Tennessee GYN
Susan E Webb, M.D.

Patient Intake Form

Name: ____

DOB: ______________________ SSN: ______________________

Address: ____

City: ______________________ State: ________ Zip: ____________

Phone: (Home)______________________ (Cell)______________________

Email: ____

Marital Status: ❒ Single ❒ Married ❒ Domestic Partner ❒ Separated ❒ Divorced ❒ Widowed

Race: ❒ White ❒ Black ❒ Asian ❒ Prefer not to answer

Ethnicity: ❒ NOT Hispanic/Latino ❒ Central American ❒ Cuban ❒ Dominican ❒ Hispanic/Latino

❒ Latin American ❒ Mexican ❒ Puerto Rican ❒ South American ❒ Spaniard

Insurance Information: ❒ No Insurance ❒ Medicare ❒ Private Insurance

Primary Insurance Company: ____________________ ID Number: ______________

Subscriber Name: ______________________ D.O.B.: ______________

Secondary Insurance Company: ____________________ ID Number: ______________

Subscriber Name: ______________________ D.O.B.: ______________

Specific lab required? ❒ No ❒ Yes If yes, lab name: ______________________

Preferred Pharmacy: ______________________ Phone: ______________

Location: ____

Primary Care Physician: ______________________ Phone: ______________

Mammogram Clinic: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone:______________

Relationship to Patient: ______________________

How did you hear about our practice? ❒ Patient in Practice: ______________________

❒ Primary Care Physician ❒ Specialist ❒ Insurance Company ❒ Internet Search ❒ Other

TENNESSEE GYN
SUSAN E WEBB M.D.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed and/or received a copy of the **Notice of Privacy Practices** for Tennessee GYN/Susan E. Webb M.D. and authorize the release of my **Protected Health Information** as outlined in the policy. This authorization will remain in effect until revoked in writing. A photocopy of this release is to be considered as valid as the original.

Tennessee GYN/Susan E Webb M.D. has my permission to discuss/leave appointment & medical information with:

Please initial each recipient / method that you approve:

_____ Patient only

_____ Spouse/Partner Name: ___________________________

_____ Parent/Caregiver Name: ___________________________

_____ Anyone in my home

_____ Cell phone/voice mail

_____ Email: ____

_____ At home answering machine

Patient Name (please print): ____

Patient Signature: ____

Patient Representative Name/Relationship to Patient (parent/guardian if minor or guardian/POA if adult): ____

Patient Representative Signature: ____

Date: ________________

TENNESSEE GYN
SUSAN E WEBB M.D.

PATIENT BROCHURE

PLEASE READ & INITIAL EACH ITEM BELOW

______ **Responsibility for changes**: I understand that it is my responsibility to notify this office of any changes in my address, phone number or insurance coverage.

_______ **Financial Responsibility**: I understand that I am financially responsible for any balance not paid by my insurance carrier. I understand that such balances will be due upon receipt of statement from Tennessee GYN. I understand that a **late charge of $30** will be assessed on any balances **still due after 90 days** from date of billing. I understand that any dispute in payment by my insurance company is my responsibility. If it becomes necessary to refer my account balance for collection, I understand that a 30% collection fee will be added to my account balance.

_______ **Appointment No Show/Cancellations**: Appointments that you do not show up for or you do not cancel with 24 hours notice will be charged a **$35 office fee**. Appointments scheduled less than 24 hours are non-cancellable.

_______ **Release for Billing**: I authorize the release of any medical information necessary to process claims for medical services, as per HIPAA regulations. I request payments of medical benefits directly to Tennessee GYN.

_______ **Responsibility for Copayments**: I understand that co-payments are due at the time of service. If my insurance charges a co-payment on labs or other tests, I will pay those charges when billed.

_______ **Responsibility for Referrals**: I understand that if my insurance requires a referral from my primary Care Physician, it is my responsibility to obtain that referral prior to my visit in this office. I understand that failure to do so will result in my being responsible for full payment of that day's charges.

