Desert Jewel Obstetrics & Gynecology
Courtney A. Hunt MD, FACOG

3501 N. Scottsdale Rd Suite 230
Scottsdale, AZ 85251

Tel (480) 970-1937
Fax (480) 970-1938

Dear Patients,

In effort to streamline processes you now have the ability to view your patient results online through www.my.patientfusion.com. Please provide one of our staff members with your email address and we will sign you up and give you a temporary password.

Your physician or her assistant will call you with any abnormal results however, all of your normal results will be posted online as soon as they are received and reviewed by your physician. The typical time frame is 2 weeks from the date of your visit. Once you have reviewed your results online should you have any questions please call us directly. If you have any trouble getting through the phone system, you can now contact your provider directly through Practice Fusion by writing them a message, your provider or one of their assistants will return your request within 24-48 hours.

Thank you for helping us to provide you with a more efficient way of providing you with your results.

Patient Email: ______________________________

Revised 03/31/2016

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INSURANCE & FINANCIAL POLICY

Patient's Name:______________________________ Date of Birth:____________

Welcome to our practice! We are committed to providing you with the best possible care by offering treatment options that may or may not be covered by your insurance. Your clear understanding of our Insurance & Financial Policy is important to our practice. Please ask if you have any questions about our policies, fees, and your financial responsibility as a patient.

- Please be aware that we order labs, cultures, pap smears, HPV testing, etc based on what we deem best for your health care. Not all of these services may be covered by your insurance and it would be impossible for us to know each person's individual policy to assess if they are covered. <u>It is your responsibility to be aware of your benefits.</u> We will do our best to order labs that we feel appropriate and necessary to take care of you in the best way possible.

- Bio Reference is the laboratory we use in this office, unless you tell us to do otherwise. In certain cases we will send biopsies and other samples to other laboratories for their expertise on gynecologic pathology. Please feel free to ask any questions you might have as to where your specimens are going. The laboratory/pathology will bill you or your insurance company for all labs performed. If you have any questions regarding your lab bill, please contact the laboratory directly or your insurance carrier.

- We require you to present your insurance card at all appointments in order to minimize errors. All copays, deductibles, and payments are due at the time of service, with copays being collected prior to you seeing the doctor. If you are coming in for a well woman exam and have an additional medical problem that you would like to discuss with the doctor, your insurance will be billed additionally for this. Additional copays WILL be required if you have a problem at your annual visit (this includes things like uti, yeast infection, pain, menopausal symptoms etc).

- In consideration of maintaining an on-time schedule for the doctor and other patients, we request that you be on time for your appointment. We require you to arrive 15 minutes early in order to fill out any necessary paperwork. <u>Arriving more than 15 minutes late for your appointment will necessitate rescheduling your appointment</u>.

- Any patient who commits any of the following offenses, including but not limited to: abusive behavior or language, non-compliance with treatment plan, prescription misuse or abuse, multiple missed office visits, or failure to pay account shall be grounds for immediate dismissal from our practice

Thank you for understanding your financial and insurance policies. If you have any questions about the above information, please do not hesitate to ask us. We are here to assist you.

Patient Signature:______________________________ Date:____________

Revised March 31, 2016

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Please initial the indicated lines to guarantee that you have read, understood, and agree with Desert Jewel's Insurance and Financial Policies.

_____We at Desert Jewel understand that situations may arise that require you to cancel your appointment; however we do require a 24 hour notice of such cancellation. We may charge a $50.00 fee for any appointments that have not been canceled within this timeframe. If you are scheduled for surgery and cancel less than five days prior to your surgery date you will be assessed a fee of $125.00.

_____We are happy to supply you with a copy of your medical records; however this service is subject to a $30.00 processing fee. We require all patients to fill out a Medical Release form. After the form is completed and the fee is paid, please give our staff up to 7 business days to get these records together. We can fax medical records through a secure fax line to another medical provider, or we can mail them to you directly.

_____ A prepaid administrative fee of $30.00 will be charged for any forms that need to be reviewed and/or completed by our physicians.

_____Desert Jewel Obstetrics and Gynecology will assign all accounts (30) days or more past due to an outside collection agency. This may be an automatic assignment unless prior arrangements have been approved by management.

_____I hereby acknowledge and agree that Desert Jewel Obstetrics and Gynecology is authorized to charge my account as listed below for any unreimbursed charges based upon my agreement with any payor of any status. It is Desert Jewel's policy that I must provide credit card information before being seen by any of the providers. I will be sent statements of any unreimbursed charges twice. After the second statement, my credit card that is on file will be charged for the balance on my account. If payment is not received, I understand that I was informed of the precise amount of any unreimbursed charge in an official statement. (The only exception to this rule is for Hormone Replacement Therapy patients who will have their cards ran after the Explanation of Benefits is received).

I have read the above Insurance & Financial Policy, and understand and agree to these terms.

