Care For Women Joplin

Jack Tyrone Adcock, D.O., F.A.C.O.G.

Ciri D. Corbin, APRN

PHONE: 417-623-1222 FAX: 417-623-1049

Dear Patient,

Thank you for choosing Care For Women Joplin as you GYN provider.

Enclosed you will find forms that will need to be filled out by you in advance.

If a record request form is included, please fill it out and return it immediately to our office.
You may:

- *Fax it 417-623-1049*
- *Email it to careforwomenjoplin@gmail.com*
- *Drop it by our office 8am-4pm Monday-Thursday or 8am-11:30am Fridays*
- *Mail to our office:* ***2531 E 32nd St., Joplin, MO 64804***

Complete the remaining forms and bring them with you to your appointment.

You MUST bring your most current insurance card(s) to your appointment, as well as a co-payment or co-insurance that might be required to apply to the visit. It is the policy of this office that co-payments and/or co-insurance be collected at the time of service.

Our building is located at 2531 E 32nd St. in Joplin, on the North side of 32nd Street next to Phelan Dermatology and in front of Tanglewood Apartments.

We do have a 24-hour cancellation policy for any change or cancellation of an appointment.

We require a 48-hour notification for any prescription refills. Please have your pharmacy fax refill requests to 417-623-1049.

Again, thank you for choosing Care for Women Joplin and we look forward to seeing you!

Sincerely yours,
J. Tyrone Adcock and staff

Your appointment with

Dr. Adcock, D.O., F.A.C.O.G. Ciri Corbin, A.P.R.N.

is _____.

PLEASE CHECK IN 30 MINUTES EARLY IF YOU DO NOT HAVE YOUR NEW PATIENT FORMS COMPLETED.

Our Financial Policy

PATIENT MAY KEEP THIS INFORMATION FOR THEIR PERSONAL RECORDS

Care For Women Joplin

2531 E 32nd St., Joplin, MO 64804
P.417-623-1222 F.417-623-1049

Thank you for choosing Care for Women Joplin. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, for you to read, agree and sign prior to treatment. All patients must complete our patient information form before seeing the doctor. Payment for co-pays, deductibles and patient balances are due at the time of service unless other arrangements have been made with the office. We accept cash, checks, MasterCard, Visa, Discover and Care Credit. We send eStatements so please make sure that your email address is on file. Please let the receptionist know if you would like to opt out of this service and receive your statement by mail.

Regarding Insurance: As a courtesy to you we can file your insurance for you. Please remember your insurance policy is a contract between you and your insurance company. We are not party to that contract unless it is a managed care policy that we have carefully negotiated prior to your visit to this office. In the event that we do not accept assignment of benefits the balance is your responsibility whether insurance pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. The ultimate responsibility for payment lies with you

We cannot bill your insurance unless you have provided us with the necessary information. Insurance companies have timely filing limits so it is very important to make sure we have your current insurance cards. It is your responsibility to make sure we have the correct ins. information to file on time. We will make every effort to file your claims, but if we don't have the correct insurance to file and/or you provide it too late for timely filing the balance will be your responsibility. We are contracted with both the Freeman and Mercy PHO's which covers 90% of insurances, but we cannot guarantee we are in-network. It is your, the patient's, responsibility to verify we are in-network with your insurance before your visit.

We reserve the right to reschedule any appointments due to non-payment of outstanding or past due balances. If you can't pay your balance in full, please call our office and make arrangements with the office manager. We would rather work with you then have to reschedule or turn an account over to collections.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Self-pay patients: Self pay patients with no insurance are responsible for full payment at time of service. If you can not pay your balance in full you must make arrangements with the office manager or reschedule your appointment.

Minor patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover, Care Credit or payment by cash or check at time of service has been verified.

No show: We may assess a charge of $25.00 for no-show appointments. Upon the third no show occurrence you will be dismissed from the practice. If appointments are cancelled in advance we can accommodate patients who need to be seen. We do not like to have to be so strict, but it is in the best interest of all our patients.

