

**PATIENT INFORMATION SHEET**

<b>Name:</b>	Today's Date:	
SSN:	Birth date:	Marital Status:
Home Phone:	Cell Phone:	
Address:		
City:	State:	Zip:
Email Address:		
Primary Care Physician:	Referring Physician:	
Name of Spouse:		
Your Employer:	Occupation:	
Work Phone:		
<b>In Case of Emergency, Contact:</b>	Relationship:	
Emergency Contact Address:		
Emergency Contact Home Phone:	Work Phone:	
<b>Pharmacy Name:</b>	Pharmacy Phone:	
Pharmacy Fax:		
Pharmacy Address:	City/State/Zip:	
<b>Primary Insurance Company:</b>	Effective Date:	Termination Date:
Address:	Phone #:	
Subscriber #:	Group #:	
Insured's Name/SS#:	Patient Relationship to the Insured:	
Insured's Date of Birth:	Co-payment Amount: \$	
<b>Secondary Insurance Company:</b>	Effective Date:	Termination Date:
Please check: <input type="checkbox"/> Supplemental Insurance <input type="checkbox"/> Retirement Insurance		
Address:	Phone #:	
Subscriber #:	Group #:	
Insured's Name/SS#:	Patient Relationship to the Insured:	
Insured's Date of Birth:	Co-payment Amount: \$	

## How Did You Learn About Our Practice?

The greatest compliment that we can receive is a referral. If someone referred you, please list their name below so that we may thank them! Or if you saw our ad somewhere, please tell us!

Please check the appropriate circle below and fill out any other helpful information.

- 
- Primary Care Physician Name: \_\_\_\_\_
- Referring Physician Name: \_\_\_\_\_
- Current Patient Name: \_\_\_\_\_
- Insurance Provider Directory or Website
- Advertisement
- Westlake Picayune
  - Lake Travis View
  - Austin Woman Magazine
  - Phone Book Directory Please specify: \_\_\_\_\_
  - Other: \_\_\_\_\_
- Mail Correspondence
- Internet (Check any that apply)
- Search engine (Google, Yahoo, MSN, AOL, etc.)
  - www.lisamjukesmd.com
  - www.yellowpages.com
  - www.essure.com
  - Other: \_\_\_\_\_
- Other Please specify: \_\_\_\_\_

### Credit Card Payment Authorization

For your convenience, the office of Lisa M. Jukes, M.D. offers you the option to keep a credit card on file for payment of small balances or co-payments required on your account. **This information will be kept confidential and is only an option and not required.**

If you would like to participate in this option please fill out the credit card information required below. You may opt out of this credit card option at any time by contacting our office.

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By signing below, I authorize the office of Lisa M. Jukes, M.D., to utilize my credit card information to pay towards my co-payments, co-insurance percentages, and/or deductibles. This authorization is valid for as long as I am a patient of Lisa M. Jukes, M.D. I authorize amounts of \$50.00 or less to be deducted from my credit card file. Any amounts due over \$50.00 will necessitate a call to me prior to the utilization of the card.

Please check the credit card name below (we do not accept American Express or Discover):

Visa                       MasterCard

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Full Credit Card Number

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Expiration Date

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Printed Name of Authorized Card Holder

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Signature of Authorized Card Holder

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Mailing Address for Credit Card

## CONSENT FOR TREATMENT

I authorize and direct Lisa M. Jukes, M.D., and her providers/mid-level providers (nurse practitioner/physician assistant)/assistants to perform quality care, including, but not limited to, diagnostic procedures and surgical and medical treatment(s), as may be necessary in their professional judgment.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I acknowledge that when medically appropriate I may receive care from a mid-level provider or assistant.

I grant this consent without duress, confusion, or pressure from Lisa M. Jukes, M.D. and/or her staff, associates, or colleagues.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

If patient is a minor or has a legally designated representative:

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship of Witness \_\_\_\_\_

## HIPAA NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### **1. Use and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

#### **2. Your Rights**

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIAL COMMUNICATIONS  
REGARDING YOUR HEALTH INFORMATION**

The confidentiality of your personal health information is of the utmost importance to our office. Please indicate below any requests for restrictions on how we may communicate your personal health information and/or billing information. If this form is left blank, then our office will only disclose information to you.

Please be specific and list names of family members, guardian, spouse, children, etc.

Person(s) who we are permitted to discuss your personal health information and/or billing information:

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**This authorization will remain valid one (1) year from the date listed below. It is the responsibility of the patient to notify the office of any changes to this information.**

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**FINANCIAL POLICY FOR THE OFFICE OF  
LISA M. JUKES, M.D., P.A.**

- A. **All payments are required at the time services are rendered.** If we are in network with your insurance company, your co-pay and/or deductible not met must be paid at the time of service. Federal law requires that we collect copays at the time of service; otherwise we can be charged with fraudulent business practice.

