Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

Women's Care of Alaska

Wynd Counts, MD * Wendy Cruz, MD

Migel Hadley, ANP
Wendy Koehler,ANP
Haley Gomez, ANP

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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

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COMPLETE ENTIRE FORM

PATIENT:

Patient Name _____ DOB _____ SS# _____

Preferred Ph# _____ Email Address: _____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address _____ City _____ State ____ Zip _____

Relationship Status:_____ Pronouns: _____ Gender Identity:_____ Sexual Orientation:_____

(please circle)
Race: *White * Black * Asian * Pac. Islander/Nat. Hawaiian * Amer. Indian/AK Native*

(please circle)
Ethnicity: *Latino/Hispanic * Not Latino/Hispanic * Other*

IF PATIENT IS A MINOR

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

PARTNER:

Partner Name _____ DOB _____ SS# _____

Preferred Ph# _____ Email Address: _____

Mailing Address SAME (or) _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address_____ City _____ State ____ Zip _____

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.

How did you hear about our practice? _____

Patient Signature _____ **Date**: _____

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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) AUTHORIZATION

PATIENT NAME: _____ **DOB:** _____
Month Day Year

CHECK ALL METHODS OF COMMUNICATION, THAT YOU AUTHORIZE

☐ YOUR CELL PHONE	☐ YOUR WORK TELEPHONE	☐ RESIDENCE 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 or on voicemail	☐ OK to leave detailed message with person or on voicemail	☐ OK to leave detailed message with person or on voicemail

MY PREFERRED CONTACT NUMBER IS: ( ) _____ - _____

If you would like to authorize us to speak with another individual, such as a spouse/partner, or other relative regarding your PHI, please fill in their name, relation to you, and their contact number below. This information can be changed at any time, per your request. Examples of PHI include, but are not limited to:

(T) Treatment	**(P) Payment**	**(O) Healthcare Operations Activities**
Test results	Insurance questions/problems	Messages returned, Referral options, Records Release
Prescriptions/refills	Account balance/payment options	

CIRCLE WHAT TO RELEASE:

Name: _____/_____/_____ (T) (P) (O)
PLEASE PRINT (Relation to Pat.) (CONTACT#)

Name: _____/_____/_____ (T) (P) (O)
PLEASE PRINT (Relation to Pat.) (CONTACT#)

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT PORTAL ACCESS

Our patient portal is set up through www.myhealthrecords.com. The portal allows us to send you automated appointment reminders and messages. In addition, it allows you the ability to 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.

CURRENT EMAIL ADDRESS: _____ @ _____

(√) CHECK THE WAYS YOU WISH TO RECEIVE YOUR APPOINTMENT REMINDERS/MESSAGES?

☐Voice Call ☐Text ☐Email ☐Do Not Contact Me for Reminders

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 ***DO*** consent to Telemedicine Appointments.

☐ I ***DO NOT*** consent to Telemedicine Appointments.

_____ _____

PRINTED NAME DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE

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Medical and Reproductive History – Infertility

Today's date: _____/_____/_____

Female Patient:
(LEGAL) Last name: _____ **(LEGAL)** First name: _____ Middle initial: _____

Age: _____ Date of birth: _____/_____/_____

Marital status: _____ single _____ married _____ domestic partner Length of relationship: _____years

Partner:
(LEGAL) Last name: _____ **(LEGAL)** First name: _____ Middle initial: _____

Age: _____ Date of birth: _____/_____/_____

Reason for visit: _____

Fertility History – Female Patient

Do you have any theories as to why you have been unable to conceive? _____

How long have you been trying to conceive? _____

Pregnancy History: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Pregnancy ended (mo. / yr.)	Pregnancy length (weeks, months)	Outcome	Father (check one)	
				Present partner	Previous partner

Previous Fertility Evaluation: List any previous testing or procedures you have had done. _____

_____

_____

_____

Reproductive Health History – Female Patient

Menstrual History:
Age when you had your first menstrual period: _____ years old

The first day of your most recent menstrual period: _____/_____/_____

Menstrual cycle pattern without hormone or oral contraceptive pills (OCP's) – (check all that apply):

☐ Regular periods ☐ Irregular periods ☐ Heavy periods ☐ Light periods
☐ No periods ☐ Spotting between periods

How many days from the first day of one period to the first day of the next? _____ days

How many days of bleeding do you usually have? _____ days

Do you need medication to bring on a period? ☐ Yes ☐ No If Yes, what type? _____

Do you have cramping or pelvic pain with your periods? (check one)