Printed Patient Name:_________________________

Patient Signature:_________________________ Date:___________

Payment Information – **THIS AREA MUST BE COMPLETED IN ITS ENTIRETY.**

Type of Card: __ MasterCard __ Visa __ American Express __ Discover

Credit Card Number: _____________________ Exp. Date: __________

(If you do not want to write your credit card number on this paper for security reasons we understand, we would be glad to swipe it securely into our system.)

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Authorization to Release Medical Information to Individuals/ Family Members

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPPA), in order for your healthcare provider or Desert Jewel Staff to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

___ I authorize Desert Jewel OBGYN to share my medical information (including but not limited to lab results, appointment times, dates and reasons for visits, pregnancy information, ultrasound reports etc) with any individual listed below.

___ I DO NOT authorize Desert Jewel OBGYN to share my medical information with any other individual other than myself.

___ I authorize the Providers of Desert Jewel and Staff to leave lab results, appointment information, and any other medical information on my voicemail in case I cannot be reached.

___ I DO NOT authorize the Providers of Desert Jewel and Staff to leave any information on my voicemail in case I cannot be reached.

___ I give permission to Desert Jewel to communicate lab results and health information to me through the Patient Health Record (PHR) that is operated by Practice Fusion Electronic Medical Records System.

Name: ______________________ Relationship to Patient: ______________________

Name: ______________________ Relationship to Patient: ______________________

Name: ______________________ Relationship to Patient: ______________________

Name: ______________________ Relationship to Patient: ______________________

Patient Signature: ____

Date of Birth: ______________________ Date: ______________________

PATIENT INFORMATION

PATIENT NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____

ZIP CODE: ______________ CITY: ______________________ STATE: ________

CELL #: (____) ____-____ OTHER #: (____) ____-____ EMAIL ADDRESS: ______________

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: ____-____-____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER SEX: (circle one) FEMALE MALE

RACE/ ETHNICITY: ______________________

PATIENT'S EMPLOYER: ______________________ WORK PHONE#: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ______________________ COVERAGE EFFECTIVE DATE: ______________

CLAIMS ADDRESS: ______________________ PHONE: ______________

CONTRACT (ID#) NUMBER: ______________ SUBSCRIBER'S NAME: ______________

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle) SELF SPOUSE CHILD OTHER INSURED'S DATE OF BIRTH: ____/____/____

GROUP NUMBER: ______________________ GROUP NAME: ______________

SPECIALIST/OBGYN COPAYMENT: $ ________ OFFICE VISIT COPAYMENT: $________

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN SELF)

RESPONSIBLE PARTY NAME____

PATIENT RELATIONSHIP TO RESPOSIBLE PARTY: (circle) SELF SPOUSE CHILD OTHER SEX: (circle) FEMALE MALE

ADDRESS: ____

DATE OF BIRTH: ____/____/____ SOCAL SECURITY NUMBER: ______________

CELL #: ______________________ HOME #: ______________________

RESPONSIBLE PARTY'S EMPLOYER: ______________________ WORK PHONE: ______________

SECONDARY INSURANCE COMPANY: ______________________ COVERAGE EFFECTIVE DATE: ______________

CLAIMS ADDRESS: ______________________ PHONE: ______________

SUBSCRIBER ID #: ______________________ SUBSCRIBE'S NAME: ______________

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle) SELF SPOUSE CHILD OTHER INSURED'S DATE OF BIRTH: ______________

GROUP NUMBER: ______________________ GROUP NAME: ______________

All patients must complete our patient form before being seen by the provider. It is your duty as a patient to notify us of any changes of address, phone number, or insurance. In addition to your insurance card, we will need a copy of your driver's license. If you change insurance companies or benefits, you must call our office with the new information at least 48 hours prior to your appointment. You are required to supply us with the complete information of every insurance policy that you are covered under. If you do not, you will be responsible for the bill.

PATIENT SIGNATURE:______________________________ DATE:______________

By signing this form you are consenting that you have provided information on any and all insurance policies that you are covered under.

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General Medical History

Patient name: ____ DOB: ____________________

Primary care physician: ______________________________ Who sent patient: ________________________

Reason for visit: (please list all symptoms and pertinent information):

____

____

____

Past Medical History : ____

____

Past surgeries:

____

____

When was your last:

Blood Test: ________________ Colonoscopy: ______________ Pap smear: __________

Bone Density Test: __________ EKG: ______________________ Rectal Exam: _________

Chest X-Ray: _______________ Mammogram: _____________ Stress Test: __________

History of heart attack: ____

List all medications/supplements you are taking including dosage: ____________________________________

____

List any allergies: ____

____

Any diseases or illnesses that run in your family (including deceased family members and relationship):

____

Tobacco use: Yes No

Alcohol use: Yes No

Drug use: Yes No

I am:

- ☐ Married
- ☐ Divorced
- ☐ Single

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Diet and Nutritional Information

Please describe what you eat on a typical day:

Breakfast: ____

Lunch: ____

Dinner: ____

Snack: ____

Water intake (ounces per day): _____ Coffee intake (ounces per day): ______

Other beverages: ____

Exercise information:

