

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.

____ **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)

*****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: _____

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

Revised 9/20/11

- 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 co-pays 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 may be available to you. 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 financed with this service.

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 plan. 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.** There will be a fee applied to your account if we do not have your 24 hour notice of cancellation. This fee also applies to missed appointments. In addition, please note that you are only considered on time and ready for your appointment if all required paperwork is completed by your appointment time. If you arrive late for your appointment and your paperwork is not completed, our ability to see you may be minimized or eliminated, and in this case cancellation fees will also apply. Fees will be assessed as follows: **New Patient - \$100.00, Established Patient Annual Exam - \$100.00, Follow-up Visit - \$50.00, any in-office procedure - \$150.00.** In addition, if you accumulate three missed appointments, meaning you did not provide us with 24 hour cancellation notice for scheduled appointments, it will result in the termination of the doctor-patient relationship.
- C. For any balances on your account, you will receive an invoice requesting the payment that is due. **Please note that a finance charge of 3% will be accrued on any balance left unpaid for more than 30 days.** 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 Financial Coordinator, Hannah, at (512) 301-6767.
- D. Please be aware that there is a \$35.00 fee for release of medical records to the patient. There is **no** fee for release of medical records to another physician with written request by the patient. A minimum of \$20.00 will be charged for paperwork to be completed by Dr. Jukes for your employer, for school requests, attorneys, etc...Fee will be dependent on documentation required.
- 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 and adhere to it.

Signature: _____ Date: _____

EXISTING PATIENT HISTORY FORM

Name: _____ Age: _____ Date: _____

Marital/Relationship Status _____

Occupation: _____ Partner's Name: _____

Referred by: _____ Primary MD: _____

Reason for visit: _____

GYNECOLOGICAL HISTORY:

Menstruation: Age your periods started _____ First day of last period _____
Are periods regular? **Y N** Length of cycle _____
Degree of flow: **Light Med Heavy** [Change tampons every ____ hours.]
Pain with periods? **No Some A lot** Medication taken for pain? **Y N**
Menstrual tension or mood swings? **Y N**

PAP smear: Date of last PAP smear: _____ Result _____
Have you had abnormal Pap smear? **Y N** Describe _____

Contraception: Current type: [include condoms, tubals etc.] _____
How long used? _____ Satisfied with method? **Y N**
Have you tried anything different? _____

Sexual History: Sexual preference: **Men Women Both**
Currently sexual active? **Y N** Virginal? **Y N**
How long in current relationship? _____ Age at first intercourse _____
Total # of partners _____ Have you been abused? **Y N**

Vaginal infections: Do you currently have discharge? **Y N**
Describe: _____
Are you having pain with intercourse? **Y N**
Please check any previous infections: Herpes _____ Syphilis _____ Gonorrhea _____
Chlamydia _____ Genital Warts [HPV] _____ Trichomonas _____ PID _____
Do you want to be tested for sexually transmitted infections today? **Y N**

Menopause: [if applicable] What age did it begin? _____
Do you have hot flashes? **Y N** Frequency? _____
Do you have mood swings? **Y N** Frequency? _____
Do you have any other symptoms? **Y N** Taking meds for them? **Y N**

Urinary problems: Do you have leakage of urine? **Y N**
Is it during cough or laughing? **Y N** Do you have urgency? **Y N**

Bowel problems: Do you have constipation? **Y N Blood in stool? Y N**
Do you have leakage of stool? **Y N**

Any changes in your medical history since last visit? [New diagnoses, hospitalizations, etc]

HEALTH MAINTENANCE:

Do you exercise regularly? **Y N Sometimes** [1-3 x week]
 Smoking cigarettes? **Y N** Amount _____ Alcohol use? **Y N** Amount _____
 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: _____

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 CURRENT PROBLEMS: [please check any that are appropriate]

<ul style="list-style-type: none"> <input type="radio"/> Recent weight change <input type="radio"/> Feeling panicked/anxious <input type="radio"/> Decreased interest in sex <input type="radio"/> Increased stress <input type="radio"/> Feeling of hurting yourself <input type="radio"/> Change in sleep patterns <input type="radio"/> Change in eating habits <input type="radio"/> New headaches 	<ul style="list-style-type: none"> <input type="radio"/> Decrease in energy level <input type="radio"/> Lack of interest in activities <input type="radio"/> Pain/discomfort <input type="radio"/> Chest pain <input type="radio"/> Shortness of breath <input type="radio"/> Blood in stools or urine <input type="radio"/> Dizziness
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Race: (please circle most appropriate)

Asian White Hispanic Other Native Hawaiian or other Pacific Black or African American

Other Pacific Islander Prefer Not to Say

Ethnicity: (please circle most appropriate)

Hispanic or Latino Note Hispanic or Latino Prefer Not to Say

Primary Language Spoken by Patient:

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____ Date of Birth: _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	<i>none</i>	<i>—</i>	<i>Brother</i>	<i>36 yrs</i>	<i>Aunt Cousin</i>	<i>44 yrs 58 yrs</i>	<i>Grandfather</i>	<i>65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer

Ovarian cancer

Breast cancer in both breasts OR multiple primary breast cancers

Male breast cancer

Are you of Ashkenazi Jewish descent? Yes No

COLON AND UTERINE CANCER

Uterine (endometrial) cancer

Colorectal cancer

Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer

10 or more cumulative colon polyps

MELANOMA

Melanoma

Pancreatic cancer

OTHER CANCER

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HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

Yes No If yes, please explain: _____

FOR OFFICE USE ONLY	
<input type="checkbox"/> Patient appropriate for further risk assessment and/or genetic testing <ul style="list-style-type: none"> <input type="checkbox"/> BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer Syndrome <input type="checkbox"/> COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® – A test for Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma 	<input type="checkbox"/> Discussed hereditary cancer risk with patient <input type="checkbox"/> Patient offered genetic testing <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED <input type="checkbox"/> Follow up appointment scheduled Date: _____