For patients who may have difficulty paying at the time services are rendered, please ask our office about payment options that you may be eligible for including finance options through CareCredit®. For self-pay patients utilizing CareCredit®, standard office fees will apply and the prompt-pay discount will be waived. For patients who have insurance and choose to utilize CareCredit®, **YOU WILL WAIVE** your right to have the claim filed to insurance for each date of service using CareCredit®.

**It is the patient's responsibility to know whether or not the provider of service is in network.** The agreement with your insurance company is a contract between you and the insurance company. Please contact your insurance company for this information. If we are not in network with your insurance, you will be responsible for the difference paid to the physician and any out of network fees.

If you have an HMO plan, and your plan states that you must have a referral to see Dr. Jukes, it is your responsibility to get the referral from your primary care physician or insurance carrier, depending on your plan's requirements. This must be done prior to service.

**Patients are responsible for verifying lab test coverage prior to testing.** Some lab tests such as STD or hormone testing and Lipid panels may not be covered by your insurance. You will be responsible for any lab fees not paid by your insurance.

If you are undergoing surgery, it may be necessary, at Dr. Jukes' discretion, to use an assistant surgeon to safely complete your surgery. Any assistant surgeon fees not covered by your insurance will be your responsibility to pay.

- B. **A 24 hour cancellation notice is required if you cannot keep your appointment.** A \$35.00 fee will be applied to your account if we do not have 24 hours notice of cancellation. Three "no-shows" without 24 hour cancellation notice for scheduled appointments will result in termination of the doctor-patient relationship.
- C. For any balances on your account, you will receive an invoice requesting the payment that is due. Failure to pay an outstanding balance will result in sending your account to a Collection Agency. If your account is turned over to Collections, you will be responsible for payment of the balance as well as a 40% charge to cover the cost of turning over the account to Collections. We will also have no alternative but to terminate the doctor-patient relationship. If there are unusual circumstances preventing you from paying this bill or if you believe our information may be incorrect, please call our billing company immediately at (512) 220-9490.
- D. Please be aware that there is a \$35.00 fee for release of medical records. A \$20.00 fee will be charged for paperwork to be completed by Dr. Jukes for your employer, for school requests, attorneys, etc...
- E. We do not take insurance for the following insurance plans: Medicaid, Humana Military and Medicare Managed Care.

Please sign below that you acknowledge this financial policy and agree to adhere to it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### NEW PATIENT HISTORY FORM

[All information is confidential and will assist in providing you the best care]

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship Status: M S D W Partner's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary MD: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

[Please CIRCLE, or fill in the blanks below]

#### GYNECOLOGICAL HISTORY:

**Menstruation:** Age when your periods started \_\_\_\_\_ First day of last normal period \_\_\_\_\_  
Are periods regular? Y N Length of period \_\_\_\_\_  
Amount of flow: **Light Med Heavy** [Change tampons/pads every \_\_\_ hours?]  
Pain with periods? **No Some A lot** Medication taken for pain? Y N  
Menstrual tension or mood swings? Y N *Mild Mod. Severe*

#### Pap Smear History:

Date of last Pap smear: \_\_\_\_\_ Result \_\_\_\_\_  
Have you ever had abnormal Pap smear? Y N *When?* \_\_\_\_\_  
How was it treated? (Circle all that apply) Colpo LEEP/Cone Regular Fu Paps Other \_\_\_\_\_

#### Current Contraceptive Method: (Circle All that apply)

BC PILL – NUVA RING - CONDOMS – TUBES TIED - VASECTOMY - SPERMICIDE – NO SEX  
DEPO PROVERA – IMPLANON - IUD - WITHDRAWAL - NO METHOD  
How long used? \_\_\_\_\_ Satisfied with method? Y N  
List all methods you have tried \_\_\_\_\_

#### Sexual History: Sexual preference: **Men Women Both**

Currently sexual active? Y N  
Age at first sex \_\_\_\_\_ How long have you been having sex with current partner? \_\_\_\_\_  
Total # of sex partners \_\_\_\_\_ Have you been sexually abused? Y N *Raped? Y N*

#### Vaginal infections: Do you currently have **abnormal** discharge? Y N

Describe: \_\_\_\_\_ How long? \_\_\_\_\_  
Please check any previous infections: Herpes \_\_\_\_\_ Syphilis \_\_\_\_\_ Gonorrhea \_\_\_\_\_  
Chlamydia \_\_\_\_\_ Genital Warts [HPV] \_\_\_\_\_ Trichomonas \_\_\_\_\_ PID \_\_\_\_\_

