Desert Jewel Obstetrics & Gynecology
Courtney A. Hunt MD, FACOG

3501 N. Scottsdale Rd Suite 230
Scottsdale, AZ 85251

Tel (480) 970-1937
Fax (480) 970-1938

Dear Patients,

In effort to streamline processes you now have the ability to view your patient results online through www.my.patientfusion.com. Please provide one of our staff members with your email address and we will sign you up and give you a temporary password.

Your physician or her assistant will call you with any abnormal results however, all of your normal results will be posted online as soon as they are received and reviewed by your physician. The typical time frame is 2 weeks from the date of your visit. Once you have reviewed your results online should you have any questions please call us directly. If you have any trouble getting through the phone system, you can now contact your provider directly through Practice Fusion by writing them a message, your provider or one of their assistants will return your request within 24-48 hours.

Thank you for helping us to provide you with a more efficient way of providing you with your results.

Patient Email: _____

Revised 03/31/2016

Desert Jewel Obstetrics and Gynecology
3501 N Scottsdale Road, Suite 230
Scottsdale, AZ 85251
(480) 970-1937 Tel (480) 970-1938 Fax

INSURANCE & FINANCIAL POLICY

Patient's Name:_____ Date of Birth:_____

Welcome to our practice! We are committed to providing you with the best possible care by offering treatment options that may or may not be covered by your insurance. Your clear understanding of our Insurance & Financial Policy is important to our practice. Please ask if you have any questions about our policies, fees, and your financial responsibility as a patient.

- Please be aware that we order labs, cultures, pap smears, HPV testing, etc based on what we deem best for your health care. Not all of these services may be covered by your insurance and it would be impossible for us to know each person's individual policy to assess if they are covered. It is your responsibility to be aware of your benefits. We will do our best to order labs that we feel appropriate and necessary to take care of you in the best way possible.

- Bio Reference is the laboratory we use in this office, unless you tell us to do otherwise. In certain cases we will send biopsies and other samples to other laboratories for their expertise on gynecologic pathology. Please feel free to ask any questions you might have as to where your specimens are going. The laboratory/pathology will bill you or your insurance company for all labs performed. If you have any questions regarding your lab bill, please contact the laboratory directly or your insurance carrier.

- We require you to present your insurance card at all appointments in order to minimize errors. All copays, deductibles, and payments are due at the time of service, with copays being collected prior to you seeing the doctor. If you are coming in for a well woman exam and have an additional medical problem that you would like to discuss with the doctor, your insurance will be billed additionally for this. Additional copays WILL be required if you have a problem at your annual visit (this includes things like uti, yeast infection, pain, menopausal symptoms etc).

- In consideration of maintaining an on-time schedule for the doctor and other patients, we request that you be on time for your appointment. We require you to arrive 15 minutes early in order to fill out any necessary paperwork. Arriving more than 15 minutes late for your appointment will necessitate rescheduling your appointment.

- Any patient who commits any of the following offenses, including but not limited to: abusive behavior or language, non-compliance with treatment plan, prescription misuse or abuse, multiple missed office visits, or failure to pay account shall be grounds for immediate dismissal from our practice

Thank you for understanding your financial and insurance policies. If you have any questions about the above information, please do not hesitate to ask us. We are here to assist you.

Patient Signature:_____ Date:_____

Desert Jewel Obstetrics and Gynecology
3501 N Scottsdale Road, Suite 230
Scottsdale, AZ 85251
(480) 970-1937-(480) 970-1938 Fax

INSURANCE & FINANCIAL POLICY

Patient's Name:_____ Date of Birth:_____

Please initial the indicated lines to guarantee that you have read, understood, and agree with Desert Jewel's Insurance and Financial Policies.

_____We at Desert Jewel understand that situations may arise that require you to cancel your appointment; however we do require a 24 hour notice of such cancellation. We may charge a $50.00 fee for any appointments that have not been canceled within this timeframe. If you are scheduled for surgery and cancel less than five days prior to your surgery date you will be assessed a fee of $125.00.

_____We are happy to supply you with a copy of your medical records; however this service is subject to a $30.00 processing fee. We require all patients to fill out a Medical Release form. After the form is completed and the fee is paid, please give our staff up to 7 business days to get these records together. We can fax medical records through a secure fax line to another medical provider, or we can mail them to you directly.

_____ A prepaid administrative fee of $30.00 will be charged for any forms that need to be reviewed and/or completed by our physicians.

_____Desert Jewel Obstetrics and Gynecology will assign all accounts (30) days or more past due to an outside collection agency. This may be an automatic assignment unless prior arrangements have been approved by management.

_____I hereby acknowledge and agree that Desert Jewel Obstetrics and Gynecology is authorized to charge my account as listed below for any unreimbursed charges based upon my agreement with any payor of any status. It is Desert Jewel's policy that I must provide credit card information before being seen by any of the providers. I will be sent statements of any unreimbursed charges twice. After the second statement, my credit card that is on file will be charged for the balance on my account. If payment is not received, I understand that I was informed of the precise amount of any unreimbursed charge in an official statement. (The only exception to this rule is for Hormone Replacement Therapy patients who will have their cards ran after the Explanation of Benefits is received).