☐ Always ☐ Sometimes ☐ Recently ☐ In the past
☐ No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same

If you do not have periods, at what age did you stop having them? _____ years old

When was your last Pap smear? _____/_____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, date and treatment: _____/_____ _____

Contraceptive Method History:

Type	Years used
☐ Birth control pills / Patch	
☐ Depo Provera, Lunelle	
☐ Nuva Ring	
☐ Nexplanon/Implanted Device	
☐ Diaphragm	
☐ IUD	
☐ Condoms	
☐ Tubal sterilization	
☐ Vasectomy	
☐ Rhythm method	
☐ Other	

Sexual History:

How many times per week do you have intercourse? _____

How many times do you have intercourse mid-cycle? _____

Do you experience any pain with intercourse? ☐ Yes ☐ No

Do you regularly use lubricant with intercourse? ☐ Yes ☐ No If yes, what type? _____

Have you ever had any sexually transmitted infections? (check all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphilis
☐ Genital Warts ☐ Trichomonas ☐ HIV ☐ HPV
☐ Hepatitis ☐ Other _____

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No If yes, when? _____

Were you hospitalized? ☐ Yes ☐ No

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

General Medical History – Female Patient

What is your current weight? _____ Height? _____ Usual weight? _____

Have you had recent weight loss or gain in the past 6 months? ☐ Yes ☐ No

Are you currently being treated or being seen for any medical condition(s)? ☐ Yes ☐ No

If yes, describe: _____

_____

Review of systems: Check any of the following that you are presently having or have had in the past:

Eye problems ☐	Gall bladder problems ☐	Excessive thirst ☐
Stuffy nose or hay fever ☐	Liver disease ☐	Temperature intolerance ☐
Frequent nose bleeds ☐	Frequent urination at night ☐	Headaches ☐
Fast or irregular heartbeat ☐	Vaginal discharge, itching, pain ☐	Shaking or tremor ☐
Heart murmur ☐	Pelvic pain ☐	Anxiety ☐
Mitral valve prolapse ☐	Sexual problems ☐	Depression ☐
Dizziness or fainting ☐	Endometriosis ☐	Bulimia or anorexia ☐
Shortness of breath ☐	Ovarian tumor ☐	Anemia ☐
Lung disease ☐	Dark skin on neck or armpits ☐	Easy bleeding or bruising ☐
Asthma ☐	Acne or pimples ☐	Poor circulation ☐
Tuberculosis ☐	Enlarged or painful breast ☐	Blood transfusion ☐
Heartburn or indigestion ☐	Discharge from nipples ☐	Fatigue ☐
Gas, cramps or pain ☐	Breast lumps ☐	Low energy ☐
Blood in stool or black stool ☐	Breast disease ☐	Past history of IV drug use ☐
Nausea or vomiting ☐	Hot flashes ☐	Rubella (German measles) ☐
Constipation ☐	Excessive face or body hair ☐	Other ☐
Diarrhea ☐	Hair thinning or loss ☐	_____ ☐
Hernia ☐	Fever, sweats or chills ☐	_____ ☐

Explain any positive responses: _____

_____

_____

Surgical History: List any major illnesses, surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

Date (month / year)	Procedure	Reason

Current Medications: List all medications (including vitamins, herbs and over the counter medications) or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

Allergies: List all drug, environmental and food allergies:

Allergy	Reaction

Social History – Female Patient

Current occupation: _____

Have you or do you partake in any of the following?

	Never	Not in the last 3 months	Yes	List type, amount and frequency (how often / per day or week)
Tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	
Caffeine	☐	☐	☐	
Social Drugs	☐	☐	☐	
Exercise	☐	☐	☐	

Family and Genetic Health History – Female Patient

Are there any known genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, describe: _____

Are you adopted? ☐ Yes ☐ No

Are you of any of the following ethnic backgrounds? (check all that apply)

☐ Ashkenazi Jewish ☐ Mediterranean ☐ Middle Eastern ☐ Asian
☐ African ☐ Hispanic or Caribbean ☐ French Canadian of Cajun ☐ Caucasian

Have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
α (alpha) thalassemia	☐ Yes ☐ No	
β (beta) thalassemia	☐ Yes ☐ No	
Sickle Cell Anemia	☐ Yes ☐ No	
Tay Sach's Disease	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No	
Spinal Muscular Atrophy	☐ Yes ☐ No	

