Williams OB/GYN & Associates, INC.

PATIENT ACCOUNT INFORMATION

PATIENT

Patient Full Legal Name _____
Last First M.I.

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____ Date of Birth _____

Marital Status: Single Married Divorced Physician _____

Employer Name _____ Social Security# _____

Employer Address _____ Email _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell ☐ OK to leave message

RESPONSIBLE PARTY

Check here if same as patient and skip to insurance information:

Name _____
Last First M.I.

Address _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ PPO ☐ Private ☐

Insurance Address _____ City _____ State _____ Zip Code _____

Name of Insured _____ ☐ Male ☐ Female

Insured Date of Birth _____ Insurance I.D.# _____ Group# _____

Insured Employer Name _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____ PPO ☐ Private ☐

Insurance Address _____ City _____ State _____ Zip Code _____

Name of Insured _____ ☐ Male ☐ Female

Insured Date of Birth _____ Insurance I.D. # _____ Group# _____

Insured Employer Name _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT INFORMATION

Name of Person to Contact _____ PPO ☐ Private ☐

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians for services rendered. I hereby attest that the above insurance information accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other physicians and insurance carriers upOon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. I understand that services cannot be rendered on the assumption that charges will be paid by the insuance company and that insurance is an agreement between me and my insurance company. If there are problems collecting payment, attorney fees, collection agency costs and any released feed will be added to the bill. I hereby acknowledge that I have read, understand and agree to hereby give consent to access, treat and test.

Patient's Signature: _____ Date _____

WILLIAMS OBGYN
OBSTETRICS, GYNECOLOGY & INFERTILITY

1334 W. Covina Blvd., #102
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*Richard A. Williams, M.D., F.A.C.O.G.

*Diplomate - American College of Obstetrics & Gynecology

PATIENT QUESTIONNAIRE

Please bring this completed form to your scheduled appointment (DO NOT MAIL).

Name: _____ **Age:** _____ **Date/Time:** _____

What brings you to the office today: _____

Who referred you to our office: _____

Do you have any questions, problems, or concerns that you would like to discuss with us today?

_____

_____

MENSTRUAL/GYNECOLOGICAL HISTORY

Date of your last period: _____

Has there been a change in your periods? Yes ☐ No ☐ If yes, please specify: _____

Do you have hot flashes, night sweats, or trouble sleeping? Yes ☐ No ☐ If yes, please specify:

_____

Are you taking any hormones? Yes ☐ No ☐ ***If yes, please specify:*** _____

Are you taking any vitamin, calcium, herbal or other supplements? Yes ☐ No ☐ ***If yes, please specify:***

_____

Age period started: _____ **# of days your period last:** _____ **Days between periods:** _____

Cramps? Yes ☐ No ☐ PMS? Yes ☐ No ☐

OBSTETRICAL HISTORY

Number of pregnancies ___ **Vaginal deliveries** ____ **C-Section** ____ **Miscarriages** ___ **Abortions** _____

SEXUALITY HISTORY

Do you use a method of contraception? Yes ☐ No ☐

If yes, what type? ☐ pills ☐ IUD ☐ diaphragm ☐ spennicide ☐ natura/rhythm
☐ sponge ☐ condoms ☐ other

Do you want any infonnation about birth control/safer sex? Yes ☐ No ☐

Have you ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Venereal Warts ☐ Herpes

Do you have pain with sexual intercourse? Yes ☐ No ☐

Any other problems with sex? _____

URINARY HISTORY

Do you lose urine involuntarily?	**Yes ☐**	**No ☐**
Do you frequently have a strong, sudden urge to urinate?	**Yes ☐**	**No ☐**
Do you get up 2 or more times during the night to go the bathroom?	**Yes ☐**	**No ☐**
Do you sometimes not make it to the bathroom in time?	**Yes ☐**	**No ☐**
Do you to the bathroom more than 8 times during a 24-hour period?	**Yes ☐**	**No ☐**

BREAST HISTORY

Do you have fibrocystic condition? **Yes ☐** **No ☐**

Have you ever had a breast lump or cyst? **Yes ☐** **No ☐** ***Biopsy results:*** _____

Do you experience breast pain? **Yes ☐** **No ☐**

When was your last mammogram? _____ ***Results:*** _____

Where was your last mammogram performed? _____

SCREENING SECTION:

