The Menopause Center

The Menopause Center
Women's Care
590 Country Club Parkway, Suite A
Eugene, OR 97401
541-683-1559 • Fax 541-683-1709
Douglas J. Austin, MD
Michelle Brookey, CNM, NP
Carolyn Camille McGregor, WHNP

Dear New Patient,

If you have included your insurance information we will bill them for your New Patient Consult. If there is no insurance coverage listed or your insurance does not cover a consult, the cost is $638.00. Any additional testing done during this consultation visit will be an additional charge.

If you have questions, please don't hesitate to call me prior to your appointment.

Thank you.

Patient Financial Coordinator
541-868-9759

Thank you for taking the time to fill out this new patient packet. We ask that you fully complete and sign each form *before we will schedule your appointment*. In order to serve you best, we will request records for all the previous treatment you have received that are relevant to your condition.

Once we receive the completed forms, we will contact you to schedule your appointment. All new patient appointments will be scheduled on a first-come first-serve basis *after* receiving the information requested. We will do our best to see you as soon as we can and we appreciate your patience.

Table of Contents Checklist

- □ Patient Profile
- □ Financial Agreement
    - o If you write down insurance information our financial coordinator will call prior to your appointment to discuss benefits.
    - o New Patient Consults are $638.00 if not covered by insurance.
- □ HIPAA Policy
- □ Release of Information
    - o This is the form we use to request records from your previous providers.
    - o Please make sure to sign, date, and INITIAL all appropriate spaces.
    - o If this form is not filled out and signed, we will return the packet to be completed.
    - o If you have not seen any providers in the last 2 years please write that on the form, you don't need to fill it out.
- □ Oregon Genetics Privacy and Research
    - o State of Oregon mandated program, fill out the form entirely.
    - o If you would like to opt out make sure the check box to decline is selected
- □ Authorization to Share Health/Treatment Information with Another Person
    - o This form allows you to elect up to two people who can call in and discuss your health information.
    - o We cannot share any of your medical information with anyone without this consent signed.
    - o This form is optional.
- □ Medical History Questionnaire
    - o This form allows Dr. Austin to review your health history prior to your initial consult.
    - o Please fill out as completely as you are able. It's ok to leave blank if you are unsure or it does not apply to you.

If you would like an email confirmation that we received your new patient packet please list your email here:

_____

If you do not provide your email, we will not confirm receipt of receiving your packet, but you will receive a call when we are ready to schedule your consult.

The Menopause Center

THE MENOPAUSE CENTER
Women's Care
Patient Information

Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Note: Please use your full legal name.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Street Address *(if different from mailing address)*: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred phone: _____

Date of Birth: _____ SSN: _____ Marital Status: _____

Employer/School: _____ Occupation/Retired/Student: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance Information

Insurance Company Name: _____ Insurance Company Phone: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Relationship to Patient: _____ ☐ Male ☐ Female

Insured Party Date of Birth: _____ Insured Party Employer: _____ Insurance Effective Date: _____

Secondary Insurance Information

Insurance Company Name: _____ Insurance Company Phone: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Relationship to Patient: _____ ☐ Male ☐ Female

Insured Party Date of Birth: _____ Insured Party Employer: _____ Insurance Effective Date: _____

Guarantor

Who is the guarantor? ☐ Same as patient. ☐ Other If other, please list name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Street Address *(if different from mailing address)*: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Emergency Contact

Name: _____ Phone Number _____ Relationship: _____

Authorization

I authorize the Fertility Center of Oregon to bill the above insurance on my behalf, and assign any insurance benefits payable directly to the Fertility Center of Oregon. I understand that I am financially responsible for all non-covered services.

Date: _____ Signature: _____

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MENOPAUSE HEALTH QUESTIONNAIRE

Full Legal Name: _____ Prefered Name: _____

Date of Birth: _____ Age: _____ Today's Date: _____ Who referred you to us for care? _____

Primary Care Physician: _____ OB/GYN Physician: _____

TODAY'S OFFICE VISIT

Menopause is a normal event in a woman's life and is marked by the end of menstrual periods. Usually during the 40s a gradual process leading to menopause begins. This is called the menopause transition or perimenopause. Changes in the pattern of menstrual periods are very common during this stage. Sometimes a woman can have other symptoms too, and these symptoms may extend beyond menopause. Even if a woman has no symptoms, it's important for her to understand the effects of menopause on her health.

