Taylor & Karoly, P.C.

101 Medical Drive
Dublin, GA 31021
(478) 275-3782

REGISTRATION: (Please Print)

Date: _____ **Age:** _____

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Number: (_____) _____ **Cell Number:** (_____) _____

Employer Name and Number:

_____

Spouse's Name: _____

Spouse Birth Date: _____ **Spouse Social Security Number:** _____

Emergency Contact Name, Number and Relation: _____

_____

If under 18 years of age, Guardian Name and Number: _____

_____

Referred By: _____

Signature: _____

Thank you for becoming part of
Taylor & Karoly, P.C.

Taylor & Karoly, P.C.
101 Medical Drive
Dublin, GA 31021
(478) 275-3782

Insurance Information

If you have any insurance (Medicare, Medicaid, and/or Private Insurance), please allow the receptionist to make a copy of your insurance card and your picture ID.

Payment is expected at the time of service unless prior arrangements have been made.
If you have a co-payment and or co-insurance, please be prepared to pay it at each visit.
If you are self pay, a minimum of $100 is required before being seen by the doctor.
If we may assist you in any way, please feel free to ask.

Payment method: Cash Check Visa MasterCard

Insurance Company: _____

Policy Number: _____

Group Number: _____

If you are not the policy holder for this insurance, Please name the policy holder:

_____

Policy holder's relation to you: _____

Policy holder's date of birth: _____

Policy holder's social security number: _____

Signature: _____ **Date**: _____

Taylor & Karoly, P.C.

101 Medical Drive
Dublin, GA 31021
(478) 275-3782

Physician Practice Financial Policy and Release of Information

The following is a statement of our Financial Policy for services provided within our office and any services provided at Fairview Park Hospital under the orders of H. Kevin Taylor, M.D., Michael J. Karoly, M.D. or Chereese B. Rowe, P.A.-C. We require you to read and sign this document prior to treatment by this facility.

Patient Responsibility

All professional services rendered are charged to the patient and are due at the time of service. As a courtesty, this practice will file your claim with your insurance carrier; however the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. **Any co-payments, deductable or Co-Insurance amounts not satisfied with your carrier are due at check in.**

Initial _____

Insurance carriers typically do not cover all medical cost. Some pay fixed allowances for each procedure and office visit, while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. Any disputes between my (patient) insurance company and myself (patient) are not the respnsibilty of Taylor and Karoly. P.C. ***IT IS THE PATIENT'S RESPONSIBILITY TO UNDERSTAND THEIR INSURANCE COVERAGE.***

Inital _____

When you receive a statement from Taylor and Karoly, P.C., you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are to contact our office at the telephone number provided on the statement. **Do not ignore the bill, as it will result in turning the balance over to an outside collection agency for recovery,**

Initial _____

Authorization for Treatment and to Release Information

The signature below serves as authorization for medical treament by the physician, physician assistant, or nurse for the named patient. It also provides authorization for Taylor and Karoly, P.C. To furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plans administrator, health departments and/or other health care providers in order to process health care claims incurred at the office and/or hospital for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of your complete medical record from other physician proactices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the proctice in writing. I understand that I am financially responsible to Taylor and Karoly, P.C. For any unpaid balance not covered by the insurance carrier.

Initial _____

Assignment of Benefits

I hereby assign and authorize my insurance benefits to be paid directly to Taylor and Karoly, P.C.

Patient Name (please print)	Signature of Patient or Responsible Party	Date

HOSPITAL ADMISSIONS:
(List operations and/or serious illnesses that required hospitalization excluding pregnancy)

YEAR	REASON FOR ADMISSION	HOSPITAL

MEDICATIONS: (List all medications you are currently taking)

_____

_____

MENSTRUAL HISTORY:

Age at first period:_____ Date of LMP: _____ Period interval (# of Days): _____

Duration of Bleeding: _____ Do you have cramps? YES or NO - Mild Moderate Severe

Are cramps always present? YES or NO Cramps start Before During or After bleeding?

Medications for cramps? YES or NO What type of medication?_____

How many periods have you had in the last year?_____

Do you have bleeding or spotting between periods? YES or NO

VAGINAL INFECTIONS:

History of YEAST TRICHOMONAS CHLAMYDIA HERPES or GONORRHEA

Date of last PAP Test:_____ Was it NORMAL or ABNORMAL

Date of last Mammogram:_____ Was it NORMAL or ABNORMAL

Current Contraceptive Method:_____ If Pill, What Brand? _____

OBSTETRICAL HISTORY:

How many times have you been pregnant?_____ Premature babies_____ Miscarriages ____
Abortions_____ Living Children_____

	BIRTHDATE (Month/Year)	WEEKS PREG	WEIGHT	SEX	TYPE OF DELIVERY	REMARKS
1.						
2.						
3.						
4.						
5.						

