Quality Care for Women, LLC
601 N. Flamingo Rd. Suite 317 Pembroke Pines, FL 33028
Phone: 954-538-3375 Fax: 877-261-9431
Email: yaradelgadospasic@gmail.com

Patient Demographics:

Patient Name: _____

Birthday: _____/_____/_____ **Social Security #:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Number: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Employer: _____ **Occupation:** _____

Primary Insurance:

Insurance Carrier: _____ **ID #:** _____

Subscriber Name: _____ **Relationship to Patient:** _____

Emergency Contact:

Name: _____ **Relationship to Patient:** _____

Home Phone: _____ **Cell Phone:** _____

Patient Signature: _____

GUARANTEE OF PAYMENT AND RESPONSIBILTY

I fully understand that I am directly responsible for payment to the physicians in this office for all medical services (consultations, evaluations, follow-up, procedures, treatment, etc.), and/or rendered supplies (IUD, Essure, Implanon, vaccines, etc.). I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made or covered by the insurance plan. Patients with no insurance coverage (Self-Pay) are responsible for all laboratory services (specimens, blood work, general testing, etc.). Patient will be billed ***directly*** by the laboratory, Genpath (BioReference), LabCorp, Quest Diagnostic, etc. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance, disability or FMLA company for the purpose of processing any insurance or disability claim.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy for Quality Care for Women, LLC. The NPP is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any payment of any benefits to the physicians in this office for medical or surgical treatment rendered to me. In these circumstances, I understand that I am financially responsible for any charges, services or supplies not covered by insurance. I permit a copy of the authorization to be used in place of the original.

PERSONAL INFORMATION CONFIRMATION

I confirm that all of the above Information is *current* and *accurate*, and I *consent* to all of the above specifications.

Patient Signature: _____Date: _____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I, _____ (Patient name), *authorize* Quality Care for Women, LLC to *release* or *discuss* information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

- PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL **NOT BE GIVEN** ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

- YOU ARE **NOT REQUIRED** TO LIST ANY NAME IF YOU DO NOT CHOOSE.

Patient Signature: _____ Date: _____

PREFERRED PHARMACY

NAME OF PHARMACY: _____

ADDRESS: _____

TELEPHONE # _____

PATIENT'S RESPONSIBILITY FOR PAYMENT

Patient's Name: _____ Date of Birth: _____

I am a member of _____ health insurance plan. My plan may or will only provide payment for certain covered medical services. I have requested that Quality Care for Women, LLC provide medical services which my health insurance plan may or may not pay for (Deductible, Co-Insurance, Out-of-Pocket, Termination of Coverage, etc.). I agree that I am financially responsible for these services.

Signature: _____

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**

Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for a hereditary cancer syndrome (BRCA/Colaris) in the past? YES NO

Have you ever been diagnosed with cancer? What site: _____ Age: _____

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	***EXAMPLE: Two or more relatives with a Lynch syndrome cancer; one under age 50***			***Aunt-colon Sister-uterine***	***47 yrs 60 yrs***
Y	N	Have **YOU** been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	Two or more relatives on the same side of the family w/ any of the following, one diagnosed before 50 **(please circle):** *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Three or more relatives on the same side of the family w/ any of the following diagnosed at any age **(please circle):** *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	10 or more LIFETIME Colon Polyps (Specify #)				

		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast, aggressive prostate, pancreatic or ovarian at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian, aggressive prostate or pancreatic cancer at any age				
Y	N	Triple Negative breast cancer under age 60 (Estrogen receptor, Progesterone receptor and Her2 negative)				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

_____

Patient's signature: _____ **Date:** _____

FOR OFFICE USE ONLY

- ☐ Patient is appropriate for further risk assessment and/or genetic testing
- ☐ Patient offered genetic testing: Accepted OR Declined
- ☐ Information given to patient to review Follow-up appointment scheduled on _____
- ☐ Patient does not have risk factors HCP Signature: _____