The Center for Gynecology & Restorative Medicine
Michelle Starke, M.D., FACOG, FABAARM

Welcome to our Practice!

We strive to provide the highest quality of care to our patients in a professional and personalized manner. In order to maximize your visit to our office today we will need to gather some important information.

Please see the following new patient documents included in this packet that need to be filled out and returned to our office completely before your scheduled appointment.

- Welcome Letter
- Map and Directions to Office
- Patient Demographics Form
- Patient Medical History Forms (3 pages)
- Financial Policy / Malpractice Notice
- Notice of Privacy Practice Acknowledgment
- Communication Consent
- Hereditary Cancer Questionnaire

We recommend you try to arrive at least 20 minutes prior to your appointment. Make sure you allow yourself enough time to locate our office.

Your patient experience is very important to Dr. Starke. If, for whatever reason, you feel your visit to our office has not been up to your expectations, please do not hesitate to contact me via phone at (786) 775-5395.

Please go to our website at www.drstarkemiami.com to review our services in more detail. If you would like a copy of our Notice of Privacy Practices please refer to our website to obtain your copy.

Sincerely,

Mark E. Frye, CCS-P
Practice Administrator

Directions heading **North** on S Dixie Hwy/US-1

Turn **left** onto Ponce de Leon Blvd off of S Dixie Hwy/US-1 N

Enter roundabout and take the **2nd** exit onto Ponce de Leon Blvd

135 San Lorenzo Avenue will be on your **left** hand side

The parking garage will be directly to your **right**

Directions heading **South** on S Dixie Hwy/US-1

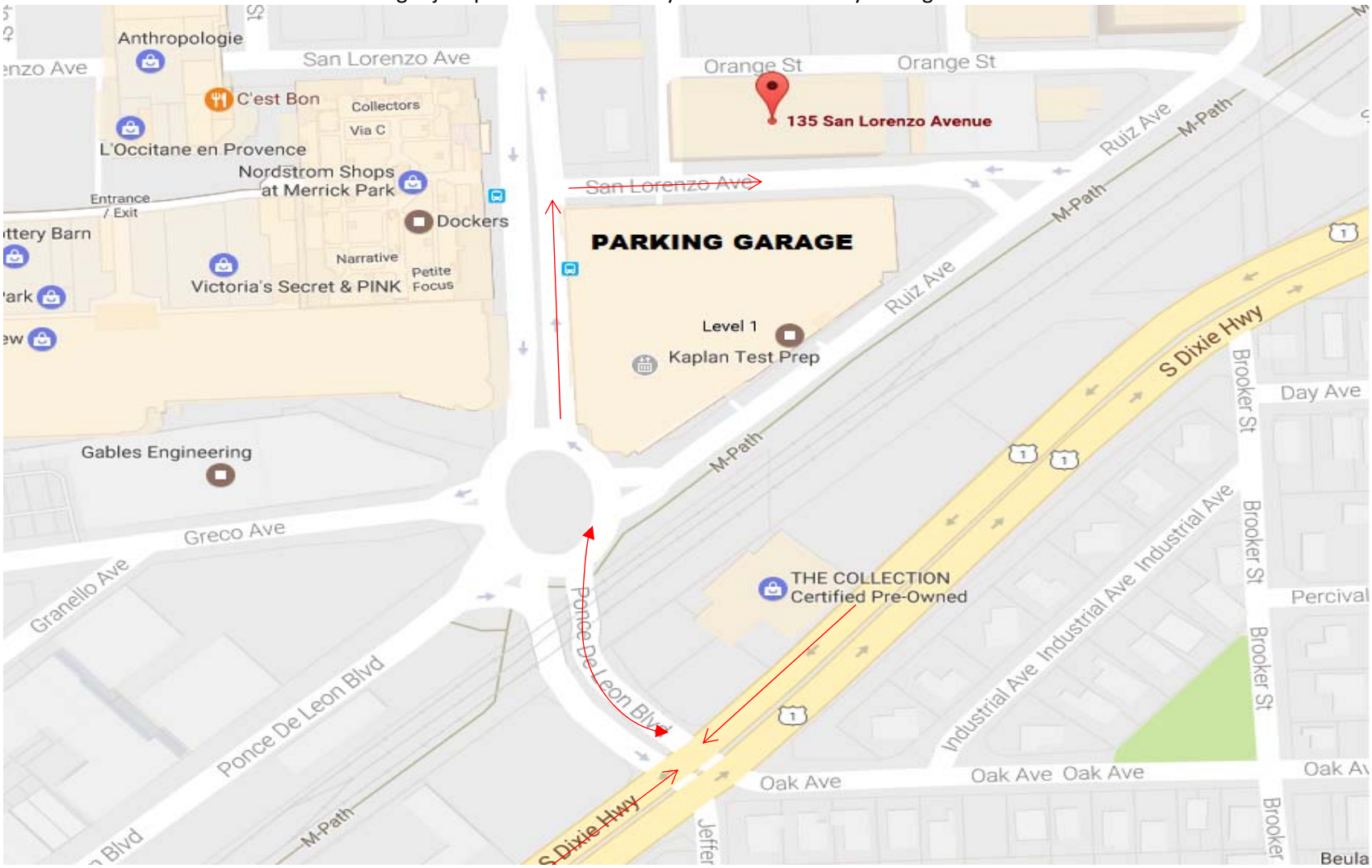
Turn **right** onto Ponce de Leon Blvd off of S Dixie Hwy/US-1 N