Collections: It is the policy of our office to turn unpaid balances over to a collection agency unless extenuating circumstances are involved, communicated, documented and approved by our office. Failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

Returned checks: We will assess a charge of $35 for returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Care For Women Joplin 2531 E 32nd St, Joplin, MO 64804 417.623.1222 Gynecology / Gynecologic Surgery / Incontinence

PATIENT INFORMATION (please print):

Last Name: _____ First Name: _____ MI_____

Patient SS#_____ Marital Status:_____ Date of Birth: _____

Mailing Address (**including city/ state/ zip**): _____

Email Address: _____ Primary Physician_____
(By entering your e-mail address above you agree to e-statements and will not receive paper statements.)

Race (circle one): Caucasian African American Asian Hispanic Other_____ Preferred Language: _____

Phone: Home _____ Cell _____ Other _____

Preferred Pharmacy Name: _____ **Location**: _____

How do you prefer to be contacted for reminders/messages (circle one): Home Phone Cell Other _____

Employer: _____ Phone _____Ext_____

Emergency Contact: Name: _____ Phone: _____ Relationship _____

Person responsible for bill (if other than patient): Name_____ Relationship_____

Date of Birth_____ SSN _____-_____-_____ Address_____ Phone # _____

INSURANCE INFORMATION:
Primary Insurance Company: _____ Member ID #_____

Group #: _____Group Name: _____Policy Holder Name: _____

Date of Birth: _____ SSN _____-_____-_____ Relationship to Patient: _____

(If Applicable)
Secondary Insurance Company: _____ Member ID #_____

Group #: _____Group Name: _____Policy Holder Name: _____

Date of Birth: _____ SSN _____-_____-_____ Relationship to Patient: _____

How did you hear about us (select all that apply): I was a previous patient of Dr. Adcock's _____
Physician referral (name):_____ Patient referral (name): _____
Sign: _____ Internet: _____ CFWJ website: _____Radio: _____ TV: _____ Other: _____

I have read and agree to Care For Women Joplin's (CFWJ) financial policy included with this paperwork. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to CFWJ all money to which I owe for medical expenses related to the services performed by CFWJ. I authorize CFWJ to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to CFWJ. I authorize any information needed to determine these benefits and/or the benefits payable for related services be released by any holder of medical information about me. Your signature on this form states that you agree to our office policy and financial policy.

FORMULARY BENEFITS DATA CONSENT FORM

Formulary 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 dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for CFWJ to access my pharmacy benefits data electronically through RxHub. This consent will allow us to do the following:

- ✓ *Determine the pharmacy benefits and drug copays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.*
- ✓ *Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.*
- ✓ *Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.*
- ✓ *Download a historic list of all medications prescribed for a patient by any provider.*

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____ _____
Patient Name (printed) Patient/Guardian Signature Date

Office Policy

Care for Women Joplin 2531 E 32nd St., Joplin, MO 64804 Phone (417) 623-1222 Fax (417)623-1049

Medication Refills

Prior to running out of your medication, please contact your pharmacy and ask them to fax a request to our office. Please allow our staff 48 business hours to fulfill the request. For your convenience, you should contact the pharmacy before picking up your prescription to verify approval and that it is ready for pick-up.

Nurse Messages

In order for our nurses and clinical assistants to give the same time and consideration to each of our patients, **please allow 48 hours for a nurse to return your call**. Please do not call multiple times as it may delay calls further by adding to the nurses message list. If you have not heard back from us after 48 hours please feel free to contact us again. If there is an emergency, please do not leave a message-go to the nearest emergency room or urgent care for evaluation. **Please allow one week to hear back from our office regarding lab and test results. Results must be received, reviewed and signed off on before we can discuss results with you.**

Forms Completion

There is a standard fee for completion of forms left in or sent to our office. The fee(s) for FMLA or Disability paperwork is $20.00 per set of forms, or $30.00 if our office completes both sets at the same time. Please allow two weeks for completion. We will contact you once the form(s) are ready for you to pick up, unless you have requested otherwise.

Laboratory

We use PathGroup for all pathology. PathGroup processes and bills all insurance as in-network benefits. We do not bill for specimens that are sent to PathGroup. If you receive a statement from PathGroup you will need to contact PathGroup.

