Patient History

Name_____ **DOB**___/___/_____

Address: _____

Phone Number: Cell: _____ **Home:** _____

Primary Care Physician: _____

Pharmacy: _____

Lab (for bloodwork): _____

Imaging Location (Mammogram/Breast Ultrasound): _____

Medication Allergies: _____

Daily Prescriptions: _____

_____

_____

Over the Counter Medications (including supplements): _____

_____

PLEASE CIRCLE YOUR ANSWER BELOW AND EXPLAIN AS NEEDED

Marital Status: Married Single Divorced Widowed Domestic Partner Separated

Occupation _____

Diet: Regular Vegetarian Vegan Gluten Free Diabetic Specific:_____

Education: Less than grade 8, High School, 2 year college, 4 year college, Post Grad **Exercise:** None, Occasional 1-2 day/week, Moderate 3-4 days/week, Heavy 5-7 days/week

Alcohol Consumption: Never Occasional Weekly Daily: # per day:_____

Cigarettes: Never Currently Smoke____ packs per day Previous / **Quit date:** _____

How many years of smoking in your lifetime? _____

E-Cigarettes/Vape: Never used Current user Previous user: **Quit Date:** _____

Have you smoked MORE than 100 cigarettes in your lifetime? YES NO

Are you exposed to secondhand smoke? YES NO

Do you use any recreational drugs? Y/N If so, what do you use? _____

OB/GYN HISTORY

Date of Last Pap Smear: _____Last Annual GYN Exam (if different than Pap) _____

Have you ever been told you had an abnormal pap smear? YES NO

If yes, when was your last Colposcopy? __/__/____ Where was it done? _____

If under 17 years old, are you or have you ever been sexually active? YES NO

Have you ever had: Endometrial Ablation Tubal Ligation (tubes tied) Hysterectomy

Date of Last Mammogram __/__/____ Where was it done? _____

Date of Last Colonoscopy __/__/____ Where was it done? _____

Date of Last Bone Density __/__/____ Where was it done? _____

Age at first period? _____ If menopausal, age at menopause: _____

Ever been pregnant? Y/N How many pregnancies? ____ How many living? _____

Have you ever had an ectopic (tubal) pregnancy? YES NO How many? _____

Have you had a cesarean delivery? YES NO How many? _____

If you are Post-Menopausal,

Have you ever had bleeding after menopause? YES NO, If so, when: _____

Do you have any other issues associated with menopause? YES NO

Please explain issues: _____

If you still get menstrual periods, please answer the following questions:

Do you average one period a month? YES NO

How many days do you bleed each month on average? _____Heavy ____ Light _____

On the worst days of flow do you wear: pads tampons both or Menstrual cup

How often do you change? _____ How often do you change during the night? _____

If you have clots, please indicate size: dime, nickel, quarter or larger (you can use common objects to describe size) _____

