We Care Questionnaire

please complete and return to your provider

Name:____Date of Birth:____________Today's Date:__________

Phone Number:______________________Insurance Company:______________________________

	Not at All	1-2 times a week	1 time a week	3-4 times a week	5-6 times a week	Everyday	Your Score
1. Over the past month, have you leaked urine *(even small drops)* or wet yourself when you: *Cough, Sneeze, Change Position, Walk quickly or exercise.....*	0	1	2	3	4	5	STRESS
2. Have a sudden strong urge to rush to the restroom or when you are undressing to go to the restroom......	0	1	2	3	4	5	URGENCY

How many times do you wake at night to void?____________

Would you be interested in learning more about a cure ***WITHOUT*** medicine or surgery? YES ☐ NO ☐

Quality of Life Due to Urinary Leakage

If you were to spend the rest of your life with your urinary incontinence just the way it is now, how would you feel about it?

Happy ☐ *Mixed* ☐ *Unhappy* ☐ *Satisfied* ☐ *Mostly Satisfied* ☐ *Terrible* ☐

Would you be interested in learning more about a cure ***WITHOUT*** medicine or surgery? YES ☐ NO ☐

If **NO** – What are your plans?____

Menstrual Periods

1. How long does your average monthly period last?__________Days
2. Do your periods ever keep you from work, play, or family functions? YES ☐ NO ☐
3. Do you ever experience irregular or inconsistent bleeding patterns? YES ☐ NO ☐
4. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? YES ☐ NO ☐

Birth Control

Is your family complete? YES ☐ NO ☐

Would you be interested in a non-hormonal permanent sterilization that can be performed safely and painlessly in the office? YES ☐ NO ☐

HALO™ Pap Test Waiver

NEW BREAST CANCER SCREENING

Breast cancer is a significant health issue for women. Some of the statistics you should understand are:

- 1 in 8 women are expected to develop breast cancer during their lifetime.
- Breast cancer is the leading cause of cancer death for women 25-55.
- Over 200,000 new cases of breast cancer are expected this year, with over 40,000 deaths.

As your physician, I think it is important that you know that the key to surviving breast cancer is to detect it as soon as possible. If cancer is found in its early stages, particularly if it is still contained in the breast, 5-year survival is near 100%. Ideally, I want to identify my patients at the greatest risk of developing breast cancer, so we can monitor their breast health. Currently, most women (over 70%) diagnosed with breast cancer are not considered to be high risk.

I am pleased to introduce a new test, the HALO Pap Test for the Breast that specifically looks for abnormalities in cells of nipple aspirate fluid (NAF), similar to the cells we take in a Pap smear to look for precursors of cervical cancer. Approximately 50% of women will produce fluid, which is sent to the lab, just like a pap smear, where it is analyzed. For women with abnormalities, we will develop a specific care path dependent on the exact results, family history, lifestyle, etc.

The test takes five minutes and is noninvasive. A combination of warmth, compression, and vacuum is used to collect fluid from the breast. Most women report no discomfort or mild discomfort during the test. I believe this is an important test to help understand your risk of breast cancer, as well as providing us our best chance of developing a successful care path if your test shows any abnormalities.

We consider this test to be on the cutting edge of early breast cancer risk assessment and prevention. It is best to have the HALO test in the first two weeks after your period. Most patients feel that the test is moderately uncomfortable, but not painful. This test is so new, insurance companies are not *yet* paying for it. Our office has set an all inclusive fee of $125.00 for this test, payable at checkout.

If you elect to not take this test, please sign this waiver saying you understand the risks of breast cancer, and have read the above, but are not interested in taking the HALO Pap Test for the Breast.

☐ **Yes – I want to take this test and agree to the fee of $125.00 payable at checkout.**

☐ **I understand the risks of breast cancer, but I am not interested in the HALO Pap Test for the Breast.**

Name (Print): ____

Signature: ______________________________ Date: ______________

Suncoast Women's Care
2044 Trinity Oaks Blvd, Ste 215, Trinity, Florida 34655 – (727) 376-0060 – Fax: (727) 375-7308

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	*none*	*–*	*Brother*	*36 yrs*	*Aunt Cousin*	*44 yrs 58 yrs*	*Grandfather*	*65 yrs*
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic cancer								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
______________________								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: ______________________

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

- ☐ Patient appropriate for further risk assessment and/or genetic testing
  - ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
  - ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
  - ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
  - ☐ MELARIS® – A test for Hereditary Melanoma
- ☐ Discussed hereditary cancer risk with patient
- ☐ Patient offered genetic testing
  - ☐ ACCEPTED ☐ DECLINED
- ☐ Follow up appointment scheduled
  - Date: __________

