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

***Effective Date: January 23, 2014***

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please call our office with any questions or concerns.***

## OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of Protected Health Information (PHI).
- Provide notice of our legal duties and privacy practices regarding Health Information about you.
- Follow the terms of our notice that is currently in effect.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use disclosed Health Information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

***For Treatment:*** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

***For Payment:*** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

***For Health Care Operations:*** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

***Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services:*** We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Individuals Involved in Your Care or Payment for Your:*** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

***Research:*** Under certain circumstances, we my use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, if they do not remove or take a copy of any Health Information.

## SPECIAL SITUATIONS:

***As Required by Law:*** We will disclose Health Information when required to do so by international, federal, state or local law enforcement agencies.

***To Avert a Serious Threat to Health or Safety*:** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. However, disclosures will be made only to someone who may be able to help prevent the threat.

***Business Associates:*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Organ and Tissue Donation:*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking, transportation of organs eyes or tissues to facilitate organ, eye or tissue donation and transportation.

***Military and Veterans:*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

***Workers' Compensation:*** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Public Health Risks:*** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

***Health Oversight Activities:*** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and relicensing. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

***Data Breach Notification Purposes:*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

***Lawsuits and Disputes:*** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

***Law Enforcement:*** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be a result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

***Coroners, Medical Examiners and Funeral Directors:*** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

***National Security and Intelligence Activities:*** We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

***Protective Services for the President and Others:*** We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

***Inmates or Individuals in Custody:*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary; 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) the safety and security of the correctional institution.

## USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT-OUT.

***Individuals Involved in Your Care or Payment for Your Care:*** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

***Disaster Relief:*** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

## YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

## YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

***Right to Inspect and Copy.*** You have a right to inspect and copy health information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this health information, you must make your request, in writing, to Women's Care of Alaska, at the address listed on page one. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request under certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review.

***Right to an Electronic Copy of Electronic Medical Records:*** If your protected health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health Information in the form or format you request, if it is readily available in such form or format. If the Protected Health Information is not readily available in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy. We may charge you a reasonable, cost-based fee for the labor associated with transmitting or printing the electronic medical record.

***Right to Get Notice of a Breach:*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

***Right to Amend:*** If you feel that the health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Women's Care of Alaska, at the address listed on page one.

***Right to an Accounting of Disclosures:*** You have the right to request a list of certain disclosures we made of your Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization . To request an accounting of disclosures, you must make your request, in writing to Women's Care of Alaska at the address listed on page one.

***Right to Request Restrictions:*** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Women's Care of Alaska on our Disclosure Form. We are not required to agree to your request unless you are asking us to restrict the use and dis closure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

***Out-of-Pocket-Payments:*** If you paid out-of-pocket (or, in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not to be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

***Right to Request Confidential Communications:*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For Example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing to our office, at the address listed on page one. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

***Right to a Paper Copy of This Notice:*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask any of our receptionists to make you a copy.

## COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing and can be sent to Women's Care of Alaska at the address listed on page one. If you have questions, please contact our office at 907-279-2273. ***You will not be penalized for filing a complaint.***


**2741 DeBarr Road, Suite C-205**
**Anchorage, Alaska 99508**
**(907) 279-2273 * Fax (907) 258-7705**

# RECEIPT OF NOTICE OF PRIVACY PRACTICES
# WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the:
Patient's Printed Name

***Women's Care of Alaska's Notice of Privacy Practices***

_____ _____
Signature of Patient Date

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

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**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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WCAK
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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

| | | | | | |
|---|---|---|---|---|---|
| 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

| 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

| SURGERY | YEAR | SURGERY | YEAR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## FAMILY HISTORY

| 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

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

**Women's Care of Alaska**
2741 DeBarr Road, Suite C205
Anchorage, AK 99508
(907) 279-2273 * Fax (907) 258-7705
**Wynd Counts, MD * Wendy Cruz, MD * Kristina Eaton, MD**
**Allison van Haastert, MD * Jessica Goldberger, MD**

Patient Addressograph

# OBSTETRIC MEDICAL HISTORY

Name:
LAST FIRST MIDDLE

Date Form Completed: – –

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

## Personal Health History

1. ☐ Yes ☐ No **Have you ever had an allergic reaction to a medication or vaccine component?**

