PATIENT REGISTRATION FORM :

DATE: _____

Patient's name: (last) _____ **(first)** _____ **(middle)** _____
Street Address: _____
City, State, Zip code: _____
Email address: _____
Phone # (home): _____ **(work):** _____
(cell): _____ **(fax):** _____
Date of Birth: _____ **SS #:** _____
Language: _____ **Marital Status:** _____
Race: _____ **Ethnicity:** _____

EMERGENCY CONTACT :

Name: _____
Phone #: _____ **Relation to patient:** _____

PRIMARY INSURANCE INFORMATION :

Insurance Company Name: _____
Street Address: _____
City,State, Zip code: _____
Insurance Phone #: _____
Responsible Party Name: (last) _____ **(first)** _____ **(middle)** _____
Street Address: _____
City, State, Zip code: _____
Phone # (home): _____ **(work):** _____
(cell): _____ **(fax):** _____
Date of Birth: _____ **SS #:** _____
Subscriber ID #: _____ **Group ID #:** _____
Co-pay: _____ **Effective date:** _____

SECONDARY INSURANCE INFORMATION :

Insurance Company Name: _____
Street Address: _____
City,State, Zip code: _____
Insurance Phone #: _____
Responsible Party Name: (last) _____ **(first)** _____ **(middle)** _____
Street Address: _____
City, State, Zip code: _____
Phone # (home): _____ **(work):** _____
(cell): _____ **(fax):** _____
Date of Birth: _____ **SS #:** _____
Subscriber ID #: _____ **Group ID #:** _____
Co-pay: _____ **Effective date:** _____

PHARMACY INFORMATION:

Pharmacy Name: _____
Address: _____
Phone # : _____ **Fax # :** _____

EMPLOYMENT INFORMATION :

Employment status: __Employed __Part-time employment __Full-time employment __Unemployed
__Full-time student __Part-time student __Retired __Self-employed
Name of employer: _____ **Phone #:** _____
Occupation: _____

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice has been updated to include revision effective September 2013, will take effect for our practice 08/01/2013 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

Our office will promptly notify affected individual(s) in the event of breaches of their unsecured PHI.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION
We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to your. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of nay emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with product reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS AS OUR PATRIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of the this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_25.00_ . If you want the copies mailed to you postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made to your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or pertinent purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other* than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003,. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing. You also have the right to request a restriction on certain disclosures to your health plan if the disclosure is purely for carrying out payment or health care operations and the requested restriction is for services paid out-of-pocket.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Practice Name: COMPLETE WOMEN'S HEALTHCARE

Telephone: 770-622-9810 Fax: 770-622-9811

E-Mail: WOMENSCAREONLINE.COM

Address: 634 Peachtree Parkway Suite 200

Cumming, Ga 30041

HEALTH INFORMATION EXCHANGE STANDARD ADDENDUM TO THE NOTICE OF PRIVACY PRACTICES

Effective Date: December 15, 2017

Complete Women's Healthcare ("Provider") participates in Emory Health Network Health Information Exchanges (HIE).

Generally, a HIE is an organization that regional providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in a HIE, the Provider may share certain health information with other providers that participate in the HIE (each a "Participating Provider") or participants of other health information exchanges. This health information includes, but is not limited to:

- General laboratory results including microbiology
- Pathology test results including biopsies, Pap smears, etc.
- Radiology results including x-rays, MRIs, CT scans etc.
- Results of outpatient diagnostic testing including GI testing, cardiac testing, neurological testing, etc.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary notes
- Urgent Care visit progress notes

All Participating Providers of a HIE have agreed to a set of standards relating to their use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws.

As a result, you understand and agree that unless you notify the Provider that you do not wish for your health information to be available through a HIE ("Opt-Out"):

- Health information that results from any Participating Provider providing services to you will be made available through HIEs in which Provider participates. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIEs in which Provider participates. However, your opt-out does not affect health information that was disclosed through a HIE prior to the time that you opted out;
- Regardless of whether you choose to opt-out, your health information will still be provided to the HIEs in which Provider participates. However, if you choose to Opt-Out, the HIEs will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information;
- All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;
- Information available through a HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment related healthcare services to you. This includes providers, pharmacies, laboratories, etc.
- Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.

You may Opt-Out at any time by notifying the Provider. A form may be obtained at the front desk or online at emoryhealthcare.org/ehealthexchange. A list of Participating Providers and more information on the HIE may be found at: emoryhealthcare.org/ehealthexchange

Complete Women's Healthcare, LLC
Financial and Payment Policy Form

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy that we would like you to read an sign as evidence of your agreement prior to any treatments.

