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Date: _____

<u>Last Name:</u>		<u>First Name, Middle Initial:</u>		<u>Maiden Name:</u>	
<u>Mailing Address:</u>				<u>City / State / Zip Code:</u>	
<u>Date of Birth:</u>		<u>Social Security Number:</u>		<u>Email Address:</u>	
<u>Home Phone:</u>		<u>Cell Phone:</u>		<u>Preferred Language:</u>	
<u>Marital Status: (Please check)</u> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		<u>Race: (Please check)</u> <input type="checkbox"/> American Indian or Alaska <input type="checkbox"/> Native Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Bi-Racial		<u>Ethnicity: (Please check)</u> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino	
<u>Employer:</u>		<u>Work Phone:</u>		<u>Work Address:</u>	
<u>Emergency Contact (Name & Relation):</u>			<u>Emergency Contact Number:</u>		
<u>Referred By:</u>		<u>Preferred Pharmacy:</u>		<u>Primary Care Doctor:</u>	
<u>Spouses Name:</u>			<u>Spouses Cell Phone:</u>		
<u>Spouses Employer:</u>			<u>Spouses Work Phone:</u>		

Primary Insurance Information		Secondary Insurance Information	
<u>Policy Holder:</u>		<u>Policy Holder:</u>	
<u>Date of Birth & S.S #:</u>		<u>Date of Birth & S.S #:</u>	
<u>Insurance Provider:</u>		<u>Insurance Provider:</u>	
<u>Effective Date:</u>	<u>Expiration Date:</u>	<u>Effective Date:</u>	<u>Expiration Date:</u>
<u>Policy ID #:</u>		<u>Policy ID #:</u>	
<u>Group Name or #:</u>		<u>Group Name or #:</u>	
<u>Copay Amount:</u>		<u>Copay Amount:</u>	

By signing below, you acknowledge receipt or have read our financial policy on our website under "New Patient FYI Forms", and agree to the terms.

Signature: _____ Date: _____

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Gender (M/F): _____ Today's Date(MM/DD/YY): _____ Healthcare Provider: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren

YOU and YOUR FAMILY'S Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EXAMPLE: BREAST CANCER	45	---	--	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER (Female or Male)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	UTERINE (ENDOMETRIAL) CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME GASTROINTESTINAL POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER CANCER(S) (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

Y N Are you of Ashkenazi Jewish descent?

Y N Are you concerned about your personal and/or family history of cancer?

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

<input type="checkbox"/>	Multiple A combination of cancers on the same side of the family:	<input type="checkbox"/> 2 or more: breast / ovarian / prostate / pancreatic cancer <input type="checkbox"/> 2 or more: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) <input type="checkbox"/> 2 or more: melanoma / pancreatic
<input type="checkbox"/>	Young Any 1 of the following at age 50 or younger :	<input type="checkbox"/> Breast cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Endometrial cancer
<input type="checkbox"/>	Rare Any 1 of these rare presentations at any age :	<input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Breast: Male breast cancer or Triple negative breast cancer <input type="checkbox"/> Colorectal cancer with abnormal MSI/IHC, or MSI associated histology ^{††} <input type="checkbox"/> Endometrial cancer with abnormal MSI/IHC <input type="checkbox"/> 10 or more gastrointestinal polyps*

^{††}Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

Follow-up appointment scheduled: YES NO Date of Next Appointment: _____

INTAKE HISTORY FORM

NAME: _____ DATE OF BIRTH: _____

ALLERGIES:

- 1. _____ REACTION: _____
- 2. _____ REACTION: _____
- 3. _____ REACTION: _____
- 4. _____ REACTION: _____
- 5. _____ REACTION: _____

PAST MEDICAL HISTORY: (CIRCLE ALL THAT APPLY):

Glaucoma Stroke Hypothyroid(underactive) Hyperthyroid(overactive) Asthma Anemia Blood Clots
Heart Attack Heart Murmur High Blood Pressure High Cholesterol Diabetes Seizures/Epilepsy
Irritable Bowel Crohn's Disease Diverticulitis Stomach Ulcers Hepatitis HIV Kidney Infection/Stones
Other: _____

Last Pap Smear: _____ (Normal / Abnormal) Last Mammogram: _____ (Normal / Abnormal)
Last Colonoscopy: _____ (Normal / Abnormal) Last Bone Density: _____ (Normal / Abnormal)

PAST SURGICAL HISTORY: (CIRCLE ALL THAT APPLY):

Gallbladder Appendix Umbilical Hernia Incisional Hernia Ablation Hysterectomy (Abdominal)
Hysterectomy (Vaginal) Hysterectomy (Laparoscopic) Right Tube/Ovary Out Left Tube/ Ovary Removed
Both Tubes/Ovaries Out Knee Hip Mastectomy Breast Lumpectomy Tonsils Tonsils & Adenoids
Wisdom Teeth Other: _____

MEDICATIONS:

- 1. _____ 6: _____
- 2. _____ 7: _____
- 3. _____ 8: _____
- 4. _____ 9: _____
- 5. _____ 10: _____

SOCIAL HISTORY (PLEASE CIRCLE):

SMOKE NO YES: Current or Former _____ Packs Per Day
ALCOHOL NO YES: Social Occasional Weekly Daily _____
DRUGS NO YES: _____

GENERATIONS WOMEN'S HEALTH

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure. - This means we will only use or disclose your PHI as described in this Notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication. - This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI. - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI. - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information. - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability. - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice. - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. 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. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g., a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests; and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint, or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:
330 956-5300

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