If yes, please list: _____

Any other allergies or reactions? _____

2. **Please mark any condition that you have or have had in the past:**

- ☐ Epilepsy
- ☐ Headaches
- ☐ Thyroid Disorder
- ☐ Breast Disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Anemia
- ☐ von Willebrand disease or other bleeding disorders
- ☐ Blood Clotting Disorder (eg, Phlebitis/Thrombophilia)
- ☐ Blood Transfusion
- ☐ Gastrointestinal Illness
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Recurrent Urinary Tract Infections
- ☐ Gestational Diabetes
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Arthritis or Lupus
- ☐ Skin Disorders
- ☐ Prior Preterm Birth
- ☐ Group B Streptococcus In Prior Pregnancy
- ☐ Herpes
- ☐ Sexually Transmitted Infections
- ☐ HIV/AIDS
- ☐ Frequent Infections
- ☐ Psychiatric Illness
- ☐ Depression/Postpartum Depression
- ☐ Eating Disorder
- ☐ Other: _____

Describe, if needed: _____

3. **Please indicate any surgery or hospitalization that you have had and the date:**

4. **Please describe any health problems or symptoms that you are having at this time:**

5. ☐ Yes ☐ No **Do you or any family member have a history of problems with anesthesia?**

If yes, please describe: _____

6. ☐ Yes ☐ No **Do you have any objections to any form of medical treatment (eg, blood transfusion)?**

If yes, please describe: _____

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## Exposures Affecting Health

1. ☐ Yes ☐ No **Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped?**

   **If yes, how many packs per day?** _____ **If former smoker/user, when did you quit?** _____

2. ☐ Yes ☐ No **Do you drink alcoholic beverages now or did you before you became pregnant?**

   **If yes, please indicate number of drinks per week:** _____

   **What type of drinks?** _____

3. **Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines:** _____

4. ☐ **Yes** ☐ **No** **Have you used any street drugs since your last menstrual period (eg, cocaine, marijuana, opioids)?**

   **If yes, please indicate number of uses per week:** _____

   **What type of drugs?** _____

5. ☐ **Yes** ☐ **No** **Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs?**

6. ☐ **Yes** ☐ **No** **Have you been exposed to chemicals (eg, pesticides, lead, hazardous material/agents) or radiation (eg, X-rays) since you became pregnant? If yes, please describe:** _____

7. ☐ **Yes** ☐ **No** **Are you on a restricted diet?**

   **If yes, please describe:** _____

## Gynecologic Health History

1. **When was your last Pap test?** _____

   ☐ **Yes** ☐ **No** **Have you received all three doses of the HPV vaccine?**

   ☐ **Yes** ☐ **No** **Have you ever had an abnormal pap test?**

   **If yes, when and how were you treated?** _____

   **What was the diagnosis?** _____

   ☐ **Yes** ☐ **No** **Have you ever had HPV?**

2. ☐ **Yes** ☐ **No** **Have you ever had** ☐ **Gonorrhea** ☐ **Chlamydia** ☐ **Pelvic Inflammatory Disease**

   **If yes, when, how, and where were you treated?** _____

3. ☐ **Yes** ☐ **No** **Have you ever had herpes?**

   **If yes, where do you have outbreaks?** _____

   **If yes, how often do you have outbreaks?** _____

   ☐ **Yes** ☐ **No** **Have you ever had syphilis?**

   **If yes, how, when, and where were you treated?** _____

4. ☐ **Yes** ☐ **No** **Have you ever used an intrauterine device (IUD) for contraception?**

   **If yes, please indicate when:** _____

   ☐ Yes ☐ No **Did you have any problem with the IUD?**

   **If yes, please describe:** _____

5. ☐ **Yes** ☐ **No** **Have you been treated for infertility?**

   **If yes, please describe when and treatment received:** _____

6. ☐ **Yes** ☐ **No** **Do you have any other concerns related to your past health history?If yes, please list:** _____

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## Family History & Genetic Screening

1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

2. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?

   If yes, please describe: _____

3. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?

   If yes, please describe: _____

4. Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):

   _____

   _____

   How is this child/person related to you? _____

5. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?

