Caring for Women's Health

Lori L. Davidson, MD, FACOG
107 N. State Road 135, Suite 102
Greenwood, IN 46142

Welcome to Caring for Women's Health!

When I started my medical practice, I wanted to build a personal relationship with my patients by spending time to listen to them and address their needs and concerns.

As medicine has changed I continue to focus on you and your concerns. I continue to give each patient the time they need. One other thing that hasn't changed is the need to fill-out paperwork before your visit. Even as we move to electronic medical records we need to have information from you at the time of your visit.

The attached forms are created to allow you to complete them on a PC or tablet. You may also print them and fill them out by hand. If you have any questions, or things you aren't sure of, we can answer those questions when you arrive.

We always schedule extra time for new patients so don't be too concerned about the medical history or other questions, I will review them with you.

Thank you for choosing me to provide your care. I look forward to getting to know you.

Sincerely,

Lori L. Davidson, MD

Lori L. Davidson, MD, FACOG

Caring for Women's Health

Thank you for updating your information!

Name	Home Phone
Address	Cell Phone
City, State, Zip	E-Mail
Mail Statements to this Address? ☐ Yes ☐ No	Date of Birth
Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	
Employer	Work Phone
Work Status? ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Retired	OK to Contact at work? ☐ Yes ☐ No
If Student, Where?	Status? ☐ Full-time ☐Part-time
You may leave appointment reminder messages at which of these locations. Check all your preferences: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐Work Phone	

Emergency Contact 1	Relationship	
☐ Granted Full Personal Health Information Access	☐ May pickup medications	Phone
Emergency Contact 2	Relationship	
☐ Granted Full Personal Health Information Access	☐ May pickup medications	Phone

Family Doctor

First	Last	City, State
Referred By ☐ Friend ☐ Parent ☐ My Doctor ☐ Search Online ☐ Other_____		

Insurance Information

Insurance Carrier	**If TRICARE SSN Required**	
Policy/Identification #	Group#	Plan Code

Guarantor – *Please complete if **YOUR NAME is NOT** on the insurance card*

Name	**IMPORTANT: Date of Birth**
Address	
City, State, Zip	
Phone	Relationship

I certify the above information to be true and accurate. I authorize my insurance company to make payment to Caring for Women's Health directly for all services rendered. I authorize the release of my medical records as necessary to process my insurance claims and to the contacts listed above if so indicated. I understand and agree, regardless of my insurance status, I am responsible for the balance of my account. I designate your office, employees, and agents as my representatives to file grievances in accordance with Indiana Code, Title 27, Chapters 8 and 13.

_____ _____

Patient/Guardian/Guarantor Signature **Today's Date**

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Caring for Women's Health

INITIAL PATIENT HISTORY FORM

Please complete both pages/sides of this form. If have any questions, please ask for assistance.

Your Name _____ Age _____ DOB _____

Religion _____ Marital Status _____

SSN Required for TriCare Insurance_____ Primary Care Doctor _____

MEDICAL HISTORY

Reason for Appointment or Problems _____

Have you ever had any of the following conditions? Self		Has any family member had any of the following? Parents, Grandparents, siblings etc.	
YES	**NO**	**YES**	**NO**
☐	☐ Diabetes	☐	☐ Who?_____
☐	☐ High Blood Pressure	☐	☐ Who?_____
☐	☐ Epilepsy or Seizures	☐	☐ Who?_____
☐	☐ Frequent or Severe Headache	☐	☐ Who?_____
☐	☐ Sickle Cell	☐	☐ Who?_____
☐	☐ Heart Disease/Heart Attack	☐	☐ Who?_____
☐	☐ Stroke	☐	☐ Who?_____
☐	☐ Cancer	☐	☐ Who?_____

Have you ever had any of the following conditions? If you answer YES please EXPLAIN

