a fibroid is important.
5. Dating of an early pregnancy if the transabdominal exam is inconclusive.

Therefore if there is insufficient resolution on the transabdominal exam, a transvaginal exam will be performed.

Doppler studies of the uterus or ovarian vessels may be added when indicated due to ovarian masses or an abnormal uterine lining. This is to rule out torsion of the ovary or to visualize abnormal masses suspicious for cancer. ***Your insurance may apply this toward your deductible or leave you responsible for a copay.***

Annual GYN Exam vs Sick/Problem Visit (E/M)

An annual well women exam is a yearly preventative/routine visit for screening and updates. A sick/problem (E/M) visit is a discussion or concern regarding a new problem or a detailed review of a chronic condition. Below is a list of what to expect during an annual well women's exam and what is considered an E/M (sick/problem) visit:

Annual GYN Exam	*Sick/Problem Visit (E/M)*
Weight, blood pressure, vitals are taken.	Weight, blood pressure, vitals are taken.
Physical exam, including breast exam.	Abnormal or heavy vaginal discharge that itches, burns, has an odor, or causes discomfort.
Pelvic exam, with a pap smear, if indicated.	Heavy, abnormal, or irregular bleeding of any kind.
Rectal exam for women 40 and over.	Bleeding between periods or missed periods.
Update of life, work situation, family health history, and any new family illnesses.	Problems or side effects from your birth control and obtaining new contraception.
Review of your health history.	Painful intercourse or sexual issues.
Update of current medications, herbs, and supplements.	Menstrual cramps that cause you to miss school or work.
Need for medication refills.	Breast pain, lump, or discharge from nipple.
Scripts for health screening tests based on age, personal, and family history; such as	Discussion of pregnancy, infertility, or relationship issues.
Mammograms	Pain of any kind.
Lab Scripts (STD/bloodwork)	New Prescriptions of any kind.
Colon Cancer	Menopausal symptoms.
BMD/Ultrasound	Fibroids, polyps, or lesions of any kind.
Referrals to specialist, if indicated	Genetic counseling with blood draw.

If you are experiencing any of the sick/problem issues at the time of your annual exam these can be addressed at that time. ***Please keep in mind, this would be considered an E/M visit which is a separate charge and is subject to a copay and/or deductible, if you have one.***

Artemis Inspired Medicine, PC

OFFICE POLICIES AND PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Artemis Inspired Medicine, PC as your gynecological (GYN) provider. We are committed to providing you with the best possible medical care. Letting you know in advance of our policies and your financial responsibility allows for a good flow of communication and enables us to provide and focus on your medical needs. Please read this carefully and sign in the space provided. If you have any questions please do not hesitate to ask a staff member.

INSURANCE: Our providers participate and are in-network with most insurance plans, including Medicare. We will submit your claims to any insurance plan we are in-network with. If we are out-of-network or do not participate with your plan, you will be responsible to pay at time of visit and submit claim to your insurance plan. Please remember your insurance coverage is a contract between you and the insurance company. It is your responsibility to know your insurance benefits, participating providers, and if a referral is needed to see a provider. ***We do not participate in Worker's Compensation.***

PATIENT RESPONSIBILIES:

1. At each visit you will be required to verify and update personal information.
2. Present current copy of insurance card(s), along with picture ID.
3. Pay for any copay, co-insurance, deductible, past due balance, and services not covered by your insurance plan at time of visit. ***We accept Cash, Checks, Visa, Discover, and MasterCard.*** We do not accept post-dated checks. If a check is returned due to insufficient funds you will be charged a **$25.00** returned check fee.
4. Be on time for your scheduled appointment; ***we reserve the right to reschedule if you are late.*** We require a 24-hour notice for canceling or rescheduling an appointment. There is a **$35.00** charge for missed appointments OR if 24-hour notice is not given. As a ***COURTESY***, we attempt to contact our patients to remind them of their scheduled appointments. ***HOWEVER***, it is your responsibility to remember your scheduled appointment. ***There is a $250.00 charge for failure to show or reschedule for surgery.***
5. You will be billed for any non-covered procedure or denial from your insurance plan. Payment is expected within 30 days of receiving the bill. If your account remains unpaid after 90 days you will receive a letter and have 10 days to pay in full. Partial payments will not be accepted unless otherwise negotiated. If your balance remains unpaid, we will refer your account to a collection agency and discharge you from the practice via certified mail. You will be responsible for any court and attorney fees we incur from collections. ***If you are unable to pay your bill due to financial hardship please speak with the billing department in regards to a payment plan.***
6. All specimens are sent to an outside lab. We contract with ProPath and Kaleida. If you receive a bill, please contact them with any questions.
7. An office visit is required for ***ALL*** prescription refills. ***We do not diagnosis over the phone, therefore, an appointment is required. We charge a $25.00 fee for non-emergent after hour calls.***