This questionnaire is intended to help you inform your healthcare provider about your menopause experience and your general health. Working together, you can develop a plan to support your health, not only now but also in years to come. If you feel uncomfortable answering any of the questions on this form, you may wait and discuss them with your healthcare provider.

Why are you here *today*?

_____

What are your *main* concerns or questions you would like to have answered during your visit?

_____

Other health problems (describe): What are your strengths?

_____

What are your weaknesses (describe)?

_____

HEIGHT AND WEIGHT INFORMATION

What is your height? _____ What is your maximum remembered height? _____ How old were you then? _____

What is your weight? _____ What is your maximum remembered weight? _____ How old were you then? _____

What is your lowest remembered weight as an adult? _____ How old were you then? _____

MEDICAL HISTORY

Please check if you have had problems with:

- ☐ Migraines
- ☐ Blood pressure
- ☐ Stroke
- ☐ Cholesterol
- ☐ Heart attack
- ☐ Chest pain
- ☐ Blood clots
- ☐ Varicose veins
- ☐ Easy bruising
- ☐ Anemia
- ☐ Indigestion
- ☐ Colitis
- ☐ Frequent nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody or black bowel movements
- ☐ Hepatitis
- ☐ Liver
- ☐ Gallbladder
- ☐ Incontinence (urine or feces)
- ☐ Breasts
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Infertility
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid
- ☐ Asthma
- ☐ Arthritis
- ☐ Muscle or joint pain
- ☐ Back pain
- ☐ Seizures
- ☐ Eyesight
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Depression
- ☐ Anxiety
- ☐ Weight loss or gain
- ☐ Stress
- ☐ Fatigue
- ☐ Sleeping
- ☐ Dizziness
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Teeth or gums
- ☐ Hair loss or growth
- ☐ Skin
- ☐ Frequent falling
- ☐ Losing height
- ☐ Broken bones

MAJOR ILLNESS AND INJURY HISTORY

lease list below, dates of all operations, hospitalizations, psychological therapy, major injuries, and illnesses (excluding pregnancies).
If you need more space please continue on the back, or add another page.

OPERATIONS - Please list any opetations below.

Date: _____ Procedure: _____

Date: _____ Procedure: _____

HOSPITALIZATIONS - Please list any hopitalizations below.

Date: _____ Reason: _____

Date: _____ Reason: _____

PSYCHOLOGICAL THERAPY - Please list any psychological therapies below.

Date: _____ Reason: _____

Date: _____ Reason: _____

MAJOR INJURIES - Please list any major injuries below.

Date: _____ Injury: _____

Date: _____ Injury: _____

MAJOR ILLNESSES - Please list any major illnesses below.

Date: _____ Illness: _____

Date: _____ Illness: _____

ALLERGY INFORMATION

Are you allergic to any medications? If so, please list below

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

ALLERGIES - Please list any allergies you may have.

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

MEDICATION HISTORY

Are you currently using hormone therapy for menopause? ☐ No ☐ Yes

If no, why not? If yes, for what reasons? Please describe below:

_____

Please indicate the **medications and supplements** (such as vitamins, calcium, herbs, soy) you are currently using. Please note if you are taking a multivitamin and if taking calcium specify whether it is with or without vitamin D. **Include prescription drugs and those purchased without a prescription.** Also include all hormone therapy you have used in the past (examples: contraceptives, thyroid hormones, and hormone therapy for menopause).

Name: _____ Type: _____

Dose: _____ Frequency: _____ Date Started: _____ Date Stopped: _____ If stopped, why?

Explain here: _____

Name: _____ Type: _____

Dose: _____ Frequency: _____ Date Started: _____ Date Stopped: _____ If stopped, why?