#### Menopause: [if applicable] What age did it begin? \_\_\_\_\_

Do you have hot flashes? Y N How often? \_\_\_\_\_ Night sweats? Y N How often? \_\_\_\_\_  
Do you have mood swings? Y N *Mild Mod. Severe*  
Do you have any other symptoms? Y N Taking meds for them? Y N

#### Urinary problems: Do you have leakage of urine with coughing/sneezing, etc? Y N

Do you have urgency? Y N *Do you wear protection? Y N*

#### Bowel problems: Do you have constipation? Y N *Leakage of stool? Y N*

#### Other gynecological history? [Include ovarian cysts, pelvic pain, endometriosis, fibroids,

surgery, and pain with intercourse]

**PREGNANCY HISTORY:** Are you pregnant? **Y N** Breast feeding? **Y N**

List the number of: Times pregnant \_\_\_\_\_ Children born \_\_\_\_\_ Ectopic \_\_\_\_\_  
Abortions \_\_\_\_\_ Miscarriages \_\_\_\_\_

#	Year	Weight		Weeks	Type	Complications	
	Born	Lb	Oz	Pregnant	Delivery	Y	N
#1		Lb	Oz			Y	N
#2		Lb	Oz			Y	N
#3		Lb	Oz			Y	N
#4		Lb	Oz			Y	N
#5		Lb	Oz			Y	N

**MEDICAL HISTORY:** [Circle any that apply]

- Persistent headaches    Thyroid problems    Heart disease  
High blood pressure    Lung disease    Breast problems  
Liver disorder    Stomach, bowel or gallbladder problems  
Kidney or bladder problems    Anemia or blood disorders  
Diabetes    Cancer    Birth defects or inherited disease?  
Depression    Anxiety disorder    Skin problems    High Cholesterol

**SURGICAL HISTORY AND PREVIOUS HOSPITALIZATIONS:** [exclude pregnancy]

Date: \_\_\_\_\_ Reason: \_\_\_\_\_


Have you ever had a blood transfusion? **Y N**

**FAMILY HISTORY:**

	Age at		Health Problems	Age at		Health Problems
	Age	death		Age	death	
Father			Paternal Grandmother Paternal Grandfather			
Mother			Maternal Grandmother Maternal Grandfather			
Brothers & sisters #1 M F #2 M F #3 M F #4 M F #5 M F #6 M F			Children #1 M F #2 M F #3 M F #4 M F			

**SOCIAL HISTORY:**

Smoking cigarettes? **Y N** Amount \_\_\_\_\_ Years smoked \_\_\_\_\_  
Street drug use? **Y N** Type \_\_\_\_\_ Alcohol? **Y N** Amount \_\_\_\_\_  
Exposure to tuberculosis? **Y N** Travel out of country? **Y N**

**HEALTH MAINTENANCE:**

Do you exercise regularly? **Y N Sometimes** [1-3 x week]  
When was last cholesterol screening? \_\_\_\_\_ Was it normal? \_\_\_\_\_  
How many 8 oz servings of milk or yogurt daily? \_\_\_\_\_  
Do you take calcium supplements? **Y N** Do you take vitamins? **Y N**  
Do you perform self breast exam monthly? **Y N Sometimes**  
Have you had mammogram? **Y N** Date of last mammo \_\_\_\_\_  
Was it normal or abnormal? \_\_\_\_\_  
If abnormal, describe: \_\_\_\_\_  
Have you had colonoscopy? **Y N** Date: \_\_\_\_\_  
Have you had bone density screening? **Y N** Date: \_\_\_\_\_  
Results: \_\_\_\_\_  
Last tetanus booster? \_\_\_\_\_

**CURRENT MEDICATIONS** [include herbs and vitamins]:

Name/location of Pharmacy: \_\_\_\_\_

Name	Strength	How often taken?

**ALLERGIES to medications:**

Name of drug	Type of reaction

**OTHER PROBLEMS:** [please check any that are appropriate]

<input type="checkbox"/> Recent weight change	<input type="checkbox"/> Decrease in energy level
<input type="checkbox"/> Feeling panicked/anxious	<input type="checkbox"/> Lack of interest in activities
<input type="checkbox"/> Decreased interest in sex	<input type="checkbox"/> Pain/discomfort
<input type="checkbox"/> Increased stress	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Feeling of hurting yourself	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Change in sleep patterns	<input type="checkbox"/> Blood in stools or urine
<input type="checkbox"/> Change in eating habits	<input type="checkbox"/> Dizziness
<input type="checkbox"/> New headaches	

**FAMILY HISTORY QUESTIONNAIRE FOR HEREDITARY CANCER SYNDROMES**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The purpose of this questionnaire is to help determine if your family history could indicate the presence of a gene mutation for certain cancers. People who have inherited certain gene mutations are at extreme risk of these cancers. Testing for gene mutations in those people with a concerning family history is important because it has been proven to save lives. Once a gene mutation is diagnosed, much earlier testing and treatment can be started. This can catch cancer at the earliest possible stage (greatly increasing survival) or prevent cancer altogether.

