Patient:

Name: ____
Address:____
City: ________________________________ State: ________ Zip:______________
Social Security No.:________-________-_________ Date of Birth:______/_______/_________
Phone Number: ________-_________-_________ Cell Number: _______-________-________
Email:____
Race: White African American Asian Other:_______________________________________
Ethnicity: ____Hispanic/Latino ____Not Hispanic/Latino
Emergency Contact Name:______________________________ Phone #: ______-_______-_______
Can we release all Medical and/or Financial info to the above listed Emergency Contact? Yes / No

Patient Employer (if unemployed please leave blank):

Employer Name : ____
Employer Phone Number: ______-_______-_______ May we contact you at work? ____yes ____no
Employer Address:____

Spouse Information (if not married please leave blank):

Spouse Name:____________________________________ Social Security No.:______-______-_______
Spouse Address:____
City: ________________________________ State: ________ Zip:_____________
Date of Birth:_______/________/_________ Phone Number: ________-__________-__________
May we contact in an emergency? ____yes ____no
Spouse Employer Name: ______________________________________ or ____Unemployed

Insurance Information:

***If you have Commercial Insurance (i.e. Baptist, Anthem, Aetna, Bluegrass, Cigna, ETC.) and the card holder is NOT yourself, please provide the following information about the card holder.**

Name: ____ Date of birth: _____________________
Relationship to patient: __________________________ Social Security Number: ___________________

How did you hear about us?: ___Internet Search ___Social Network (Facebook/Twitter)
___Referral from another doctor ___Friend/family member ___Other: _________________

Insurance Authorization Assignment:

When visiting Women's Health of Winchester I, the undersigned, understand and grant permission to Compliance Advantage, LLC to bill my health insurance for services provided. I understand that I may be responsible for co-pays and deductibles not covered by my insurer. By signing I acknowledge that payment(s) may be made on my behalf to Compliance Advantage, LLC. I hereby allow the release of any medical information as needed to process this claim.

Signature:____ Date:________________

Women's Health of Winchester
225 Hospital Dr Bldg. B, Ste. 255
Winchester, KY 40391
Phone (859) 744-2623
Fax (859) 744-9421

HIPAA Acknowledgment of Receipt of Notice of Privacy

We are required by law to maintain the privacy of, and provide individual with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the phone number listed above. By signing below is only an acknowledgment that you have received this Notice of our Privacy Practices.

Printed Name:____

Signature:____ Date: __________________________

Laboratory Consent

I, the undersigned, understand that Women's Health of Winchester does accept Cigna Healthcare and is considered an in-network facility but Clark Regional Medical Center does not participate with Cigna. I also understand that Women's Health of Winchester utilizes many different outsourced laboratory companies to process different samples including Labcorp, Medical Diagnostic Laboratory, Clark Regional Medical Center Laboratory, etc. I authorize Women's Health of Winchester to submit any blood work, swabs, biopsies, etc. to the laboratory of their choice, depending on the type of lab collected. By signing I acknowledge that I will be responsible for any amount not covered by insurance.

Printed Name:____

Signature:____ Date: __________________________

Women's Health of Winchester
225 Hospital Dr Bldg. B, Ste. 255
Winchester, KY 40391
Phone (859) 744-2623
Fax (859) 744-9421

No Show Consent

To provide proper service to all patients, we have adopted a new policy regarding scheduled appointments and office procedures.

If you do not show up for and/or reschedule an appointment within a 24 hour notice, you will be charged a $20 fee which will be due in full payment at the time of your next visit. If you do not show up for any scheduled procedures (I.E. Novasure, Hysterectomy, Hysteroscopy, Diagnostic Scope, ETC.), you will be charged $100 and potentially dismissed from the practice. When you do not show up for scheduled appointments/procedures or do not provide proper notification, you are not only prolonging possible treatment for yourself but also others. We understand that emergency situations occur and we will take this into consideration on an individual basis. If you are unable to keep your scheduled appointment **please call the office at least 24 hours prior to your appointment** to avoid any charges.

I have read and fully understand this policy, if any no show charge is added to my account I agree to pay this balance in full at my next scheduled appointment.

____

Patient Printed Name

____ ____________________

Patient Signature Date

Hereditary Cancer Family History Information

Patient/Physician Information

Patient's name: ______________________ / Date of birth: ______________

Physician's name: ______________________ / Date: ______________

Instructions: Please indicate your family's history of cancer in the table below. Check Yes for the cancer(s) that apply to you and/or your blood relatives. Please list the relative, side of the family, and age of diagnosis for each cancer type.

Blood relatives to consider: parents, children, siblings, half-siblings, aunts, uncles, cousins, nieces, nephews, and grandparents

Are you of Ashkenazi Jewish descent? ❍ Yes ❍ No

Patient/Family Cancer History

Please fill in as completely as possible		Your Age at Diagnosis	Family Member	Side of the Family Mother's or Father's	Age at Diagnosis
Example: Breast	✓ Yes ❍ No	53	Mother Grandmother Aunt	– Mother's Father's	65 62 55
Breast (one breast)	❍ Yes ❍ No				
Breast (both breasts or multiple primary breast cancers)	❍ Yes ❍ No				
Was the breast cancer triple negative?	❍ Yes ❍ No ❍ Unknown	**Who:**			
Ovarian (Fallopian Tube, Peritoneal)	❍ Yes ❍ No				
Pancreatic	❍ Yes ❍ No				
Prostate	❍ Yes ❍ No				
Uterine (endometrial)	❍ Yes ❍ No				
Colorectal	❍ Yes ❍ No				
Stomach	❍ Yes ❍ No				
Other – *Please specify* *Examples of other cancers: melanoma, kidney/urinary tract, brain, or small bowel*	❍ Yes ❍ No				

Have you or any of your family members had genetic testing for any hereditary risk of cancer? ❍ Yes ❍ No

If yes, please explain: ____

____

Patient's Signature (required): ______________________ **Date:** ______________

For office use only

Patient appropriate for further risk assessment or genetic testing? ❍ Yes ❍ No

❍ Patient offered genetic testing? ❍ Accepted ❍ Declined

❍ Patient offered genetic counseling? ❍ Accepted ❍ Declined

Physician's signature: ______________________ **Date :** ______________

Integrated GENETICS
LabCorp Specialty Testing Group

Integrated ONCOLOGY
LabCorp Specialty Testing Group

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