Explain here: _____

Have you used any other therapy for menopause (such as acupuncture or yoga)? ☐ Yes ☐ No

If yes, please indicate: _____

Of these, what are you currently using? _____

Is this therapy helpful? ☐ Yes ☐ No

FAMILY HISTORY

Please list below any members of your family including parents, grandparents, aunts, uncles, brothers and sisters **who currently has or once had the following:**

High Blood Pressure: _____

Heart Disease (Indicate age): _____

Stroke (indicate age): _____

Blood Problems (including sickle cell trait): _____

Blood Clots: _____

Bleeding Tendency: _____

Glaucoma: _____

Osteoporosis: _____

Hip Fracture: _____

Diabetes: _____

Breast Cancer (indicate age): _____

Colorectal Cancer: _____

Ovarian Cancer: _____

Other Cancer: _____

Depression: _____

Other Mental Health or Emotional Problems: _____

Alzheimer's Disease: _____

Domestic Violence Victim: _____

Domestically Violent Person: _____

Sexual Abuse Victim: _____

Sexually Abusive Person: _____

Alcoholism: _____

Drug Abuse: _____

Is there anything about your family's history that concerns you or that you would like to discuss? ☐ No ☐ Yes (If yes, please explain.)

_____

REVIEW OF SYMPTOMS

Please check if symptom is present. If present, please describe briefly.

Symptom	Symptom Present?	If present, please describe briefly.
Sense of well being	☐ No ☐ Yes	
Recent change in weight	☐ No ☐ Yes	
Shortness of breath with exercise	☐ No ☐ Yes	
Chest pain with exercise	☐ No ☐ Yes	
Swelling in ankles by evening	☐ No ☐ Yes	
Nausea	☐ No ☐ Yes	
Heartburn	☐ No ☐ Yes	
Constipation	☐ No ☐ Yes	
Diarrhea	☐ No ☐ Yes	
Blood in stool	☐ No ☐ Yes	
Very frequent urination	☐ No ☐ Yes	
Muscle weakness	☐ No ☐ Yes	
Joint pain	☐ No ☐ Yes	
Numbness in hands or feet	☐ No ☐ Yes	
Unexplained sadness	☐ No ☐ Yes	
Difficulty sleeping	☐ No ☐ Yes	

GYNECOLOGICAL HISTORY

How would you describe your current status?

- ☐ Premenopause (before menopause; having regular periods)
- ☐ Perimenopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)
- ☐ Postmenopause (after menopause):

Was your menopause:

- ☐ Spontaneous ("natural")
- ☐ Surgical with removal of both ovaries ☐ Yes ☐ No ☐ Don't know
- ☐ Surgical with removal of uterus ☐ Yes ☐ No ☐ Don't know
- ☐ Other (explain): _____
- ☐ Due to chemotherapy or radiation therapy; reason for therapy: _____

Age at first menstration: _____ Are your periods (or were your periods) usually regular? ☐ Yes ☐ No

If not still having periods, what was your age when you had your last period? _____

If still having periods, how often do they occur? _____ How many days does your period last? _____

Are your periods painful? ☐ Yes ☐ No If yes, how painful? ☐ Mild ☐ Moderate ☐ Severe

Do you have spotting or bleeding between periods? ☐ Yes ☐ No

Is there a recent change in how often you have periods? ☐ Yes ☐ No

Is there a recent change in how many days you bleed? ☐ Yes ☐ No

Has your period recently become very heavy? ☐ Yes ☐ No

Do you think you have a problem with your period? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any problems with PMS? (PMS is having mood swings, bloating, headaches just prior to your period.) ☐ Yes ☐ No

Do you examine your breasts? ☐ Yes ☐ No

If yes, how often? _____

Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

If yes, how often? _____

Do you douche? ☐ Yes ☐ No

What is the date and results (if known) of your last test regarding:

Pap Smear: _____ Any abnormal Pap tests? ☐ Yes ☐ No If yes, when? _____

Results: _____

Mammogram: _____ Any breast biopsies? ☐ Yes ☐ No If yes, when? _____

Results: _____

Thyroid: _____ Any abnormal thyroid tests? ☐ Yes ☐ No If yes, when? _____

Results: _____

Cholesterol: _____ Results: _____

Colonoscopy: _____ Results: _____

Blood Sugar Test: _____ Results: _____

Sigmoidoscopy: _____ Results: _____

Fecal Occult Blood Test: _____ Results: _____

Bone Density Test: _____ Results: _____

Do you leak urine when you cough? ☐ Yes ☐ No

Do you have urgency/trouble making it to the bathroom in time? ☐ Yes ☐ No

OBSTETRICAL HISTORY

Please indicate the method of birth control, if any, that you are currently using or have used previously:

	Using now	Previously Used		Using now	Previously used
None	☐	☐	Implanted Hormone	☐	☐
Sterilization (tubes ties)	☐	☐	Diaphragm	☐	☐
Male partner had vasectomy	☐	☐	Foam/gel	☐	☐
Birth control pill, ring, skin patch	☐	☐	Condoms	☐	☐
IUD	☐	☐	Natural family plan/rhythm	☐	☐
Injectable hormone	☐	☐	Other	☐	☐

How many times have you been pregnant? _____ How many children do you have? _____ How many were adopted? _____

How old were you when your first child was born? _____ How old were you when you had your last child? _____

Please provide the number of your:

Full term births: _____ Premature births: _____ Miscarriages: _____ Abortions: _____ Living children: _____

Any complications during pregnancy, delivery, or postpartum? ☐ Yes ☐ No If yes, please describe below:

_____

SEXUAL HISTORY

Are you currently sexually active? ☐ Yes ☐ No

If yes, are you currently having sex with: ☐ a man (or men) ☐ a woman (or women) ☐ both men and women

How long have you been with your current sex partner? _____

Are you in a committed, mutually monogamous relationship?	☐ Yes	☐ No
If not, do you use condoms (practice safe sex)?	☐ Yes	☐ No
Have you had any sexually transmitted infections?	☐ Yes	☐ No
Do you have concerns about your sex life?	☐ Yes	☐ No
Do you have a loss of interest in sexual activities (libido, desire)?	☐ Yes	☐ No
Do you have a loss of arousal (tingling in the genitals or breasts; vaginal moisture, warmth)?	☐ Yes	☐ No
Do you have a loss of response (weaker or absent orgasm)?	☐ Yes	☐ No
Do you have any pain with intercourse (vaginal penetration)?	☐ Yes	☐ No

If yes, how long ago did the pain start? _____

Please check which best describes your pain. ☐ Pain with penetration ☐ Pain inside ☐ Feels dry

PERSONAL HISTORY

Do you consider your health to be: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

EXCERCISE

How often do you exercise? ☐ Almost daily ☐ At least 3x/wk ☐ Occasionally ☐ Rarely ☐ Never

If you exercise, what type? ☐ Aerobic ☐ Weights / Resistance ☐ Stretching / Balance

Please explain below, for each exercise type, how long and how often:

_____

Do you enjoy these activities? _____

Do you have any physically active leisure activities? _____

DIET

How many meals do you eat each day? _____

Do you try to eat a special diet? ☐ Low-fat ☐ Low carbohydrate ☐ High protein ☐ Vegetarian ☐ Other

If other, please describe: _____

What dairy products do you consume each day and how much?

☐ Milk How much? _____ ☐ Yogurt How much? _____

☐ Cheese How much? _____ ☐ Other What and how much? _____

Are you lactose intolerant(diarrhea or gastrointestinal/GI upset after dairy products)? ☐ Yes ☐ No

How many of the following do you consume *each day?* Fruits: _____ Vegetables: _____

How many of the following do you consume *each week?* Fish: _____ Soy foods _____

What is your daily nutrient intake: Calcium (mg.): _____ Vitamin D (IU): _____

TOBACCO USE

Do you currently smoke cigarettes? ☐ Yes ☐ No

If yes, how many per day? _____ When did you start? _____

How do you feel about quitting smoking? _____

If you do not currently smoke cigarettes, have you ever smoked? ☐ Yes ☐ No

If yes, when did you start? _____ How many per day? _____

Do you use any other type of tobacco? ☐ Yes ☐ No If yes, what? _____

CAFFEINE USE

Do you consume drinks with caffeine (coffee, tea, soda drinks)? ☐ Yes ☐ No If yes, how many drinks each day? _____

ALCOHOL AND DRUG USE

Do you drink alcohol? ☐ Yes ☐ No Do you ever have a drink in the morning to get you going? ☐ Yes ☐ No