Cramps on a scale of 0-10 (0 being no cramps and 10 being unbearable) _____

Do you bleed after intercourse? YES NO

SURGERIES

Operation	Date of Surgery

COVID-19

Have you ever tested positive for COVID-19? YES NO If yes, date __/__/____

Have you been immunized against COVID-19? YES NO If yes, date __/__/___

Name: _____ DOB: __/__/____

Past Medical History

Name: _____

Please check the boxes for conditions you do have and explain if needed

- ☐ Acid Reflux (GERD)_____
- ☐ Allergies (food, seasonal, environmental) _____
- ☐ Anemia_____
- ☐ Anesthesia Complications_____
- ☐ Anxiety Disorder_____
- ☐ Arthritis_____
- ☐ Autoimmune Disease_____
- ☐ Cancer_____
- ☐ Depression/Postpartum Depression_____
- ☐ Dermatologic Disorders_____
- ☐ Diabetes_____
- ☐ Dyslipidemia_____
- ☐ Eating Disorder_____
- ☐ Endometriosis_____
- ☐ Fibromyalgia_____
- ☐ GI Problems_____
- ☐ Headaches/Migraines_____
- ☐ Heart Disease_____
- ☐ Hematologic Disorders_____
- ☐ Hepatitis/Liver Disease_____
- ☐ High Cholesterol_____
- ☐ Hypertension_____
- ☐ Infertility_____
- ☐ Kidney or Bladder Problems_____
- ☐ Lung Disease_____
- ☐ Neurologic/Epilepsy_____
- ☐ Psychiatric Illness_____
- ☐ Polycystic Ovarian Syndrome (PCOS)_____
- ☐ Pulmonary Disorders (TB, Asthma) _____
- ☐ Stroke_____
- ☐ Thyroid Problems_____
- ☐ Trauma/Violence_____
- ☐ Other_____
- ☐ Have you ever been sexually assaulted? Yes No
  - ☐ If yes, would you like to talk about it with the provider? Yes No

Tyrer-Cuzick Assessment Form

Artemis Menstrual Health & Gynecology
Julie A. Madejski, MD, FACOG
5846 Snyder Drive, Lockport, NY 14094
P: 716-433-3053 F: 716-433-3118

Name: _____ DOB: ___/___/_____

Height: _____ Weight: _____ Age at First Period: _____

Childbirth Status:

Never had Child(ren) ____ Had Child(ren) ____ - Age first child was born _____

Menopause Status:

Premenopausal: _____ Postmenopausal: _____ - Age at Menopause: _____

Hormone Therapy Use:

Currently use ____ Less than 5 years ago _____ More than 5 years ago _____

Past Breast Biopsy: No ____

Yes ____, Date: _____, Results: _____

Family History: (Circle)

Mother: Breast or Ovarian Cancer: Yes/No If yes, age at diagnosis: _____

Any Sisters? Yes/No How many sisters? ____ Breast or Ovarian Cancer? Yes/No
Age at Diagnosis: _____

Paternal Grandmother: Breast or Ovarian Cancer: Yes/No Age at Diagnosis: ___

Maternal Grandmother: Breast or Ovarian Cancer: Yes/No Age at Diagnosis: ___

Paternal Aunt(s): Total #: ____ Breast or Ovarian Cancer: Yes/No Age at Diagnosis: ____

Maternal Aunt(s): Total #: ____ Breast or Ovarian Cancer: Yes/No Age at Diagnosis: ____

Daughter(s): Total #: ____ Breast or Ovarian Cancer: Yes/No Age at Diagnosis: _____

Male Relatives with Breast Cancer History: Father or Brother Age at Diagnosis: _____

Half Sister(s): Mother's side: ____ Breast Cancer History: Yes/No Age at Diagnosis: ___
Father's side: ____ Breast Cancer History: Yes/No Age at Diagnosis: ___

Cousins with Breast Cancer History: Yes/No Age at Diagnosis: _____

Nieces with Breast Cancer History: Yes/No Age at Diagnosis: _____

Ashkenazi Jewish Inheritance: Yes/No

Genetic Testing: Yes/No Results: BRCA 1- Pos/Neg BRCA 2- Pos/Neg

Signature: _____ Date: ____/_____/_____

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information			
Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know. The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)	Which Cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)	Which Relative?	Maternal (M) or Paternal (P) side	Age at diagnosis?
Breast Cancer at age 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two breast cancers (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at age 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of other cancers?	☐ Y ☐ N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review: (To be completed after discussion with your healthcare provider)

Patient Signiture_____ Date_____

Healthcare Provider Signiture_____ Date_____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRCA*nalysis*® with Myraid myRisk® ☐ Multisite 3BRCA*nalysis*® REFLEX to BRCA*nalysis*® with Myraid myRisk®

☐ COLORIS®Plus with Myraid myRisk® ☐ COLORIS AP®Plus with Myraid myRisk® ☐ Single Site Testing ☐ Myraid myRisk® Update

☐ Other:_____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment_____

Artemis Inspired Medicine, PC

OFFICE POLICIES AND PATIENT FINANCIAL RESPONSIBILITIES

Thank you for choosing Artemis Inspired Medicine, PC as your gynecological (GYN) provider. We are committed to providing you with the best possible medical care. Letting you know in advance about our policies and your financial responsibility allows for effective communication and enables us to provide and focus on your medical needs. Please read this carefully and sign in the space provided. If you have any questions, please do not hesitate to ask for clarification.