YES	**NO**	
☐	☐	Thyroid disease _____
☐	☐	Breast mass (lumps) or discharge _____
☐	☐	Asthma _____
☐	☐	TB or any other type of lung condition _____
☐	☐	Rheumatic Fever_____
☐	☐	Stomach/intestinal problems _____
☐	☐	Hepatitis/mono or liver problems _____
☐	☐	Gall bladder disease _____
☐	☐	Chronic bladder or kidney infections _____
☐	☐	VD or STD (gonorrhea, syphilis, herpes, clap) _____
☐	☐	Frequent vaginal infections _____
☐	☐	Infection of the uterus, tubes, ovaries_____
☐	☐	Tumors_____
☐	☐	Blood clots in veins _____
☐	☐	Varicose veins _____
☐	☐	Anemia _____
☐	☐	Rubella (German measles/3 day measles)_____
☐	☐	Immunizations (vaccinations)_____
☐	☐	Mental/emotional problems _____
☐	☐	Other _____

Allergies: are you allergic to anything (medication, food, other)? _____
_____

Please list any type of medication that you are taking (prescribed, herbal, over the counter) _____
_____

Do you use any of the following? If so, how much'?

YES NO ☐ ☐ Cigarettes _____ **YES NO** ☐ ☐Alcohol_____ **YES NO** ☐ ☐ Drugs _____

SURGERY HISTORY

Please list any surgeries that you may have had and the dates: _____
_____

PREGNANCY HISTORY: Have you ever been pregnant? YES ❑ NO ❑ If yes, please complete these questions:

Number of times pregnant _____ Number of live births _____
Number of miscarriages _____ Number of elective abortions _____
Number of vaginal births _____ Number of C-Sections _____
Number of Living Children _____ Age at first pregnancy _____
Any complications with the delivery or pregnancy _____

MENSTRUAL HISTORY:

First date of last period _____ Age when periods started _____
Number of days between periods_____ Number of days your periods last _____
Cramping: ☐ Mild ☐ Moderate ☐ Severe Amount of Flow: ☐ Heavy ☐ Medium ☐ Light

Do you have any of the following?

☐Cramps ☐Vaginal sores ☐Discomfort before periods ☐ Spotting after intercourse
☐ Abnormal Vaginal Discharge ☐ Painful intercourse ☐ Vaginal odor, itching, swelling, burning

Have you ever had a mammogram? ☐ Yes ☐ No If Yes Most Recent _____

Date of last PAP smear? ☐ Normal ☐ Abnormal Where? _____

If abnormal, what type of treatment was used? _____

Do you use feminine hygiene products? ☐ Yes ☐ No

CONTRACEPTIVE HISTORY

Are you trying to get pregnant? ☐ Yes ☐ No If yes, how long? _____

What type of contraception do you use? _____

How long have you used this method? _____

What method do you want to use now? _____

How many partners have you had? _____ Your age when you started having sex? _____

Please check all methods that you have used for contraception:

☐ Withdrawal ☐ Rhythm ☐ Tubes tied ☐ Oral ☐ Natural Family Planning ☐ IUD ☐ Injection
☐ Condoms ☐ Abstinence ☐ Diaphragm ☐Luck ☐ Foam, jelly, cream ☐ Vasectomy

Signature: _____ Date: _____

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

Patient Name: _____ Physician: _____

Date of Birth: _____ Today's Date: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) to any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the age of diagnosis and relationship of family member with cancer.

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

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives** Cousin/Great Grandparent = **3rd Degree Relatives**

		COLON AND UTERINE CANCER (COLARIS)	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Uterine (endometrial) cancer before age 50				
Y	N	Colorectal cancer before age 50				
Y	N	Two or more of the following cancers on the same side of the family: colon, uterine (endometrial), ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
Y	N	A family member with a known Lynch Syndrome mutation				
		BREAST AND OVARIAN CANCER (BRAC ANALYSIS)	**SELF**	**FAMILY MEMBER**		**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 cancer at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Triple negative breast cancer under the age of 60 (ER, PR and HER2 negative receptor status)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer on the Ashkenazi Jewish side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	A family member with a known BRCA mutation				