Date of your last Pap test: _____ ***Date of your last stool test:*** _____

Have you ever had an abnormal Pap? Yes ☐ No ☐ If yes, please specify: _____

Have you had a colon examination ("sigmoidoscopy") within three to five years after age 50 (more often for high-risk people)? Yes ☐ No ☐ ***If yes,when?*** _____

Have you ever had a Bone Density Exam? Yes ☐ No ☐ ***If yes, when?*** _____

MEDICAL HISTORY

Have you had any illnesses? Yes ☐ No ☐ ***If yes, please specify:*** _____

Please list all doctors who you see now: Primary Care:. _____ **Specialist:** _____

Please list all medications including herbal and OTC _____

Drug allergies? Yes ☐ No ☐ ***If yes, please specify:*** _____

Food or environmental allergies? Yes ☐ No ☐ Results: _____

Has your cholesterol been tested? Yes ☐ No ☐ Don't Know ☐

Are your blood tests normal? Yes ☐ No ☐ Have not had ☐

Do you get regular dental and eye exams? Yes ☐ No ☐ ***Any Problems?*** _____

Do you have problems hearing? Yes ☐ No ☐

Vaccine History Date: _____ **Tetanus** _____ **Hep. B** _____ **Hep. A** _____ **Flu** _____ **HPV (Gardasil)**

SURGICAL HISTORY

Please list all surgeries - gynecological, plastic, or other. (Please include dates/year).

_____

_____

_____

FAMILY MEDICAL HISTORY

Have you or anyone in your family (parents, brothers, sisters, children, grandparents, aunts, uncles, cousins) ever been diagnosed with:

	SELF		FAMILY	
	YES	If yes, when diagnosed	YES	If yes, who?
Heart Disease	☐		☐	
High Blood Pressure	☐		☐	
Stroke	☐		☐	
Diabetes	☐		☐	
Lung Problems	☐		☐	
Thyroid Problems	☐		☐	
Blood Disorders	☐		☐	
Early Menopause	☐		☐	
DES Exposure	☐		☐	
Tubal Infection	☐		☐	
Infertility	☐		☐	
Varicose Veins	☐		☐	
Arthritis	☐		☐	
Osteoporosis	☐		☐	
Breast Cancer	☐		☐	
Ovarian Cancer	☐		☐	
Colon Cancer	☐		☐	
Uterine Cancer	☐		☐	
Lung Cancer	☐		☐	
Melanoma/Skin Cancer	☐		☐	
More than I kind of cancer Diagnosed in the same person	☐		☐	
Other types of cancer	☐		☐	
Birth Defects	☐		☐	
Mental Retardation	☐		☐	
Multiple miscarriages	☐		☐	
Childhood Tumors	☐		☐	

SOCIAL HISTORY

What is your occupation? _____ **Have you recently changed jobs? Yes☐ No☐**

Do you have any problems at home? Yes☐ No☐ ***If yes, please specify:*** _____

Has there been any change in your relationship with your husband, partner, or boyfriend? Yes☐ No☐

If yes, please specify: _____

How are you relationships with others? _____

Do you suffer from anxiety or depression? _____

Do you smoke cigarettes? Yes☐ No☐ FORMER ***How much/how long?*** _____

Do you use street drugs? Yes☐ No☐ ***If yes, please specify:*** _____

Do you drink alcohol on a regular basis? Yes☐ No☐ ***If yes, please specify:*** _____

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose your health information about you for treatment. payment and healthcare operations. For example:

Treatment: We may use or dsdose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment fer services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities,, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation wil not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necesary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person(s) Involved in Care: We may use or disclose health information to notify, or assist in the notification or (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use of disclosure of your health information, we wil provide you with an opportunity to object to such use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our profesional judgement and our experience with common practice to make reasonable inferences of your best interest in alowing a person to pick up filed prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We wil not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody or protected health information of an inmate or patient under certain circumstacnes.

Appointment Reminders: We may use or disclose your health information to provide your with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this Notice. If you request copies, we wil charge you $15.00/$45.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee strcuture.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment payment, healthcare operations and certain other activities for the last 6 years., but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

RESTRICTIONS: You have the right to request that we place additional restriction on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATIONS: You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. You request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your right concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03 and will remain in efect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use of disclosure of your health information, or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy officer or with the Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102
Voice: (415) 437-8310
Fax: (415) 437-8329
TDD: (415) 437-8311

This form does not constitue legal advice, and covers only federal not state law in effect or proposed as of August 14, 2002. Subsequent law changes may require form revision.