MENOPAUSAL HISTORY: If applicable, Do you have Hot Flashes and/or Night Sweats? Y or N
SEXUAL HISTORY: Satisfactory Uncomfortable Wish to Discuss
SOCIAL HISTORY: Smokes ____ packs of cigarettes per day Alcohol ___ oz per week
Coffee ____cups per day Street Drugs_____

TAYLOR & KAROLY, P.C.

NAME:_____ DATE:_____

REVIEW OF SYSTEMS

Pertinent (at least 1 system) **Extended (at least 2 systems)** **Complete (at least 10 systems)**

PLEASE CIRCLE YES or NO

CONSTITUTIONAL

Good general health	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Headaches	YES	NO

EYES

Eye disease or injury	YES	NO
Glasses/contact lenses	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

EARS, NOSE MOUTH, THROAT

Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic Sinus Problems	YES	NO
Nose Bleeds	YES	NO
Mouth Sores	YES	NO
Bleeding Gums	YES	NO
Sore Throat/Voice Change	YES	NO
Swollen Glands in Neck	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pain or angina	YES	NO
Palpitation	YES	NO
Shortness of Breath with Walking or lying flat	YES	NO
Swelling of feet or ankles	YES	NO

RESPIRATORY

Chronic cough	YES	NO
Spitting up blood	YES	NO
Shortness of Breath	YES	NO
Asthma or Wheezing	YES	NO

GASTRONITESTIONAL

Loss of Appetite	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Nausea or Vomiting	YES	NO
Rectal Bleeding/Blood in Stool	YES	NO
Abdominal pain or heartburn	YES	NO
Stomach duodenal Ulcer	YES	NO

GENITOURINARY

Frequent Urination	YES	NO
Burning or Painful Urination	YES	NO
Blood in Urine	YES	NO
Straining when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney Stones	YES	NO
Sexual Difficulty	YES	NO
Pain with periods	YES	NO
Vaginal Discharge	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint Stiffness or Swelling	YES	NO
Weakness of muscles or joints	YES	NO
Back Pain	YES	NO
Difficulty in walking	YES	NO

INTEGUMENTARY (skin, breast)

Rash or itching	YES	NO
Change in hair or nails	YES	NO
Varicose Veins	YES	NO
Breast Pain	YES	NO
Breast Lump	YES	NO
Breast Discharge	YES	NO

NEUROLOGICAL

Frequent Headaches	YES	NO
Light-Headed or Dizzy	YES	NO
Convulsions or Seizures	YES	NO
Numbness or tingling	YES	NO
Tremors	YES	NO
Paralysis	YES	NO
Stroke	YES	NO
Head Injury	YES	NO

PSYCHIATRIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Insomnia	YES	NO

ENDOCRINE

Glandular or Hormone Problem	YES	NO
Thyroid Disease	YES	NO
Excessive Thirst or Urination	YES	NO
Heat or cold intolerance	YES	NO
Skin becoming dryer	YES	NO

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	YES	NO
Bleeding or Bruising Tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Enlarged Glands	YES	NO

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other reaction

Penicillin or other antibiotic	YES	NO
_____		
Narcotic Pain Medication	YES	NO
_____		
Aspirin or other pain remedy	YES	NO
_____		
Iodine, or other antiseptic	YES	NO
_____		
Tetanus Antitoxin	YES	NO
_____		
_____		
Other Drug/Medication	YES	NO
_____		
_____		
Known Food Allergies	YES	NO
_____		
_____		

Will you have a blood transfusion in a life or death situation YES NO

HIPAA Notice of Privacy Practices

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW TAYLOR & KAROLY, P.C. MAY USE AND/OR DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Michelle Haigh

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies your ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and/or disclose your Health Information for your treatment and to provide you with treatment-related health care services. For example, we may use your information to disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and/or disclose your Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and/or disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and/or disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and/or disclose Health Information to contact you to remind you that you have an appointment with us. Our communications to you may be by telephone, cell phone, e-mail, or mail. We also may use and/or disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care and/or payment for your care, such as your family and/or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and/or disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use and/or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

How Taylor & Karoly, P.C. May Use or Disclose Your Health Information Without Your Written Authorization

SPECIAL SITUATIONS:

1. ***As Required by Law.*** We may use and/or disclose Health Information when required to do so by international, federal, state or local law. For example, we may disclose medical information to report child abuse or to respond to a court order.
2. ***To Avert a Serious Threat to Health or Safety.*** We may use and/or disclose Health Information when necessary to prevent a serious threat to your health and/or safety and/or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
3. ***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions and/or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
4. ***Organ and Tissue Donation.*** If you are an organ donor, we may use and/or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.
5. ***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
6. ***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries and/or illness.
7. ***Public Health Risks.*** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
8. ***Health Oversight Activities.*** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
9. ***Data Breach Notification Purposes.*** We may use and/or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
10. ***Lawsuits and Disputes.*** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
11. ***Law Enforcement.*** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
12. ***Coroners, Medical Examiners and Funeral Directors.*** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
13. ***National Security and Intelligence Activities.*** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
14. ***Protective Services for the President and Others.*** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.
15. ***Inmates or Individuals in Custody.*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

1. ***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

2. ***Disaster Relief.*** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and/or disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and/or disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR HEALTH INFORMATION RIGHTS:

You have the following rights regarding Health Information we have about you:

1. ***Right to Inspect and Copy.*** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Taylor & Karoly, P.C., Michelle Haigh, Privacy Officer, 101 Medical Drive, Dublin, GA 31021. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
2. ***Right to an Electronic Copy of Electronic Medical Records.*** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
3. ***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
4. ***Right to Amend.*** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Taylor & Karoly, P.C., Michelle Haigh, Privacy Officer, 101 Medical Drive, Dublin, GA 31021.
5. ***Right to an Accounting of Disclosures.*** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Taylor & Karoly, P.C., Michelle Haigh, Privacy Officer, 101 Medical Drive, Dublin, GA 31021.
6. ***Right to Request Restrictions.*** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Taylor & Karoly, P.C., Michelle Haigh, Privacy Officer, 101 Medical Drive, Dublin, GA 31021. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
7. ***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
8. ***Right to Request Confidential Communications.*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Taylor & Karoly, P.C., Michelle Haigh, Privacy Officer, 101 Medical Drive, Dublin, GA 31021.Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
9. ***Right to a Paper Copy of This Notice.*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our office located at 101 Medical Drive, Dublin, GA 31021. To obtain a paper copy of this notice, through the mail please call our office (478) 275-3782 or write and mail to Taylor & Karoly, P.C., Michelle Haigh, Privacy Officer, 101 Medical Drive, Dublin, GA 31021.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Taylor & Karoly, P.C., Michelle Haigh, Privacy Officer, 101 Medical Drive, Dublin, GA 31021. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Taylor & Karoly, P.C.'s Notice of Privacy Practices.

_____ _____

Signature Date

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign our acknowledgement
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify)

Taylor & Karoly, P.C.
101 Medical Drive
Dublin, GA 31021
(478) 275-3782

Disclosure of Protected Health Information

Please read carefully

Date: _____

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I _____ am authorizing Taylor & Karoly P.C. to give all medical information to _____ _____.

Initial one ONLY

DO disclose medical information to the person(s) listed above. _____ Initial

DO NOT disclose any medical information to anyone other than myself. _____ Initial

Scheduled Appointment Times	Yes_____	No_____
Leave Messages on answering machine or voicemail	Yes_____	No_____
Call me at home	Yes_____	No_____
If not, please provide alternate telephone contact information: _____		
Mail reminders or other correspondence to my home	Yes_____	No_____
If not, please provide alternate mailing address: _____		
Give results of any tests or lab work?	Yes_____	No_____

This remains in effect until I give written notification to discontinue.

_____ _____

Signature of Patient **Date**

Parent/Guardian of minors under age 18 has access to medical records, with the exception of any State Law protecting the privacy of information of minors.

Taylor & Karoly, P.C.
101 Medical Drive
Dublin, GA 31021
(478) 275-3782

NO SHOW and CANCELLATION POLICY

$25.00 Fee if you No Show

Cancellation of an appointment
If it is necessary to cancel your scheduled appointment, we require that you call 24 business hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment
To cancel your appointment, please call (478) 275-3752.

No Show Policy
A "no show" is someone who misses an appointment without cancelling it 24 business hours in advance of the scheduled appointment. No shows inconvenience those individuals who need access to medical care in a timely manner. Failure to arrive on time to your scheduled appointment will be recorded in your chart as a "no show". The first time there is a "no show", you will be sent a letter alerting you of your missed appointment and copy will be put in your chart. If there is a second "no show", a fee of $25.00 will be billed to you. Your insurance company will not pay this. This fee will cover administrative tasks associated with your appointment. This fee must be paid before scheduling any further appointments.

By Signing below I acknowledge receipt and will abide by the no show and cancellation policy.

Signature: _____ Date: _____

Print Name: _____

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing: ☐ Lynch ☐ HBOC

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing:
☐ Accepted
☐ Declined

_____ _____

Healthcare Professional's Signature Date

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

MYRIAD ©