Mammograms

Mammogram orders are given ONLY if you've been seen in advance for a breast exam. This will allow our providers to direct your mammogram technician towards any areas of concern. If you are due for a mammogram and want to schedule for the same day, we ask that you schedule 2 hours after your appointment with our office (you will get the order at your appointment).

WELL WOMAN/ANNUAL APPOINTMENTS

With most policies, the following services do not require cost-sharing (copayment, coinsurance or dollars paid toward a deductible) as a part of a 'Well Woman' annual exam at Care For Women Joplin:

- Breast exams
- Pelvic exams
- PAP test to sample cervical cells to check for abnormalities.

I understand that if any topics are discussed and/or services are provided outside of those listed above during my Well Woman appointment an additional office visit code will be applied and cost-sharing (copayment, coinsurance or dollars paid toward a deductible) will be required as per my insurance plan.

Appointment

Please arrive 15 minutes prior to your scheduled appointment. If you are more than 10 minutes late, we may have to reschedule your appointment. Please notify our office at least 24 hours in advance, when possible, if you are unable to keep your appointment. If the need arises for an urgent appointment, we will try to fit you into the schedule to the best of our ability. However, if we are unable to get you a timely appointment, again, you should seek care at the nearest emergency room or urgent care clinic.

eStatements:

We send eStatements so please make sure that your email address is on file. Please let the receptionist know if you would like to opt out of this service and receive your statement by mail. By listing your email address on the form, you agree to receive eStatements only and will not receive paper statements by mail.

Consent for Heath Care: Patient voluntarily consents to such medical care including but not limited to laboratory, diagnostic or medical treatment which may be ordered by patient's physician or assistants, or designees for medical treatment which they may deem necessary and advisable. The agreements and assignments will remain in effect until revoked by me in writing. A photo copy of this assignment is considered as valid as an original. I, the undersigned, authorize Care for Women Joplin to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician or agents or employees of pertinent entities for the purposes of business operations payment for health care services rendered and continual treatment or coordination of care. I consent to the taking of photographs for the limited purpose of medical treatment and/or medical educations.

☐ **I acknowledge that I have had the opportunity to read and/or receive a copy of Care for Women Joplin's Notice of Privacy Practices, Office Policy and Financial Policy. A complete copy of the Notice is available at the check in desk or on our website at cfwjoplin.com. I agree to the polices of Care For Women Joplin, LLC.**

Yes ***No*** (circle one) I give Care for Women Joplin staff permission to leave information about my appointments and health information on my voicemail.

I give Care for Women Joplin permission to relay my appointment and/or medical information to the following person(s):

_____ _____ _____

***** IF NAMES ARE NOT LISTED ABOVE, WE WILL NOT BE ABLE TO SPEAK WITH ANYONE EXCEPT THE PATIENT ABOUT MEDICAL INFORMATION. *****

_____ _____ _____

Patient Name (printed) Patient/Guardian Signature Date

Health Survey

Name_____ Age_____ Date of Birth _____ Today's Date_____

Referred by_____ Primary Care Physician _____

Reason for visit_____

PLEASE LIST ALLERGIES TO MEDICATIONS:

MEDICATIONS **(USE BACK OF SHEET IF NEEDED)** ***List all current prescriptions, over the counter, injections, vitamins, herbals:***

Name	Strength	Dosage		Name	Strength	Dosage

Immunizations and Vaccines: (Please check those you have received) □ Flu shot □ HPV vaccine (9-26 years)
□ Pneumonia vaccine (65 yrs or high risk) □ Varicella-Zoster (60 yrs and older) □ Hepatitis A □ Hepatitis B
□ MMR □ Tetanus-diptheria □ Other_____

MEDICAL HISTORY: Please check any conditions you have now and/or have had in the past.

