Patient: _____ Date: _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**

General

Have you gained or lost weight recently?	Y	N
How many pounds?	_____	
Are you concerned about your weight?	Y	N
Other		

Integumentary

Skin rash	Y	N
Nipple discharge	Y	N
Persistent itch	Y	N

Neurological

Trouble sleeping	Y	N
Headache	Y	N
Seizures	Y	N
Other		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Frequent urination	Y	N
Other		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Respiratory

Asthma	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Anemia	Y	N

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other		

Psychiatric

Are you unhappy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other		

Aesthetics

Are you troubled by painful intercourse, vaginal dryness?	Y	N
Are you concerned with your appearance? (fine lines, wrinkles, sun spots)	Y	N

Physician Reviewed: _____

Aviso De Privacidad Reconocimiento

Andrew Krinsky, MD, LLC

Entiendo que bajo el Health Insurance Portability And Accountability Act (HIPPA), tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida. Reconozco que han recibido o han tenido la oportunidad de recibir una copia de su aviso de practicas de privacidad. También entiendo que esta práctica tiene el derecho de cambiar su aviso de practicas de privacidad y que puedo contactar con la practica en cualquier momento para obtener una copia actual de la notificación de practicas de privacidad

_____ _____

Nombre del paciente o la legal de guarda (impresión) Fecha

_____

Firma

Uso de oficina solamente:

Hemos hecho el siguiente intento de obtener la firma del paciente reconoce el recibo de la notificación de practicas de privacidad:

Fecha: _____ Intento:_____

Nobre De Empleado:_____

Notice Of Privacy Acknowledgement

Andrew Krinsky, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice Of privacy Practices.

_____ _____

Patient Name or Legal Guardian (PRINT) Date

Office Use Only

We have made the following attempt to obtain the patients signature acknowledging receipt of Notice of privacy practices:

Date:_____ Attempt:_____

Staff Name:_____

Notice of Malpractice Insurance, No Show Appointments & Assignment of Benefits

A: I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Andrew H. Krinsky LLC, Inc.

B: **I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said Assignor to release all information necessary to secure payment.**

C: **I understand it is my responsibility to know what my insurance coverage is, if I am responsible for any deductible, co-ins or copay.**

D: **EVEN THOUGH WE MAY HAVE CONTACTED YOUR INSURANCE COMPANY TO VERIFY YOUR COVERAGE, IT IS NOT A GUARANTEE OF PAYMENT.**

E: Payments **MUST** be made at the time of each visit, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I understand Andrew H. Krinsky LLC, Inc. reserves the right to charge an administrative fee of $15.00 for any deductible, co-ins or copay not paid at the time of service. A surcharge of 35% will be added to any accounts sent to our collection department.

F: We confirm appointments as a courtesy through a third party vendor. Via text, call or email. It is your RESPONSIBILITY to be aware of the time and date.

G: I understand that I will be charged a $25.00 fee for any no show appointments or cancellations without 24 hour prior notice.

H: I understand that as of 03/01/05 Dr Krinsky does not carry medical malpractice insurance.

I. Dr. Krinsky's practice primarily consists of office gynecology and minor outpatient surgery. Should you need hospitalization or major surgery Dr. Krinsky will provide you with an appropriate referral.

J. If you are going to be more the 10 minutes late for your appointment, we ask that you make a courtesy call informing the office. If you are more then 20 minutes late for your appointment depending on how the schedule is running, you may be asked to reschedule your appointment.

K. I understand that it may be necessary for Dr. Krinsky to perform certain lab tests during my visit that may not be covered by my insurance company. In that event I understand I will be responsible for the charge upon check-out.

I HAVE READ AND UNDERSTAND THE ABOVE

Signed by: _____ DATE: _____

I herby authorize my medical information and/or results to be discussed with anyone listed below.

Signed by: _____ DATE: _____

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

Dr. Andrew Krinsky
Gynecology & Women's Wellness

TopLine MD Alliance

In an effort to relay Normal results faster to our patients we have implemented Electronic Medical Records.

I understand that in order for Andrew Krinsky, MD, LLC to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Andrew Krinsky, MD, LLC.

I further understand that in order for Andrew Krinsky, MD, LLC to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Andrew Krinsky, MD, LLC. I also understand that my healthcare information at Andrew Krinsky, MD, LLC is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages

I give my written express consent to Andrew Krinsky, MD, LLC to leave detailed messages on my voicemail/answering machine about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders.

No abnormal results will be communicated via our automated system.

I AUTHORIZE ANDREW KRINSKY, MD, LLC TO SEND AUTOMATIC ELECTRONIC COMMUNICATION VIA TEXT/EMAIL/VOICEMAIL MESSAGES.

Patient Name (Please Print):_____ **Date:**_____

Patient Signature:_____ **Cell #:**_____

(this number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.