_______ **TennCare Program**: I acknowledge that Tennessee GYN does not participate in any TennCare program and claims will not be filed to any of these programs as primary or secondary insurance. I accept full financial responsibility for all bills due relating these claims.

_______ **Receipt of Patient Brochure**: I acknowledge that I have received a copy of the practice brochure and agree to abide by the policies listed.

Patient Name: ____

Patient Signature: ____ Date: _____________

TENNESSEE GYN
SUSAN E WEBB M.D.

ANNUAL HEALTH HISTORY

Name: ____________________ DOB: ____________________

Primary Care Physician: ____________________ Phone: ____________________

Preferred Pharmacy: ____________________ Phone: ____________________

Drug Allergies: ❒ None Known ❒ Yes (please list drug names & reaction)

____

____

Current Medications: (please include drug name, strength, and frequency)

____

____

____

Past Medical History: (check any that apply to you)

❒ Anxiety ❒ Asthma ❒ Blood clots in legs ❒ Bone problems ❒ Bowel problems ❒ Cancer ❒ Depression ❒ Diabetes

❒ Heart disease ❒ Heart murmur ❒ High blood pressure ❒ Kidney problems ❒ Skin problems ❒ Thyroid problems

Past Surgeries: ❒ None ❒ Yes: (please give surgery, date, and physician name)

____

____

Social History

Smoker: ❒ Never ❒ Past ❒ Current
If yes: Packs per day: ____________ Number of years: ____________
Alcohol: ❒ Never ❒ Occasionally ❒ Regularly
If yes: Quantity: ________ Frequency: ________ Number of years: ________
Recreational Drugs: (Marijuana, Cocaine etc) ❒ Never ❒ Past ❒ Current
If yes: Drug: ____________ Quantity: ______ Frequency: ________

Gynecological History

Number of pregnancies: ____________ Number of living children: ____________
Date of last menstrual period: ____________
How many days do you bleed: ____________ How many days between periods: ________
How heavy: ❒ Light ❒ Moderate ❒ Heavy
Do you have pain before your period: ❒ No ❒ Yes How many days before?________
What do you currently use for birth control: ❒ Tubal Ligation ❒ IUD ❒ Nexplanon ❒ Depo ❒ Pills ❒ Ring ❒ Patch
❒ Condoms ❒ Withdrawal method ❒ Abstinence ❒ N/A (menopause/hysterectomy, etc)
Painful intercourse: ❒ No ❒ Yes
Menopause: ❒ No ❒ Yes If yes, age: ________
Do you have a history of STDs: ❒ No ❒ Yes If yes, please check:
❒ Chlamydia ❒ Gonorrhea ❒ Herpes ❒ Warts ❒ HIV ❒ Hepatitis ❒ Syphilis
Date of last pap smear:__________
Have you ever had an abnormal pap: ❒ No ❒ Yes If yes, result: ____________
Date of last mammogram:__________ Date of last colonoscopy:__________
Date of last Bone Mineral Density (DEXA)Scan:________ Date of last cholesterol test:________

Family History
Does anyone in your immediate family have a history of cancer: ❒ No ❒ Yes
If yes, type: ❒ Breast ❒ Bowel ❒ Ovarian ❒ Other: ________
Any other major medical problems in your immediate family: ❒ No ❒ Yes (please explain)

____

REVIEW OF SYSTEMS

Are you experiencing problems with:

1. Eyes, ears, throat: ❐ No ❐ Yes
If yes, explain: ____

2. Thyroid: ❐ No ❐ Yes
If yes, explain:____

3. Diabetes: ❐ No ❐ Yes
If yes, explain:____

4. Heart, Vessels: ❐ No ❐ Yes
If yes, explain:____

5. Lungs, Chest: ❐ No ❐ Yes
If yes, explain:____

6. Stomach, Abdomen: ❐ No ❐ Yes
If yes, explain: ____

7. Kidneys, Bladder: ❐ No ❐ Yes
If yes, explain: ____

8. Breasts: ❐ No ❐ Yes
If yes, explain: ____

9. Genital Area: ❐ No ❐ Yes
If yes, explain: ____

10. Legs, Feet: ❐ No ❐ Yes
If yes, explain: ____

11. Arms, Hand: ❐ No ❐ Yes
If yes, explain: ____

12. Nerves: ❐ No ❐ Yes
If yes, explain: ____

13. Brain, Nervous System: ❐ No ❐ Yes
If yes, explain: ____

14. Sleep problems: ❐ No ❐ Yes
If yes, explain: ____

Did you fill out this form yourself? ❐ No ❐ Yes

Patient Signature:____ Date:____________________

Did you have help? ❐ No ❐ Yes
If yes, by whom? (name/relationship to patient) ____

Helper's signature:____ Date:____________________

Reviewed by:____Date:____________________

Family History for Common Hereditary Cancer Syndromes

Patient Name ____________________________ **Physician** ______________________________

Date of Birth _____________________________ **Date** ___________________________________

Have you previously had genetic testing (Example, BRCA) Y N

If yes, when? ___________________________ What were the results? ___________________

Please circle Y to those that apply to **YOU and/or YOUR FAMILY** (on both **MOTHER or FATHER'**S side.) Please list your relationship to the individual diagnosed and the age at cancer diagnosis. This is a screening tool for the common features of hereditary cancer syndromes. Based on the family history information you provide here, you MAY be appropriate for genetic testing. Please consider the following family members:

YOURSELF, PARENTS, SIBLINGS, GRANDPARENTS, AUNTS, UNCLES, NIECES, & NEPHEWS

BREAST AND OVARIAN CANCER		Relationship	Age at Diagnosis
Breast cancer at/or before age 50	Y N	________________	________________
Ovarian cancer at any age	Y N	________________	________________
Male breast cancer at any age	Y N	________________	________________
2 breast cancers on the same side of the family with one diagnosed at/under 50	Y N	________________ ________________	________________ ________________
3 or more breast cancers on the same side of the family at any age	Y N	________________ ________________ ________________	________________ ________________ ________________
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y N	________________	________________
COLON AND ENDOMETRIAL (UTERINE) CANCER			
Endometrial (uterine) cancer before age 50	Y N	________________	________________
Colorectal cancer before age 50	Y N	________________	________________
Colorectal or endometrial (uterine) cancer at any age and two additional family members on the same side of the family with any cancer listed below*	Y N	________________ ________________ ________________	________________ ________________ ________________

*Colorectal, Endometrial, Ovarian, Stomach, Pancreatic, Kidney/ Urinary Tract, Brain, or Small Bowel

FOR OFFICE USE ONLY

Candidate for testing? ☐ Yes ☐ No

Patient offered genetic testing ☐ Accepted ☐ Declined

_________________________________ _________________________________

Patient Signature Date Physician Signature Date

BRCA Risk Factors

Personal History:

- Patient was personally affected with Breast Cancer at age 50 or younger or
- Patient was personally affected with Ovarian Cancer at ANY AGE

One Relative:

- One first or second degree relative with Breast Cancer at age 50 or younger or
- One first or second degree relative with Ovarian Cancer at ANY AGE or
- One first or second degree relative with Bilateral Breast Cancer when the first cancer dx was at age 50 or younger or
- One first or second degree MALE relative with Breast Cancer at ANY AGE or
- First or second degree relative with Triple Negative Breast Cancer at 60 or younger

Or Two Relatives:

- Two first or second degree relatives with Breast Cancer, one diagnosed at 50 or younger

Or Three Relatives:

- Three first or second degree relatives with Breast Cancer at ANY AGE or
- Three first, second or THIRD degree relatives with Breast Cancer, one diagnosed at 50 or younger or
- Combination of Pancreatic and/or Prostate (Gleason 27) and/or Breast and/or Ovarian cancer at ANY AGE in three first, second or THIRD degree relatives

Lynch Risk Factors

Personal History:

- Patient personally affected by Colorectal or Endometrial Cancer before age 50 or
- Patient was personally affected with 2 Lynch Syndrome Cancers at ANY AGE; could be 2 separate colon cancer diagnoses (diagnosed at the same time or different times) or
- Patient has a Lynch Syndrome Cancer AND at least 1 first degree relative with a Lynch Syndrome Cancer, one of the cancers must be diagnosed under age 50 or
- Patient has a Lynch Syndrome cancer at ANY AGE AND 2 or more first or second degree relatives with a Lynch Syndrome Cancer at ANY AGE or

Family History:

- At least 1 first or second degree relative with Colorectal or Endometrial Cancer diagnosed before age 50 or
- At least 1 first or second degree relative with 2 Lynch Syndrome Cancers at. ANY AGE or
- At least 2 first or second degree relatives with Lynch Syndrome Cancers, one of them being in bold below (Main Lynch Cancers)

Lynch Syndrome Cancers: **Colorectal, Endometrial, Ovarian, Stomach**, Pancreatic, Small Intestine, Kidney (Renal Pelvis), Brain (Glioblastoma), Ureter, or Bile Duct

*****Relatives MUST BE ON SAME SIDE OF FAMILY*****

First Degree Relatives = Mom, Dad, Brother, Sister, Son, Daughter

Second Degree Relatives - Grandmother, Grandfather, Aunt, Uncle, Niece, Nephew, Granddaughter, Grandson

Third Degree Relatives = First Cousin, Great Aunt, Great Uncle, Great Grandmother, Great Grandfather

TENNESSEE GYN
SUSAN E WEBB M.D.

IMPORTANT INFORMATION REGARDING ANNUAL WELL WOMAN EXAMS AND INSURANCE COVERAGE

The physician and staff of Tennessee GYN value the trust and responsibility you place in us to care for you. We acknowledge our nation's healthcare and insurance systems are very complex. This pamphlet is to help you learn more about the annual well woman exam, what may be covered (and what may not be covered) by your insurance plan when it comes to preventive health services.

If you have questions, please ask to speak with our Office Manager or the provider during your exam. Our Office Manager may be reached at 865-531-1173.

The purpose of your physician or other provider's recommendation to have a periodic "pap, pelvic and breast exam" is to screen for potential reproductive health problems, including breast cancer. It is important to have these exams regularly so that any problems you may have can be treated early when they are easier to cure and have caused less damage.

The Annual Well Woman Exam:

- **Comprehensive history and physical**: Your provider will ask you a few questions about your sexual, medical and family history and then will perform a physical exam to check your overall health.
- **Breast exam**: your provider will inspect and palpate your breasts and your underarms while your arms are in various positions.
- **Pelvic exam and pap smear**: Your provider will examine your reproductive organs for problems and check you for cervical cancer.
- **Wellness Counseling**: Issues such as diet and exercise, smoking, self-breast exam, menopausal symptoms and hormones.

Your health insurance plan may not provide coverage for preventative services. Many traditional insurance plans only cover services to treat known problems or to diagnose a problem when there are other presenting problems. Most HMO plans and many PPO and POS plans do cover preventative services. If you have any questions about whether preventative or "screening" services are covered under your health insurance plan, we encourage you to talk with the benefits representative at the employer who provides your insurance coverage or talk with a customer service representative at your health plan.

What if a service is not a covered benefit?

Many insurance plans require the patient to be informed when benefits may not cover a service. Medicare requires the Advance Beneficiary Notification (or ABN) form to be completed prior to the visit. Other insurers require a documented notice or a Waiver of Financial Liability. We may mail one of these forms to you, or provide one at our Reception Desk depending on your insurance coverage and the services which the appointment is scheduled for.

Billing for Preventive Services

So that insurance carriers and providers "talk the same language" when submitting claims for payment, the healthcare industry uses a system designed by the American Medical Association to report provider services to insurance plans. Each one of the codes in this system (called Current Procedural Terminology, or CPT for short) has a specific definition that is universally recognized by providers and insurances alike. All insurance company contracts with our providers, and the federal Health Insurance Portability and Accountability Act, August 1996 (HIPAA) require we adhere to this CPT system.

