FemCare Ob-Gyn, LLC *Geoffrey N. James, MD, Jason S. James, MD, Jila Senemar, MD, Karen Salazar Valdes, MD, Ingrid Paredes, MD*

PATIENT INFORMATION

Social Security # _____ Home Address _____ Apt ____

First Name _____ City _____ State ____ Zip _____

Last Name _____ Email address _____

Sex _____ Date of Birth _____ Home Phone (____) _____

(Check One) ❒Employed ❒Retired ❒Full-Time Student Cell Phone (____) _____

❒Other _____ Work Phone (____) _____

Occupation _____ Pharmacy Number (____) _____

Employer _____ Primary Physician _____

Marital Status: ❒Married ❒Single ❒Divorced ❒Widowed Referred By _____

Spouse's Name _____ Primary Language _____

INSURANCE INFORMATION – *Please provide your insurance card and Driver's License to the receptionist*

Primary Insurance _____ Secondary Insurance _____

Name of Subscriber _____ Name of Subscriber _____

Policy # _____ Group # _____ Policy # _____ Group # _____

EMERGENCY CONTACT

Name _____ Relationship _____ Sex _____

Home Phone (____) _____ Work Phone (____) _____

I allow Doctor/Staff to leave messages/fax results at: ❒Home ❒Work ❒Cell ❒Fax ❒None

I authorize FemCare Ob-Gyn, LLC to disclose certain protected health information (PHI) about me to the parties listed below:

1._____ 2._____

Fees and Insurance Information

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency, I authorize said attorney to obtain my credit report and I understand that I will be liable for any charges incurred, including reasonable attorney's fees, court costs and collection expenses.

Malpractice Insurance Notification

We have elected not to carry Medical Malpractice Insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320(5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

Physician's Release and Assignment

I hereby authorize payment directly to FemCare Ob-Gyn, LLC ("Physician") of all benefits applicable and otherwise payable to me from my insurance carrier or other third party payor, for services rendered by the Physician. I understand that I am financially responsible to the Physician for any and all charges that the carrier declines to pay. I hereby authorize release of my medical records as deemed necessary for payment of benefits.

HIPAA Acknowledgement

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices of the Federal HIPAA Privacy Rule.

Consent to Treat

By signing below, I acknowledge that I consent to treatment by the physicians and other healthcare providers of FemCare Ob-Gyn, LLC, including performance of a medically necessary examination including, but not limited to, a pelvic examination.

Patient's/Guarantor's Signature _____ Date _____

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GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

This consent form is being requested pursuant to Florida law.

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

- A female Gynecological Exam which may include a rectal exam and a pelvic examination
- An Ultrasound Exam which may include a probe placed in the vagina.
- Examination of external genitalia

This examination will be performed by any provider from FemCare Ob-Gyn, LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient:

_____

Signature of Patient or Patient's Representative if under 18:

_____

Date _____

Family History Questionnaire

PATIENT INFORMATION

Patient's first name	Patient's last name	Age	Date of birth (MM/DD/YYYY)
Sex	Today's date (MM/DD/YYYY)	Healthcare provider	

YOU AND YOUR FAMILY'S CANCER HISTORY (please be as thorough and accurate as possible)

This is a screening tool for cancers that run in families. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. **You and the following close blood relatives should be considered:** You, parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half-Siblings, first-Cousins, great-grandparents and great-grandchildren.

Cancer	Personal/family history?	Your age of diagnosis	Parents/siblings/children (include their sex and age of diagnosis)	Relatives on mother's side (include their sex and age of diagnosis)	Relatives on father's side (include their sex and age of diagnosis)
Breast (male or female)	◯ Yes ◯ No				
Colon/rectal	◯ Yes ◯ No				
10 or more lifetime colorectal polyps	◯ Yes ◯ No				
Kidney (renal)	◯ Yes ◯ No				
Ovarian (peritoneal/ fallopian tube)	◯ Yes ◯ No				
Pancreatic	◯ Yes ◯ No				
Prostate	◯ Yes ◯ No				
Uterine (endometrial)	◯ Yes ◯ No				
Melanoma	◯ Yes ◯ No				
Other cancer(s) *(specify cancer type)*	◯ Yes ◯ No				

FAMILY HISTORY REVIEW (Wait to complete this with your healthcare provider - check all that apply)

Personal and/or family history of any one of the following:

- ☐ Two or more cancers on the same side of the family
- ☐ A personal or family history of cancer at age 60 or younger
- ☐ Any one or more of the following rare conditions:
  - Male breast cancer
  - 10 or more colorectal polyps
  - Triple negative breast cancer
  - Sarcoma
- ☐ Concerned about personal and/or family history of cancer
- ☐ Ashkenazi Jewish descent
- ☐ A family member that has had genetic testing for hereditary cancer risk