We must emphasize that as your physician our relationship is with you, not your insurance company. We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date rendered. Not every service is a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is important that you read and understand **YOUR** health insurance policy and its requirements for coverage including pre-authorizations of services. We are **NOT** responsible for knowing the requirements of your specific plan.

It is your responsibility to contact your insurance carrier to confirm that our office participates in your plan. If you receive services from our office and we are not on your plan, you will be responsible for payments in full of our fee(s).

If you are unable to provide us with current insurance information (i.e. a current insurance card or written documentation of coverage from your insurance carrier),or if you do not provide us with the correct insurance information and claims are denied, you will be required to pay for any services you receive. When you have provided us with the corrected insurance information, we will file a claim with your insurance carrier and reimburse you once we have received their payment. Please be aware, if too much time has passed your insurance may not cover your services and you will be required to pay for services.

Complete Women's Healthcare is NOT a participating provider of Medicaid, you will be responsible for payment in full if you are insured with them. Patient responsible balances are expected to be paid within 30 days. Failure to pay a balance will result in collection actions. If a patient's balance is turned over to a collections agency an additional 30% of the balance will be added to the account.

DEDUCTIBLE, CO-INSURANCE, AND CO-PAYS

All deductibles and co-pays are due at the time of service. We accept cash, checks, Visa and Mastercard. If payment is not received on the date of service, a $20.00 administration fee may apply.

LABS

We use PathGroup for all laboratory services. All labs are billed separately through PathGroup and you will receive a separate statement for any laboratory services not covered by your insurance. If your insurance requires us to use a specific lab, it is your responsibility to let us know at the time of the visit.

HMO, MANAGED CARE AND PPO PLANS

Specific plans may require referrals from primary care physicians. It is your responsibility to provide a current referral form at the time of your visit. You are financially responsible for any services provided without a referral form.

RETURN CHECK FEES

Checks returned for non-sufficient funds will be charged a $30.00 administration fee in addition to the patient balance.

COPY OF RECORDS/FORMS

Copy of records requests require approximately 2 weeks to complete. A $25.00 charge is applied for each request. Records less than 20 pages will be faxed; records over 20 pages will be mailed. A $25.00 administrative fee is charged for forms and letters completed by our office. This includes any verification of pregnancy letters, letters and/or forms for disability, return to work letter, etc. This is a one-time fee payable before forms are completed. This fee will not be submitted to your insurance.

MISSED APPOINTMENTS

If you are unable to keep your scheduled appointment please notify our office at least 24 hours in advance of your appointment time. Failure to do so will result in a $25.00 no show charge. After 3 no shows on your account you will be dismissed from the practice.

Complete Women's Healthcare

Receipt of Notice of Privacy Practices & HIE
Written Acknowledgement Form

I, _____, have received a copy of Complete Women's Healthcare of Privacy Practices.

_____ _____

Signature of Patient Date

Complete Women's Healthcare

Receipt of Financial and Payment Policy
Written Acknowledgement Form

I have read and understand this financial agreement of Complete Women's Healthcare.

_____ _____

Signature Date

PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication
- Performance or diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that COMPLETE WOMEN'S HEALTHCARE will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize COMPLETE WOMEN'S HEALTHCARE to release information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to COMPLETE WOMEN'S HEALTHCARE.

I acknowledge that I have been given the COMPLETE WOMEN'S HEALTHCARE Notice of Privacy Practice. I understand that if I have questions or complaints that I should contact the Privacy official.
Patient initial: _____

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its consent.

_____ _____

Patient (or responsible Party) Signature Date

Revision Date: March 16, 2007

COMPLETE WOMEN'S HEALTHCARE

Consent for Release of Personal and Health Information

Patient Name:_____ Date of Birth:_____

Address:_____

Telephone Number:_____

I authorize the use or disclosure of personal and health information by Complete Women's Healthcare, as described below:

- Any and all personal and health information Complete Women's Healthcare maintains.
- Personal and health information regarding the treatment for the following condition:_____
- Personal and health information covering the period of time _____to _____
- Other (Please specify and include dates)_____

_____

Note: This consent form allows personal and health information to be shared via a telephone call with the person being authorized.

This information may be disclosed to, and used by, the following individuals or organizations:

Name:_____Relationship:_____
Address:_____

Name:_____Relationship:_____
Address:_____

Name:_____Relationship:_____
Address:_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Complete Women's Healthcare. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that I do not have to sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be re disclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Patient or Guardian:_____Date:_____

MEDICAL HISTORY QUESTIONNAIRE

Name_____ Age:_____ Today's Date: _____

Date of last complete physical exam _____, performed by _____

FAMILY HISTORY

List all family medical history by member including cancer, heart attacks, diabetes, high cholesterol, osteoporosis, stroke, blood clotting disorders, etc. Please indicate current age or if deceased at what age and why.

