

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



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

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

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

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
☐ PREFERRED NUMBER	☐ PREFERRED NUMBER	☐ PREFERRED NUMBER
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 <u>person</u> or on voicemail	☐ OK to leave detailed message with <u>person</u> or on voicemail	☐ OK to leave detailed message with <u>person</u> or on voicemail

*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 PORTAL ACCESS

If you would like our patient portal access, include your email below. The patient portal is set up through www.myhealthrecords.com. 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

By signing below, I authorize the use of the preferred telephone number provided above for contact, designate the listed individual(s) to speak on my behalf, and consent to utilizing the patient portal (if email provided).

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.

(Printed Name of Patient, Parent, or Guardian)

Date: _____

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 STOPPED _____

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) (i.e.. Gastric, ovarian, brain, kidney, small bowel) 1 or more Lynch cancers, 1 dx ≤ 50 yrs
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