Medicare Annual Gynecological Exam

Medicare began paying for special Annual Wellness Visits on January 2011. These services should be performed by your primary care provider and are geared toward addressing ongoing medical problems, a personalized prevention plan, and counseling unrelated to gynecology. Some of the services you normally receive in our office (pap smear, pelvic exam, and breast exam) are NOT included in this Annual Wellness Visit.

As always, we recommend Annual Gynecological Exams for women. Guidelines for certain tests change from time to time. We typically do a pap test every two years, but advise a breast exam, pelvic exam and cancer screening exam every year. Your yearly visit also provides you with guidance of testing, prescriptions and women’s health advice through our office. Medicare will pay a portion of your Gynecological Annual Exam every 24 months. The screening portion of the exam is not a covered benefit and the patient will be responsible for that $58.00 charge at the time of service. The Women’s Health Exam, along with the collection of the pap smear, will be billed to Medicare, and may be covered if you have met the guidelines, applicable copays and deductibles every 24 months.

If you have any questions, please call our office at 941-330-8885.
Advanced Beneficiary Notice of Non-coverage (ABN)

Date: ______________

Patient Name: __________________________________________

Note: Medicare may not cover services described below, even though our provider may feel it is necessary for a quality healthcare program.

___ Annual Well Woman Exam  *Reason: Medicare does not pay for well exams. Cost: $58.00

___ G0101 Pelvic, Breast Exam  *Reason: Medicare pays every 24 months. Cost: $61.00

___ Q0091 Pap Smear Collection  *Reason: Medicare pays every 24 months. Cost: $56.00

___ Fecal Occult Testing  *Reason: Medicare pays every 12 months. Cost: $50.00

(You will only be responsible for $58.00 at the time of service, the rest will be billed to Medicare and your Secondary.)

What you need to know:

Read this notice, so you can make an informed decision about your care.

Ask us any questions you may have after reading this document.

Choose an option below about whether to receive the treatment listed above.

Options:

___ I want the treatment listed above. I understand I will be asked for payment now, but I also want Medicare billed.

___ I want the treatment listed above, but do not bill Medicare. I understand I will be asked for payment now. I understand I cannot appeal if Medicare is not billed.

___ I do not want the treatment listed above. By choosing this option you will be denying yourself treatment, which the practitioner feels is important to your healthcare.

Signature: ____________________________________________
<table>
<thead>
<tr>
<th>PATIENT’S INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please Print)</td>
<td>Today’s Date: / /</td>
</tr>
<tr>
<td>Last name:</td>
<td></td>
</tr>
<tr>
<td>Birth Date: [ / / ]</td>
<td>Age:</td>
</tr>
<tr>
<td>Is this your legal name? [ ] Yes [ ] No</td>
<td>Marital Status: Single Married Divorced Separated Widow</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Email Address:</td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td></td>
</tr>
<tr>
<td>How did you hear about our office? [ ] Dr. [ ] Insurance Plan [ ] Hospital [ ] Family [ ] Friend [ ] Close to home/work [ ] Yellow Pages [ ] Other</td>
<td></td>
</tr>
<tr>
<td>Race: [ ] African American/ Black [ ] Asian [ ] Caucasian/ White [ ] Pacific Islander/ Native American [ ] Hispanic/Latino [ ] American Indian/ Alaskan Native [ ] Other</td>
<td></td>
</tr>
<tr>
<td>Ethnicity: [ ] Hispanic/ Latino [ ] Non Hispanic or Latino [ ] Preferred Language: [ ] English [ ] Spanish [ ] Other</td>
<td></td>
</tr>
<tr>
<td>PHARMACY INFORMATION</td>
<td></td>
</tr>
<tr>
<td>Pharmacy:</td>
<td>Location:</td>
</tr>
<tr>
<td>INSURANCE INFORMATION</td>
<td></td>
</tr>
<tr>
<td>(Please give your Insurance card and photo identification to the receptionist)</td>
<td></td>
</tr>
<tr>
<td>Primary Insurance:</td>
<td>Secondary Insurance:</td>
</tr>
<tr>
<td>What Laboratory does your insurance require you to use?</td>
<td></td>
</tr>
<tr>
<td>IN CASE OF EMERGENCY</td>
<td></td>
</tr>
<tr>
<td>Name of local friend or relative:</td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Work Phone:</td>
</tr>
<tr>
<td>Relationship to patient:</td>
<td></td>
</tr>
<tr>
<td>AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION</td>
<td></td>
</tr>
<tr>
<td>May we leave a message at your home? [ ] Yes [ ] No</td>
<td>May we leave a message on your cell? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>May we send a yearly recall to your home? [ ] Yes [ ] No</td>
<td>Do we have consent to text your cell? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>I authorize Swor Women’s Care to speak with</td>
<td></td>
</tr>
<tr>
<td>regarding my healthcare/PHI. (relationship to patient):</td>
<td></td>
</tr>
<tr>
<td>I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.</td>
<td></td>
</tr>
<tr>
<td>Patient Signature:</td>
<td>Date: / /</td>
</tr>
<tr>
<td>CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION</td>
<td></td>
</tr>
<tr>
<td>I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Swor Women’s Care to provide medical care and treatment for me. I authorize Swor Women’s Care to obtain verification of my medication/prescription history in order to provide continuity of care. I authorize release of my medical information as directed by my physician for outside referrals to specialists, hospitals, laboratories and others as necessary for my continued care. I hereby authorize payment of benefits to be made directly to Swor Women’s Care and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fee may be assessed.</td>
<td></td>
</tr>
<tr>
<td>Patient Signature:</td>
<td>Date: / /</td>
</tr>
</tbody>
</table>
Annual Exam Update Form