Mother: _____

Father: _____

Siblings: _____

Children: _____

MEDICAL HISTORY

Please check/circle all that apply to you in the past or currently that have required medical treatment.

__ Migraines/Seizures
__ Stroke
__ Thyroid Disorder
__ Hypertension
__ Elevated Cholesterol
__ Anxiety/Insomnia
__ Heart Disease/CAD

_____ Diabetes
_____ Eye Disease/Surgery
_____ COPD/Emphysema/Asthma
_____ Kidney Disease/Infection
_____ GERD/Ulcers
_____ Anemia
_____ Liver Disease/Hepatitis

_____ IBS/Colon Polyps/Colitis
_____ Blood/Bleeding Disorder
_____ Urinary Infection
_____ Muscular Disease/MS
_____ Depression
_____ Cancer (type :_____)
_____ Osteoporosis

SURGICAL HISTORY

Include type of surgery and approximate date

_____

_____

_____

OBSTETRICAL HISTORY

Total number of pregnancies: _____

Number of miscarriages: _____

Number of abortions: _____

Number of births: _____

Please give details about each birth:

	Birth (most recent)	Birth	Birth	Birth
Date of birth	____/____/_____ mm/dd/yyyy	____/____/_____ mm/dd/yyyy	____/____/_____ mm/dd/yyyy	____/____/_____ mm/dd/yyyy
Gestational age (duration of pregnancy)	_____ weeks	_____ weeks	_____ weeks	_____ weeks
Route of delivery	vaginal c-section	vaginal c-section	vaginal c-section	vaginal c-section
Weight at birth	_____ lbs. _____ oz.	_____ lbs. _____ oz.	_____ lbs. _____ oz.	_____ lbs. _____ oz.
Length of labor	_____ hours	_____ hours	_____ hours	_____ hours
Anesthetic				
Complications				

MENSTUAL HISTORY

Age of onset_____

Average # of days in-between start of each period_____

Total # days bleeding_____

Do you experience: clots, heavy, moderate, light or scant bleeding?

Do you experience cramping every month during your period that is not controlled? YES NO

Date of last period____/_____/_____

Please list types of current or prior contraception used: _____

OTHER MEDICAL PROVIDERS OR HOSPITALIZATIONS

List all medical providers, hospitalizations, ER visits, tests you have had since your last visit/past year:
i.e., X-rays, mammograms, ultrasounds, EKG, physical therapist, lab tests, immunizations, etc.

Name of Physician/Hospital **Date** **Reason for Visit or Procedure**

_____

_____

_____

_____

SYMPTOMS

Do you have now or have you had *within the last year on a recurrent basis*? (check all that apply)

__ Change in frequency/severity of headaches
__ Blurred or double vision
__ Excessive thirst
__ Chronic cough/Coughing up blood
__ Wake up at night short of breath
__ *Unusual* shortness of breath at rest
__ Chest pressure or heaviness
__ Unusual leg/foot pain with exercise
__ Recurrent stomach pain
__ Persistent nausea, vomiting or diarrhea
__ Change in appetite -- Increase / Decrease
__ *Unexplained* weight loss / weight gain
__ Blood in urine or dark brown urine
__ Leakage of urine w/ cough/sneeze
__ Persistent or worsening back or neck pain
__ Persistent tingling in fingers, hands or feet
__ Itching, scaling, redness or change in mole
__ Serious depression
__ Excessive anxiety or nervousness
__ Current daily stress level ___Low ___Moderate ___High ___Extreme

__ Persistent or severe dizziness_____
__ Unusual dryness or oiliness of skin/hair
__ Unusual increase in amount of urination
__ Snoring/stop breathing w/ sleep _____
__ Difficulty breathing when lying flat _____
__ New/increased swelling of ankles/feet
__ Palpitations or fluttering of heart
__ Persistent difficulty swallowing _____
__ Persistent heartburn or indigestion _____
__ Blood in vomit/stool, or tar-like stools
__ Night sweats/hot flashes/mood swings
__ Persistent pain or burning with urination
__ Significant urge to urinate _____
__ Difficulty starting or stopping urine_____
__ Persistent pain/swelling or heat in joints
__ Persistent muscle weakness in arms/legs
__ Persistent or recurrent rash _____
__ Sleep disturbances _____

PERSONAL DETAILS

Do you or are you ... (Please circle or answer to the best of your knowledge)

Marital status: Married Single Divorced Widowed Dating monogamously Dating several

