Wynd Counts, MD
Wendy Cruz, MD
Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD

WC AK
Women's Care of Alaska
2741 Debarr Rd, Suite C-205
Anchorage, AK 99508
(907) 279-2273 * Fax (907) 258-7705

Katie Ulmer, ANP
Migel Hadley, ANP
Winifred Koehler, ANP

PATIENT:

Patient Name _____ DOB _____ SS# _____

Preferred Ph# _____ _____ Other # _____ _____Email_____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address_____ City _____ State ____ Zip _____

Relationship Status _____Gender Identity _____Sexual Orientation _____

Race _____ Ethnicity _____

How did you hear about our practice? _____

PARTNER:

Partner Name _____ DOB _____ SS# _____

Preferred Ph# _____ _____ Other # _____ _____ Email _____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address_____ City _____ State ____ Zip _____

IF PATIENT IS A MINOR

Who may authorize treatment? _____ *Relationship* _____ *Contact#:* _____ _____

INSURANCE:

PRIMARY INSURANCE COMPANY: _____

Subscriber Name_____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name_____

Employer Address_____ City _____ State ____ Zip _____

SECONDARY INSURANCE COMPANY: _____

Subscriber Name_____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name _____

Employer Address_____ City _____ State ____ Zip _____

EMERGENCY CONTACT:

Emergency Contact Name _____ Relationship _____ Ph# _____ _____

Emergency Contact Name _____ Relationship _____ Ph# _____ _____

AUTHORIZATION Please initial each line, and sign the bottom

_____ I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care.

_____ I authorize direct payment to the provider(s) for my medical and/or surgical care.

_____ I understand that I am responsible to pay any non-covered charges or services.

_____ I understand that if I am uninsured, I am responsible to pay for any services provided.

_____ I have read and agree to the PATIENT FINANCIAL POLICY for Women's Care of Alaska.

_____ _____

Patient Signature Date

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PATIENT PORTAL

In the Summer of 2018, we launched our online Patient Portal with www.myhealthrecords.com. The implementation of this new system allows us to send automated appointment reminders / messages. Please provide your most current information below, so what we may ensure timely and accurate delivery of appointment reminders/messages:

CURRENT EMAIL ADDRESS:

_____

PREFERRED PHONE NUMBER FOR CONTACT:

Home * Mobile * Business

(_____)_____- _____

PREFERRED METHOD TO RECEIVE REMINDERS/ MESSAGES

(***Please ONLY circle the ways you wish to receive all your appointment reminders/messages.***)

Voice Call * Text * Email* Do Not Contact for Reminders

Additionally, the Patient Portal will allow you the ability to request appointments, directly and securely message your provider, view your medical records, and much more. Activating your Patient Portal is simple. We will send you an email invitation, simply follow the instructions in the email to set up your Patient Portal Account.

_____ _____
Patient Printed Name Date

_____
Patient Signature

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CONSENT TO TREAT and PAYMENT RESPONSIBILITY

The undersigned consents to medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to, laboratory procedures, ultrasounds, medical or surgical treatment, or procedures, or other services rendered to the patient under the general and special instructions of the physician or provider.

The undersigned understands that Women's Care of Alaska (WCAK) has agreed to bill my insurance as a courtesy. In order to process such payments and obtain procedure authorizations, WCAK may disclose any or all my medical record to medical service companies, insurance companies, or workman's compensation carriers, as necessary. The undersigned authorizes all insurance carriers, with whom I have coverage, including Medicare, Medicaid, and Tricare, to assign all payment of benefits due under the terms of my policy, to **Women's Care of Alaska,** including any settlements or judgments for such items or services. The undersigned agrees to notify WCAK of any changes in my insurance coverage, as soon as possible, to ensure there is no delay in billing. If, for some reason, my health insurance sends payment directly to me, I agree to immediately forward all payments that I have received for my care, and treatment, to WCAK. I understand and agree that I have been advised that I may be billed by WCAK and that this Assignment of Benefits and Agreement to Pay applies to any and all WCAK physician services, including both inpatient and outpatient charges, performed by my provider.

The undersigned understands that some items or services provided may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services in excess of the limits in my member benefit agreement. I understand that I am personally responsible for any item or service determined by my insurance company to be experimental, investigational, or to be non-covered for any other reason. I understand that I am personally responsible for any non-covered Medicare, Medicaid, Tricare items or services that are listed on the financial responsibility for non-covered items or services form. I am responsible for all copays, deductibles, and coinsurance established by my member benefit agreement.