INSURANCE:

Our providers participate and are in-network with most insurance plans, including MOST Medicare plans. **If MEDICARE does not cover the full cost of your visit, you will be responsible for the remainder of the cost.** We will submit your claims to all insurance carriers that we are in-network with. If we are out-of-network or do not participate in your plan, you will be responsible for paying the full visit cost on the day of service. For these out-of-network insurance plans, you may submit your own claims to your insurance company for reimbursement. We do not guarantee reimbursement. Please remember that your insurance coverage is a contract between you and your carrier. It is your responsibility to know your benefits, deductibles, copays, participating providers and if referrals are required. If your insurance is with Medicaid, we cannot accept any form of payment.

PATIENT RESPONSIBILITIES:

At each visit you will be required to:

- Verify and update demographics (address, phone #, email etc.)
- Present current insurance card and photo ID.
- Pay copay, deductible, co-insurance, and past due balances before services with be rendered.
- To adhere to COVID-19 related policies and procedures.

We accept CASH, CREDIT and CHECKS. (Checks returned due to insufficient funds will be subject to a $25.00 returned check fee).

You must arrive 15 minutes BEFORE your appointment time to check in. We reserve the right to reschedule your appointment if you arrive 15 minutes late. 24-hour notice is required for cancellations.

There is a **$100.00 NO SHOW** fee for missed office appointments and a **$250.00 fee for missed procedure or surgery appointments**.

If your **ANNUAL WELL VISIT** involves managing problems or is lengthy, your visit can be billed at a higher code and be subject to any copay or deductible according to your insurance plan. If you would like information about what is included in your ANNUAL WELL VISIT, please inquire at the front desk.

You will be billed for any non-covered procedures or denials from your insurance company. Payment is expected within 30 days of receiving your bill. If your account remains unpaid after 90 days, you will receive a letter to pay in full within 10 days. If your balance remains unpaid, your account will be referred to collections and you will be discharged from the practice via certified mail. You will be responsible for any court or attorney fees we may incur from collections.

If you are unable to pay your bill in full, please inquire about a payment plan.

All lab specimens are processed by an outside lab. We primarily contract with Kaleida and Quest laboratories. If you receive a bill for a lab service, please contact the lab directly.

Our office policy requires an office visit for ALL prescription refills and diagnoses.

There is a **$25.00 fee for non-emergent calls** made to the answering service.

PATIENT AUTHORIZATION AND CONSENT:

Assignment of Benefits:

I hereby authorize payment of medical benefits to Artemis Inspired Medicine, PC on my behalf for any services furnished to me by their providers. I understand that I am financially responsible for any amount not covered by my insurance plan.

I hereby authorize Artemis Inspired Medicine, PC to release to my insurer, referring physician, and other medical consultants on my case information concerning my healthcare, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims benefits.

Consent to Photograph:

I hereby authorize Artemis Inspired Medicine, PC to take my photograph for inclusion in my medical chart retained by the office. I understand that this photograph is solely for the purpose of identification and familiarization by office staff.

Patient Relationship Termination:

I understand that I may be terminated as a patient if I repeatedly no-show for scheduled appointments, if I am non-compliant with medical advice, if I do not pay outstanding balances in a timely manner, if I become hostile or abusive (physically or verbally) toward staff.