Have sex with: Men only Women only Both

Sexually involved at this time? No Yes

If yes, what do you use to prevent sexually transmitted diseases?_____

What do you use to prevent pregnancy?_____

Smoke cigarettes, pipe or cigars? Never Not since (month/year) ____/_____ Yes

If yes, how old were you when you started _____

How much do you smoke per day (packs/day): half pack one pack two or more packs

Drink alcohol, beer or wine? No Yes

If yes, how much do you drink per day? Not every day One drink
Two or three drinks More than three

Drink caffeinated beverages (coffee, tea, sodas cups/day)? Not every day One to two
Three to six More than six

Have a special diet (i.e. vegan/vegetarian, no lactose)? No Yes

If yes, what? _____

Exercise: type: _____

frequency: _____/week Duration: _____

SCREENING TEST/QUESTIONS

Do you do regular monthly breast exams? Yes No

Date of last mammogram_____

Date of last pelvic exam _____

Date of last Pap smear_____

Result_____

Have you ever had an abnormal pap smear? Yes No

If yes, when? _____ What was the result? _____

Have you ever had a colonoscopy? Yes No

Have you ever had a bone density scan? Yes No

Have you had lab work for cholesterol, diabetes, thyroid disease, and/or anemia? Yes No

If yes, when? _____ What was the result? _____

Have you been or are you currently abused? Yes No

If yes, was it physical, sexual, verbal, other?_____

Is it still occurring? Yes No

ALLERGIES:

Please list all allergies to medications you have:

_____

_____

_____

_____

MEDICATIONS:

Please list all medications you are currently taking, the dose, frequency, and the doctor who prescribed it:

_____

_____

_____

_____

REASON FOR YOUR VISIT TODAY: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did you hear about us? (Please circle one, and give details if you feel comfortable doing so.)

Magazine advertisement/flyer: _____

Web search: _____

Seminar or event: _____

Family/friend: _____

Hospital/MD referral: _____

Other: _____

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
Gender (M/F): _____ Today's Date(MM/DD/YY): _____ Healthcare Provider: _____
Reason for Today's Visit: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-----	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	o **2 or more**: breast / ovarian / prostate / pancreatic cancer o **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) o **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	o Breast cancer o Colorectal cancer o Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at any age:	o Ovarian cancer o Breast: Male breast cancer or Triple negative breast cancer o Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† o Endometrial cancer with abnormal MSI/IHC o 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED
Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

We are excited to announce our new Patient Portal!

Our Organization recently made some software changes and with that will come a new patient portal called Follow My Health. Follow My Health is a universal portal, meaning you may already have an account with another physician.

FollowMyHealth.com allows you to do the following:

- View test and lab results and review medical notes from your doctor
- Communicate with your doctor; send and receive secure online messages
- Receive email reminders for preventative and follow up care
- Request medication refills
- Request and appointment
- Request a referral to a specialist
- Manage your personal health records
- Download apps to monitor your weight, track your blood pressure or manage a chronic conditon
- Create wellness goals and chart your progress

Patients that wish to join the Patient Portal will need an invitation

As mentioned above you may already have an account. If this is the case, you can select the "sign in and add connection" option when you receive your email invitation from our facility.

In order to receive an invitation we will need your email and consent. Upon receiving your request we will send you an email with a link to the portal and the three easy steps to register.

Important Note: To ensure you receive your emailed invitation and to make sure it doesn't get trapped in your spam blocker, be sure to add **noreply@followmyhealth.com** to your Safe Senders list.

For questions contact info@womenscareonline.com for assistance.

The FollowMyHealth™ patient portal at the Complete Women's Healthcare is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize Complete Women's Healthcare to email an invitation to create a portal account.

Purpose for Access	**PERSONAL ACCOUNT ACCESS: *(photo ID required)***
	■ I am 12-17 years of age and request access to my own medical record information
	■ I am 12-17 years of age and grant Read Only Access to my medical records to the authorized user listed below
	■ I am 12-17 years of age and grant Full Access to my medical records to the authorized user listed below
	■ I am 18 years or older and request access to my own medical record information
	■ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below
	■ I am 18 years or older and grant Full Access to my medical records to the authorized listed below
	AUTHORIZED USER ACCESS: *(copies of legal documents and photo ID required)*
	■ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*
	■ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*
	■ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**
	■ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Patient Information *(please print)*:

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Complete Women's Healthcare to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Complete Women's Healthcare health care information:

Patient Signature: _____ Date: _____

Authorized User Information (*please print*): (Person receiving access to a Patient Portal account)

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Authorized User Signature: _____ Date: _____

For Front Desk Use Only

Photo ID & Copies of Legal Documents Verified By: _____ Date: _____

For Portal Use Only	
Patient Portal Invite sent by:	Date:
(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)	