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  
Age when periods started: ________  
Race: Caucasian Asian African-American  
Native-American Hispanic  
How many days apart are your periods: ________  
Age when menopause occurred: ________  
How long do your periods last: ________  
Date of last menstrual period: ________

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: _____  
Date of last pap smear (mm/yy): ________  
Number of miscarriages/abortions: _____  
Date of last mammogram (mm/yy): ________  
Number of tubal pregnancies: _____  
Date of last bone density (mm/yy): ________  
History of infertility? Yes No  
Date of last colonoscopy (mm/yy): ________  

Method of birth control: □ Check if none  

Date of last fecal occult (mm/yy): ________  

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  □ Memory loss  □ Painful periods  
□ Hot Flashes/Night Sweats  □ Difficulty concentrating  □ Menopausal symptoms  
□ Vaginal discharge  □ Decrease in sexual desire  □ PMS  
□ Unpleasant vaginal odor  □ Decrease in energy level  □ Bleeding post menopause  
□ Vaginal itching  □ Digestion problems  □ Abnormal weight gain  
□ Vaginal Burning  □ Acne  □ Abnormal weight loss  
□ Vaginal dryness  □ Urinary leakage  □ Migraines  
□ Pain with intercourse  □ Urinary incontinence  □ Bloating  
□ Bleeding with intercourse  □ Burning with urination  □ Other ____________  
□ Mood swings  □ Breast pain
Financial and Office Policies

We would like to thank you for choosing Swor Women’s Care as your women’s health care provider. This document explains our current office and financial policies. It is important that you read and agree to these policies.

Financial Responsibility: Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.

Payment Form: Swor Women’s Care accepts Cash, Personal Checks, MasterCard, Visa, and Discover Cards as payment for services rendered.

Insured Patients: Please bring your insurance card with you to your appointment. If your insurance plan requires an office visit copay, this will be collected at the time of service. The copay cannot be waived by our office; it is a requirement placed on us by your insurance carrier. You are financially responsible for any copay, deductible or non-covered service. If you are a member of a health plan that Swor Women’s Care participates with, we will submit a claim to your primary insurance company on your behalf. If you participate with an insurance plan that we are not providers of, payment is due at the time of service and we will assist you in submitting your claim for reimbursement to your insurance company.

Authorizations: If your insurance requires authorization for office visits, then 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.

Balance Due: Once we have received payment along with an Explanation of Benefits (EOB) from your insurance plan, you will receive a statement from our office indicating what your insurance has paid. Any remaining balance will then be due and payable. Patients with large deductibles will be asked to pre-pay a portion of their known medical expenses. If you are a member of a health plan that Swor Women’s Care participates with, we will submit a claim to your primary insurance company on your behalf.

Non Insured Patients: Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager prior to your visit.

Medicare Patients: You are personally responsible for your deductible, co-insurance and any service that Medicare deems as “Medically Unnecessary”. Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for certain services.

In Office Labs/Testing: Please verify your benefits with your insurance company prior to having any lab or diagnostic testing performed. If your insurance company does not cover screening lab tests, we do offer certain tests at a reduced cost to you if performed in our office on a cash-pay basis.

Returned Checks: A $25 fee will be assessed for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

Collection Accounts: Swor Women’s Care reserves the right to turn an account over to collections if it is deemed that the account is in default of payment or compliance with this policy and you will be discharged from the practice. You can avoid collections and discharge from the practice by arranging a payment plan with the office.

Financial Hardship: We understand that sometimes it is a hardship to pay your medical bills timely. Please discuss with our Office Manager so we can work out a payment plan. Ignoring medical bills is not advisable. Let us know your situation so we can work with you.

I hereby authorize Swor Women’s Care as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Swor Women’s Care and authorize Swor Women’s Care to submit claims on my behalf for any bills or services furnished to me during the next 12 month period/year. I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

I have read and understand the handout, Financial and Office Policies. By signing below, I am stating that I understand and agree to the above policies. I also understand that at any time our financial policy may be updated.

Signature: ____________________________ Date: ____________