PATIENT INFORMATION

NAME:_____ DOB:_____ PHONE:_____

EMAIL:_____ WORK#:_____

MARITAL STATUS:_____ RELATIONSHIP TO REPONSIBLE PARTY:_____

PRIMARY CARE PROVIDER_____

RESPONSIBLE PARTY INFORMATION

LAST NAME:_____ FIRST NAME: _____

ADDRESS: _____

PHONE #: _____ EMAIL: _____ WORK#: _____

DOB: _____ SEX:_____ SSN _____ EMAIL: _____

INSURANCE INFORMATION

IF YOU ARE THE SUBSCRIBER SKIP THIS SECTION

CARRIER NAME:_____ CARRIER ADDRESS: _____

ID # _____ GROUP #_____ CARRIER PHONE#_____

EMERGENCY CONTACT

NAME: _____ DOB:_____RELATIONSHIP:_____PHONE#_____

FINANCIAL AGREEMENT

I the undersigned, authorize direct payments to Central Oregon OB/GYN. I acknowledge that I will be financially responsible for all changes, whether or not paid by my insurance. I authorize Central Oregon OB/GYN to release information, as necessary, in order to facilitate treatment. Payment or other healthcare operations to insurance companies or medical providers involved in my medical care.

PRINT PATIENT NAME:_____

SIGNATURE:_____ DATE:_____

Patient or legal Guardian

CENTRAL OREGON OB/GYN
John A. Murphy, MD, PC
Erin Legrand, DO FACOOG
2450 NE Mary Rose Pl. Ste. 220
Bend, OR 97702

HIPPA Privacy and Release of Information Authorization

I,_____, hereby authorize CENTRAL OREGON OB/GYN and its affiliates, it's employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, SSN, member id number) for the purpose of helping me resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclose by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to Central Oregon OB/GYN. However, this authorization may not be revoked if it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of billing information policy, assignment of benefits policy, and grant the practice medications history authority. If applicable, Legal Representative sign below:

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g., Power of attorney, living will, guardianship papers. etc)
that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient print name_____Date_____

Patient signature_____

HIPPA Right of Access Form for Family Member/Friend

I,_____, direct my health care and medical service providers and payers to disclose and release my protected health information described below to:

Name:_____Relationship_____Phone #_____

_____

_____

Name of individual giving Authorization_____DOB_____

Signature of Individual giving this Authorization_____Today's Date_____

FINANCIAL POLICY FOR CENTRAL OREGON OB/GYN

CENTRAL OREGON OB/GYN is dedicated to providing quality care to our patients and is committed to helping patients understand our financial expectations for services provided in our physician clinic settings.

PAYMENT

We accept cash, checks, Visa, MasterCard and Discover. Payment is expected at the time of service for scheduled, routine services. If the patient does not pay the required amount or make approved financial arrangements, routine services (i.e. non-emergent/urgent, not medically necessary) may be rescheduled or cancelled.

- Patients with Insurance Coverage
  - Co-pay/Co-insurance - 100% payable at time of service
  - Deductible - minimum of 50% of any remaining deductible amount or 50% of estimated charges
- Patients with No Insurance / Self Pay
  - Payment in full is expected at time of service and will result in a 10% discount.

Obstetric Patients

- Obstetric patients are asked to pay their estimated balance in full by their delivery date. They are required to contact the clinic Billing Office staff to discuss the monthly pre-payment plan.

BILLING INSURANCE

We submit claims to primary, secondary and supplemental insurance as a courtesy to patients. Health insurance is a contract between the patient and their insurance carrier and patients are encouraged to contact their insurance to resolve any delays in payment

FINANCING OPTIONS

Any balance remaining after insurance pays or denies as non-covered is **due upon receipt of a statement from our office**. It is the patient's responsibility to contact the billing office if they require financing.

- Patients meeting an agreed upon monthly payment plan are not assigned to a collection agency and will not be charged interest on the remaining balance, provided they meet the commitments of the payment plan.
- Patients are responsible for communicating in advance to the Billing office anytime an agreed upon payment plan may be broken. Lack of communication from the patient may result in further collection action. Patient accounts sent to collection agencies will have any discounted amounts reversed and patient will be responsible for the entire cost of the services. There will be no appeal options if the account is sent to collection.
- There will be three (3) statements sent out prior to assigning the account to the collection agency for recovery. Once a patient's account is sent to collections, the patient is considered discharged for our practice and is not allowed to return.

FORMS FEES

A fee of $25 will be charged for completion of medical leave forms, attending physician statements and disability forms. There may be an additional fee of $10 for any additional paperwork submitted.
This fee covers our administrative expenses related to physician/staff time, photocopying and mailing.