The undersigned understands and agrees that all account balances are **due within 30 days of billing**. I also understand that if my account becomes delinquent, the account will be referred to an outside collection agency for payment resolution. If my account is referred to an outside collection agency, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process.

_____ Date: _____
(Printed Name of Patient, Parent, or Guardian)

_____
Patient, Parent, Guardian Signature:

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PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

PATIENT NAME: _____ DOB: _____
Month Day Year

AUTHORIZED METHODS OF COMMUNICATION
(√ Check all that apply)

☐ **RESIDENCE TELEPHONE**	☐ **CELL PHONE**	☐ **WORK TELEPHONE**
Number: ( ) _____	Number: ( ) _____	Number: ( ) _____
☐ Leave a call back number only. Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message
☐ OK to leave detailed message with person	☐ OK to leave detailed message with person	☐ OK to leave detailed message with person
☐ OK to leave detailed message on voicemail	☐ OK to leave detailed message on voicemail	☐ OK to leave detailed message on voicemail

Do you authorize us to speak with another individual, such as a spouse/partner, or other relative, regarding your PHI? If so, please write their name down below, along with their relationship to you. This information can be changed any time you request a change. Forms of PHI include, but are not limited to, the following examples:

(T) Treatment
Test results
Prescriptions/refills
Treatment Options

(P) Payment
Insurance questions/problems
Account balance/payment options

(O) Healthcare Operations Activities
Appointment reminder, Messages returned
Referral options/appointments, Records release
Messages that results are available

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

PATIENT SIGNATURE: _____ DATE:_____

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INFORMED CONSENT – TELEMEDICINE APPOINTMENT

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through use of interactive video, audio, or other telecommunication technology. Additionally, a physical examination of you may take place, and video, audio and/or photo recordings may be taken.

ANTICIPATED BENEFITS:

- Improved access to medical care by enabling a patient to remain in their location while the healthcare provider provides care from a distant site.
- Limiting the spread of COVID-19.
- More efficient medical evaluation and management.

POSSIBLE RISKS:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- It may be determined that that information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation / treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all your medical records may result in adverse drug reactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
- I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed without my authorization.
- I understand that during the COVID-19 Pandemic, security measurements may be lessened in accordance with U.S. Department of Health and Human Services to ensure improved access to care.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time without affecting my right to future care or treatment.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
- I understand that certain fees for service may be waived during the COVID-19 Pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I understand that I am still responsible for any co-payments or co-insurance that may apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost(s), I will be responsible for payment.

I have read and understand the information provided above regarding telemedicine. I hereby authorize the use of Telemedicine in the course of my diagnosis and treatment.

_____	_____
PRINTED NAME	DATE OF BIRTH
_____	_____
PATIENT SIGNATURE	DATE

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Patient Name: _____ DOB:_____ Date:_____

What brings you to our office today?_____

If we need to contact you, regarding any future appointments or to give you test results, may we leave a message?

☐ Yes ☐ No Please specify the preferred phone number: (_____)_____

ALLERGIES

LIST DRUG, ENVIRONMENTAL AND FOOD ALLERGIES	REACTION

CURRENT MEDICATIONS

DRUG NAME	DOSE	DRUG NAME	DOSE

GYN HISTORY | ANNUAL UPDATE

☐ ***N/A – I no longer have a period.*** ***Age when periods stopped:*** _____

**** If you answered N/A above – Skip this section.****

Date last menstrual period began:_____ Menstrual cycles are: ☐ Regular ☐ Irregular

Age when periods started: _____ Menstrual bleeding is: ☐ Light ☐ Moderate ☐ Heavy Periods last: _____ days

Cramps are: ☐ Mild ☐ Moderate ☐ Severe ☐ N/A Cramps last: _____ days

Spotting occurs between periods: ☐ Yes ☐ No Spotting Occurs after intercourse: ☐ Yes ☐ No

EXAM HISTORY

Date of last dental exam:_____ Date of last eye exam: _____

Date of last mammogram: _____ ☐ Normal ☐ Abnormal Date of last PAP: _____ ☐ Normal ☐ Abnormal

Date of last colon screening: _____ ☐ Normal ☐ Abnormal

STD HISTORY

☐ ***N/A – Have never been tested/treated for any sexually transmitted diseases.***

Have you ever been treated for any of the following conditions: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ PID

