Dr. Shefali Patel-Shusterman, MD FACOG
505 East Broad St. Westfield, NJ
Office 908.232.6001
Fax 908.232.0780

Welcome To My Office

Insurance Co. ________________________________ Date ____________________

Name ____

Address ________________________________ City ____________________

State ____________________ Zip ____________________

Home Phone ______________ Work ______________ Cell ____________________

Email ________________________ Can we leave message on phone/email Yes / NO

SS# ____________________ Date of Birth ______________ Marital Status ____________

Place of Birth ____________________ If Married, Maiden Name ____________________

Occupation ________________________ Employed By ________________________

Employers Address ____

Spouse/Parent/Legal Partner Information

Spouses Name (Or parent if patient is under 18) ________________________________

Spouses Date of Birth __________ SS# ____________ Occupation ________________

Spouse Employed By ____________________________ Work Phone ______________

Spouses Employers Address

In Case of Emergency Notify Name ________________________ Phone ____________

Referred By ____

If Referred By Physician / Name and Address ________________________________

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In order to submit your prescriptions promptly, please provide your pharmacy information.

DO NOT LEAVE BLANK

Pharmacy	**City**	**Fax or Phone**

Beneficiary Statement

I certify that I, or the undersigned, have insurance coverage with the company listed above. I understand that I am responsible for any co-payments, deductibles of any balance after insurance, as outlined in the "Explanation of Benefits" (EOB). I request that payment of authorized benefits be made to Dr. Patel-Shusterman to provide pertinent medical records to any insurance company.

Authorized Signature: ____

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Office Financial Agreement

Dr. Shefali Patel-Shusterman's goal is to provide and maintain a good physician-patient relationship. Informing you in advance of our Office Policy allows for a good flow of communication, and enables us to achieve this goal. Please read this document carefully and if you have questions please do not hesitate to ask a member of our staff.

1. Upon arrival, please sign in at the front desk and present your current insurance cards at every visit. It is your responsibility to understand your insurance benefit plan. It is your responsibility to know if a written referral or authorization is required to see a medical Specialist.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles and co-insurances.
3. If our physicians do not participate in your insurance plan, full payment is expected at the time of your office visit unless other arrangements are made. For scheduled appointments, any prior financial balances must be paid prior to the visit.
4. If you have no health insurance, payment for an office visit is expected upon check-in, prior to the exam. Please check with the front desk for the fee for services.
5. Co-Pays are due at the time of service.
6. Patient balances are billed monthly after the payment has been received from your insurance company. Payment is due 10 business days from receipt of your bill.
7. If previous arrangements have not been made with our Finance office, any account balances exceeding 90 days, will be submitted to a collection agency.
8. A $35 fee will be assessed for all appointment cancelled without a 24 hour notification.
9. A $50 fee will be assessed for failure to arrive for a scheduled appointment.
10. Patients who accumulate a total of 3 NO SHOWS/SAME DAY CANCELLATIONs in a calendar year, will be terminated as a patient of Dr. Patel-Shusterman. Exceptions will be considered upon circumstances.
11. If your last appointment exceeds a ONE YEAR (12 MONTHS) period, Dr Patel-Shusterman will not refill any prescriptions until you are seen for an exam in our office.
12. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
13. We charge $1per page (first time copies are free) for copying Medical Records up to 100 pages; and .25 for each page exceeding 100. There is no charge for Disclosure of Medical Records for a TPO (Treatment, Payment, and Health Care Operations).
14. If you have school, camp and/or sports forms etc. to be completed, there is a $10 charge for each form. Payment is due when forms are presented to our office, before completion. We require a one week lead time to complete all forms.

I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as stated above.

Patient Name ____

____ ________________

Patient, Parent, or Guardians Signature Date

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ACKNOWLEGEMENT OF PRIVACY POLICY

HIPPA

The undersigned (patient or legal representative) consents to the use or disclosure of my (patient) individually identifiable health information by the Center for Woman's Health, and its physicians and staff, as outlined by Federal Law for the purposes set forth below.

- To provide the patient with medical treatment and related services, including coordination or management of the patients care with a third party that is also involved in the patient's treatment, such as your Primary Care physician, a Specialist, or a Laboratory to which we refer the patient for further care or tests.

- As necessary to run our business operations and to support the core functions of treatment and payment, including without limitations, quality assessment and improvement activities, employee evaluation, activities, conducting medical reviews, legal auditing services, business planning and development activities, business management and general administrative activities.

- As required or permitted by applicable state and/or federal law as described at greater length in Notice of Privacy Practices provided to you along with this Acknowledgement Of Privacy Policy.

Furthermore, in order to facilitate and expedite my care, my signature below authorizes Dr. Shefali Patel-Shusterman to have access to and obtain copies of my prior, current and future medical records (physician, hospital, laboratory etc.) for the purpose of treatment and payment in accordance with the HIPPA regulation.

In addition, my signature below confirms that I have received the complete "Notice of Privacy Practices". This authorization will remain valid until my written revocation.

- Patient authorizes the release of her health information to the following family member(s), close personal friend(s), or other person(s).

____

____ ____________________
Print Name of Patient (or Patient's Representative) Date

____ ____________________
Signature of Patient (or Patient's Representative) Relationship to Patient

Risk Assessment for Hereditary Cancer Syndromes

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/ paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer* (ER-, PR-, HER2-pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		POLYPOSIS SYNDROMES	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	10 or more cumulative (lifetime) colorectal adenomas (colon polyps)			

		MELANOMA	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Two or more melanomas in an individual or family			
Y	N	Melanoma and pancreatic cancer in an individual or family			

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?
If yes, please explain:

____
Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing:
☐ HBOC ☐ Lynch ☐ Polyposis ☐ Melanoma

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: ______________

☐ Patient offered genetic testing: ☐ Accepted ☐ Declined

____
Healthcare Professional's Signature Date