Have you ever felt guilty about the amount you drink? ☐ Yes ☐ No Have you ever been an alcoholic? ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No

ABUSE

In the last year, have you been hit, slapped, kicked, or physically hurt by someone? ☐ Yes ☐ No

Within the last year, has anyone ever forced you to have sexual activities? ☐ Yes ☐ No

Do you feel you are verbally or emotionally abused by someone? ☐ Yes ☐ No

If you answered yes to any of the questions above, have you had counseling for these issues? ☐ Yes ☐ No

STRESS MANAGEMENT

What are the current major stressors or life changes in your life? (Please explain below.)

_____

Are there any major changes in the family health during the past year? ☐ Yes ☐ No If yes, please explain below.

_____

How do you handle stress? ☐ Very well ☐ Moderately well ☐ Poorly

What do you do to relax? _____

Please describe below any symptoms and/or problems we didn't ask you about that you feel are important.

_____

Race/Ethnicity	Preferred Language	
☐ American Indian/ Alaska Native	☐ Arabic	☐ Chinese
☐ Asian	☐ English	☐ French
☐ Black/African American	☐ German	☐ Hindi
☐ Caucasian	☐ Italian	☐ Japanese
☐ Hispanic or Latin/o/a/x	☐ Korean	☐ Mandarin
☐ Native Hawaiian or Pacific Islander	☐ Polish	☐ Portuguese
☐ Decline	☐ Spanish	☐ Thai
☐ Other	☐ Vietnamese	☐ Other
		☐ Declined

The Federal Offices of the Centers for Medicare and Medicaid Services is asking health care providers to submit data on race and ethnicity in their effort to end disparities in health care.

Your participation is entirely voluntary and answers are confidential.

Thank you for taking the time to complete our questionnaire. Upon completion, please save your completed packet to your computer and then send the packet as an attachment via email to The Menopause Center at FCONP@womenscare.com

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GAIL MODEL - CALCULATING BREAST CANCER RISK

Name: _____ **Date:** _____

1. Age: _____
2. Age of first period (menarche): _____
3. Age of first live birth (not applicable if no births): _____
4. Number of 1st degree relatives with breast cancer:

   Mother: _____ Sister(s): _____ Daughter(s): _____ Total: _____
5. Number of previous breast biopsies: _____
6. Have you had at least one biopsy with atypical hyperplasia? ☐ Yes ☐ No

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MENSI CLINICAL QUESTIONNAIRE

Name: _____ **Date:** _____

In the past month, did you experience:

Symptom	Choose One			Was it a problem?	
1. Hot or warm flashes?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
2. Palpitations?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
3. Headaches?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
4. Sleep Disturbances?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
5. Chest pressure/pain?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
6. Shortness of breath?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
7. Numbness?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
8. Weakness or Fatigue?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
9. Pain in bone joints?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
10. Memory loss?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
11. Anxiety?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
12. Depression?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
13. Fear of being alone in public?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
14. Loss of urinary control?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
15. Vaginal dryness?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
16. Loss of sexual drive?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
17. Pain with intercourse?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
18. Disrupted function at home?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No
19. Disrupted function at work?	☐ No	☐ Occationally	☐ Frequently	☐ Yes	☐ No

20. Please list any other symptoms below:

_____

MENSI score (1-38) Number of "Yes" answers: _____

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RISK FACTORS FOR OSTEOPOROTIC FRACTURE

Name: _____ Date: _____

Non-modifiable (please check all positives)

- [ ] Personal history of fracture as an adult.
- [ ] History of fracture in a first-degree relative (mother, father, sibling, child)
- [ ] Caucasian race
- [ ] Advanced age (>70)
- [ ] Female sex
- [ ] Dementia
- [ ] Poor health/frailty

Potentially modifiable (please check all positives)

- [ ] Current cigarette smoking
- [ ] Low body weight (<127 pounds)
- [ ] Estrogen deficiency
- [ ] Early menopause (<age 45) or bilateral ovariectomy
- [ ] Prolonged premenopausal amenorrhea (>1 year)
- [ ] Low calcium intake (lifelong)
- [ ] Alcoholism
- [ ] Impaired eyesight despite adequate correction
- [ ] Recurrent falls
- [ ] Inadequate physical activity
- [ ] Poor health/frailty