If you are of Eastern European Jewish (Ashkenazi) ancestry, have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
Canavan Disease	☐ Yes ☐ No	
Familial Dysautonomia	☐ Yes ☐ No	
Fanconi Anemia	☐ Yes ☐ No	
Neimann-Pick Disease	☐ Yes ☐ No	
Mucolipidosis Type IV	☐ Yes ☐ No	
Bloom Syndrome	☐ Yes ☐ No	
Gaucher Disease	☐ Yes ☐ No	

Indicate which of the following conditions may be found in your family:

Medical Condition	Self	Parents		Siblings		Maternal Grandparents		Paternal Grandparents		Your children	Other relatives
		M	F	S	B	GM	GF	GM	GF		
Autoimmune disorder, such as lupus or rheumatoid arthritis											
Birth defects requiring surgery (cleft lip, etc.)											
Bleeding disorders (hemophilia, etc.)											
Blindness											
Bone Disorder											
Cancer before age 50 (Specify)											
Chromosome disorders (Down syndrome, Klinefelter syndrome)											
Clotting disorders (Factor V Leiden, etc.)											
Deafness											
Diabetes (insulin dependent)											
Endocrine disorders (thyroid disorders, adrenal hyperplasia, etc.)											
Epilepsy											
Heart defects ("hole in the heart", etc.)											

Heart Disease											
High blood pressure											
High cholesterol											
Hydrocephaly (“water on the brain”)											
Kidney disease											

Medical Condition	Self	Parents		Siblings		Maternal Grandparents		Paternal Grandparents		Your children	Other Relatives
		M	F	S	B	GM	GF	GM	GF		
Limb defects (missing or extra fingers or toes, shorten arms or legs)											
Marfan Syndrome											
Mental illness (schizophrenia, bipolar, etc.)											
Mental retardation, autism or learning disabilities											
Muscular dystrophy											
Neurofibromatosis											
Neurologic or neurodegenerative disease (Alzheimer, Huntington, etc.)											
Neuromuscular diseases (muscular dystrophies, etc.)											
Phenylketonuria (PKU)											
Polycystic kidney disease											
Skin diseases (eczema, melanoma)											
Stillbirth of children who have died as infants											
Stroke											
Thalassemia (Cooley’s anemia)											
Unusual genitals in boys or girls											
Urinary tract abnormalities											
Women who have had multiple miscarriage											
Other serious health issues											

Explain any positive responses: _____

_____

_____

Fertility History – Partner

Do you have any theories as to why you have been unable to conceive? _____

_____

Pregnancy History: List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Pregnancy ended (mo. / yr.)	Pregnancy length (weeks, months)	Outcome	Father (check one)	
				Present partner	Previous partner

Have you ever been unable to conceive with anyone other than your current partner? ☐ Yes ☐ No

Have you ever consulted a urologist or male infertility specialist? ☐ Yes ☐ No If yes, when? _____/_____

Reason: _____

Findings / Recommendations: _____

_____

Previous Fertility Evaluation: List any previous testing or procedures you have had done. _____

_____

General Medical History – Partner

Surgical History: List any major illnesses, surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

Date (month / year)	Procedure	Reason

Current Medications: List all medications (including vitamins, herbs and over the counter medications) or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

Social History – Partner

Current occupation: _____

Have you or do you partake in any of the following?

	Never	Not in the last 3 months	Yes	List type, amount and frequency (how often / per day or week)
Tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	
Social Drugs	☐	☐	☐	
Caffeine	☐	☐	☐	
Exercise	☐	☐	☐	

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? ☐ Yes ☐ No

Family and Genetic Health History – Partner

Are there any known genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, describe: _____

Do any of your blood relatives (siblings, children, aunts, uncles, etc.) have a birth defect (e.g. mental retardation, spina bifida, heart abnormalities, etc.)? ☐ Yes ☐ No

If yes, describe: _____

_____

Are you adopted? ☐ Yes ☐ No

Are you of any of the following ethnic backgrounds? (check all that apply)

☐ Ashkenazi Jewish ☐ Mediterranean ☐ Middle Eastern ☐ Asian
☐ African ☐ Hispanic or Caribbean ☐ French Canadian of Cajun ☐ Caucasian

Have you had a blood test to see if you were a genetic carrier for:

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Sickle Cell Anemia	☐ Yes ☐ No	
Tay Sach's Disease	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No	
Spinal Muscular Atrophy	☐ Yes ☐ No	

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Fanconi Anemia	☐ Yes ☐ No	
Neimann-Pick Disease	☐ Yes ☐ No	
Mucolipidosis Type IV	☐ Yes ☐ No	
Bloom Syndrome	☐ Yes ☐ No	
Gaucher Disease	☐ Yes ☐ No	