Serene Health OB/GYN & Wellness
1625 SE 3rd Ave, Ste 502
Fort Lauderdale, FL 33316
Phone: 954-581-8706 Fax 954-581-8705
Dr. Delisa Skeete-Henry, M.D.

Erin Gilbert, A.R.N.P.
Imelda Jean-Pierre, A.R.N.P.
Amy Gordon, A.R.N.P.
Tatyana Jack-Ruddock, A.R.N.P.

GYN EXAM FORM

Date of exam: _____

Name: _____ DOB: _____ SS#: _____
Address: _____ Phone: _____ Age: _____

Family History – Has anyone in your family had trouble with the following? Include mother (M), father (F), brother (B), sister (S), aunt (A), uncle(U), grandmother (GM), grandfather (GF).

	NO	Not Sure	YES	WHO
Anemia	___	___	___	___
Bleeding Problem	___	___	___	___
Breast Disease	___	___	___	___
Cancer	___	___	___	___
Gyn Cancer	___	___	___	___

	NO	Not Sure	YES	WHO
Diabetes	___	___	___	___
High Blood Pressure	___	___	___	___
Stroke	___	___	___	___
Heart Attack (before 50)	___	___	___	___
Other Hereditary Disease	_____			

MEDICAL HISTORY – Information about you. Check all that applies

	NO	YES	NOW
Anemia	___	___	___
Blurred vision	___	___	___
Headaches	___	___	___
Migraines	___	___	___
Stroke	___	___	___
Severe depression	___	___	___
Severe mood swings	___	___	___
Psychiatric problems	___	___	___
Diabetes	___	___	___
Cancer	___	___	___

	NO	YES	NOW
Lung disease	___	___	___
Liver disease	___	___	___
Thyroid problem	___	___	___
Breast surgery	___	___	___
High blood pressure	___	___	___
Chest pain	___	___	___
Shortness of breath	___	___	___
Heart murmur	___	___	___
Heart disease	___	___	___
Asthma	___	___	___

	NO	YES	NOW
Varicose veins	___	___	___
Blood clots	___	___	___
Redness/pain in leg	___	___	___
Gallbladder problems	___	___	___
Urinary tract infections	___	___	___
Smoking	___	___	___
Alcohol use	___	___	___
Recreational drug use	___	___	___
Eating disorder	___	___	___
Regular exercise	___	___	___

GYN HISTORY

	NO	YES	When
Pelvic tumors/fibroids	___	___	_____
Pelvic infections	___	___	_____
Pelvic surgery	___	___	_____
Abnormal PAP	___	___	_____
Vaginal infection	___	___	_____

	NO	YES	When
Unusual vaginal bleeding	___	___	_____
Unusual vaginal discharge	___	___	_____
Pregnancy	___	___	_____
Abortions	___	___	_____
Hepatitis B vaccine	___	___	1___2___3___

First day of last menstrual period _____ Was last period normal _____ Last PAP date _____ Result _____
Period started at age _____ Occur every _____ days. Duration _____ days.
Periods are: __regular __irregular __light __moderate __heavy __painful. Do you do a self-breast exam monthly __YES __NO
Have you ever had sexual intercourse __YES __NO If yes, __vaginal __anal __oral Do you/have you had sex with __men __women __both
Number of sexual partners in the past 2 years _____ Length of time with current/most recent sexual partner? _____
Condom protection always __YES __NO Have any of your sexual partners been in a high risk category for HIV/AIDS? __YES __NO
____More than one partner? ___Bisexual? ___Used Drugs? ___
Have you had unprotected sex since your last menstrual period? __YES __NO Any missed birth control pills? __YES __NO
What are you doing to protect yourself from HIV/AIDS, Hepatitis B or C, and all STD'S? _____
How many times have you used condoms in the last 10 acts of intercourse? _____
Have you ever had any of the following: **Chlamydia:** __YES __NO **Genital warts:** ___YES __NO **Gonorrhea:** ___YES __NO Herpes: __YES __NO
Hepatitis B: ___YES __NO