Communication Notification:

With my consent, Artemis Inspired Medicine, PC personnel may call my home, cell, or emergency contact listed, leave a voicemail, send an SMS, and/or email in references to appointment reminders, insurance issues, information pertaining to my clinical care, and information regarding outstanding balances owed to the office. Please see HIPAA form for consents on information that can be left on voicemail.

Acknowledgement:

I have read and understand the financial policy and patient responsibility of Artemis Inspired Medicine, PC. I agree to comply and accept responsibility for any payment that is due as outlined above.

Name (Print) _____ Date: _____

Signature: _____

If under 18, party assuming financial responsibility:

Name (Print) _____

Relationship to patient: _____

Signature: _____ Date: _____

Medical Information Release

HIPAA Consent Form

Name: _____ DOB: ____/____/_____

Release of Information

I authorize the release of information, including diagnoses, records, examinations rendered to me, and claims information.

This information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR

_____ This information is to be released to no one.

In case of Emergency please contact:

Name: _____ Phone #: _____

If unable to reach me:

_____ You may leave a detailed message on my voicemail.

_____ You may leave a message to return the call. (NO details left on voicemail)

_____ You may leave a detailed message with any of the above-named people.

Signature: _____ Date: _____

Artemis Menstrual Health and Gynecology

Julie A. Madejski, M.D. FACOG
5846 Snyder Drive Lockport, NY 14094
Phone (716) 433-3053 Fax (716) 433-3118

Notice of Privacy Practices

In keeping with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how personal information collected in this office may be used and exchanged.

Protected health information (PHI) includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or healthcare coverage. 'Protected' means the information is protected under the HIPAA Privacy Rule.

We must obtain a signed general consent form to release PHI for the purposes of payment or health care operations. In some cases, permission to share pertinent PHI with another healthcare provider will be assumed.

You have the right to:

- Request restrictions on certain disclosures, while we are not obligated to agree to these restrictions, we will honor them whenever possible.
- Inspect and request a copy of your PHI.
- Amend your PHI.
- Obtain an accounting of disclosures of your PHI.
- Revoke permission of future PHI disclosures (this would not apply to previous disclosures submitted under previous permissions).

We are obligated to:

- Maintain the privacy of your PHI.
- Provide this notice of our privacy policies.
- Abide by the terms of this notice.
- Make public any changes to this notice.
- Inform you of any breaches to your PHI.

You have the right to register a complaint concerning any suspected violations of HIPAA with our office and/or the Secretary of the Department of Health and Human Services (DHHS). There will be no retaliation against you if you file a complaint. If you have any questions or would like to file a complaint with the office, please speak to the Practice Manager.

I have read and understand the Privacy Practices of Artemis Advanced Office Gynecology.

Printed Name: _____

Signature: _____ Date: _____

ARTEMIS ADVANCED OFFICE GYNECOLOGY

Patient Rights and Responsibilities

This Center and staff members have adopted the following list of patient rights and responsibilities. This list includes, but is not limited to:

PATIENT RIGHTS

Impartial treatment without regard to race, color, sex, national origin, religion, handicap or disability.

