Women's Health of Winchester, PSC

Mark J. Pascuzzi, MD
Andrea M. Tucker, MD
Aaron M. Ferda, MD
Leigh Doane, MD
Joanna Banks, APRN CNM

Welcome to Women's Health of Winchester!

Please complete the FRONT AND BACK of the forms in this packet and bring them in to your appointment. You will also need to bring your insurance card and driver's license **to be seen**. Failure to provide these cards will result in your appointment being rescheduled to the next available appointment as we cannot see you without them.

_____Winchester Office: **225 Hospital Dr. Ste 255, Winchester.** We are located @ the NEW hospital in Winchester behind the Wendy's on Winchester Rd. There are 3 entrances into the hospital – we are in building B which is the awning on the FAR RIGHT of the complex (door is on the side of the building looking at the interstate). When you enter, ride the elevators to the second floor, turn right off the elevators, turn left at the end of that short hall and we are the first GLASS door on the right.

_____Paris Office: **5 Linville Dr. Ste 105, Paris.** We are located here only the FIRST Wednesday of the month. The building is white with a blue roof called the "Triple Crown Suites" and sits on the corner of Linville Dr and the Bypass directly next to the hospital.

_____Stanton Office: **68 E Elkins St., Stanton.** We are located here only the 2nd, 3rd, and 4th Wednesday morning of every month. The building is called the "Powell Co Clinic" off Main St. on the corner of Elkins & Lycoming St. The office is also between the Bluegrass Craft & Antique Mall & Whitaker Bank on Elkins.

If you are unable to keep your appointment, kindly give our office a 24 hour notice. Otherwise, we reserve the right to charge $20 for missed appointments.

Thank you,

Andrea Tucker, MD
Mark Pascuzzi, MD
Aaron Ferda, MD
Leigh Doane, MD
Joanna Banks, APRN CNM

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:

Employer: _____ or _____Unemployed
Employer Phone Number: _____-_____-_____ May we call you at work? ____yes ____no
Employer Address:_____

Spouse Information (only if married):

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:

____ Medicare ____Medicaid (wellcare, passport, aetna, etc.) ____Self Pay ____Commercial***

****If you have Commercial Insurance and the card holder is NOT yourself, please provide the name, birth date, and social security number of the holder.**

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

Insurance Authorization Assignment:

I hereby authorize Dr. Mark Pascuzzi, Dr. Andrea Tucker, Dr. Aaron Ferda, and Joanna Banks CNM APRN to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

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.

Signature below is only an acknowledgment that you have received this Notice of our Privacy Practices.

Printed Name:_____

Signature:_____ Date: _____

Compliance Advantage Consent

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.

Printed Name:_____

Signature:_____ Date: _____

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Winchester, KY 40391
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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