Days per week: _____

Minutes per day: ____

Type of exercise: ____

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Female Health History

Hormones or supplements I am currently on or have been on in the past:

____

____

Date of last pap: ____________ Date of last mammogram: ___________

Where it was done: __________ Where it was done: _________________

History of abnormal paps: Yes No History of abnormal mammograms: Yes No

Number of pregnancies: _______ Current birth control methods: ________

Number of live births: _________ Previous birth control methods: _______

Age at first period: ___________ Date of last menstrual period: _________

I have had the following procedures:

- ☐ Hysterectomy If yes, do you still have your ovaries? Yes No
- ☐ History of Fibroids
- ☐ History of uterine ablation If yes, why? ____

I have the following medical conditions:

- ☐ Clotting disorders
- ☐ Bone loss /Osteoporosis
- ☐ Polycystic Ovarian Syndrome
- ☐ Other: _______________

I am (circle one): Premenopausal Perimenopausal Postmenopausal Unsure

I am:

- ☐ Sexually active
- ☐ Interested in becoming sexually active
- ☐ Not interested in sexual activity
- ☐ I have STDs

Review of Systems Form

*Please check all that apply

Please initial if NONE apply ______

Constitutional

- Weight Loss
- Weight Gain
- Fever
- Fatigue
- Other: ____________

Eyes

- Vision Change
- Use of Glasses/ Contacts
- Other: ____________________

Cardiovascular

- Chest Pain
- Palpitations
- Shortness of breath
- Edema
- Other: _____________

Gastrointestinal

- Diarrhea
- Bloody Stool
- Constipation
- Pain
- Other:

Genitourinary

- Hematuria (blood in urine)
- Dysuria (painful urination)
- Urgency
- Frequency
- Incontinent
- Other: _______________

Skin/ Breast

- Mastalgia (breast pain)
- Discharge
- Masses
- Rash
- Ulcers
- Other:_________________

Neurological

- Syncope
- Seizures
- Numbness
- Trouble Walking
- Other:__________________

Psychiatric

- Depression
- Crying
- Other: ________________

Endocrine

- Diabetes
- Hypothyroid
- Hyperthyroid
- Other:__________________

Hemat/Lymph

- Bruises
- Bleeding
- Other:

Updated 03/31/16

Risk Assessment for Hereditary Cancer Syndromes

Patient Name:____________________ **Date of Birth:** __________ **Today's Date:** __________

Instructions: Please fill out the family history form below. Your health is very important to us and family history is a tool to help us better manage you and offer recommendations for reducing your risk for cancer.

1st degree relatives: Mother, Father, Sister, Brother, Children
2nd degree relatives: Aunt, Uncle, Grandparent, Niece, Nephew, Half siblings
3rd degree relatives: Cousin, Great Grandparents, Great Aunts and Uncles

HAVE YOU OR ANY FAMILY MEMBER EVER HAD HEREDITARY CANCER TESTING (BRCA/Lynch/Myriad myRisk):
YES or NO Test/Result:

		BREAST AND OVARIAN CANCER	SELF (Age at Diagnosis)	FAMILY MEMBER	
				MOTHER'S SIDE/AGE	FATHER'S SIDE/AGE
Y	N	Breast cancer at age 45 or younger ***(In yourself, first or second degree relatives)***			
Y	N	Ovarian cancer at any age ***(In yourself, first or second degree relatives)***			
Y	N	Two relatives on the same side of the family with breast cancer; ONE at or under the age of 50 ***(In yourself, first, second or third degree relatives)***			
Y	N	Three or more of the following cancers at any age on the same side of the family: breast, ovarian, pancreatic, or prostate ***(In yourself, first, second or third degree relatives)***			
Y	N	One relative with TWO separate breast cancers; one diagnosed at or before the age of 50 ***(In yourself, first or second degree relatives)***			
Y	N	Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2) ***(In yourself, first or second degree relatives)***			
Y	N	Male breast cancer at any age ***(In yourself, first or second degree relatives)***			
Y	N	Breast, ovarian, or pancreatic cancer at any age in Ashkenazi Jewish family members ***(In yourself, first or second degree relatives)***			
Y	N	A family member with a known BRCA mutation			

		COLON AND UTERINE CANCER	SELF (Age at Diagnosis)	FAMILY MEMBER	
				MOTHER'S SIDE/AGE	FATHER'S SIDE/AGE
Y	N	Have you PERSONALLY had Uterine (endometrial) cancer?			
Y	N	Uterine or Colon/rectal cancer at or under age 50 ***(In yourself, first or second degree relatives)***			
Y	N	A family member with a known Lynch Syndrome mutation			

Please List ANY and ALL other cancers in your family and who had them *(please indicate Maternal/Paternal, Relative and Age at Diagnosis)*:

Patient's signature: ________________________ **Date:** __________

Provider signature: ________________________ **Date:** __________