Any other pertinent history or concern:
_____
_____
_____

natera | Empower™ Hereditary cancer test

Name:

Date of Birth (MM/DD/YY):

Hereditary Cancer Risk Assessment Questionnaire - General Instructions

Please answer the following questions about your personal and family history to the best of your knowledge. This will help your provider understand if there could be patterns of hereditary cancer in your family. For personal history, enter the types of cancer you have had and your age at diagnosis. For family members who are blood relatives, enter the types of cancer they had and their approximate age at diagnosis. Family members include parents, siblings, children, uncles, aunts, grandparents, great-grandparents, grandchildren, great-grandchildren, great-uncles, great-aunts, nieces, nephews, or half-sibling.

Family history of cancer

Type of Cancer	Personal / Family History	Personal - age at diagnosis	Parent/sibling/child - list sex and age at diagnosis	Family members on mother's side - list sex and age at diagnosis	Family members on father's side - list sex and age at diagnosis
Example: Breast Cancer	☑ Yes ☐ No	40	Mom, F, 47 Sister, F, 55	Aunt, F, 50	Niece, F, 36
Breast	☐ Yes ☐ No				
Ovarian	☐ Yes ☐ No				
Prostate	☐ Yes ☐ No				
Pancreatic	☐ Yes ☐ No				
Colorectal	☐ Yes ☐ No				
Uterine	☐ Yes ☐ No				
Gastric	☐ Yes ☐ No				
Melanoma	☐ Yes ☐ No				
Other (please fill in):	☐ Yes ☐ No				
Other (please fill in):	☐ Yes ☐ No				

Please complete the following with your provider, check all that apply:

- ☐ Personal or family history of cancer at age 50 or younger
- ☐ Personal or family history of ovarian or pancreatic cancer
- ☐ Personal or family history of one or more of the following conditions: Male Breast Cancer / Triple Negative Breast cancer / 10 or more colorectal polyps
- ☐ Two relatives with cancer on the same side of your family
- ☐ Ashkenazi Jewish descent
- ☐ You have had hereditary cancer genetic testing (if yes, please attach the report to the Empower Requisition Form)
- ☐ Family member that has had hereditary cancer genetic testing. If yes, list gene mutations found, if any:_____
- ☐ Concerned about personal and/or family history of cancer

Signatures

Patient Name	Patient Signature	Date

Provider's Name	Provider's Signature	Date

For office use only

Patient offered hereditary cancer genetic testing (check all that apply)

☐ Yes ☐ No ☐ Patient accepted ☐ Patient declined

PREVENTATIVE MEDICINE AND SCREENING POLICY

This notification describes billing for **Preventative Medicine Services** (Routine Annual Well Exam) performed on the same day as an **Evaluation and Management** (Standard Office Visit) service.

Preventative Medicine services such as your annual routine physical are usually separate from other office visits.

Occasionally, an abnormality is encountered or pre-existing problem is addressed during the Preventative exam and significant elements related to Evaluation and Management (E/M) services (standard office visits) are provided during the same visit.

When this occurs, your provider will bill for the Preventative Medicine service (Physical Exam) plus 50% of a problem-oriented Evaluation and Management service (standard office visit charge).

This coding and billing logic is in line with correct coding policies recognized by all insurance carriers. When this scenario occurs, the standard office visit is often subject to a copayment, co-insurance or deductible as determined by your insurance carrier.

We are unable to pre-determine if your preventative visit today will be subject to the additional charge as the level of service provided is determined during the face-to-face evaluation with your provider.

If you have any questions, please feel free to speak to the office manager.

I have received the above notice:

Patient Signature Date

PATIENT FINANCIAL RESPONSIBILITY

CO-PAYS, deductibles and co-insurance applied to the visit will be collected at the time of service.