☐ Herpes ☐ Trichomonas Have you ever been tested for HIV: ☐ Yes ☐ No

SEXUAL HISTORY

☐ ***N/A – Have never been sexually active.***

Are you currently sexually active? ☐ Yes ☐ No - Males ☐ Females ☐ Both ☐

Did you begin sexual activity before 16 y/o? ☐ Yes ☐ No If yes, what age started? _____

Have you had > 5 sexual partners in your lifetime? ☐ Yes ☐ No If yes, how many? _____

PATIENT NAME:_____

CONTRACEPTION ☐ *N/A – Not currently using any form of birth control.*

Current Birth Control Method: ☐ Condoms ☐ Birth Control Pills ☐ Tubal Ligation ☐ Vasectomy
☐ Depo Provera ☐ Natural / Rhythm ☐ IUD ☐ Nexplanon® ☐ Other _____

PREGNANCY HISTORY ☐ *N/A – No changes since last visit.*

Total number of times pregnant		Number of Cesarean Sections		Number of miscarriages	
Number of full-term deliveries		Number of living children		Number of elective abortions	

PERSONAL MEDICAL HISTORY ☐ *N/A – No changes since last visit.*

YES	CONDITION	YES	CONDITION	YES	CONDITION
	Diabetes		Heart disease		Anxiety
	High Blood Pressure		Hepatitis		Seizures
	GI Reflux Disease		Liver Problems		Asthma
	Other GI Disease		Kidney Infections/stones		Lung Disease
	Fibroids		Arthritis		Tuberculosis
	Endometriosis		Joint Pain		Thyroid Disease
	Osteopenia		Fracture		Clotting Disorder
	Osteoporosis		PCOS		Ovarian Cyst
	Cancer (type)		Migraine		Other
	High Cholesterol		Depression		

SURGICAL HISTORY ☐ *N/A – No changes since last visit.*

SURGERY	YEAR	SURGERY	YEAR

FAMILY HISTORY ☐ *N/A – No changes since last visit.*

CONDITION	YES	RELATION	CONDITION	YES	RELATION	CONDITION	YES	RELATION
Diabetes			Heart Disease			Depression		
High Blood Pressure			High Cholesterol			Lung Disease		
GI Reflux			Liver Problem			Asthma		
Fibroids			Kidney Infections/Stones			Tuberculosis		
Endometriosis			Arthritis			Thyroid Disease		
Osteopenia			Cancer - Type:			Clotting Disorder		
Osteoporosis			Joint Pain			Other		

SOCIAL HISTORY | HABITS| PERSONAL SAFETY

Special Diet? ☐ Yes ☐ No Type: _____

Do you exercise? ☐ Never ☐ Rarely (1-2x/yr) ☐ Occasionally (1-2x/month) ☐ Often (1-2x/wk) ☐ Regularly (3-5x/wk)

Smoking: ☐ Yes ☐ No ☐ Former Packs/day: _____ Number of years: _____ Quit Date: _____

Alcohol: ☐ Yes ☐ No ☐ Former Drinks/day: _____ Drinks per week: _____ Quit Date: _____

Drug Use: ☐ Yes ☐ No ☐ Former T y p e :_____Number of Years? _____ Quit Date: _____