SIGNATURES

Patient's signature: _____ Date: _____

Provider's signature: _____ Date: _____

FOR OFFICE USE ONLY

Patient offered hereditary cancer genetic testing?	Appointment scheduled?	Date of next appointment
◯ Yes ◯ No ◯ Accepted ◯ Declined	◯ Yes ◯ No	

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Dear Patient,

As Women's Health Physicians, our primary goal is to keep you healthy and prevent disease, especially cancer. At the same time, we want to minimize your discomfort and avoid performing unnecessary tests and procedure.

With that in mind, the American College of Obstetricians and Gynecologists (ACOG), the American Cancer Society (ACS), and the United States Preventive Services Task Force have updated their recommendations for cervical cancer screening in 2013. We will be implementing these recommendations in order to provide you with the most comprehensive and up to date care possible. The new recommendations are as follows:

- Start performing Pap smears at age 21
- Between the ages of 21-65, *in low risk individuals*, Pap smear and HPV testing **every 3 years**
- Stop performing Pap smears after age 65 or after hysterectomy except for patients with a history of cervical dysplasia/cancer

These guidelines apply **only** to cervical cancer screenings. The Pap smear is only a small part of your annual preventative screening visit. It is critical that you continue to be seen **every year** for a breast and pelvic exam to screen for cancers of the breast, vulva, and ovary, among other medical conditions. An annual exam is the ONLY way to ensure that various medical conditions are caught at an early and treatable stage.

Please also note that performing Pap smears outside of this recommended schedule may result in your insurance provider declining to cover its costs.

Please do not hesitate to ask your doctor or health provider if you have any questions. We are always available to help you make the best informed decisions about your health.

FemCare Ob-Gyn

Please acknowledge receipt of this notification:

Print name _____ Patient signature _____ Date _____

"We Care Questionnaire"

Name: _____ Date of Birth: ____/____/_____ Today's Date: ____/____/_____

Doctor: _____ Insurance Company: _____

	Not at all	1-2 times a Month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your Score
1. Over the past month, have you leaked urine (even small drops) or wet yourself when you: *Cough, Sneeze, Change Position, Walk quickly or Exercise*.....	0	1	2	3	4	5	STRESS
2. Have a sudden strong urge to rush to the restroom or when you are undressing to go to the restroom.....	0	1	2	3	4	5	URGENCY

•How many times do you wake at night to empty your bladder? _____

•Would you be interested in learning more about a cure from leaking ***WITHOUT*** medicine or surgery? ☐Yes ☐No

FEMCARE OB-GYN

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Original

FEMCARE OB-GYN

PATIENT NAME:_____ **TEMP:** _____

DOB:_____

	PRE-APPT	IN-OFFICE
	Date:	Date:
HAVE YOU RECENTLY HAD FEVER AND/OR CHILLS WITHIN THE LAST WEEK?	o Yes o No	o Yes o No
HAVE YOU EXPERIENCED SHORTNESS OF BREATH OR OTHER DIFFICULTIES BREATHING?	o Yes o No	o Yes o No
DO YOU HAVE A COUGH?	o Yes o No	o Yes o No
ANY OTHER FLU-LIKE SYMPTOMS, SUCH AS GASTROINTESTINAL UPSET, HEADACHE OR FATIGUE?	o Yes o No	o YES o NO
HAVE YOU EXPERIENCED LOSS OF TASTE OR SMELL?	o YES o NO	o YES o NO
~~ARE YOU IN CONTACT WITH CONFIRMED COVID-19 POSITIVE PATIENTS?~~ (PATIENTS WHO ARE WELL BUT WHO HAVE A SICK FAMILY MEMBER AT HOME WITH COVID-19 SHOULD POSTPONE ELECTIVE TREATMENT)	o YES o NO	o YES o NO
HAVE YOU BEEN IN CONTACT WITH ANYONE WHO HAS BEEN OUT OF TOWN IN THE LAST 14 DAYS?	o YES o NO	o YES o NO
HAVE YOU TRAVELED OUT OF TOWN IN THE LAST 14 DAYS?	o YES o NO	o YES o NO
HAVE YOU COME IN CONTACT WITH SOMEONE WHO HAS TRAVELED INTERNATIONALLY IN THE PAST MONTH?	o YES o NO	o YES o NO
HAVE YOU BEEN TESTED FOR COVID-19 OR ANTIBODY?	o YES o NO	o YES o NO
IF YES, WHEN? WHAT WERE THE RESULTS? _____		

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