YOU MAY GET A BILL FROM THE LAB, Well women visits only includes examination and pap smear. During your visit, if you address any symptoms or problems that you are having; labs may be drawn; *deductible is applied*. HPV is required for patients over 30 years of age. (Some insurances pay for it). It is your responsibility to understand your insurance plan's benefits and or/limitations.

INSURANCE: We will bill your insurance company for your visit AS A COURTESY to you. Due to difficulty obtaining payment for your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider with your insurance plan, and to verify patient financial responsibility for today's visit.

HMO REFERRALS: It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visits. It is the patient's responsibility to know and understand the requirement of your insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying a minor is responsible for payment of the bill.

RETURNED CHECKS: Checks returned for any reason will be subject to all bank fees charged to us along with 5% of the face value of the check or $25.00 administrative fee (whichever is greater).

COLLECTIONS: Should your account become a collections problem, the patient/debtor assumes all costs of collections including but not limited to collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

NON-COVERED SERVICES: You will be responsible for payments of service "NOT COVERED" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and or limitations.

DISCLOSURE OF HEALTH INFORMATION TO HEALTH PROVIDER: I hereby authorize Delisa Skeete Henry, M.D., LLC: To furnish information to my insurance carriers and I hereby irrevocably assign to Delisa Skeete Henry, M.D., LLC. all payment for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance, and all cost of collection, should the account become delinquent and need to be referred to a collection agency.

HIPAA ACKNOWLEDGEMENT: We are required to provide you with a copy of Notice of Privacy Practices, which states how we may use and/or disclose your health information.

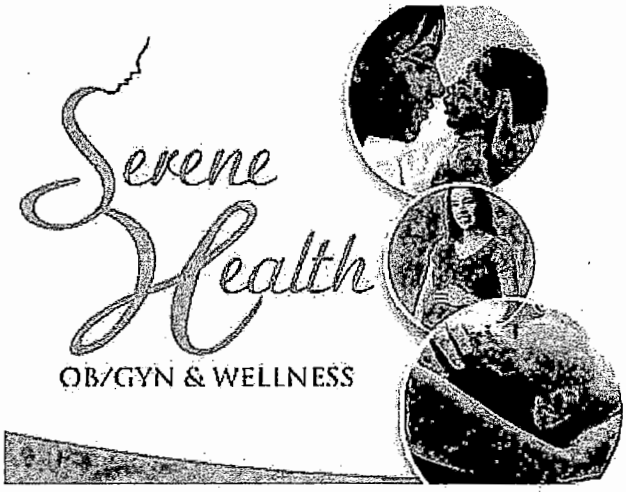
MALPRACTICE INSURANCE: Under the Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical practice.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is proved pursuant to Florida law. Florida Satue 458.320(5)(g)(1).

Please sign this form as an acknowledgement that you have read and agree to the above information.

Print Patient Name: _____

Patient responsibility party signature: _____ Date: _____



Dr. Skeete Henry & Associates

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NOTICE OF NON-MEDICAID PROVIDER AND ACKNOWLEDGMENT OF PATIENT FINANCIAL RESPONSIBILITY FOR NON-COVERED SERVICES

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

NON-MEDICAID PROVIDER NOTICE

Delisa Skeete Henry, MD, LLC d/b/a Serene Health OBGYN & Wellness and any physicians employed by or associated therewith are not Medicaid providers and do not submit claims for reimbursement to Medicaid. If, after becoming an established patient at our office, you subsequently become covered by Medicaid, you are hereby advised that any services that you receive from Delisa Skeete Henry, MD, LLC d/b/a Serene Health OBGYN & Wellness while you are covered by Medicaid will not be billed to, or paid by, Medicaid as Delisa Skeete Henry, MD, LLC d/b/a Serene Health OBGYN & Wellness is not a participating provider in Medicaid. Therefore, any non-covered services provided to you by Delisa Skeete Henry, MD, LLC d/b/a Serene Health OBGYN & Wellness will be billed to you directly and it will be your responsibility to remit payment in full for said services.