Caffeine: ☐ Yes ☐ No # Of cups per day: _____ Cups per week: _____

Has anyone close to you, ever threatened to, or physically hurt you? ☐ Yes ☐ No

Has anyone, including your partner, ever forced you to have sex? ☐ Yes ☐ No

Do you fear harm from anyone at home, or school, or anywhere else? ☐ Yes ☐ No

Do you have any concerns about your body image? ☐ Yes ☐ No

PATIENT NAME:_____

REVIEW OF SYSTEMS

Please check **ONLY** those conditions, that you are **CURRENTLY** experiencing

CONSTITUTIONAL	YES	NOTES	GENITOURINARY	YES	NOTES
Fever			Abnormal Bleeding		
Chills			Vaginal Discharge/odor		
Fatigue			Vaginal Itching/burning		
Weight Loss			Pelvic Pain		
Weight Gain			Menstrual Cramps		
EYES			Painful Intercourse		
Change in Vision			Genital Lump		
Double Vision			Fertility Concerns		
HEE NT			Menopausal Concerns		
Earaches			**MUSCULOSKELETAL**		
Ringing in ears			Muscle Weakness		
Sinus Problems			Joint Stiffness		
Sore Throat			Joint Pain		
Mouth Sores			Joint Swelling		
Dry Mouth			**SKIN/BREAST**		
CARDIOVASCULAR			Breast Pain		
Chest Pain			Nipple Discharge		
Diff. breathing w/exertion			Breast Lumps		
Swelling of legs			Rash		
Palpitations			Ulcers		
Heart Murmurs			**PSYCHIATRIC**		
RESPIRATORY			Depression		
Wheezing			Mood Swings		
Spitting up blood			Anxiety		
Shortness of Breath			Suicidal Thoughts		
Cough			Homicidal Thoughts		
GASTROINTESTINAL			**ENDOCRINE**		
Diarrhea			Abnormal Thirst		
Constipation			Hot Flashes		
Nausea/vomiting			Tremors		
Bloody Stool			Cold/Heat Intolerance		
Abdominal Pain			**HEMATOLOGIC**		
Indigestion			Frequent Bruising		
Bloating			Cuts do not stop bleeding		
Liver Problem/Hepatitis			Enlarged Lymph nodes		
GENITOURINARY			**OTHER**		
Blood in Urine					
Pain with Urination					
Urgency					
Urinary Incontinence					
Urinary Frequency					

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Height: _____ Weight: _____ Age of First Period: _____ Your Age When First Child Delivered (If applicable): _____ Age of Your Mother: _____

Are you Menopausal: _____ Have you ever used hormone replacement therapy? Please circle **Yes** or **No** If Yes, how long have you been it? _____

Has anyone in your family had genetic testing for hereditary cancer syndrome (Ex: BRCA or LYNCH)? Please circle **Yes** or **No** If Yes, what was the result? _____

Best Contact Phone Number(s): _____ Email: _____

Please mark below if there is a **personal or family history** of any of the following cancer and **indicate family relationship** and **their AGE at diagnosis** in the appropriate column. Consider parents, children, siblings, grandparents, aunts, uncles, and cousins.

Please Check			**You (age at diagnosis)**	**Siblings/Children (Who + age at diagnosis)** ***Ex: Brother, 36 yrs***	**Your Mother's side (Who + age at diagnosis)** ***Ex: Aunt, 44 yrs***	**Your father's side (Who + age at diagnosis)** ***Ex: Grandpa, 65 yrs***
Y	**N**	Breast cancer				
Y	**N**	Breast cancer in both breasts or multiple primary breast cancers				
Y	**N**	Ovarian cancer				
Y	**N**	Male breast cancer				
Y	**N**	Are you of Ashkenazi Jewish descent				
Y	**N**	Uterine (endometrial) cancer (*NOTE: do not include cervical cancer*)				
Y	**N**	Colon cancer				
Y	**N**	Stomach, kidney/urinary tract, brain, or small bowel/intestinal cancer *(NOTE: Please circle or write appropriate cancer in column)*				
Y	**N**	10 or more colon polyps found in a lifetime				
Y	**N**	Prostate cancer				
Y	**N**	Pancreatic cancer (Col/BRCA)				
Y	**N**	Malignant melanoma				

Patient's Signature: _____ **Date:** _____

For Office Use Only

BRCA/Lynch/myRisk Testing Indicated? **Yes** **No**

Patient offered hereditary cancer testing? **Yes** **No** If YES: **ACCEPTED** **DECLINED:**_____

Follow-up appointment scheduled? **Yes** **No** Date of Appointment: _____

Provider Signature: _____ **Date:** _____

BRCA - Personal or Fam History

One person with (out to 2nd degree)

- Breast cancer at 45 or younger
- Ovarian cancer at any age
- Male breast cancer at any age
- Breast cancer + Jewish Heritage
- Bilateral Breast cancer at 50 or younger
- Triple negative breast cancer at any age
- Family history of known BRCA1 or BRCA2 mutations

BRCA - Personal or Fam History

Two persons with (out to 3rd degree)

- 2 breast cancers w/ 1 ≤ 50 yrs
- Breast & ovarian cancer (any age)

Three persons with (out to 3rd degree)

- Breast and/or Ovarian and/or Pancreatic (any age) and/or aggressive prostate cancer

Lynch Syndrome (Colon/Endometrial)

Personally affected with:

- Colon and/or Endometrial cancer at ≤ 50 yrs
- Family history of known Lynch mutations

Family History of Colon, Endometrial, or Lynch Cancers (out to 2nd degree) (ie. Gastric, ovarian, brain, kidney, small bowel)

- 1 or more Lynch cancers, 1 dx ≤ 50 yrs