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*Richard A. Williams, M.D., F.A.C.O.G.

*Diplomate - American College of Obstetrics & Gynecology

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers involved in that treatment directly and indirectly.**
2. **Obtain payment from third party payers if necessary.**
3. **Conduct normal healthcare operations such as quality assessments and physician certifications.**

My signature below confirms I have had the opportunity to read and understand your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my health information. I understand that Richard A. Williams M.D. has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this office during normal business hours to obtain a current copy.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

PATIENT NAME _____

RELATIONSHIP TO PATIENT _____

SIGNATURE _____

DATE _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices*, but was unable to do so as documented below.

Date _____ Employee's Signature _____

Reason _____

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FINANCIAL RESPONSIBILITY/INSURANCE WAIVER

I have chosen to receive services from Williams Ob/Gyn and Associates. I understand that my benefits cannot be verified at this time. I understand I am responsible for all deductibles, copayments, coinsurance, non-covered expenses, other out-of-network expenses incurred by seeking services, by a non-preferred/out-of-network provider. I am also aware that any outside services (Labs, ultrasounds, Mammograms, hospital care, ect.) ordered by the physician are also subject to out of network reimbursement depending on my individual plan according to my insurance.

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage and as assignment of benefits. I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photo copy of this agreement shall be as valid as the original.

Payment is due at the time of services are rendered. All charges are the direct responsibility of the patientI understands that services cannot be rendered on the assumption that charges will be paid by the insurance company and that insurance is n agreement between insured patient and their insurance company. If there are problems collecting payment, attorney fees, collection agency costs and any related fees will be added to the bill. I hereby acknowledge that I have read, understand and agree to hereby give consent to access, treat, and test.

Patient Full Legal Name_____
Last First M.I.

PatientSignature_____Date_____

PHARMACY INFORMATION AND DISCLOSURE

Pharmacy Name_____City_____Phone#_____

I authorize and grant permission for Williams Ob/Gyn and Associates to view my prescription history from external sources.

Patient Full Legal Name_____
Last First M.I.

PatientSignature_____Date_____

Consent to Use Telemedicine

Patient's Name_____ My Doctor's Name_____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

THIS AUTHORIZATION ALLOWS THE HEALTHCARE PROVIDER(S) NAMED BELOW TO RELEASE CONFIDENTIAL MEDCIAL INFORMATION AND RECORDS. NOTE: INFORMATION AND·RECORDS REGARDING TREATMENT OF MINORS, HIV, PSYCHIATRIC / MENTAL HEALTH CONDITIONS, OR ALCOHOL / SUBSTANCE ABUSE HAVE SPECIAL RULES THAT APPLY AND REQUIRE SPECIFIC AUTHORIZATION.

AUTHORIZATION

I HEREBY AUTHORIZE: _____
PHYSICIAN / HEALTHCARE FACILITY

TO RELEASE INFORMATION REGARDING MY MEDICAL HISTORY, ILLNESS OR INJURY, CONSULTATION, PRESCRIPTIONS, TREATMENT, DIAGNOSIS OR PROGNOSIS, INCLUDING X-RAYS, CORRESPONDENCE AND /OR, MEDICAL RECORDS BY MEANS OF MAIL, FAX OR OTHER ELECTRONIC METHODS .

TO **Williams Ob/Gyn & Associates, Inc** — NAME
909-599-8677 — PHONE#

1334 W. COVINA BLVD. SUITE 102 — ADDRESS
909-592-0999 — FAX#

SAN DIMAS — CITY
CA — STATE
91773 — ZIP CODE

THE MEDICAL INFORMATION/ RECORDS WILL BE USED FOR THE FOLLOWING PURPOSE

X_____

THIS AUTHORIZATION IS:

[ ] UNLIMITED (ALL MEDICAL RECORDS)
[ ] LIMITED TO THE FOLLOWING MEDICAL INFORMATION

DURATION THIS AUTHORIZATION SHALL BE EFFECTIVE IMMEDIATELY AND WILL REMAIN IN EFFECT UNTIL

_____
MONTH/DAY/YEAR

RESTRICTIONS - PERMISSION FOR FURTHER USE OR DISCLOSURE OF THIS MEDICAL INFORMATION IS NOT GRANTED UNLESS ANOTHER AUTHORIZATION IS OBTAINED FROM ME OR UNLESS SUCH DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITIED BYLAW.

