Cypress Women's Center

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Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. **Cancellation/No Show Policy for Doctor Appointment**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. **Scheduled Appointments**

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. **Cancellation/No Show Policy for Surgery**

Due to large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance company.

4. **Account balances**

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ____/___/____

Print Patient Name **Signature Patient/Guardian** **Date**

CYPRESS WOMEN'S CENTER
PATIENT REGISTRATION FORM

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Mailing Address: _____

_____
(City) (State) (Zip)

Email address: _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Marital Status:** M S D W **Race:** _____

Employer: _____ **Occupation:** _____

Emergency Contact Information:

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

Phone Number: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at anytime to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are abide by such restrictions.

_____ _____
PATIENT SIGNATURE DATE

_____
PARENT SIGNATURE IF MINOR

CYPRESS WOMEN'S CENTER
PATIENT ACKNOWLEDGEMENT

Forms and Medical Records:

____ (Initial) Please allow our office **at least 48-72 hours** to complete your request for medical records and completion of any forms relating to your medical care (FMLA, short term disability, etc).

Sick and Well visits:

____ (Initial) We encourage patients **NOT** to perform a sick and wellness visit on the same day. Please be aware that if our providers are treating you for any other medical symptoms on the same day as your preventative visit, **you may be liable for any additional cost that may occur.**

Labs:

____ (Initial) It is in our best interest to suggest certain labs to be drawn for appropriate medical treatments. However, Cypress Women's Center **does not** make guarantees about coverage for lab testing. We recommend that once you receive your lab requisition, you may check with your insurance carrier to verify whether or not the tests are covered by your carrier.

Financial Disclosure:

____ (Initial) It is solely the patient's responsibilities to understand their medical benefits. This is only an estimate of benefit; any claims or charges are not finalized until the insurance company processes the claims.

_____ _____

Patient's Signature **Date**

_____

Print Name

CYPRESS WOMEN'S CENTER
WELL WOMAN EXAM VS PROBLEM VISIT

Due to time constraints and insurance regulations, our office policy **DOES NOT ALLOW** for Both a well woman exam and a problem visit at the same time.

I understand that I indicated my appointment for today was for:

1. _____ MY WELL WOMAN EXAM. Insurance companies define this as a breast exam and a pap smear. It also includes appropriate screening exams and labs. As a courtesy, Cypress Women's Center will refill birth control or hormone replacement at the well woman visit. Any changes to these medications or refills of any other medications must be done as a problem visit, as insurance companies require. I will schedule a problem visit for any problems I am experiencing or to address other medications supervised by Cypress Women's Center at a later dat.

2. _____ A PROBLEM VISIT. This will require my well woman exam to be done at a later date, as insurance companies require.

Cypress Women's Center wants to stress the importance of the annual well woman exam. If you have chosen to see the physician for your problem(s) today. You need to understand that the annual well woman exam is very important to your continued health and wellbeing, and failure to have this exam could have serious consequences on your health. Our staff will assist you in makin the appointment for your well woman exam for a later date before you leave our office today. Cypress Women's Center strongly urges you to keep this appointment.

_____	_____	_____
PATIENT NAME	SIGNATURE	DATE

CYPRESS WOMEN'S CENTER

HIPPA Authorization Form for Family Members/Friends

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

NAMES	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (check all that apply)

- o My complete health record (including, but not limited to diagnosis, lab results, prognosis, treatment, and billing, for all condition)

Or

- o My complete health record, as above, with the exception of the following information:

(Check as appropriate):

- o Mental health records
- o Communicable diseases (including HIV and AIDS)
- o Alcohol/Drug abuse treatment
- o Other (please specify): _____

_____

_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for the treatment or consultation, for claims payment purposes, or related reasons:

This authorization shall be effective until (Check one):

- o All past, present and future periods or
- o Date or event: _____

Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your heath care providers, preferably in writing.)

_____	_____	_____
Name of individual giving this Authorization	Signature of the individual giving this Authorization	Date

CYPRESS WOMEN'S CENTER
PATIENT MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Age: _____
Reason for today's visit: _____ Date of last Annual Exam: _____
Current Contraception (including tubal ligation, vasectomy, condoms, etc): _____

Obstetrical History (including miscarriages and terminations)
Have you had any miscarriages? □ No □ Yes When: _____
Have you had any terminations? □ No □ Yes When: _____

Date	Child's Sex	Birth Weight	Labor Length	Vag/Cesarean	Complications

Surgical History (not including c-sections listed above)

Date	Surgery	MD/Hospital	Complications

Hospitalizations (not including surgeries listed above)

Date	Reason	MD/Hospital

Personal Health History (have you experienced any of the following)
□ AIDS/HIV □ Anorexia/Bulimia □ Anxiety/Depression □ Arthritis □ Asthma □ Cancer (type) _____
□ Chlamydia/Gonorrhea □ Diabetes □ Factor V Leiden □ Genital Warts □ Herpes □ High Blood Pressure
□ Lupus □ Multiple Sclerosis □ Phlebitis/Blood Clot □ Seizures □ Stroke □ Thyroid Problems □ Ulcers
Other conditions for which you are currently taking medications or under the care of a physician:
_____