□ Abnormal pap smears	□ Chemical dependency	□ Hepatitis	□ Ovarian cyst
□ AIDS	□ Chicken pox	□ Herpes	□ Pacemaker
□ Alcoholism	□ Chlamydia	□ High blood pressure	□ Pneumonia
□ Anemia	□ Colon cancer	□ High cholesterol	□ Psychiatric disorders
□ Anorexia	□ Depression	□ HIV positive	□ Rheumatic fever
□ Asthma	□ DES exposure	□ Kidney disease	□ Seizures
□ Anxiety	□ Diabetes	□ Liver disease	□ STDs _____
□ Arthritis	□ Emphysema	□ Measles	□ Strokes/TIA
□ Blood clots, legs, lung	□ Endometriosis	□ Migraines	□ Suicide attempt
□ Breast Cancer	□ Epilepsy	□ Mononucleosis	□ Thyroid
□ Breast lumps, problems	□ Genital warts	□ Multiple Sclerosis	□ Transfusion – Date: _____
□ Broken bones as an adult	□ Glaucoma	□ Mumps	□ Tuberculosis
□ Bronchitis	□ Goiter	□ Osteopenia	□ Ulcers
□ Bulemia	□ Gonorrhea	□ Osteoporosis	□ Uterine cancer
□ Cervical cancer/dysplasia	□ Heart problems	□ Ovarian cancer	□ Venereal disease

Additional medical history or conditions not listed above:

 Name_____ Date of Birth_____

GYNECOLOGY HISTORY: Please fill out all sections

PREGNANCY HISTORY: *Please specify number*		Complications with pregnancy or deliveries?	
Total pregnancies:			
Total live births:			
Miscarriages/abortions:		Vaginal deliveries:	
Living children:		C-sections:	

MENSTRUAL HISTORY (check all that apply)	
☐ Irregular menses	☐ Clots
☐Spotting	☐ Dime size
☐ Less than 21 days	☐ Quarter size
☐ More than 35 days	☐ Larger
☐ Longer than 10 days	☐ Pain moderate
☐ Changed from normal	☐ Pain severe
☐ Change pad/tampon less than 2 hours	
☐ PMS	
Date of last period:	
Age of first period:	
Age of menopause:	

SEXUAL HISTORY: (check all that apply)

□ Have had sexual intercourse at least once in my life
□ Male partner
□ Female Partner
□ History of sexual abuse
Method of contraception: _____
□ If unmarried, use condoms in addition to other birth control

Date of last STD test:	Date of last Pap Smear:
Date of last Bone Density:	Date of last Mammogram:
Date of last Colonoscopy:	Other:

SURGICAL HISTORY – please list all surgeries and approximate dates:

Well woman exam:
With new research, ACOG guidelines allow for pap smears to be done at 3 year intervals in low risk patients that meet specific requirements. Please check all that apply:

□ None of these apply
□ Immune system is comprised
□ Cervical or vaginal cancer, now or in the past
□ Abnormal pap smear in the past three years
□ Onset of sexual partners before age 16
□ 5 or more sexual partners in a lifetime
□ History of a sexually transmitted disease (STD)
□ Fewer than 3 negative paps within the previous 7 years
□ No paps at all within the past 7 years

FAMILY MEDICAL HISTORY: Please identify members as follows: Mother(M) Father(F) Maternal Grandmother (MG) Paternal Grandmother (PG) Maternal Aunt (MA) and/or Paternal Aunt (PA)

□ Breast Cancer _____
□ Cervical cancer/dysplasia _____
□ Colon cancer _____
□ Ovarian cancer _____
□ Uterine (endometrial) cancer _____
□ Bipolar Disoder/Manic Depression _____
□ Blood clots (legs,lungs) _____
□ Diabetes _____
□ Heart attack _____
□ High blood pressure _____
□ High cholesterol/triglycerides_____
□ Melanoma_____
□ Osteoporosis/osteopenia_____
□ Stroke_____
□ Thyroid_____
□ Other (list):

Other concerns:

□ I do not feel safe at home
□ I am being abused physically or emotionally

SOCIAL HISTORY: Please check, circle or answer all questions

Marital status: Circle one
Single Married Divorced Widowed
Occupation:

Substance Use & amounts:
Caffeine
Tobacco
Alcohol
Drugs

Work environment: Check any concerns you have
□ Stress
□ Hazardous substances
□ Healthy living
Other: _____

Bladder Symptom Questionnaire

Name: _____ Date: _____

Doctor: _____

Which symptoms best describe you? Check all that apply.

