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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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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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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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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Patient Name: _____ DOB: _____ DATE: _____

What brings you to our office today?_____

ALLERGIES ☐N/A – No known drug allergies

LIST DRUG, ENVIRONMENTAL AND FOOD ALLERGIES	REACTION

CURRENT MEDICATIONS ☐N/A – No medications

DRUG NAME	DOSE	DRUG NAME	DOSE

GYN HISTORY / ANNUAL UPDATE ☐N/A – I no longer have a menstrual cycle Age _____

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: ☐N/A ☐Mild ☐Moderate ☐Severe 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 mammogram: _____ ☐Normal ☐Abnormal

Date of last eye exam: _____ Date of last PAP: _____ ☐Normal ☐Abnormal

Date of last colon screening: _____ ☐Normal ☐Abnormal

STD HISTORY ☐N/A – I have never had a sexually transmitted disease

Have you ever had any of the following STDs? (√ all that apply):

☐Chlamydia ☐Gonorrhea ☐Genital Warts ☐Herpes ☐Trichomonas ☐Syphilis ☐PID

Have you ever tested positive for HIV? ☐Yes ☐No

SEXUAL HISTORY ☐N/A – I have never been sexually active

Are you currently sexually active? ☐Yes ☐No - ☐ Male ☐ Female ☐ Both

Did you begin sexual activity before the age of 16? ☐Yes ☐No If yes, what age did you start? _____

PATIENT NAME: _____

CONTRACEPTION ☐N/A – I am 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 / FAMILY MEDICAL HISTORY √ Box for Personal History or Family History of condition

Condition	Pers. Hx	Family Hx		Pers. Hx	Family Hx		Pers. Hx	Family Hx
Anemia			Fibroids			Liver Problems		
Anxiety			Fracture(s)			Lung Disease		
Arthritis			GI Reflux Disease			Migraine		
Asthma			GI (other) Disease			Osteopenia/Osteoporosis		
Autoimmune Disease			Heart Disease			Ovarian Cyst		
Cancer (type)			Hepatitis			PCOS		
Clotting Disorder			High Blood Pressure			Seizures		
Depression			High Cholesterol			Thyroid Disease		
Diabetes			Joint Pain			Tuberculosis		
Endometriosis			Kidney Infections/stones			OTHER		

SURGICAL HISTORY

_____

_____

_____

_____

_____

SOCIAL HISTORY / HABITS / PERSONAL SAFETY

Do you follow a Special Diet? ☐Yes ☐No If yes, type?: _____

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

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

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

Drug Use: ☐Yes ☐No ☐Former Type? _____ Number of years: _____ Quit Date: _____

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

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REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ Date: _____

What brings you to our office today? _____

☑ **Check only those conditions that you are CURRENTLY having now.**

CONSTITUTIONAL		NOTES	GENITOURINARY		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		
HEENT			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

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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: _____

W. Counts, MD * W. Cruz, MD * A. van Haastert, MD * J. Goldberger, MD * M. Byrne, DO

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:** _____

W. Counts, MD * W. Cruz, MD * A. van Haastert, MD * J. Goldberger, MD * M. Byrne, DO

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?

W. Counts, MD * W. Cruz, MD * A. van Haastert, MD * J. Goldberger, MD * M. Byrne, DO

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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