Women's Care OBSTETRICS, GYNECOLOGY & MIDWIFERY CENTER

FERTILITY CENTER of OREGON

Patient			
Preferred Name/Maiden Name/Other			
Date of Birth (MM/DD/YYYY)		Phone number	
Street Address or PO Box			
City	State	Zip Code	

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize the use and disclosure of a copy of the specific health and medical information as described below:

To: The Fertility Center of Oregon — 541-683-1559
Individual or Facility — Phone Number

590 Country Club Parkway, Ste A, Eugene OR, 97401 — 541-683-1709
Mailing Address, City/State, Zip — Fax Number

From: _____ _____
Individual or Facility — Phone Number

_____ _____
Mailing Address, City/State, Zip — Fax Number

The purpose of this request is:
- ☐ Referred Medical Care
- ☐ Transferring Primary Care
- ☐ Relocation
- ☐ Personal Preference
- ☐ Clinical Research
- ☐ Billing Purposes
- ☐ Personal Request
- ☐ Legal Matter
- ☐ Other: _____

The purpose of this request is at the request of the individual

Please INITIAL all types of Information to be released:

- ☐ *All Medical Records (Last 2 years)
- ☐ Hospital Records/Consultations
- ☐ Imaging Reports
- ☐ Physician Notes
- ☐ Immunization Records
- ☐ Other: _____
- ☐ Lab/Pathology Reports
- ☐ Billing Information

*All Medical Records includes Physician Notes, Lab/Pathology reports, Hospital Records/Consultations and Immunization Records for the last 2 years unless otherwise specified

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I **place my initials** in the applicable space next to each type of information:

- ____ Drug/Alcohol diagnosis, treatment or referral information
- ____ Mental Health information – including provider notes
- ____ HIV/AIDS information
- ____ Genetic testing Information

Copy Format: Electronic Paper Fax

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. I specifically give authorization to fax or electronically provide my medical information. I understand that risk is involved in electronically transmitting records and confidentiality at the receiving end cannot always be guaranteed. All disclosed information will contain a confidentiality statement and instructions for returning misdirected information. ____ (INITIALS)

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that, you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to: *Women's Care HIPAA Compliance Officer, P.O. Box 70368 Springfield Oregon 97475* that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. Records will be released within 30 days of receipt of this authorization.

This Authorization will expire on the earlier of _____ (date), 365 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

_____ Date: _____
Signature of Individual or Personal Representative

_____ _____
Description of Representative's Authority — (For internal use - Center for Genetics Patient)

Women's Care
OBSTETRICS & GYNECOLOGY

Women's Care Financial Agreement

Thank you for trusting Women's Care to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Date:_____ Printed Full Legal Name: _____

Patient Signature: _____

Date:_____ Printed Full Legal Name: _____

Parent/Guardian Signature:_____

Insurance

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits.

As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare

We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which lists our fee and notifies you of your financial responsibility for certain medical services.

Managed Care

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations, it is important that we have your current insurance information. Depending on individual policies, your provided care may not have a covered benefit. **It is your responsibility to check for optimal coverage by your insurance company. Please contact your insurance company with questions regarding your coverage.**

Patient Responsibility for Payment:

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your visit. Patient due balances noted on your monthly statement are due within 30 days of receipt.

Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

OB Care and Delivery

OB patients will meet with our business office representatives to discuss insurance coverage and payment options. Automatic payments from your bank account are available for your convenience.

Deposits:

New patients without insurance, or if insurance co-payment cannot be verified, are required to pay a deposit on or before the first date of service. If insurance payment results in a credit balance, it will be refunded to you.

Payment Options:

We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our Business Office at (541) 868-9746 to make payment arrangements.

We offer uninsured patients a 20% discount for payment by cash, check or credit card received on the date of service or as soon as charges are available for the service. Discount does not apply to infertility services, lab, or supply charges.

Non-Payment:

Failure to pay may result in your account being referred to a collection agency, which may affect your credit. Please contact our business staff to discuss payment arrangements. Referral to a collection agency, or naming Women's Care in a bankruptcy filing, may result in dismissal from our practice.