Current Medications (please include vitamins, herbal supplements, and over-the-counter medications)

Medications	Strength	Dosage	Medications	Strength	Dosage

Current Pharmacy Name/Location/Phone number: _____
Medication Allergies/Reactions: _____ **□ None (NKDA)**

Menstrual History
Age at onset: _____ Frequency: _____ Days of flow: _____
□ Heavy Flow □ Bleeding between periods □ Bleeding after intercourse □ Other: _____
First Day of Last Menstrual Period: _____ Menopause (age): _____ Surgical Menopause (date): _____

Social History

CYPRESS WOMEN'S CENTER
PATIENT MEDICAL HISTORY FORM

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated
Number of children living: _____ Number of children deceased: _____ Number of children adopted: _____
Are you sexually active? □ Yes □ No Do you have multiple sexual partners? □ No □ Yes
Partners in last year _____ # Lifetime Partners _____ Is/Are your partner(s): □ Male □ Female □ Both
Do you smoke? □ Yes □ No Quantity/Frequency: _____
Are you employed? □ Yes □ No Where: _____ Position: _____
Is anyone physically, sexually, or emotionally hurting you? □ No □ Yes Who? _____
Do you use street drugs? □ No □ Yes □ Marijuana □ Other Quantity/Frequency: _____
Exercise: None / Routine of: _____
Special diet: □ None □ Weight Loss □ Low Fat □ Vegan □ Diabetic □ Vegetarian □ Low Carb
Do you drink caffeinated beverages? □ Yes □ No Quantity/Frequency: _____
Do you drink alcohol? □ No □ Yes Quantity/Frequency: _____

Pap Smear: Date of last pap smear: _____ □ Normal □ Abnormal
Have you ever had an abnormal pap smear? □ Yes □ No Date/Treatment: _____
Mammogram: Date of last mammogram: _____ □ Normal □ Abnormal □ Never
Colonoscopy: Date of last colonoscopy: _____ □ Normal □ Abnormal □ Never
Bone Density: Date of last dexa scan: _____ □ Normal □ Abnormal □ Never

Family History	Living		If Yes, Age	If No, cause of death/age	Lifetime diseases
Mother	Y	N			□ NONE
Father	Y	N			□ NONE
Brother/Sister	Y	N			□ NONE
Brother/Sister	Y	N			□ NONE
Brother/Sister	Y	N			□ NONE
Brother/Sister	Y	N			□ NONE

Personal/Family History
Have you or any close members of your family (not listed above) including grandparents, aunts, and/or uncles had any of the following medical conditions? .

	SELF	FAMILY	RELATIONSHIP/AGE DIAGNOSED
BREAST CANCER			
OVARIAN CANCER			
ENDOMETRIAL CANCER			
COLON CANCER/POLYPS			
OTHER CANCERS (LIST TYPE)			
HIGH BLOOD PRESSURE			
HEART DISEASE/ANGINA			
ELEVATED CHOLESTEROL			
OSTEOPOROSIS			
DIABETES			
MENTAL ILLNESS (ANXIETY, DEPRESSION, BI-POLAR)			
SUBSTANCE/ABUSE			
BLOOD CLOTS/THROMBOSIS			
PROBLEMS WITH ANESTHESIA			

_____ _____
PATIENT'S SIGNATURE **DATE**

NORTH CYPRESS

North Cypress Medical Center Is A Doctor Owned, Patient Centered Healthcare Institution

Risk Assessment for Hereditary Cancer Syndromes
HRBC Risk Assessment – Mammography

IMAG

Patient Name: _____

Instructions: We are committed to your health and cancer prevention. To best serve you, we need a detailed personal and family cancer history. Please be as complete as possible, considering **all relatives** on both **maternal** and **paternal** side & **age at cancer diagnosis**. THANK YOU!

		Cancer History	Self Age @ Diagnosis	Siblings / Children Age @ Diagnosis	Relatives Mom's Side/ Age @ Dx	Relatives Dad's Side/ Age @ Dx
Y	N	***Example: Breast Cancer***			***Mom @ 55***	***Paternal Aunt @ 60***
Y	N	Breast Cancer				
Y	N	Ovarian Cancer				
Y	N	Bilateral Breast Cancer				
Y	N	Breast Cancer that is Triple Negative Breast Cancer				
Y	N	Any Prostate or Pancreatic Cancer? Please specify				
Y	N	Male Breast Cancer at any age				
Y	N	Endometrial Cancer				
Y	N	Colon Cancer				
Y	N	A family member with a known BRCA or Lynch mutation				
Y	N	Any Other Cancers?				

Are you of Jewish descent (relevant for some syndromes)? YES NO

Have you had hereditary cancer testing (BRCA testing)? YES NO If yes, result?_____ Year?_____

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

OFFICE USE ONLY

TECH: Patient accepted testing? YES NO If NO, Reason for Decline: _____

Patient offered literature? YES NO

Ok to call patient? YES NO

Tech Initials: _____ TC%: _____

Clinical Staff Signature: _____ **Date:** _____ **Time:** _____

*All criteria are based on National Comprehensive Cancer Network Criteria (NCCN.org) for hereditary cancer diagnosis.

Adm:

Attending:

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