Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing: ☐ Lynch ☐ HBOC

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing:
☐ Accepted
☐ Declined

_____ _____

Healthcare Professional's Signature Date

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

MYRIAD®

North Florida OB GYN LLC

Update History Form since Your Last Visit

Reason for visit/ Complaints: _____

Single _____ Married _____ Divorced_____ Widowed_____

Pharmacy: _____ Pharmacy number_____

Preferred Method of contact: home # __ cell # __ mail __ email__ Email address: _____

ANY Drug, Food, Latex or Iodine Allergies: _____

Medications/OTC/Dosage: _____

Birth Control Method: _____ Are you HIV positive? Y N

Last Period Date :_____ Cycle regular? Yes No Length/Days_____ Flow: ____light____mod _____heavy

Any new surgeries since your last visit: _____

Smoking History: Never smoker ___ Someday (social) smoker ___ Current every day smoker __ Former smoker __

Last Pap:_____ Last HPV screening: _____ History of abnormal paps ? _____

Family History of breast/ovarian/colon cancer ? ___ yes ___ no (if yes who _____)

Last Bone Density:_____ Last Colonoscopy:_____ Last Mammogram:_____

Age 50 and Older - Last Flu Shot: _____ Last Pneumovax: _____

Age 17 & under - Diet: select one of the items below
___Well-balanced diet
___ Poorly balance diet
___ Vegetarian diet
___ Low fat diet
___ Low-carbohydrate diet

Age 17 & under - Level of exercise and Immunization:
Does not exercise ___
Exercises occasionally __ frequency __ per week Duration __m
Exercises regularly ___ frequency __ per week Duration __ mi
Inactive __ frequency __ per week Duration ____ min

Have you had your Gardasil Vaccine yet? _____

Has anyone close to you ever threatened to hurt you ? Yes_____No_____
Has anyone ever hit, slapped, kicked, or hurt you physically? Yes_____No_____
Has anyone, including a partner or family member, pressured or forced you to do something sexually that you did not want to do? Yes_____No_____
Are you ever afraid of your partner or anyone at home ? Yes_____ No_____

Do you have an advanced directive? (Do Not Resuscitate) Yes No

Do you want a copy of today's visit (Please understand that your physician may take up to 3 business days to Complete) If you want a copy of today's visit and the provider has not signed off you may pick up a copy of today's visit in 3 business days.
Yes, I want a copy and understand the copy will be available in 3 business days _____
No, I do not want a copy of today's visit _____

Name: _____ DOB:_____

Signature: _____ Date:_____

Revised 6/25/15ts

NORTH FLORIDA OB GYN LLC

Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release and any item we should not disclose. Make your own notes if necessary for clarification.

Definitions:

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, Trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship	Name of person allowed to receive information	Type of information which may be released
Mother	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Father	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Husband	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC

☐ **NO INFORMATION TO BE RELEASED**

This consent to release information will remain in effect until revoked in writing.

_____ _____ _____
Print Patient's Name Signature Patient Date

_____ _____ Division: _____
Staff Witness Date

January 2013

North Florida OB/GYN
Of Jacksonville Beach

Well Woman Annual Examination Consent

It is our understanding that your appointment today is for an "Annual Well Woman Examination." This does not include treatment for a problem and only provides you with a preventative check up to ensure you do not have any problems that need to be addressed during a future visit.

If you wish to have both an annual exam and treat for a problem or if a problem is discovered during your annual exam, your charges will include evaluation of both (in consideration of doctor's schedule that will allow time for both). However, if your insurance company requires a referral or authorization for the problem visit and you do not have one, it will then become your financial responsibility.

Please sign below indicating that you are here for an "Annual Well Woman Examination" and will be responsible for any charges not covered by your insurance policy. **Any co-payments, co-insurance and/or deductibles will also be your responsibility**. Payments are due at time of service. Please speak with check-in staff if you have any questions.

Patient Name:_____ Account #:_____

Patient Signature:_____ Date:_____

Staff Witness:_____ Date:_____

Notice to Our Patients

Effective August 2015

****Patients that are 15 minutes late for an appointment may be rescheduled at the doctor's discretion****

Due to increasing costs and complexity of regulations, we have found it necessary to charge for some services, which we have provided for free in the past. Insurance carriers do not cover these services and **we must request payment at the time of service.**

These NON-COVERED SERVICES include:

- A "No Show" charge of $40.00 for appointments which are missed without notifying this office 24 hours in advance.
- Forms to be completed such as Disability, Life Insurance, Short Term Disability and FMLA, etc. Our fee is $25.00 per form. Please leave the form with us and **allow 7-10 business days for completion.**
- Copies of your Medical Records. In accordance with Florida Administrative Code 64B8-10.003 the set price is $1.00 per page up to 25 pages, then 25¢ per page for the remaining pages.
- Return to Work or School, Proof of Pregnancy and Dental letters are $5.00 per letter.
- Elective optional ultrasounds (gender determination) are $75.00. 3D ultrasounds are $150.00.
- DVD for ultrasound recording is $5.00.

Patient Signature:_____ Date:_____

Staff Witness:_____ Date:_____

Patient Name: _____ NORTH FLORIDA OB GYN, LLC FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **North Florida OB GYN LLC's Privacy Notice** dated **September 01, 2013** ("Notice"). I understand that I am responsible to read this Notice and notify North Florida OB GYN, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. North Florida OB GYN has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.nfobgyn.com. North Florida OB GYN will provide me with a copy of its most recent Notice upon my request.

Patient Signature: _____ Date of Birth:_____

Parent, Guardian or Legal Representative Signature:_____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at North Florida OB GYN, LLC. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, North Florida OB GYN LLC will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment

North Florida OB GYN, LLC is a wholly owned subsidiary of North Florida Obstetrical & Gynecological Associates, P.A. (“PA”) who may file a claim for payment and accept assignment with my insurance company as required by contractual agreement. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide North Florida OB GYN with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. North Florida OB GYN is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify North Florida OB GYN immediately upon any change to my insurance**.

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, North Florida OB GYN is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither the PA, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan “Non-Covered Services”; I understand I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual "well-women" exams are preventive visits and are not paid for by all insurance carriers. Medicare only pays for a portion of this exam (Pap, Pelvic and Breast Exam) once every two (2) years. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record ("EMR"). To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

ADDITIONAL INFORMATION

Payment may be made to the PA in the form of: Cash, Check, Debit and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to me by North Florida OB GYN, LLC. Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued, including balances owed to other wholly owned subsidiaries of the PA.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

ASSIGNMENT OF BENEFITS

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or to the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed name _____Patient's Date of Birth:_____

Patient's Signature:_____ Date signed:_____

Parent, Guardian or Legal Representative Signature:_____

Employee's signature who reviewed intake of form:_____