Comprehensive Women's Care *of Paramus*

How did you hear about us?

Internet | Facebook | Print ad | Friend/Word of mouth ______________

Name:	**Date of Birth:**
Preferred Phone:	**Email:**
Address:	
Insurance company:	**Social Security Number**

What Lab would you like us to use? LabCorp | Quest | BioReference | Other *please specify*______________

Some insurances require specifice labs, it is the patient's responsibility to know their insurance.

Pharmacy Name & Address

Are you on the Patient Portal? *Clinical results are sent to patients through a secure server for convenient access* Yes | No

Reason for today's visit? *Circle one* Annual Well Woman Exam/PapSmear | Problem visit

Chief Complaint:

Age at first menstrual cycle	Date of last menstrual cycle
How often do you get your period?	How long does your period last?
Do you have irregular or heavy periods?	Current method of birth control
How many miscarriages have you had?	How many abortions have you had?
How many pregnancies have you had in total?	How many children have you delivered? _____*vaginally* _____*c-section*
Allergies: *list all known*	Current Medications:

Have you ever had any prior surgeries? Yes *please list* | No

Have you ever had an abnormal papsmear? Yes No	What was the treatment?
Have you ever had a sexually transmitted infection? Yes No	Which one?

Review of symptoms:			Are you a diabetic?	Y	N	Do you use illicit drugs?	Y	N
Weight loss/gain?	Y	N	Diarrhea?	Y	N	Thyroid issues?	Y	N
Visual changes?	Y	N	Constipation?	Y	N	Rash?	Y	N
Headaches?	Y	N	Nausea/vomitting?	Y	N	Nipple discharge?	Y	N
Cold sores?	Y	N	Frequent urination?	Y	N	Breast lumps?	Y	N
Chest pains/palpitations?	Y	N	Painful urination?	Y	N	Hot flashes?	Y	N
Swelling/edema?	Y	N	Incontinenance?	Y	N	Depression?	Y	N
Shortness of breath?	Y	N	Recurrent infections?	Y	N	Anxiety/mood changes?	Y	N
Are you currently a smoker?	Y	N	Painful Intercourse?	Y	N	Do you consume alcohol?	Y	N
Do you have a family history of any of the following:								
Diabetes	Y	N	Stroke	Y	N	Colon Cancer	Y	N
High blood pressure	Y	N	Breast Cancer	Y	N	Ovarian Cancer	Y	N
Heart Disease	Y	N	Uterine Cancer	Y	N	Osteoporosis	Y	N

an affiliate of Lifeline Medical Associates

patient signature | Date

Breast Cancer Risk Assessment Questionnaire

Patient Name______________________________________ Date__________________

Patient Age______________________________ Patient Date of Birth__________________

Patient Ethnicity: Caucasian_______ African American_______ Hispanic_______ Other__________________

The following questions will help your healthcare provider identify your risk factors for hereditary breast and ovarian cancer (HBOC) syndrome. Please mark **Yes** for any cancers that have affected you or any members of your family. If a family member is affected with any of the following cancers, please be specific as to how that family member is related to you, and provide the age of diagnosis. Here is a list of relatives to consider when filling out these questions: *You, Mother, Father, Sisters, Brothers, Daughters, Sons, Aunts, Uncles, Grandparents, Grandchildren, Nephews, Nieces, Half-Siblings, First Cousins, Great-Grandparents and Great-Grandchildren*. If the cancer type has not affected you or members of your family, please mark **No**

Yes	No	Cancer Type	Age at Diagnosis (YOU)	Parents/ Siblings/ Children	Age at Diagnosis	List Relatives on your MOTHER'S side	Age at Diagnosis	List Relatives on your FATHER'S side	Age at Diagnosis
		Breast Cancer							
		Breast Cancer in both breasts OR multiple primary breast cancers							
		Male Breast Cancer							
		Ovarian Cancer							
		Other: (specify cancer type)							
		Are you of Ashkenazi Jewish descent?							

The following questions will help your healthcare provider identify if you have clinical risk factors that may increase your risk for developing sporadic breast cancer. Sporadic breast cancer makes up approximately 85% of breast cancer cases and is a type of breast cancer that develops in individuals with little to no family history. Please answer **Yes** or **No** for each question, and provide the additional information requested.

Yes	No	
		Have you ever been diagnosed with Breast Cancer, ductal carcinoma insitu (DCIS) or lobular carcinoma insitu (LCIS)?
		Have you ever been tested for BRCA 1 or 2? If your answer is yes, was your test result: Negative_____ Positive_____ Other ________________
		Are you younger than 35 years of age?
		Did you start your first menstrual period before the age of 12? Your age at first menstrual period ______________________
		Check yes if you had your first child after the age of 30, or if you have never given birth Your age of first childbirth __________ or Never given birth __________
		Do you have one 1st degree relative (mother, sister, daughter) with breast cancer? If yes, who:______________________________
		Have you ever had a breast biopsy? If so, were your results: Normal_____ Abnormal_____Other__________________

Patient Signature ______________________________________ **Date**____________________

I accept testing ________________ **I decline testing** ________________

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Lifeline Medical Associates, LLC Notice of Privacy Practice. By signing below, I am only giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practice.

Patient Name : (Please Print) ____

Signature:____ Date: _______________________

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by Comprehensive Women's Care of Paramus via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions: I understand that whether or not I sign this authorization cannot influence treatment.

Patient Name: ____

Signature:____ Date: _______________________

If Patient is a Minor

Parent / Legal Guardian: ____

Signature:____ Date: _______________________

2 Sears Drive, Suite 104
Paramus, NJ 07652

www.womenscareparamus.com
p. (201) 262-0075
f. (201) 262-9440

260 Old Hook Road, Suite 303B
Westwood, NJ 07675

HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at lma-llc.com or calling the Privacy Officer at 973-316-6760

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for <u>fundraising activities</u>, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:
We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to

the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures" every 12 months, except for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 973-316-6760, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

LIFELINE MEDICAL ASSOCIATES, LLC
WOMEN'S HEALTHCARE IS OUR LIFE'S WORK
Comprehensive Women's Care Of Paramus

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Paramus, NJ 07652
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Health Insurance Portability and Accountability Act of 1996

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Revised: March 25, 2013

Privacy Officer
Walter Friedel, MD

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

A. Notifier: Lifeline Medical Associates, LLC
99 Cherry Hill Road, Suite 220
Parsippany, NJ 07054
800-845-2785

B. Patient Name: ____________________

C. Identification Number: ____________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**______________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. Pap Smear – Q0091	Effect. July 1, 2001 paid only every two years	$50
2. Pelvic & Breast Exam – G0101	Effect. July 1, 2001 paid only every two years	$50
3. New Patient (Preventative) – 99387	Non – Covered Service	$50
4. Estab. Patient (Preventative) – 99397	Non – Covered Service	$50

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**____________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**__________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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