Swor Women's Care
Sworcare.com

*Gynecology • Obstetrics • Infertility • UroGynecology*

**G. Michael Swor, MD, FPMRS**
*Gynecology, Minimally Invasive/ Reconstructive Surgery*
**Kelly-Anne Shedd-Hartman, DO, FACOOG**
*Obstetrics and Gynecology*
**April Campbell, CNM**
**Allison Smith, ARNP**
**Cynthia Day, ARNP**

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:_____

**A. Notifier:** Swor Women's Care

**B. Patient Name:** **C. Identification Number:**

# Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for **D. Services** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Services** below.

| | | |
|---|---|---|
| **D. Services** | □ Annual Wellness Women Exam | □ Pelvic & Breast Exam<br>□ Pap Smear Collection<br>□ Fecal Occult Testing |
| **E. Reason Medicare May Not Pay:** | Medicare does not pay for these tests. | Medicare does not pay for these tests as often as ordered for you. |
| **F. Estimated Cost** | Annual Wellness $58 | Pelvic & Breast Exam $61<br>Pap Smear Collection $56<br>Fecal Occult Testing $50 |

**WHAT YOU NEED TO DO NOW:**

a. Read this notice, so you can make an informed decision about your care.
b. Ask us any questions that you may have after you finish reading.
c. Choose an option below about whether to receive the **D. Services** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D. Services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D. Services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| | |
|---|---|
| **I. Signature:** | **J. Date:** |

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.**

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## Patient Consent to Communicate

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):_____

Signature:_____

Date:_____

***Your Home for Women's Health***
*1900 South Tuttle Avenue Sarasota, Florida 34239*
*Phone: 941-330-8885 Fax: 941-906-8774*

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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: Single Married Divorced Separated Widow Partner
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

*(Please indicate Yes or No on the following questions)*

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 Obstuctive 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 or Birth?<br>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.*