Patient Information:

Name: _____
Address:_____
City: _____ State: _____ Zip:_____
Social Security No.:_____-_____-_____ Date of Birth:_____/_____/_____
Cell Phone Number: _____-_____-_____ Alt. Phone 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.

Patient/Guardian 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.

_____ I would like to receive a printed copy of the HIPAA form.
_____I DECLINE to receive my a copy printed of the HIPPA form.

Patient Printed Name:_____

Patient/Guardian Signature:_____ Date: _____

Laboratory Consent

I, the undersigned, 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 also understand that Women's Health of Winchester accepts Cigna Healthcare/WellCare Medicare and is considered an in-network facility but Clark Regional Medical Center does not participate with Cigna/WellCare Medicare. By signing below, 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 and that I will be responsible for any amount not covered by insurance.

Patient Printed Name:_____

Patient/Guardian 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 with 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 no show a scheduled surgery or reschedule/cancel within 7 days of the procedure, 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 or 7days prior to surgery/office procedures** to avoid any charges.

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

_____

Patient Printed Name

_____ _____

Patient/Guardian 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