SWOR WOMEN'S CARE

Gynecology • Obstetrics • Infertility • UroGynecology

G. Michael Swor, MD, FPMRS
Kelly-Anne Shedd-Hartman, DO, FACOOG
Jenny Lichon, DO
Holly Jackson, CNM
Allison Smith, APRN
Samantha McCormick, APRN
Gretchen Sciarrino, APRN

Dear Patient,

Thank you for choosing Swor Women's Care for your Obstetrical and Gynecological needs.

This letter confirms your upcoming appointment at Swor Women's Care.

All new patients to Swor Women's Care must arrive 15 minutes before your scheduled appointment time for registration.

Please bring any medical records that pertain to Gynecology, especially surgical reports, testing or imaging with you to your appointment. If you cannot obtain copies of your records, it may delay your treatment.

Please bring a photo identification and insurance card to each appointment.

New Patients: Please complete all paperwork mailed to you. Paperwork may be returned to us by mail, fax and/or brought to the office.

Please call us if you have any questions or need to cancel or reschedule your appointment.

It is very important that you call our office at least 24-48 hours prior to your appointment to cancel your appointment. If our office is not notified in advance, there will be a "No Show" fee of $25 billed to your patient account.

Sincerely,

Swor Women's Care
1900 S. Tuttle Ave
Sarasota, FL 34239
Phone: 941-330-8885
Fax: 941-906-8774

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PATIENT'S INFORMATION			
(Please Print)		Today's Date: / /	
Last name:		First:	M.I.
Birth Date: / /	Age:	Marital Status: Single Married Divorced Seperated Widow	
Is this your legal name? □ Yes □ No			
Street Address:		Email Address:	
City:	State:	Zip Code:	SS#:
Home Phone:	Cell Phone:	Work Phone:	
How did you hear about our office?	□ Dr.	□ Insurance Plan	□ Hospital
□ Family	□ Friend	□Close to home/work	□ Yellow Pages	□ Other _____
Race: □ African American/ Black □ Asian □ Caucasian/ White □ Pacific Islander/ Native American □ Hispanic/Latino □ American Indian/ Alaskan Native □ Other			
Ethnicity: □ Hispanic/ Latino □ Non Hispanic or Latino		**Preferred Language**: □ English □ Spanish □ Other_____	
PHARMACY INFORMATION			
Pharmacy:		**Location:**	
INSURANCE INFORMATION			
(Please give your Insurance card and photo identification to the receptionist)			
Primary Insurance:		Secondary Insurance:	
Policy Holder Name:		Policy Holder Date of Birth:	
IN CASE OF EMERGENCY			
Name of local friend or relative:			
Home Phone:	Work Phone:	Relationship to patient:	
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION			
May we leave a message at your home? □ Yes □ No		May we leave a message on your cell? □ Yes □ No	
May we send a yearly recall to your home? □ Yes □ No		Do we have consent to text your cell? □ Yes □ No	
I authorize Swor Women's Care to speak with _____ regarding my healthcare/PHI. (relationship to patient): _____			
I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.			
Patient Signature:		Date: / /	
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION			
I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Swor Women's Care to provide medical care and treatment for me. I authorize Swor Women's Care to obtain verification of my medication/prescription history in order to provide continuity of care. I authorize release of my medical information as directed by my physician for outside referrals to specialists, hospitals, laboratories and others as necessary for my continued care. I hereby authorize payment of benefits to be made directly to Swor Women's Care and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fee may be assessed.			
Patient Signature:		Date: / /	

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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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GYN Patient History Form

Today's Date:_____ Your Age:_____ Date of Birth:_____
Patient's Name(Last):_____ (First):_____ (M.I.):_____
Marital Status:_____ Cultural Identity: _____
Height: _____ Weight: _____
How did you hear about Swor Women's Care?_____
Are you here for a Gyn Annual Exam? Follow up? Problem? Consultation? Other?:_____
_____
Allergies/ Reactions:_____
Current Medication(include over the counter medications, vitamins and dosages): _____
_____
_____
_____
Other Physicians: _____
_____

Current Problems

(*If you currently have or do not have these problems, Please circle Yes or No*)

Abnormal or Unexpected bleeding?	Y/N	Abdominal or pelvic pain?	Y/N
Hormonal Problems?	Y/N	Vaginal Discharge?	Y/N
Unusual Breast Symptoms?	Y/N	Vaginal Irritation?	Y/N
Pressure in Pelvic Area?	Y/N	Genital Lesions?	Y/N
Difficulty emptying bladder or bowels?	Y/N	Changes in Bladder or Bowel Functions?	Y/N

Any other women's health issues?_____

Obstetrical History

Have you ever been pregnant Y/N History of Infertility? Y/N

Number of Pregnancies?	Full Term or Pre- Term?	Number of Abortions?	Number of live births?	Number of miscarriages?	# of tubal/ectopic pregnancies?	Number of C-Sections?