- ☐ Frequent urination—day, night, or both
- ☐ Sudden or strong urge to urinate
- ☐ Leakage with little or no warning—sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty bladder—feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below)
  - ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other
- ☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried? _____

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? ☐ Yes ☐ No

If no, why have you stopped taking them?

- ☐ Did not work as well as expected
- ☐ Side effects
- ☐ Expense
- ☐ Interaction with other medications
- ☐ Other

If Side effects or Other checked, please explain:

_____

Behavior modifications tried? _____
(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Extremely Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

☐ Yes ☐ No

UC2012008876a EN

Risk Assessment for Hereditary Breast and Ovarian Cancer and Lynch Syndrome

*Lynch Syndrome is caused by changes in specific genes and results in Increased risk for Colon, Endometrial, Ovarian, Stomach and other cancers

Patient Name: _____

Date of Birth: _____ Today's Date: _____

This is a screening tool for Cancer that runs in Families. Please consider the following Family Members when completing the form:

1st Degree Relatives = Mother/Father/Sister/Brother/Children

2nd Degree Relatives = Aunt/Uncle/Grandparent/Grandchildren/Niece/Nephew

3rd Degree Relatives = Cousin/Great-Grandparent/Great-Aunt/Great-Uncle

Have YOU or ANY OF YOUR RELATIVES been tested (BRCA/Colaris) for Hereditary Cancer Syndrome? YES NO

Have YOU ever been Diagnosed with Cancer What Site: Age:

		BREAST & OVARIAN CANCER (HBOC/BRAC*Analysis)*	**Self**	**Siblings or Children**	**Your Relationship to Family Member**		**Age at Diagnosis**	**Living?**
					Mother's Side	**Father's Side**		
Y	N	Breast Cancer at Age 50 or Younger (in Self, 1st or 2nd Degree Relative)						
Y	N	Ovarian Cancer at Any Age (in Self, 1st, 2nd or 3rd Degree Relative)						
Y	N	**2 Relatives** on Same Side of Family with Breast Cancer - **1 of them under the Age of 50**						
Y	N	3 Relatives on Same Side of Family with Breast Cancer at Any Age						
Y	N	Multiple Breast Cancers in the Same Person (in the same breast OR both breasts)						
Y	N	Triple Negative Breast Cancer (ER, PR and Her2 Negative Receptor Status) at Age 60 or Younger						
Y	N	Male Breast Cancer at Any Age (in Self, 1st, 2nd or 3rd Degree Relative)						
Y	N	Pancreatic Cancer with Breast OR Ovarian Cancer in the same person or on same side of the family						
Y	N	Ashkenazi Jewish ancestry with Breast, Ovarian or Pancreatic Cancer in same person or on same side of family						
Y	N	Family member with a known BRCA mutation						

		COLON & UTERINE CANCER (Lynch Syndrome/Colaris)	**Self**	**Siblings or Children**	**Your Relationship to Family Member**		**Age at Diagnosis**	**Living?**
					Mother's Side	**Father's Side**		
Y	N	Colon (Colorectal) or Uterine (Endometrial) Cancer before Age 50 (in self, 1st or 2nd Degree Relative)						
Y	N	**2 or more** Relatives on Same Side of Family with any of the following **1 of them under 50 (circle)**: *Colon, Uterine/Endometrial, Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis, Pancreas*						
Y	N	**3 or more** Relatives on same side of Family with any of the following **(circle)**: *Colon, Uterine/Edometrial, Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Uteter, Renal Pelvis, Pancreas*						
Y	N	Family member with a known Lynch Syndrome mutation						

Patient Signature: _____

For Office Use Only:

☐ Based on Personal & Family History, testing is not indicated for the Patient at this time

☐ Genetic Testing Recommended for Patient: BRACAnalysis (HBO or Coloris (Lynch) ☐ Patient Watched Video

☐ Patient Declined & Reason: _____

☐ Patient Accepted HCP Signature: _____