ACKNOWLEDGMENT OF PATIENT FINANCIAL RESPONSIBLITY FOR NON-COVERED SERVICES

By signing this acknowledgement, you, the patient, hereby agree that you will be solely responsible for payment in full for any services you receive while covered by Medicaid, and that claims for such services will not be submitted to Medicaid as Delisa Skeete Henry, MD, LLC d/b/a Serene Health OBGYN & Wellness is not a participating provider under Medicaid and will look to you directly for payment for services rendered. You further acknowledge and agree that you have been made aware that services provided by Delisa Skeete Henry, MD, LLC d/b/a Serene Health OBGYN & Wellness will not be covered by Medicaid and that you will bear full financial responsibility for the full cost of such services rendered to you.

_____ _____

Patient Signature Date

_____

Printed Name

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

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 exam

( ) An Ultrasound Exam which may include a probe placed in the vagina.

( ) A rectal exam only

( ) An Ultrasound Exam which may include a probe placed into the rectum.

( ) Other procedures as listed _____

( ) Examination of external genitalia_____

This examination will be performed by any provider from Serene Health OB/GYN & Wellness 1625 SE 3rd Avenue, Suite 502 Fort Lauderdale, FL 33316 ~~LLC~~

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

Print Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

Date _____

Pelvic Health Survey

Today's Date: _____

Patient's Name: _____ 1. Age: ____ 2. Sex: □Female □Male

Bladder (check one):

3. How often do you leak urine (check one box)?
   - 0 □ Never
   - 1 □ About once a week or less often
   - 2 □ Two or three times a week
   - 3 □ About once a day
   - 4 □ Several times a day
   - 5 □ All the time

4. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? Check one box.
   - 0 □ None
   - 2 □ A small amount
   - 4 □ A moderate amount
   - 6 □ A large amount

5. Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

ICIQ score: sum 3+4+5= _____

6. When does urine leak? (Please check all that apply to you.)
   - □ Never—urine does not leak
   - □ Leaks before you can get to the toilet
   - □ Leaks when you cough or sneeze
   - □ Leaks when you are asleep
   - □ Leaks when you are physically active/exercising
   - □ Leaks when you have finished urinating and are dressed
   - □ Leaks for no obvious reason
   - □ Leaks all the time

Do you wear diapers, pads, or panty liners because of leaking? □Yes □No

Are you bothered by the number of times per day you have to empty your bladder? □Yes □No

Do you wake up at night to empty your bladder? □Yes □No

If Yes, How many times? _____

Do you feel you have to rush to the toilet to avoid an accidental leak? □Yes □No

Bowel:

1) Do you accidentally leak stool? □Yes □No
2) Do you have to strain to have bowel movements? □Yes □No
3) Do you pass gas when you do not want to? □Yes □No

Gynecological:

1) Do you experience pelvic pain? □Yes □No
2) Do/did you experience pain with intercourse? □Yes □No
3) Do you have a feeling of a "ball" in your vagina? □Yes □No
4) Hysterectomy? □Yes □No
5) Vaginal Dryness? □Yes □No
6) # of Vaginal Deliveries _____
7) # of Cesarean Sections _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:
- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Disclose Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other: _____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal
☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

This document will be retained by the providing organization for seven years.

Delissa Skeete-Henry, MD, LLC
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

☐ From _____ to _____

Or

☐ All past, present, and future periods

Or

☐ The date of the signature in section VI until the following event: _____

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

This document will be retained by the providing organization for seven years.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section VI – Signature

_____ _____
Print Patient Name Date

_____
Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____

This document will be retained by the providing organization for seven years.

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AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD PROTEGIDA

Por favor complete todas las secciones de este formulario de liberación de HIPAA. Si alguna sección se deja en blanco, este formulario no será válido y no será posible que su información de salud se comparta según lo solicitado.