If we refer your account for legal action, you will be charged a processing fee and any applicable legal fees.

FERTILITY CENTER of OREGON

ACKNOWLEDGEMENT AND CONSENT

Full Legal Name: _____ Date of Birth: _____

I understand that The Fertility Center of Oregon, (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area and online at www.fertilitycenteroforegon.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices and The Fertility Center of Oregon will honor that request if approved.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Date: _____ By: _____
(Patient signature)

OR

Patient representative's full legal name: _____

Description of Representative's Authority: _____

Date: _____ By: _____
(Patient representative signature)

Fact Sheet for Health Care Consumers
Genetic Privacy & Research

Oregon's first genetic privacy laws were passed in 1995 with a goal of trying to help protect your genetic information and prevent possible employment or insurance discrimination to health care consumers like yourself.

In 2005, a few changes were made in Oregon laws about when results of a genetic test, specimens collected (such as blood or tissue), or health care information may be available for certain types of genetic research. You will be asked to make decisions about this starting in 2006.

What is the same?

- If genetic test results, specimens collected or health care information can be linked to you (for example if it includes your name or address or birth date) the researcher must still get your permission before using this information for genetic research.

What is new?

- If genetic test results, specimens collected or other health care information does not include any information that can be linked to you (or there is only a code and the key to the code is kept separately) the new law allows researchers to access these and ask permission of an independent review board (called an IRB) to use the test results, specimens collected or health care information for what is called “anonymous” or “coded” genetic research.
- The new law requires you to make a decision regarding use of your health information in anonymous or coded genetic research.
- As a result, starting July 1, 2006, the new law requires that your doctor or health care provider give you notice and asks you to complete a form at least once and mark if you DO NOT want any of your specimens or health care information available for anonymous or coded genetic research. This is often called an “opt-out” form.

Why was the change made?

- Many people want to keep their health care information, including their genetic information, private. Many people also recognize that medical and genetic research can help develop new information that allows both patients and doctors to learn more about diseases, make good health care decisions, and discover new treatments.
- The new law tries to balance the interests of those who want to keep their genetic information private by allowing them to make a decision to "opt-out" while allowing researchers to do genetic research needed to make good health care decisions by you and your health care providers.

What do I need to do?

- You will need to make a personal decision on whether your genetic test results, specimens collected or health care information will be available for anonymous or coded genetic research.
- If you DO NOT want your results of a genetic test, specimens collected or health care information available for anonymous or coded genetic research you must mark that place on the form provided by your doctor or health care provider
- If you DO want the results of a genetic test, specimens collected, or your health care information available for anonymous or coded genetic research, you don't need to do anything.
- In either case, your health care provider is responsible for providing a notice and form for you to mark. This only needs to happen once, not at every visit.
- If you change your mind in the future, it is YOUR responsibility to inform your health care provider and it would only affect results of genetic tests, specimens collected or health care information from that date forward.

Where can I get more information?

Talk to your doctor or health care provider.
The Oregon Genetics Program - (971) 673-0271 or
www.healthoregon.org/genetics

Women's Care

Notice of your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to refuse to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a review board reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants. With the exception of anonymous or coded research, use of your health information or biological samples for genetic research requires your specific written consent.

In anonymous research, personal information that could be used to identify you, like your name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, **you don't have to do anything**. If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

If you decline to have your health information and biological sample available for anonymous or coded genetic research, **you must tell your health care provider** by:

- Completing this form and giving it to your health care provider.

Your decision is effective on the date you sign this form. No matter what you decide now, you can always change your mind later. If you change your mind, inform us of your decision in writing. The new decision will apply only to health information or biological samples collected after we receive this completed form.

If you have any questions or concerns about this notice, please contact our laboratory manager at 541-683-1559.

☐ **By checking this box and signing below I decline to have my health information and biological samples available for anonymous and/or coded genetic research.**

Date: _____

Patient's printed full legal name: _____

By: _____
(Patient signature)

OR

Patient representative's printed full legal name: _____

Description of representative's authority: _____

By: _____
(Patient representative signature)