

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

Family Doctor/Internist: \_\_\_\_\_

Please Describe Reason for Appointment:

\_\_\_\_\_

Prescription Medications:  Check if none

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supplements & Non-prescriptions:  Check if none

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies:  Check if none

\_\_\_\_\_

Gynecological History:

Age: \_\_\_\_\_ Marital Status: S M D W

Race: Caucasian Asian African-American

Native-American Hispanic

Date of last menstrual period \_\_\_\_\_

Age when periods started \_\_\_\_\_

Age when menopause occurred \_\_\_\_\_

How many days apart are your periods \_\_\_\_\_

How long do your periods last \_\_\_\_\_

Describe your periods:

Have you ever been pregnant? Yes No

If "Yes" please answer the following:

Number of times you have been pregnant? \_\_\_\_\_

Number of live-born children \_\_\_\_\_

Number of miscarriages/abortions \_\_\_\_\_

Number of tubal pregnancies \_\_\_\_\_

History of infertility? Yes No

Date of last pap smear (mm/yy) \_\_\_\_\_

Date of last mammogram (mm/yy) \_\_\_\_\_

Date of last bone density (mm/yy) \_\_\_\_\_

Date of last colonoscopy (mm/yy) \_\_\_\_\_

Method of birth control:  Check if none

\_\_\_\_\_

Tobacco Use:  Yes  No  Quit If "yes" or "quit" Amount \_\_\_\_\_ How long? \_\_\_\_\_

Alcohol Use:  Yes  No How much? \_\_\_\_\_ How often? \_\_\_\_\_

In the last 12 months have you been involved in an abusive relationship?  Yes  No

Medical History Update:  Check if nothing new since last annual exam

\_\_\_\_\_

Surgical History Update:  Check if nothing new since last annual exam

\_\_\_\_\_

Please check if experiencing at this time:  Check if nothing

Abdominal pain or pelvic pain

Hot Flashes/Night Sweats

Vaginal discharge

Unpleasant vaginal odor

Vaginal itching

Vaginal Burning

Vaginal dryness

Pain with intercourse

Bleeding with intercourse

Mood swings

Depression

Memory loss

Difficulty concentrating

Sleeping problems

Decrease in sexual desire

Decrease in energy level

Digestion problems

Acne

Urinary leakage

Urinary incontinence

Burning with urination

Breast pain

Painful periods

Menopausal symptoms

PMS

Bleeding post menopause

Abnormal weight gain

Abnormal weight loss

Migraines

Bloating

Other \_\_\_\_\_



1617 S. Tuttle Avenue Suite 1A Sarasota, FL 34239  
941-330-8885

## **FINANCIAL POLICY**

Here at Swor Women's Care we are dedicated to making sure you receive the highest quality care possible, including making sure you completely understand our financial policies.

1. Unless otherwise advised, payment is due at the time of service. If the co-pay is not listed on your insurance card, it is your responsibility to find out the proper co-payment amount. For your convenience we accept Visa, MasterCard, and Discover.
2. Please remember that your insurance policy is a contract with you and your insurance company. If we are a participating provider with your insurance company we will file your insurance claim as a service to you. Please be advised, if we do not receive payment from your insurance company within a reasonable amount of time we will look to you for payment. If we receive payment from your insurance company after you have paid the balance we will reimburse you.
3. If you participate with an insurance plan that we are not providers of, payment is due at time of service and you will have to submit a claim to your insurance company for reimbursement.
4. Please understand although you may have insurance, all services may not be covered under your insurance plan. If any of the services performed come back "not covered" you will be responsible for the total charge. In the event you accrue a balance in our office we will send you a statement and payment is due upon receipt.
5. Our office does not file to secondary insurance. If you have Medicare as your primary insurance and your secondary does not automatically crossover, then it is your responsibility to pay any balance not paid by your secondary. You may then file to your secondary insurance for reimbursement.
6. If at any time Dr. Swor needs to perform an outpatient surgery on you, we will verify your benefits and submit the claim to your insurance company. Any balance accrued from surgery is the patient's responsibility and is due upon receipt of a statement.
7. If your insurance requires authorization for office visits it is your responsibility to obtain this from your primary care physician. All appointments requiring authorization will be rescheduled if an authorization is not on file.
8. Please verify with your insurance company, your coverage, before having any lab or diagnostic testing performed. If your insurance does not cover screening lab tests, we do offer certain blood tests at a reduced cost to you if performed in our office on a cash pay basis.
9. There will be a \$25.00 charge if you cancel an appointment less than 24 hours in advance. Also, if you "no show" for an appointment you will accrue a \$25.00 charge.

I have read and understand Swor Women's Care's financial policy and agree to abide by its terms. I also understand that at any time our financial policy may be amended.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change it's notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or other health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print) \_\_\_\_\_

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

Date \_\_\_\_\_

\*\*\*\*\*

### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date \_\_\_\_\_

Initials \_\_\_\_\_

Reason \_\_\_\_\_