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

_____

Patient signature: X _____ **Date:** _____

FOR OFFICE USE ONLY Based on Clinical Review, patient is

☐ **not appropriate** for further risk assessment and/or genetic testing

☐ **was given informed consent & hereditary cancer genetic testing was RECOMMENDED**

☐ **Patient ACCEPTED** & Hereditary Cancer Testing Ordered

☐ **Patient DECLINED** *I acknowledge that I have been fully advised by my healthcare provider that my refusal to undergo the recommended testing may delay or prevent diagnosis and treatment of significant illness, including cancer, and that I am at increased risk of serious disease or death.*

Patient Signature (when declining HCP recommendation)_____ (Date) _____

HCP Signature: X_____ Date: _____

Caring for Women's Health

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- Appointment Reminders and Treatment Alternatives. We may contact you to provide appointment reminders or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Communications with Individuals Involved in Your Care. Unless you tell us otherwise, we may share your PHI with friends, family members or others you have identified or who are involved in your care.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits and law enforcement.

Certain ways that your protected health information could be disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your

identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed healthcare provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fundraising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer:

Practice Manager: 317-893-3131 Fax: 317-893-2445 Manager@CFWHealth.com

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact our privacy officer or:

Office for Civil Rights http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Hotline: 1-800-368-1019

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on September 23, 2013.

Caring for Women's Health

FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is a part of your care. Your clear understanding of our financial policy is important to our professional relationship. Please ask our staff if you have any questions about our fees, financial policy, or your responsibility.

- All patients must complete (in full) our Patient Information Form and provide us with accurate insurance information including an insurance card at each visit before seeing the provider.
- Full payment is due at the time of service: We accept cash, checks, VISA, Master Card and Discover.

RESPONSIBLE PARTY

You will be responsible for your charges regardless of any divorce decree or court order regarding payment of medical bills.

MINORS ACCOMPANIED BY AN ADULT

A parent or legal guardian must accompany patients who are minors on the patient's visit, and must sign the financial statement for the patient, accepting responsibility for the account.

If you have…	You are responsible for…
HMO, PPO and POS plans with which we have a contract	If the services you receive are covered by the plan: All applicable co-pays and deductibles are expected at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is expected at the time of your visit. We suggest that you call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services. It is your responsibility to obtain all necessary referrals. We will file an insurance claim as a courtesy to you.
Medicare	If you have regular Medicare and have not met your deductible, we expect it to be paid at the time of service. Any services not covered by Medicare will be your responsibility. If you have Medicare as primary and also have secondary insurance: No payment is necessary at the time of your visit. If you have Medicare as primary, but no secondary insurance: Payment of 20% is expected at the time of your visit. We will file an insurance claim as a courtesy to you.
No Insurance/Self Pay	Payment in full at the time of the visit with a 30% self pay discount. Please ask to speak with our staff if you need assistance on an extended payment schedule.

NON-SUFFICIENT FUNDS CHECK

Your account will be charged $20.00 for each time a check is returned for non-sufficient funds. If you bank does not honor these checks, you will be responsible for the payment of the check and additional charges within 10 days. If payment is not made, a claim will be filed in court for three (3) times the amount of the check, NSF charges, court costs and any past due balance. Any future payments due to your account will need to be made with cash or credit card.

COLLECTION POLICIES

If your account is 90 days delinquent, it will be subject to a 1.5% interest charge, monthly. If your account has not been satisfied within a reasonable period of time, your account will be sent to a collection agency or an attorney. If your account is given to an attorney for collection, you will be responsible to pay court costs allowed by low, cost of collection, and reasonable attorney fees. Patient care with our office will be cancelled once your account goes to collection.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. Please help us serve you better by keeping your scheduled appointment.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-payments and deductibles are my responsibility. I authorize my insurance benefits to be paid directly to Caring for Women's Health, and I authorize them to release any pertinent medical information to facilitate payment of the claim. I may request a copy of this policy.

_____ _____/_____/_____

Responsible Party Signature Date

107 N. State Road 135 | Suite 102 | Greenwood, IN 46142 | 317-893-3131 | Fax 317-893-3141