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.myriadtests.com

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MYRIAD®

Review of Symptoms

Patient's Name: ___________________________________

1) Weight Loss/Gain ☐ Yes ☐ No ______________________________________
2) Fatigue/Dizziness ☐ Yes ☐ No ______________________________________
3) Fever/Chills ☐ Yes ☐ No ______________________________________
4) Visual Problems (Glaucoma ☐ Yes ☐ No ______________________________________
5) Headache ☐ Yes ☐ No ______________________________________
6) Shortness of Breath ☐ Yes ☐ No ______________________________________
7) Cough and Wheezing ☐ Yes ☐ No ______________________________________
8) Chest Pain ☐ Yes ☐ No ______________________________________
9) Palpitations ☐ Yes ☐ No ______________________________________
10) Abdominal Pain ☐ Yes ☐ No ______________________________________
11) Nausea ☐ Yes ☐ No ______________________________________
12) Vomiting ☐ Yes ☐ No ______________________________________
13) Diarrhea ☐ Yes ☐ No ______________________________________
14) Constipation ☐ Yes ☐ No ______________________________________
15) Blood in Stool ☐ Yes ☐ No ______________________________________
16) Decreased Appetite ☐ Yes ☐ No ______________________________________
17) Painful Urination ☐ Yes ☐ No ______________________________________
18) Increased Frequency of Urination ☐ Yes ☐ No ______________________________________
19) Urinary Incontinence ☐ Yes ☐ No ______________________________________
20) Vaginal Irritation ☐ Yes ☐ No ______________________________________
21) Abnormal Vaginal Discharge ☐ Yes ☐ No ______________________________________
22) Hot Flashes ☐ Yes ☐ No ______________________________________
23) Mood Changes/Irritability ☐ Yes ☐ No ______________________________________
24) Bleeding/Bruising/Anemia ☐ Yes ☐ No ______________________________________

Notice of Privacy

We would like to welcome you to our practice. Hoping you will find the care that you need. The following information that you are about to read is a Notice of Privacy Policy. This informs you, the patient, how your health information may be used and released. Please take the time to evaluate this information cautiously.

A. In order for our office to provide all treatment necessary, your health information may be released to pharmacies, hospitals, labs, insurance agencies and other physicians.

B. As a courtesy, our office will try to phone you in order to remind you of any upcoming appointment leaving your name, time and date.

C. It is our policy to contact you in order to inform you of any tests results whether negative or positive, however if you are not available our office will not leave any information with anyone unless you have authorized specifically whom to release information.

D. Our office will release any health information to public establishments that are certified by law to gather such information.

As our patient we would like to inform you of your rights in requesting that our office inform you of how, when and to whom your information is being release to.

A. Our office will keep a log sheet informing you the patient how, when and to whom your information is being release to.
B. As our patient, you have the right to request this information for yourself.

Our office would like to thank you for carefully reading and understanding this information. If you have any questions or comments, we will be glad to help.

Patient Signature: ____ Date: ____________________

Witness Signature: ____ Date: ____________________

Suncoast Women's Care
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Financial Policy

We have adopted the following financial policy to avoid any misunderstanding between our patients and this office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

You are expected to know your own coverage for services rendered since it is impossible to keep track of every insurance plan and how it works. Contact your insurance company referencing benefits before beginning treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE unless other arrangements have been made in advance by you or your health coverage carrier. Unpaid and past due balances are subject to a finance charge of 18% (Annual Percentage Rate) and additional collection service fees.
We now offer 12 months Interest-Free payment plans via CareCredit®.

No Insurance: We require payment at the time of service if you do not have insurance coverage for services rendered. Contact our Business Manager to arrange payment options.

Insurance: We process all insurance claims on behalf of our patients. Patient identification, insurance information and a copy of your insurance card must be provided prior to your first visit. Assignment of benefits is required with commercial insurance. Failure to provide complete information will result in account being billed directly to the patient.

Co-Payments & Referrals: Co-payments required by your insurance plan are collected at time of service. You are responsible for verifying if an insurance referral from your primary physician is required at the time they process your claim. You agree to be held responsible for any charges not covered by your insurance if you choose to be seen without the appropriate referral.

Deductibles: Pre-payments are required in the event you have not met your deductible. Any credit amount after your claim has been submitted and adjudicated by your insurance carrier will be credited towards your account or refunded upon written request.

Medicare: We accept assignment of benefits from Medicare. We collect 20% of the Medicare allowable of the charges for your visit if you do not have a secondary insurance to your Medicare.

COBRA Insurance: You are responsible to provide all COBRA insurance information and to notify the billing office when your COBRA is activated to avoid denial of your claims by your insurance.

Non-Covered Services: You will be responsible for the entire charge(s) if your medical plan determines a service is “not covered”.

Statements Due upon Receipt: Full payment is immediately due upon receipt of statement**.** Late payments are subject to finance charges and collection service fees.

Minor Patients: The adult accompanying the patient and the parent or guardian with custody will be billed for all services rendered to minor patients.

Missed Appointments (No Shows): In order to provide the best service and availability to our patients, it is your responsibility to notify us 24 hours in advance that you will be unable to keep your appointment. Missed appointments are subject to a “no show” fee of $75.00 per incident. Suncoast Women's Care reserves the right to discharge you from our practice for non-compliance.

I have read the financial policy and I understand and agree to be bound by its terms.

Patient/Guardian Name (Please PRINT): ____

Signature: ____Date: ___________________

Authorization to Release
Healthcare Information

Patient's Name:______________________ Date of Birth:___________________________

Previous Name:______________________ Social Security #: _______________________

I request and authorize **Suncoast Women's Care** to release healthcare information of the patient named above to:

1. _________________________________ 3. ____________________________________

2. _________________________________ 4. ____________________________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates: _________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No Your office may leave messages regarding appointments and/or lab results on my voice messaging service.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome, and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

☐ Yes ☐ No I understand that for billing purposes my records may be released.

Patient Signature: _______________________________________ Date Signed: _____________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

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