The "well woman" examination is reported to the insurance carrier using the appropriate preventive visit code that identifies the services outlined above for your specific age group. Any services outside of those identified above, such as laboratory tests, the collection of the pap smear specimen, bone density testing, etc. must be reported separately and billed according to these industry accepted standards.

What is billed separately from the well woman exam?

- Pap test, the Hemoccult test, ultrasound imaging, laboratory tests, and dexa scan (bone density testing) are separate charges.
- There is a separate charge for obtaining specimens for testing, as well as processing and interpretation of the specimen.
- Provider services related to a problem or illness, with further history of the problem, physical examination, diagnostic testing and/or treatment as necessary, are billed separately.

We use the latest Pap technology called Thinprep and HPV testing. If your insurance does not cover these tests, you may be responsible for the costs. If you choose not to use this technology, tell your provider in advance.

What happens to the billing if the provider discovers an abnormality during my exam – or if I also want to talk about another medical problem at the same time I'm here for my annual check-up?

The CPT coding system referred to in the previous section directs providers and their billing staff on this issue. It states, "If an abnormality is encountered or a pre-existing condition is addressed in the process of performing this preventive medicine service, and if the abnormality is significant enough to require the key components of a problem-oriented (evaluation) of the patient, then the appropriate Office/outpatient code should also be reported.

Does that mean I will be charged for two office visits?

We are legally required to bill the insurance carrier in a manner that represents the services actually provided to you, using the standards of the CPT coding system. Accordingly, the charges for an encounter that includes both "wellness" and "problem-oriented" services must be separated.

- **The preventive "wellness" exam**, which includes a history and other questions related to your overall reproductive health and well-being, and
- **The "problem-oriented" exam**, with questions related to the history of your problem or illness, with further physical examination, diagnostic testing or treatment provided, as necessary.

Since there is no single "visit" code that describes the work the physician or midwife performs when he or she does both a preventive service and a problem oriented service, providers are instructed to charge two separate "visit" codes (similar to charging for a visit and a procedure when both are performed during the same encounter).

Generally, the problem oriented service results in a lower level charge than you would have received if the total visit was just focused on the medical problem, since only the additional work for evaluating the problem is counted towards determining what this charge should be.

Does this mean I have to pay 2 copays if my insurance plan covers both preventive and problem-related office visits?

That is a question to ask your insurance carrier. Some carriers require that the patient pay a portion of each service. Other carriers apply the copay to just one service and pay their full fee schedule amount on the other. It just depends on what type of insurance coverage you have. As a courtesy to our patients, Tennessee GYN's policy is to only collect one copay at the time of your visit, and to bill your insurance for the other. If your insurance denies coverage for this, we will assign this to the patient's responsibility and invoice you.

Paying two copays does not mean the provider gets more money than they would have for the same set of services. The insurance carrier determines the "reasonable and customary" amount to pay the provider. If your benefit plan includes a copay, that amount is subtracted from the amount the insurance carrier has agreed to pay the provider. Copays are not designed to pay the physician more, but rather to share the cost of the care between the patient and the insurance plan.

While it may not seem fair that your insurance carrier requires you to share the costs of both services, one benefit to addressing both your annual exam and your medical problem at the same time is that it saves you the other expenses associated with making a separate trip to the doctor's office for an evaluation of the problem.

Why can't you just include the preventive service in with the "problem-oriented" services and bill it all to the insurance carrier with one code?

Tennessee GYN is committed to providing the highest quality care in a caring, courteous and compassionate way, yet in a cost-effective, legal and ethical manner. Intentionally misrepresenting the services that were provided to you when billing them to your insurance carrier could result in charges to your provider for submitting a false claim against a health care benefit program – an action recently defined as a violation of federal law, as amended by HIPAA.

Other credible sources of information about women's health include:
The American College of Obstetricians and Gynecologists, www.acog.org
The US Department of Health and Human Services, www.womenshealth.gov

We thank you for choosing our physician and staff as partners for your healthcare needs. As always, providing high quality healthcare to you is and remains our primary purpose.

If you have any questions about this information, please feel free to ask your provider or call our Office Manager at 865-531-1173 for more information.