I have read the above Insurance & Financial Policy, and understand and agree to these terms.

Printed Patient Name:_____

Patient Signature:_____ Date:_____

Payment Information – **THIS AREA MUST BE COMPLETED IN ITS ENTIRETY.**

Type of Card: __ MasterCard __ Visa __ American Express __ Discover

Credit Card Number: _____ Exp. Date: _____

(If you do not want to write your credit card number on this paper for security reasons we understand, we would be glad to swipe it securely into our system.)

Desert Jewel Obstetrics and Gynecology
3501 N Scottsdale Road, Suite 230
Scottsdale, AZ 85251
(480) 970-1937 Tel (480) 970-1938 Fax

Authorization to Release Medical Information to Individuals/ Family Members

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPPA), in order for your healthcare provider or Desert Jewel Staff to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____ I authorize Desert Jewel OBGYN to share my medical information (including but not limited to lab results, appointment times, dates and reasons for visits, pregnancy information, ultrasound reports etc) with any individual listed below.

____ I DO NOT authorize Desert Jewel OBGYN to share my medical information with any other individual other than myself.

____ I authorize the Providers of Desert Jewel and Staff to leave lab results, appointment information, and any other medical information on my voicemail in case I cannot be reached.

____ I DO NOT authorize the Providers of Desert Jewel and Staff to leave any information on my voicemail in case I cannot be reached.

____ I give permission to Desert Jewel to communicate lab results and health information to me through the Patient Health Record (PHR) that is operated by Practice Fusion Electronic Medical Records System.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____

Date of Birth: _____ Date: _____

PATIENT INFORMATION

PATIENT NAME: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

CELL #: (_____) _____-_____ OTHER #: (_____) _____-_____ EMAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER: _____-_____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER SEX: (circle one) FEMALE MALE

RACE/ ETHNICITY: _____

PATIENT'S EMPLOYER: _____ WORK PHONE#: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____ COVERAGE EFFECTIVE DATE: _____

CLAIMS ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle) SELF SPOUSE CHILD OTHER INSURED'S DATE OF BIRTH: _____/_____/_____

GROUP NUMBER: _____ GROUP NAME: _____

SPECIALIST/OBGYN COPAYMENT: $ _____ OFFICE VISIT COPAYMENT: $_____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN SELF)

RESPONSIBLE PARTY NAME_____

PATIENT RELATIONSHIP TO RESPOSIBLE PARTY: (circle) SELF SPOUSE CHILD OTHER SEX: (circle) FEMALE MALE

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SOCAL SECURITY NUMBER: _____

CELL #: _____ HOME #: _____

RESPONSIBLE PARTY'S EMPLOYER: _____ WORK PHONE: _____

SECONDARY INSURANCE COMPANY: _____ COVERAGE EFFECTIVE DATE: _____

CLAIMS ADDRESS: _____ PHONE: _____

SUBSCRIBER ID #: _____ SUBSCRIBE'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle) SELF SPOUSE CHILD OTHER INSURED'S DATE OF BIRTH: _____

GROUP NUMBER: _____ GROUP NAME: _____

All patients must complete our patient form before being seen by the provider. It is your duty as a patient to notify us of any changes of address, phone number, or insurance. In addition to your insurance card, we will need a copy of your driver's license. If you change insurance companies or benefits, you must call our office with the new information at least 48 hours prior to your appointment. You are required to supply us with the complete information of every insurance policy that you are covered under. If you do not, you will be responsible for the bill.

PATIENT SIGNATURE:_____ DATE:_____

By signing this form you are consenting that you have provided information on any and all insurance policies that you are covered under.

Desert Jewel Obstetrics and Gynecology
3501 N Scottsdale Road, Suite 230
Scottsdale, AZ 85251
(480) 970-1937 Tel (480) 970-1938 Fax

General Medical History

Patient name: _____ DOB: _____

Primary care physician: _____ Who sent patient: _____

Reason for visit: (please list all symptoms and pertinent information):

_____

_____

_____

Past Medical History : _____

_____

Past surgeries:

_____

_____

When was your last:

Blood Test: _____ Colonoscopy: _____ Pap smear: _____

Bone Density Test: _____ EKG: _____ Rectal Exam: _____

Chest X-Ray: _____ Mammogram: _____ Stress Test: _____

History of heart attack: _____

List all medications/supplements you are taking including dosage: _____

_____

List any allergies: _____

_____

Any diseases or illnesses that run in your family (including deceased family members and relationship):

_____

Tobacco use: Yes No

Alcohol use: Yes No

Drug use: Yes No

I am:

- ☐ Married
- ☐ Divorced
- ☐ Single

Desert Jewel Obstetrics and Gynecology
3501 N Scottsdale Road, Suite 230
Scottsdale, AZ 85251
(480) 970-1937 Tel (480) 970-1938 Fax

