Swor Women's Care
sworcare.com

Annual Exam Update Form

Swor Women's Care
1900 S. Tuttle Ave.
Sarasota, FL 34239

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: _____ Marital Status: S M D W
Race: Caucasian Asian African-American
Native-American Hispanic

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

_____

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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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

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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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

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 □ Pap Smear Collection □ 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 Pap Smear Collection $56 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:**

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