LOUISIANA WOMEN'S Healthcare

Ochsner

500 RUE DE LA VIE, SUITE 100
BATON ROUGE, LA 70817
MAIN 225-201-2000 • FAX 225-201-9357

Pat. Name _____

Date of Birth _____

Patient I.D. _____

Physician _____

AFFIX LABEL HERE

Date _____

Annual Wellness Disclaimer

I, _____, understand that, when being seen for a "Wellness" or "Annual" physical exam, if additional problems are addressed or discovered by the physician they may not be covered by my insurance with the same benefits as a wellness visit.

Annual pap smear coverage varies per insurance plan. It is my responsibility to know if my insurance covers annual pap testing which screens for cervical cancer. It is important to have an annual exam including a pelvic exam and breast exam even if a pap smear is not performed.

I understand when the physician has to address additional problems or complaints, my insurance will be billed separately, and I will be responsible for any co-pay, deductible and/or co-insurance related to the problem.

I may be charged for a problem office visit **in addition to** the Wellness/Annual visit plus any associated lab work, imaging or treatment related to the problem.

_____ _____

Patient Signature Date

LOUISIANA WOMEN'S *Healthcare* | Ochsner

Name: _____

Date of Birth: _____

Patient I.D.: _____

Physician: _____

Affix Label

Date Completed: _____

Cancer Family History Questionnaire

Instructions: This is a screening tool for cancers that run in families. Please mark below if there is a **personal** or **family history** of any of the following cancers. If yes, then indicate **family relationship** and **age at diagnosis** in the appropriate column. If you mark Y (yes) for any statement below, you may be appropriate for hereditary cancer testing.

You and the following close blood relatives should be considered:

children (sons & daughters), siblings (brothers & sisters), parents (dad & mom), grandparents, grandchildren, aunts, uncles, nieces, nephews, cousins

	CANCER	Self Age @ Diagnosis	Siblings / Children	Age @ Diagnosis	Relatives on MOM's side	Age @ Diagnosis	Relative's on DAD's side	Age @ Diagnosis
☐	**BREAST CANCER** (Female or Male)	EXAMPLE			Mom Aunt	48 58	Grandmother	67
☐	**BREAST CANCER** (Female or Male)							
☐	**OVARIAN CANCER** (Peritoneal/Fallopian Tube)							
☐	**PROSTATE CANCER**							
☐	**PANCREATIC CANCER**							
☐	**OTHER CANCERS**							

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Have you or anyone in your family had genetic testing for a hereditary cancer? (If yes, please explain) ☐ Yes ☐ No

_____

Patient Signature: _____ **Date:** _____

FOR OFFICE USE ONLY:

Patient is appropriate for further risk assessment and/or genetic testing: ☐ **Yes** ☐ **No**

☐ **Patient DECLINED Testing: Patient acknowledged understanding of increased risk due to family history of cancers noted above but declines testing today. Patient advised to RTO if desires testing in the future.**

☐ **Patient ACCEPTED Testing: Informed consent obtained, specimen received, follow-up to review results and for risk reduction counseling**

Physician Signature: _____ **Date:** _____

Multiple Cancer **Y**oung Cancers **R**are Cancers

Hereditary Cancer Red Flags: *(To be completed by Healthcare Professionals – Check all that apply)*

Hereditary Breast and Ovarian Cancer Syndrome Red Flags

Hereditary Breast and Ovarian Cancer Syndrome associated cancers include:
breast (including DCIS), ovarian, pancreatic or aggressive prostate cancer

Integrated BRACAnalysis® with Myriad myRisk™

One Diagnosis of Cancer *(Personal, 1st or 2nd degree relative)*

- ☐ Female Breast Cancer, diagnosed before age 50 (if Triple Negative, before age 60)
- ☐ Male Breast Cancer, diagnosed at any age
- ☐ Ovarian Cancer, diagnosed at any age
- ☐ Pancreatic Cancer, diagnosed at any age
- ☐ Ashkenazi Jewish heritage with one or more HBOC Cancers, diagnosed at any age
- ☐ A previously identified mutation in family

Two Diagnoses of Cancer *in the same person or on the same side of the family* *(Personal, 1st or 2nd degree relative)*

- ☐ Female Breast Cancer & one additional HBOC Cancer, at least one diagnosed at age 50 or before
- ☐ Bilateral Female Breast Cancer, diagnosed at any age

Three Diagnoses of Cancer *in the same person or on the same side of the family* *(Personal, 1st, 2nd, or 3rd degree)*

- ☐ Female Breast Cancer & two or more HBOC Cancers, diagnosed at any age

1st Degree Relatives:	2nd Degree Relatives:	3rd Degree Relatives:
Parents, Siblings, Children	Grandparents, Grandchildren, Aunts, Uncles, Nieces, Nephews	Cousins, Great-Grandparents, Great Aunts/Uncles

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Reason for Today's Visit _____

HEALTH HISTORY FORM

PLEASE LIST

Allergies	Current Medications	Previous Surgery

SCREENING TESTS

Test	Date/Year	Normal	Abnormal	HAVE YOU EVER HAD THE FOLLOWING:	
Pap Smear				☐ High Blood Pressure	☐ Seizures
Mammogram				☐ Heart Disease	☐ Hcpatitis/Jaundice
Bone Scan				☐ TB	☐ Thrombophlebitis/Blood Clots
Colon Cancer				☐ Diabetes	☐ Sexually Transmitted Diseases
Cholesterol				☐ Asthma	☐ Any other serious illness/injury

Personal History:

Do you eat a well balanced diet? _____

Do you drink alcohol? _____

Have you ever been treated for alcoholism? _____

Do you have a history of drug abuse? _____

Have you ever been treated for drug abuse? _____

Do you smoke? _____

Do you exercise? _____

Do you feel rested after sleep? _____

Have you recently experienced domestic violence or feel threatened?