   If yes, have either of you had genetic counseling? ☐ Yes ☐ No

   If yes, have either of you had chromosomal testing? ☐ Yes ☐ No

   Where and what were the results? _____

6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

   ☐ Yes ☐ No Eastern European Jewish (Ashkenazi) Ancestry

   If yes, have you had tay–sachs screening tests? ☐ Yes ☐ No

   If yes, have you had a canavan screening test? ☐ Yes ☐ No

   If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No

   Date: _____ /_____ /_____ Result: _____

   ☐ Yes ☐ No African American

   If yes, have you had sickle cell screening? ☐ Yes ☐ No

   Date:_____/_____ /_____ Result: _____

   ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry

   If yes, have you had screening for inherited forms of anemia such as Thalassemia? ☐ Yes ☐ No

   ☐ Yes ☐ No French Canadian or Cajun Ancestry

   If yes, have you had Tay–Sachs screening tests? ☐ Yes ☐ No

7. ☐ Yes ☐ No Have you had cystic fibrosis screening?

8. ☐ Yes ☐ No Have you had any other genetic carrier screening, such as an expanded carrier screening?

   Screening:_____ Date: _____ /_____ /_____ Result:_____

9. Please list any other concerns you have about birth defects or inherited disorders:

   _____

   _____

   _____

10. ☐ Yes ☐ No Do you want a test that will tell you about your risk to have a baby with Down syndrome?

11. ☐ Yes ☐ No Is the father 45 years or older?

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## Psychosocial Screening*

1. ☐ **Yes** ☐ **No** **Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments?**
2. ☐ **Yes** ☐ **No** **Do you feel unsafe where you live?**
3. ☐ **Yes** ☐ **No** **Are you exposed to second-hand smoke?** ☐ **Yes** ☐ **No** **In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), and vaped?**
4. ☐ **Yes** ☐ **No** **In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?**
5. ☐ **Yes** ☐ **No** **In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?**
6. ☐ **Yes** ☐ **No** **Has anyone forced you to perform any sexual act that you did not want to do?**
7. **On a 1–5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High**
8. **How many times have you moved in the past 12 months?** _____
9. **If you could change the timing of this pregnancy, would you want it** ☐ **earlier** ☐ **later** ☐ **not at all / NA**

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____

**PATIENT SIGNATURE**

_____

**PRINT NAME**

_____

**DATE**

## Notes

# Tricefy™ your ultrasound at

WC AK
Women's Care of Alaska

☐ I want my ultrasound images delivered digitally as an email or text.

Email Address: _____

Mobile Phone Number: (_____)_____

☐ I authorize the sending of images during my pregnancy.

☐ I have read, understand, and agree to this disclaimer.

Name: _____

Signature: _____ Date: _____

# Patient Disclaimer and Authorization

Tricefy™ is a communication service licensed to your provider. This Disclaimer and Authorization Agreement sets forth the terms and conditions under which you, the undersigned patient authorize Your Provider to transmit your ultrasound examination through Trice Imaging, Inc. to a mobile phone number and email address of your choice. This Agreement will become effective on the date of your signature and will terminate after all images throughout your current pregnancy are sent to you.

After you complete and sign this Agreement, a mobile telephone number or email address you designate will be entered into our ultrasound system and re-verified with you. When your ultrasound screening is complete, in accordance with your provider's policies and procedures, the sonographer will trigger the ultrasound machine to send an encrypted copy of your examination to the Tricefy™ server. The server will reformat and encrypt the file and provide access to the examination through your mobile phone number and a text or email. The physician will have the discretion to determine whether your ultrasound screening is complete and whether to transmit your images to Tricefy™. The Physician has the right to refuse to transmit or to delay the transmission of your images. Both the text and email message will contain secure links and instructions on how to access the images. Images and videos can be accessed and downloaded to your mobile phone and computer.

You agree to pay all costs for the services if applicable. Transmission of the images through Trice Imaging, Inc. is not a medical service. The transmitted images are not considered diagnostic medical images and are not a part of your medical record; they are not to be used for your health care, diagnosis or treatment. If you want to see your medical records, you need to contact your provider, who is responsible for maintaining your medical records. Neither your provider, nor Trice Imaging, Inc. is responsible for the security of the transmitted images once the text and email recipients you have designated download the images. By directing your provider to transmit the images to an email address and telephone number that you specify, you authorize your provider and Trice Imaging, Inc. to provide the images to the person who owns or uses the email address and telephone number and any persons who may have access to the telephone number and email address. We would recommend immediate download of any images, as the link to the images will only be active for a maximum of 90 days. Any transmission of additional images will be considered new services, the cost for which the patient is obligated to pay, if applicable. Trice Imaging, Inc. will not store the images on its server for you.

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