OBSTETRICS GYNECOLOGY
LE CONTE
WOMEN'S HEALTHCARE ASSOCIATES, P.C.

PATIENT REGISTRATION INFORMATION

*****All Sections Must Be Completed. If not applicable, please indicate as "N/A"*****

Patient's Name – Last, First, Middle ______ Date of Birth ______ Social Security Number ______

Street Address ______ City & State ______ Zip Code ______

If under 18 please provide Responsible Party's information:

Guarantor's Name – Last, First, Middle ______ Date of Birth ______ Social Security Number ______

Guarantor's Driver's License ______ State Issued ______ Mailing address (*if different from above*) ______

Check the boxes to indicate how we may contact you:	**OK to leave a voicemail?**	**OK to leave test results?**
☐ HOME PHONE # ______	yes / no	yes / no
☐ CELL PHONE # ______	yes / no	yes / no
☐ WORK PHONE # ______	yes / no	yes / no

☐ EMAIL ADDRESS ______ *(For our patient portal to see your health & appointment information)*

Which of the above is your preferred method of contact? (*Circle only one*) HOME / CELL / WORK

- **ETHNICITY** (Circle One): Hispanic or Latino / Not Hispanic
- **RACE** (Circle One): Black or African American / White / Hispanic / Asian / American Indian or Alaska Native / Hawaiian or Pacific Islander / Other
- **EMPLOYMENT STATUS** (Circle One): Full-time / Part-time / Self-Employed / Retired / Unemployed
- **EMPLOYER NAME**: ______
- **MARITAL STATUS** (Circle One): Single / Married / Divorced / Widowed / Separated / Other
  Spouse/Partner's Name: ______
  Spouse/Partner's Employer: ______ Spouse/Partner's Work Phone: ______

INSURANCE

DO YOU HAVE INSURANCE? ☐ YES ☐ NO
ARE YOU THE POLICY HOLDER? ☐ YES ☐ NO

INSURANCE POLICY HOLDER'S INFORMATION:

NAME: ______ SEX: M / F BIRTH DATE: ______
PT'S RELATIONSHIP TO INSURED: ______
POLICY HOLDER'S EMPLOYER: ______

May we discuss your healthcare, bills, and arrange appointments with family/friends? YES / NO, do not share w/ anyone.
If yes, please list those individuals that we may talk with:

			EMERGENCY CONTACT
Name______	Relationship______	Phone______	YES / NO
Name______	Relationship______	Phone______	YES / NO

This authorization will remain in effect until I provide written instructions otherwise.

Signature of Patient or Patient's Representative ______ Date ______

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

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/ paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Ovarian, stomach, kidney/urinary tract, brain or small bowel cancer			
Y	N	Two or more Lynch syndrome cancers*			

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

Y N Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:

____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: ______________

☐ Patient offered genetic testing:

☐ Accepted

☐ Declined

Healthcare Professional's Signature Date

*Lynch syndrome-related cancers include ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

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WHRA/07-11

PATIENT AUTHORIZATION FORM

Patient's Name: ___________________________________ **Date of Birth: ___________________________**

(Initial)______**FINANCIAL RESPONSIBILITY:**

1. I understand that I am ultimately responsible for payment on my account & payment is expected at the time of service.
2. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles.
3. LWH will file claims for companies we are contracted with, including Medicare, Medicaid and TennCare. Payment of benefits will be made directly to LeConte Women's Healthcare Associates.
4. *I understand and accept that if I make payment with a check and that check is dishonored or returned for any reason, there will be a $**35** processing charge and checks will no longer be accepted.*
5. *Statements are sent out each month on a 30 day billing cycle and are due upon receipt. Please note that you will be asked to pay your balance should you come into the office for an appointment. Accounts that remain unpaid after 90 days may be turned over to an outside collection agency and a fee of **43%** of the total balance due will be added to your account.*
6. **Self-Pay patients**: *If you are applying for insurance or changing benefits, it is critical that you inform us and keep us informed of the progress. You will be considered self-pay, and payment will be expected at the time of service, until we receive confirmation of active coverage.*

(Initial)______**INSURANCE COVERAGE:** I understand that I am responsible for providing any and **ALL** insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information. It is considered insurance fraud if you do not disclose all insurance coverage to our office.

(Initial)_______**LABORATORY FEES:** I understand that my physician uses LabCorp. LWH cannot guarantee my insurance will cover any lab/pathology performed at or ordered by my physician. If my insurance requires use of a different lab, I understand it is my responsibility to inform my physician for proper handling.

(Initial) **I DO______ I DO NOT______ CONSENT** to necessary examinations and/or treatments performed and prescribed by my physician, or nurse practitioner as is necessary in his/her judgment, with patient approval. ***Separate consent forms will be signed for procedures performed in the physician's office.***

(Initial) **I DO______ I DO NOT______ CONSENT** to my medication history being obtained without limitation or exclusion, from my pharmacy, my health insurance and my other healthcare providers. An accurate medication history is important to help us treat you and to avoid potentially dangerous drug interactions.

(Initial)_______**RELEASE OF INFORMATION: I do hereby authorize my physician to release information to the hospital facility** in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

(Initial)_______**HIPAA:** The Health Insurance Portability and Accountability Act is a federal law designed to protect patients' medical records and privacy. I acknowledge that I have received or have access to a copy of LWH's Notice of Privacy Practices and I have had the opportunity to ask questions. If you would like a copy of the notice, please ask the front desk. (**Office use only:** *I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because _________________________**Staff Iinitials**__________)*

____________________________________ ____________________________________

Signature of Patient or Patient's Representative Today's date**:**