- To be informed and agree to care; to be free from acts of discrimination or reprisal, to receive considerate, respectful, secure and safe care that is always dignified and to be protected from abuse, harassment and neglect and have knowledge of and access to protective services.
- Knowledge of the name and professional status of those caring for you.
- To receive information from the surgeons about your diagnosis, treatment plan, prognosis, and any unanticipated outcomes, to the best of the physicians' knowledge. You have the right to spiritual care and communication and if communication restrictions are necessary for your care and safety, we will document and explain the restrictions to you or your family.
- To participate actively in decisions regarding your medical care including being involved in resolving problems and unanticipated outcomes related to your care. Families will have input in care decisions in accordance with legal directives and court orders.
- Full consideration of privacy concerning your medical care program. Case discussion, examination and treatment are confidential and should be conducted as discreetly as possible.
- To be asked if you have an Advance Directive and if so, for it to be prominently placed in your chart.
- To be advised that should an unexpected life-threatening event occur, you will receive resuscitative or other stabilizing measures and be transferred to an acute facility that will order additional treatment according to your wishes in your Advance Directive.
- Confidential treatment of all communications and records pertaining to care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care.
- Responsible responses to any reasonable request for service.
- To leave the facility even against medical advice and to change providers if another qualified provider is available.
- To expect reasonable continuity of care.
- To be advised if the physician proposes to engage in or perform experimentation affecting your care or treatment and the right to refuse to participate in this activity without hindering access to care.
- To be informed of the continuing health care requirements following discharge from the center.
- Examine and receive an explanation of a bill for service, regardless of source of payment.
- To report any comments or complaints concerning the quality of care provided to you and for the organization to provide a prompt resolution within fourteen (14) business days to your comment or complaint. In the event, after reasonable attempts have been made, that a resolution is not achieved within fourteen (14) business days, then you will be notified when you can expect a resolution.

PATIENT RESPONSIBILITIES

- To provide accurate and complete information concerning your present complaints, past medical history and other matters relating to your health.
- To make it known whether you clearly comprehend the course of treatment and what is expected of you.
- For following the treatment plan established by the physician, including the instructions of other staff members as they carry out the physicians' orders.
- To keep your appointments and notifying the facility if unable to do so.
- To provide a responsible adult to drive you home from the facility and stay with you for 24 hours after surgery.
- For assuring that the financial obligations of your care are fulfilled as promptly as possible.
- For being considerate of the rights of other patients and staff members.
- To adhere to COVID-19 related policies and procedures.

FEEDBACK/COMPLAINTS

Our goal is to provide the best surgical experience possible while in our Center. Patients, clients, families or visitors have the right to express complaints or concerns about any aspects of their care or experience with our Center without fear of discrimination or reprisal. Please be assured that expressing a complaint or concern will not compromise your care and will be addressed according to our policy. Concerns may be directed to any staff member, or you may mail your comments to us.

If you feel it is necessary, complaints may also be shared with: Medical Director, 5846 Snyder Drive, Lockport, NY 14094, 716-433-3053, NYSED.gov Office of the Professions. 518-474-3817, Press 1 then ext. 560 or Medicare Ombudsman: www.cms.gov

Artemis Advanced Office Gynecology

Ultrasound Guidelines

We normally begin with a transabdominal (external) ultrasound to view the uterus and ovaries. **This requires a FULL BLADDER** to ensure the best viewing conditions. We may follow with a transvaginal (internal) ultrasound to ensure a superior view of the uterine lining and ovaries. If you have any questions, please feel free to ask your Diagnostic Medical Sonographer.

Depending on your plan, this exam may be applied to your deductible or subject to a copay.

Please refer to your insurance plan. It is your responsibility to know your plan and benefits.

Annual Exam versus Office/Problem Visit

The **Annual Well Woman Exam** is your yearly preventative/routine exam for screening and updating your chart and health history.

- If you have a separate and distinct problem or issue that is addressed at the Annual Well Exam, it may be subject to an additional cost. This cost will depend on your plan and if you have a copay or deductible.

A **Problem/Office Visit** is a discussion and/or exam regarding a problem or chronic condition.

Annual GYN Well Exam Includes:

- ★ Physical exam, including breast exam
- ★ Pelvic exam and pap smear (if indicated)
- ★ Rectal exam for woman over 40
- ★ Update all social history
- ★ Update family health history
- ★ Update medications
- ★ Obtain necessary refills
- ★ Obtain scripts for necessary screening:
  - o Mammograms and Ultrasounds
  - o Labs such as bloodwork, STD labs, etc.
  - o Colon Cancer Screening
  - o Bone Density
  - o Specialist Referrals

Additional issues not covered during the Well Exam can be subject to a separate charge according to your insurance plan.