_____

Menstrual History:

Age first period began _____

Cycle length (example 28 days) _____

Number of days of flow _____

How old were you when you had your first full term pregnancy _____

Date last period began _____

Irregular periods? _____

Bleed between periods? _____

Heavy flow/clots/cramps? _____

PREGNANCY HISTORY

Year of Delivery	Full Term, Premature, Stillborn, Miscarriage, Abortion, C-section, Vaginal Del., VBAC	List Complications i.e. High Blood Pressure, Tubal Pregnancy, Gestational Diabetes, etc.	Sex of Child	Weight of Child
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FAMILY HISTORY

Family Member	Illnesses or Medical Conditions	Age at Death	Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

WHO IN YOUR FAMILY (Living or Deceased) HAS OR HAD THE FOLLOWING:

Cancer	Inherited Diseases	Diabetes
Breast Cancer	Birth Defects	Epilepsy
Ovarian Cancer	Sickle Cell Anemia	Heart Disease
Uterine Cancer	Mental Retardation	High Blood Pressure
Other Female Cancer	Any other inherited diseases	Mental Illness
Colon Cancer		TB (Tuberculosis)

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Lab Preference

Please specify your preferred lab.

I understand that specimens collected in the office at the time of my visit, as well as any additional testing that may be needed, will be ordered at the lab selected below.

My lab choice is:

☐ **Lab Corp** ☐ **Woman's Hospital Lab**

If a selection is not made, orders will be placed with Woman's Hospital Lab Services.

Occasionally your physician may recommend specialty lab testing with other facilities that offer unique testing to better diagnose and treat.

I understand if my selection changes, it is my responsibility to notify Louisiana Women's Healthcare immediately. Any charges incurred for lab services will be my financial responsibility.

_____ _____

Patient Signature Date

LOUISIANA WOMEN'S Healthcare

Ochsner

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.**

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting the LWH Privacy Officer at 225-201-2000.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures:

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease / Helping with product recalls / Reporting adverse reactions to medications /Reporting suspected abuse, neglect, or domestic violence and preventing or reducing a serious threat to anyone's health or safety

Do research- We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests -We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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Physician _____

AFFIX LABEL HERE

Patient Authorization and Financial Agreement

I consent to and authorize Louisiana Women's Healthcare (LWH) to provide diagnostic procedures, medical procedures including minor procedures and routine services at the time of my office visit.

I authorize the release of all medical records, including any and all records containing HIV, substance abuse, behavioral health, or genetic information, to my insurance company if applicable. I further consent to the sharing of my health information with my other healthcare providers if requested.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician. I further authorize and direct my insurance carrier(s) to pay directly to Louisiana Women's Healthcare any insurance benefits due for services rendered on behalf of me or the named patient.

LWH participates with a variety of insurance plans. It is my responsibility to bring my current insurance card and driver's license to every visit to ensure LWH has the correct filing information. Eligibility for coverage by health insurance plans is not a guarantee of benefits. If it is determined that I am not eligible for coverage, I will be required to pay in full for all services rendered.

I am required to pay any insurance co-payments, deductibles, coinsurance, and/or non-covered charges at the time of service. LWH accepts cash, check, Visa, Master Card, Discover, and American Express. I understand I am financially responsible for any and all charges not paid by my insurance company. All NSF checks will incur a $25 charge.

If it becomes necessary to collect my financial responsibility through an attorney, then, I agree to pay all reasonable costs of collection including attorney's fees, whether suit is filed or not. Additionally, I agree to pay court costs associated with such collection efforts.

I understand that precertification or prior approval may be required by my health plan before certain procedures, or surgeries are performed. This process can take several days or weeks depending on the insurance plan. LWH will contact my insurance company on my behalf; however, it is my responsibility to confirm benefits and approval by my insurance prior to receiving services.

I understand that I may be responsible for charges related to completion of forms (FMLA, short-term disability applications) and medical records fees. Copies of medical records will be charged to the requesting party by the copying company. These fees will not be filed to my insurance.

I authorize LWH to contact me using automated voice messaging, text messaging, and/or email to any telephone number or email address that I provide. This may include, but not limited to, appointment reminders, health and wellness reminders, and marketing materials from LWH and its affiliates.

I understand that LWH may choose to discontinue treatment and/or terminate care of any patient due to the following: failure to meet financial obligations; noncompliance with treatments, follow-up appointments, or medication recommendations; or rude, inappropriate, or egregious behavior.

I acknowledge that I have been given the opportunity to review and receive a copy of LWH's Notice of Privacy Practices.

This authorization will remain in effect until revoked by me in writing.

_____ _____

Patient Signature Date

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PHARMACY BENEFIT MANAGER CONSENT

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies which are lists of preferred drugs covered by a particular drug benefit plan.

☐ I hereby authorize Louisiana Women's Healthcare to import my current medications from my Pharmacy Benefit Manager through a secure connection directly into my electronic medical record.

_____ _____

Signature of Patient/Representative Date

☐ I do not authorize access to my medications through my Pharmacy Benefit Manager. I understand that this may mean that medications prescribed may not be included in my insurance provider's formulary list of preferred medications.

_____ _____

Signature of Patient/Representative Date