Current Birth Control Method

___ Rhythm Method
___ Condoms
___ Diaphragm, Sponge, or Suppository
___ Oral Contraceptives
___Transdermal Patch
___ Vaginal Ring
___ Depo Provera
___ Intrauterine Device
___ Vasectomy
___ BTL (Tubal Sterilization)
___ None

Menstrual History

Periods are ____ days part
Menstrual bleeding usually lasts ____ days
Are your periods abnormal? Y/N
Date of last period?_____
Age of first period?_____
Age menopause occurred? _____

Sexual History

Are you sexually active? Y/N
Are you in a monogamous relationship? Y/N
Are you in a same sex relationship? Y/N
Are you in a opposite sex relationship? Y/N

Health Habits

Are you knowledgeable about and practice good nutrition? Y/N
Are you knowledgeable about and practice regular exercise? Y/N

Drugs and Alcohol

Past legal or illegal drug use? Y/N
Current legal or illegal drug use? Y/N
Do you drink alcoholic beverages? Y/N
How many drinks per week?_____

Safety

Have you been involved in domestic abuse in the past 12 months? Y/N
Have you suffered abuse in the past? Y/N
Do you live in a safe environment? Y/N

Smoking History: Current Past Never Quit

Past Medical History

Mark X if positive	Medical Problem	Year Started	Resolved Y/N		Mark X if positive	Medical Problem	Year Started	Resolved Y/N
	Cardiac Workup					Arthritis		
	Heart or Blood Vessels					Acne		
	Premature Cardiovascular Disease					Skin Cancer(Squamous, Basal Cell, Melanoma)		
	Coronary Artery Disease					Interstitial Cystitis		
	Hypertension (high blood pressure)					Recurrent UTI		
	Deep Venous Thrombosis					Kidney Stones		
	Valvular Heart Disease					Chronic Renal Disease or Insufficiency		
	Diabetes Mellitus					Amenorrhea		
	Thyroid disorder					Anovulation		
	Ear, Nose and Throat					Endometriosis		
	Viral Hepatitis					Fibroids in the Uterus		
	Easy Bleeding					Osteopenia		
	Hepatitis (chronic)					Osteoporosis		
	Chronic Colitis or Crohns					Pelvic Inflammatory		
	GERD (esophageal reflux,ulcers)					Chlamydia		
	Cholelithiasis (gallstones)					Warts (genital)		
	Hernia					HPV		
	Diverticulosis or Diverticulitis					Herpes (HSV)		
	Irritable Bowel Syndrome					Cervical Dysplasia		
	Hyperlipidemia					PCOS (Polycystic Ovaries)		
	Obesity					Ovarian Cancer		
	Migraine Headaches					Hereditary Cancer Syndrome		
	Epilepsy and Recurrent Seizures					Breast Cancer		
	Bones, Fractures, and Joints					Cervical Carcinoma		
	Anxiety Disorder					Vulvar Carcinoma		
	Depression					Endometrial Carcinoma		
	Bipolar Disorder					Ovarian Cyst		
	Asthma					Colon Cancer		
	Chronic Obstructive Pulmonary Disorder					Colon Polyps		
	Autoimmune Disease					History of Malignancy		

Surgical History

X if Yes	Year	Surgery	X If Yes	Year	Surgery
		D&C Hysteroscopy			Hysterectomy (Cervix intact or removed)
		Endometrial Ablation			Appendectomy
		Laparoscopy (diagnostic or operative)			Cholecystectomy (gallbladder removal)
		C-Section			Breast Surgery
		Leep or Cone Biopsy			Lap Band- Gastric Bypass
		Tubal Sterilization			Colectomy for Tumor
		Ovarian Cystectomy			Hemorroidectomy
		Salpingo Oophorectomy			Hernia Repair
		Ectopic Pregnancy Surgery			Fracture(s)
		Pelvic Floor Repair			Joint Replacement
		Sling or Surgery for Incontinence			

Other Past Surgery and Date

_____
_____
_____
_____
_____
_____

Family History

Condition	Affected Member	Age Diagnosed
GYN Cancer(Uterine, Ovarian, Cervical)		
Breast Cancer		
Colon Cancer		
Melanoma		
Heart Disease		
Hypertension		
Stroke		
Osteoporosis		
Diabetes Mellitus		
Alzheimer's Disease		
Thromboembolic Disease		
Other Cancer or Major Disease_____		

About You As A Person

Tell us about your cultural background?	
What is your racial background?	
Place of Birth? Hobbies?	
Occupation?	
What is your educational background?	
Describe any major life changes recently?	
Describe any recent emotional stress?	

Previous Tests and Screening

X If Yes	Month/Year of most recent	Testing/Screening	X If Yes	Month/Year of most recent	Test/Screening
		Pap Smear			Cervix Cryosurgery
		Colonoscopy			Cervix Laser Cone Excision
		GYN Ultrasound			Vaginal Biopsy
		Mammogram			Vulvar Biopsy
		Breast Ultrasound			Endometrial Biopsy
		Bone Density			Urodynamics
		Colposcopy			Sonohysterogram
		LEEP or Cone Biopsy			Blood Transfusion

Review of Systems

*(If **YOU** have had any of these conditions **in the last year**, Please indicate with X)*

X If Yes	How Long	Condition	X If Yes	How Long	Condition
		Weight Gain			Blood in Urine
		Fever			Genital Lesions
		Feeling Tired			Other Genitourinary Symptoms
		Other Constitutional Symptoms			Skin Lesions
		Head or Sinus Symptoms			Change in Mole or Non-healing Sore
		Eye Symptoms			Other Skin Symptoms
		Ear, Nose and Throat Symptoms			Endocrine Symptoms
		Neck Symptoms			Hormonal Symptoms
		Breast Related Symptoms			Musculoskeletal Symptoms
		Cardiovascular Symptoms			Neurological Symptoms
		Pulmonary Symptoms			Sleep Disturbances
		Gastrointestinal Symptoms			Anxiety
		Pain with Urinating			Depression
		Increased Urinary Frequency			Other Psychological Symptoms

Thank you for your help in collecting useful and important information for your permanent electronic records. We are trying to streamline the entry of medical data, and make it easier to share and update as you instruct us to.

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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