If gene testing is recommended by your doctor, it is typically covered by most insurance companies. Also, laws prohibit health insurance companies from penalizing you if you have a gene mutation.

It is important to remember that most people who get cancer do not have a gene mutation! **MOST CANCERS OCCUR BY CHANCE** in people who have little or no cancer in their family. Therefore, it is important to continue to follow your doctor's recommendations for cancer screening (such as routine mammograms and breast exams) regardless of your family history.

**SCREENING FOR HEREDITARY BREAST AND OVARIAN CANCER SYNDROME (BRCA1 AND BRCA2 MUTATIONS):**

Y N Have **YOU** had breast cancer? If so, at what age were you first diagnosed? \_\_\_\_\_  
Y N Have **YOU** had ovarian cancer? If so, at what age were you first diagnosed? \_\_\_\_\_

Please list everyone in your **MOTHER'S** family with breast and/or ovarian cancer and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.) \_\_\_\_\_

Please list everyone in your **FATHER'S** family with breast and/or ovarian cancer and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.) \_\_\_\_\_

Y N Has anyone had breast cancer in **BOTH** breasts in your **MOTHER'S** OR **FATHER'S** families?  
If so, who? \_\_\_\_\_ At what age? \_\_\_\_\_  
Y N Have there been any **MALES** in your **MOTHER'S** or **FATHER'S** families with breast cancer?  
Who? \_\_\_\_\_ At what age? \_\_\_\_\_  
Y N Are you of Ashkenazi Jewish ancestry?

**SCREENING FOR LYNCH SYNDROME (FORMERLY CALLED HEREDITARY NONPOLYPOSIS COLORECTAL CANCER OR HNPCC):**

Y N Have **YOU** had cancer of the uterine, colon, stomach, kidney/urinary tract, brain, or small intestine? If so, circle which ones. If so, at what age diagnosed? \_\_\_\_\_

Please list everyone in your **MOTHER'S** family with any of these cancers and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.) \_\_\_\_\_

Please list everyone in your **FATHER'S** family with any of these cancers and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.) \_\_\_\_\_

Please list everyone in your **MOTHER'S** or **FATHER'S** families found to have 10 or more colon polyps. \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Health Care Provider's Signature

## INFORMED CONSENT FOR MAMMOGRAMS AND BLOOD TESTS

**YOUR LAB WORK AND/OR MAMMOGRAM MAY OR MAY NOT BE COVERED BY YOUR INSURANCE PLAN. YOU ARE RESPONSIBLE FOR DETERMINING INSURANCE COVERAGE FOR THESE TESTS AND ANY PAYMENTS TO OUTSIDE LABORATORIES AND FACILITIES WHICH PERFORM TESTS FOR YOU.**

Please read the following tests below. Check the group of tests that you would like to have drawn during your visit or you can circle the individual test(s) if you do not want the group of tests performed. If you have any questions regarding this form, please call our office prior to your visit so that we may try and assist you.

\_\_\_\_\_ **Screening Blood Work** (Comprehensive Metabolic Panel, Complete Blood Count, Lipid Panel, Thyroid Panel)

\_\_\_\_\_ **Sexually Transmitted Diseases** (Blood Work: Hepatitis Panel (A, B, C), RPR (Syphilis), Herpes Simplex I & II) (Cervical Testing: Gonorrhea, Chlamydia)

\_\_\_\_\_ **HIV-1 Antibody** (I understand that the performance and results of the HIV antibody test are considered confidential. I understand that the test results in my health record shall not be released without my expressed written permission except to the individuals and organizations that have been given access by law, who also are required to keep my health information confidential. These include me, my physician, health care facility staff who provide my health care or handle specimens of my body fluids or tissues, funeral directors, court of record under lawful order and the Health and Human Services Department/Travis County Health Department as required by law.)

\_\_\_\_\_ **Annual Mammogram** (Baseline for patients age 35-39, age 40 and over yearly, as needed for family history of abnormal)

\_\_\_\_\_ **Bone Density** (Recommended usually every 24 months once menopausal or at risk for bone loss)

\_\_\_\_\_ **Other** (List any other tests/procedures you would like to have done on the line below)

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**\*\*\*Please note: It is our policy for the PAP test to be performed with HPV typing in order to enhance the detection of cervical dysplasia/cancer in patients 30 years of age and above. If you have questions on HPV testing please discuss with the nurse or provider during your visit.**

I have read the information above and understand its content. I understand that I may ask questions at any time regarding the tests above. I hereby give my consent to have my blood drawn for the following lab(s) listed above that I have checked/circled.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_