Sección I - Autorización

Yo, _____, doy mi permiso para _____ compartir la información que figura en la Sección II de este documento con la (s) persona (s) u organización (s) que he especificado en la Sección IV de este documento.

Sección II - Información de Salud

Me gustaría dar permiso a la organización de salud anterior para:

- ☐ Revelar mi registro de salud completo, que incluye, entre otros, diagnóstico, resultados de pruebas de laboratorio, tratamiento y registros de facturación para todas las condiciones.

O

- ☐ Revelar mi historial médico completo, excepto por la siguiente información:
  - ☐ Registros de salud mental
  - ☐ Enfermedades transmisibles que incluyen, pero no se limitan a, VIH y SIDA
  - ☐ Revelar registros de tratamiento de abuso de alcohol / drogas
  - ☐ Información genética
  - ☐ Otro: _____

_____

_____

Forma de revelación de información:

- ☐ Copia electrónica o acceso a través de un portal en el internet.
- ☐ Copia en papel.

Sección III - Motivo por el cual se está revelando la información

Por favor, detalle las razones por las que se comparte la información. Si está iniciando la solicitud de compartir información y no desea enumerar las razones para compartirla, escriba "solicitud propia".

_____

_____

_____

_____

Este documento será retenido por la organización proveedora por siete años.

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AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD PROTEGIDA

Sección IV - Quién puede recibir mi información de salud

Doy mi autorización para que la información de salud que se detalla en la sección II de este documento se comparta con la (s) siguiente (s) persona (s) u organización (es):

Nombre: _____

Organización: _____

Dirección: _____

Entiendo que la (s) persona (s) / organización (es) enumerada (s) arriba puede no estar cubierta por las reglas estatales / federales que rigen la privacidad y seguridad de los datos y se le puede permitir compartir más la información que se les proporciona.

Section V – Duración de esta Autorización

Esta autorización para compartir mi información de salud es válida:

☐ Desde _____ hasta _____

O

☐ Todos los períodos pasados, presentes y futuros.

O

☐ La fecha de la firma en la sección VI hasta el siguiente evento.: _____

_____

Entiendo que puedo revocar esta autorización para compartir mis datos de salud en cualquier momento y puedo hacerlo mediante el envío de una solicitud por escrito a:

Nombre: _____

Organización: _____

Dirección: _____

Entiendo que:

- En el caso de que mi información ya haya sido compartida para cuando se revoque mi autorización, puede ser demasiado tarde para cancelar el permiso para compartir mis datos de salud.
- Entiendo que no necesito dar ningún otro permiso para que la información detallada en la Sección II se comparta con la (s) persona (s) u organización (s) enumerada (s) en la Sección IV.
- Entiendo que no firmar o enviar esta autorización o la cancelación de esta autorización no me impedirá recibir ningún tratamiento o beneficios a los que tengo derecho, siempre que esta información no sea necesaria para determinar si soy elegible para recibir esos tratamientos. o beneficios o para pagar los servicios que recibo.

Este documento será retenido por la organización proveedora por siete años.

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AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD PROTEGIDA

Sección VI - Firma

_____ _____
Nombre del Paciente (Escriba) Fecha

_____
Firma

Si una persona con autoridad legal está completando este formulario para actuar en nombre de una persona, como un padre o tutor legal de un menor o un agente de atención médica, complete la siguiente información:

Nombre de la persona que completa este formulario: _____

Firma de la persona que completa este formulario: _____

Describa a continuación cómo esta persona tiene autoridad legal para firmar esto: _____

_____

_____

Este documento será retenido por la organización proveedora por siete años.

CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to Delissa Skeete-Henry, MD, LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by Delissa Skeete-Henry, MD, LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that Delissa Skeete-Henry, MD, LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

Delissa Skeete-Henry, MD, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold Delissa Skeete-Henry, MD, LLC its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold Delissa Skeete-Henry, MD, LLC responsible for instances of these violations.

Signature: _____ Date: _____