Diet and Nutritional Information

Please describe what you eat on a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Water intake (ounces per day): _____ Coffee intake (ounces per day): _____

Other beverages: _____

Exercise information:

Days per week: _____

Minutes per day: ____

Type of exercise: _____

Desert Jewel Obstetrics and Gynecology
3501 N Scottsdale Road, Suite 230
Scottsdale, AZ 85251
(480) 970-1937 Tel (480) 970-1938 Fax

Male Health History

Hormones or supplements I am currently on or have been on in the past:

_____

_____

Describe any history of prostate abnormality:

_____

_____

Preventative tests I have had within the past 12 months:

PSA Results: _____

Digital Rectal Results: _____

I have the following medical conditions:

- ☐ Bone Loss/ Osteoporosis
- ☐ History of use of anabolic steroids
- ☐ Prostatic Hypertrophy
- ☐ Prostate enlargement
- ☐ Severe Sleep Apnea

I have had the following surgeries:

- ☐ Prostatectomy
- ☐ Surgery for Testicular Cancer
- ☐ Thyroid Surgery
- ☐ Vasectomy

Review of Systems Form

*Please check all that apply

Please initial if NONE apply _____

Constitutional

- o Weight Loss
- o Weight Gain
- o Fever
- o Fatigue
- o Other: _____

Eyes

- o Vision Change
- o Use of Glasses/ Contacts
- o Other: _____

Cardiovascular

- o Chest Pain
- o Palpitations
- o Shortness of breath
- o Edema
- o Other: _____

Gastrointestinal

- o Diarrhea
- o Bloody Stool
- o Constipation
- o Pain
- o Other:

Genitourinary

- o Hematuria (blood in urine)
- o Dysuria (painful urination)
- o Urgency
- o Frequency
- o Incontinent
- o Other: _____

Skin/ Breast

- o Mastalgia (breast pain)
- o Discharge
- o Masses
- o Rash
- o Ulcers
- o Other:_____

Neurological

- o Syncope
- o Seizures
- o Numbness
- o Trouble Walking
- o Other:_____

Psychiatric

- o Depression
- o Crying
- o Other: _____

Endocrine

- o Diabetes
- o Hypothyroid
- o Hyperthyroid
- o Other:_____

Hemat/Lymph

- o Bruises
- o Bleeding
- o Other:

Updated 03/31/16

Risk Assessment for Hereditary Cancer Syndromes

Patient Name:_____ **Date of Birth:** _____ **Today's Date:** _____

Instructions: Please fill out the family history form below. Your health is very important to us and family history is a tool to help us better manage you and offer recommendations for reducing your risk for cancer.

1st degree relatives: Mother, Father, Sister, Brother, Children
2nd degree relatives: Aunt, Uncle, Grandparent, Niece, Nephew, Half siblings
3rd degree relatives: Cousin, Great Grandparents, Great Aunts and Uncles

HAVE YOU OR ANY FAMILY MEMBER EVER HAD HEREDITARY CANCER TESTING (BRCA/Lynch/Myriad myRisk):
YES or NO Test/Result:

		BREAST AND OVARIAN CANCER	SELF (Age at Diagnosis)	FAMILY MEMBER	
				MOTHER'S SIDE/AGE	FATHER'S SIDE/AGE
Y	N	Breast cancer at age 45 or younger ***(In yourself, first or second degree relatives)***			
Y	N	Ovarian cancer at any age ***(In yourself, first or second degree relatives)***			
Y	N	Two relatives on the same side of the family with breast cancer; ONE at or under the age of 50 ***(In yourself, first, second or third degree relatives)***			
Y	N	Three or more of the following cancers at any age on the same side of the family: breast, ovarian, pancreatic, or prostate ***(In yourself, first, second or third degree relatives)***			
Y	N	One relative with TWO separate breast cancers; one diagnosed at or before the age of 50 ***(In yourself, first or second degree relatives)***			
Y	N	Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2) ***(In yourself, first or second degree relatives)***			
Y	N	Male breast cancer at any age ***(In yourself, first or second degree relatives)***			
Y	N	Breast, ovarian, or pancreatic cancer at any age in Ashkenazi Jewish family members ***(In yourself, first or second degree relatives)***			
Y	N	A family member with a known BRCA mutation			

		COLON AND UTERINE CANCER	SELF (Age at Diagnosis)	FAMILY MEMBER	
				MOTHER'S SIDE/AGE	FATHER'S SIDE/AGE
Y	N	Have you PERSONALLY had Uterine (endometrial) cancer?			
Y	N	Uterine or Colon/rectal cancer at or under age 50 ***(In yourself, first or second degree relatives)***			
Y	N	A family member with a known Lynch Syndrome mutation			

Please List ANY and ALL other cancers in your family and who had them *(please indicate Maternal/Paternal, Relative and Age at Diagnosis)*:

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

Provider signature: _____ **Date:** _____