A PHOTOCOPY OR FACSIMILE OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I HAVE BEEN ADVISED OF MY RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION.

_____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN
_____ RELATIONSHIP IF OTHER THAN PATIENT

_____ PATIENT'S NAME
_____ DATE OF REQUEST

_____ PATIENT'S SS#
_____ WITNESS SIGNATURE

Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call 24 hours prior to canceling an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments:

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery:

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a seventy-five-dollar ($75) fee; this is will not be covered by your insurance company.

4. Account Balances:

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

5. Well Woman Exam/Physical Exam:

A well woman exam/ physical exam are preventative exams that include breast exam, pap smear, pelvic exam, and blood occult test with no chief complaint. If patient has any other chief complaint the patient will be subject to office visit which is not preventative therefore patient will be subject to copay, deductible, and/or coinsurance. Please keep in mind providers will always ask at a preventative exam if there are any other concerns you might want to discuss. It's the patient reasonability to decide to discuss further or make another appointment to discuss other concerns to ensure coverage of visit. Insurance will many times deny and office visit with a preventative visit please discuss your benefit with your insurance carrier. Also, well woman exams/Physical are in some cases billed with your primary doctor it's the patient responsibility to make sure their preventive visit is covered prior to scheduling with our providers.

_____ _____ ____/____/____

Print Name **Patient Signature Patient/Guardian** **Date**

Cancer Risk Assessment

_____ ____/____/____ ____/____/____

Patient Name Date of Birth Date Completed

This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.

Circle Y for those that apply to <u>YOU and/or YOUR FAMILY</u> (consider all relatives on both mother's and father's side). YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED. ***Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins, Great Grandparents, Great Aunt/Uncle***

		CANCER	RELATIONSHIP TO FAMILY MEMBER w/ CANCER and AGE at DIAGNOSIS		
			SELF/ SIBLING	MOTHER or Relatives on MOTHERS's side	FATHER or Relatives on FATHER's side
		EXAMPLE:	Me 35 Sister 40	Aunt 35	Grandmother 75
Y	N	Breast cancer <u>before</u> age 50?			
Y	N	Multiple breast cancers on the <u>same side</u> of the family? • If two breast cancers one must be <u>at or before</u> age 50 • If three or more breast cancers they can be at <u>any age</u>			
Y	N	Ovarian cancer <u>at any age</u>?			
Y	N	Male breast cancer <u>at any age</u>?			
Y	N	Ashkenazi Jewish ancestry ***with*** breast or ovarian cancer in a ***family member*** <u>at any age</u>?			
Y	N	Colon Cancer <u>before</u> Age 50?			
Y	N	Endometrial Cancer <u>before</u> Age 50?			
Y	N	Colon <u>and/or</u> Endometrial Cancer at any age <u>AND</u> two or more of the following cancers in the same person or on the same side of the family <u>at any age</u>? (*ovarian, stomach, kidney/renal, small bowel, pancreas, brain)*			
Y	N	<u>Ten or more</u> lifetime colon polyps?			
Y	N	Any other cancers?			

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No

Patient signature: _____ Date: _____

For Office Use Only: Reason for Decline:

Patient offered testing ☐ Accepted ☐ Declined

Patient MRN#_____ **Provider Signature**_____

WILLIAMS OBGYN
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Email and SMS (text) Correspondence Consent

I understand that unencrypted Email and SMS (text) messaging is not a secure form of communication. There is some risk that any identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. I understand that SCCRM and OVATION FERTILIlY will use the minimum necessary amount of protected health information when corresponding via email or text message.

I hereby consent to the following: **(choose one only)**

☐ I **consent to and accept** the risk of receiving information as it pertains to future treatment. This may also include appointment confirmations, general correspondence, and information regarding SCCRM and OVATION FERTILITY. I can withdraw my consent at any time.

My email address is: _____

☐ I consent **only** to receiving appointment reminders via email or SMS messaging. I understand I can withdraw my consent at any time.

My email address is: _____

☐ I **do not** consent to receiving any information via email or SMS messaging. I understand that I can change my mind and provide consent later.

Patient Name: _____

Signature: _____

Partner Name: _____

Signature: _____