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth in this policy for services rendered by CENTRAL OREGON OB/GYN.

_____ _____ Date: _____

Patient / Guarantor printed name Patient / Guarantor Signature

ANNUAL/HEALTHY HISTORY FORM

Name: _____ DOB: _____ Today's Date: _____
Phone: _____ PCP: _____ Referring Physician: _____
Preferred Pronoun_____She _____He_____They Reason for today's visit _____

MEDICATIONS

Medication name & dosage

_____
_____
_____

Allergies & Reaction

_____
_____
_____

GYNECOLOGICAL & OBSTETRICS HISTORY

Age you started your menstrual period?_____ Frequency (# of days)_____LMP: _____
Frequency of cycle (qty of days)_____
What do you use for contraception?_____ Have you gone through menopause? _____ What age? _____
Date of last pap smear_____Normal? _____ Have you ever had an abnormal pap smear _____
Do you have: Cryo _____ Colpo_____ Keep or Cone_____ Associated symptoms? _____
Have you ever had:

_____ Fibroids _____ Genital Herpes _____Bacterial Vaginosis _____Endometriosis
_____ Gonnorrhea _____ Yeast Infection _____ Ovarian Cysts _____Chlamydia
_____ Hot flashes _____ Endometrial Polyps _____ Genital Warts _____ Vaginal Dryness/Itching
_____ Pelvic Inflammatory Disease _____ Syphilis _____ Mood Swings

Date of last Mammogram: _____ Normal? ____Yes ____No Self Breast Exam? _____Yes _____No
Total # of pregnancies ____ How many living children ____ Number of miscarriages ____ Ectopic pregnancies _____
Terminations _____ Difficulty getting pregnant? _____Yes _____ No

Previous Deliveries	Vaginal or C-Section	How many weeks @ delivery	LBS?
Date: _____	_____	_____	_____
Date: _____	_____	_____	_____
Date: _____	_____	_____	_____
Date: _____	_____	_____	_____

SEXUAL ACTIVITY

Are you sexually active? ____ Yes ____ No
Any history of sexual abuse? ____ Yes ____ No
Do you every have pain with intercourse? ____ Yes ____No
Sexual Preference _____ Female _____ Male

SURGICAL HISTORY

Have you had any surgeries? ____ Yes ____ No If yes, please list what kind and date of surgery

_____ _____ _____
_____ _____ _____
_____ _____ _____

****PLEASE TURN PAGE OVER TO COMPLETE QUESTIONNARE****

SOCIAL/PERSONAL HISTORY

Do you smoke cigarettes? ____Yes ____ No If yes, how many per day? _____

Do you drink beer, wine or liquor? _____ Yes _____ No If yes, how often? _____

Have you, or do you, use marijuana, cocaine, crack or other street drugs? _____ Yes _____ No

Have you ever had a blood transfusion? _____ Yes _____ No If yes, when and where _____

URINARY ISSUES

_____ Urine loss with coughing
_____ Urine loss with urgency
_____ Up at night to urinate (____)times
_____ Difficulty urinating
_____ Pain with urination
_____ Blood in urine
_____ Bladder infection
_____ Incontinence
_____ Bed wetting
_____ Urine urgency
_____ Urinary frequency

MEDICAL HISTORY

_____ Diabetes
_____ Bleeding problems
_____ Parkinson's
_____ Clotting disorder
_____ Hepatitis
_____ Anemia
_____ Multiple Sclerosis
_____ Arthritis
_____ Gall bladder disease
_____ HIV/AIDS
_____ Cancer
_____ Stroke
_____ Osteoporosis
_____ Fibromyalgia
_____ Asthma
_____ High blood pressure
_____ Liver disease
_____ Alzheimer's
_____ Tuberculosis
_____ Depression/anxiety
_____ Thyroid

FAMILY HISTORY

Has you Mother, Father, Brother/Sister or Grandparents had any of the following conditions? If so, please make a check mark by the condition and indicate which relative was affected.

_____ Diabetes
_____ Heart disease
_____ Seizure disorder
_____ Clotting disorder/DVT
_____ High blood pressure
_____ Stroke
_____ Parkinson's
_____ Sickle cell
_____ Alzheimer's
_____ Alcohol/Drug abuse
_____ Psychiatric disorders
_____ Birth defects
_____ *Did your mother take DES when pregnant with you?*

Any recent or current concerns

_____

_____

_____

_____

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F):_____ **Today's Date(MM/DD/YY):**_____ **Health Care 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
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ 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)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage
‡In the same individual or on the same side of the family
§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Lynch Syndrome - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

¶ MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern
***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^Cancer history should be on the same side of the family

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

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

Patient's Signature:_____ Date: _____

Health Care 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:_____