Enter roundabout and take the **2nd** exit onto Ponce de Leon Blvd

135 San Lorenzo Avenue will be on your **left** hand side

The parking garage will be directly to your **right**

* The building is just past SW 39th Ave. If you reach Ruiz Ave you've gone a little too far



THE CENTER FOR GYNECOLOGY AND RESTORATIVE MEDICINE

Michelle M. Starke, MD

Board Certified in Gynecology & Anti-Aging Medicine

PATIENT DEMOGRAPHICS	
Patient Name	Home Phone
Home Address	Work Phone
City State Zip	Cell Phone
Date of Birth Age	Email Address
Occupation	Social Security #
Employer	Marital Status
Work Address	City State Zip
Referred By	Primary Language Spoken

SPOUSE/EMERGENCY CONTACT	
Name	Date of Birth
Relation to Patient	Phone Number

INSURANCE INFORMATION	
Name of Primary Insurance	
Group Number	Member/Subscriber ID
Name of Subscriber	Subscriber's Social Security #
Subscriber's Date of Birth	Relation to Patient
Subscriber Employer	Work Phone

RELEASE OF INFORMATION	
I authorize the release of any medical information necessary to process a claim.	
Signed by Subscriber:	Date:

ASSIGNMENT OF BENEFITS	
I authorize payment of medical benefits to myself or the name provider for professional services rendered.	
Signed by Subscriber:	Date:

PHARMACY INFORMATION:

NAME OF PHARMACY: _____ PHARMACY PHONE #: _____

ADDRESS OF PHARMACY: _____

THE CENTER FOR GYNECOLOGY AND RESTORATIVE MEDICINE
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Patient History Form - Page 1

NAME:_____

Date:_____

Please choose **ONLY ONE** of the following office visit types you would like to have today:

(DO NOT CHOOSE MORE THAN ONE)

☐ _____ New Patient Well Woman Visit – Last Pap: _____

OR

☐ _____ New Patient Problem Visit – Details: _____

OR

☐ _____ New Patient Hormone Consult – Details: _____

LIST ALL MEDICATIONS:

Name	Dosage	# of times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES:_____

LAST MENSTRUAL PERIOD:_____

PREVIOUS GYNECOLOGIST:_____

THE CENTER FOR GYNECOLOGY AND RESTORATIVE MEDICINE
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Patient History Form - Page 2

NAME:_____

Date:_____

Medical Problems:

_____

_____

_____

_____

Surgeries:

_____

_____

_____

_____

Obstetrical History:

Number of children: _____ Vaginal deliveries _____ Cesareans _____ Miscarriages _____
Terminations of pregnancies _____ Ectopic pregnancies _____

Social History:

Marital status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed
Alcohol: ___ Never ___ Occasional ___ 3-4 x /week ___ Daily
Tobacco: ___ Never ___ Quit date: _____ Current, packs/ day _____
Exercise: ___ None ___ 1-2x/week ___ 3-4x/week ___ Daily

Family History: (Please include Type of Cancer, Diabetes, Hypertension, Stroke, Osteoporosis). Circle if alive or deceased (A/D)

Mother: ___ A ___ D; Type: _____ Maternal Grandmother: ___ A ___ D; Type: _____
Father: ___ A ___ D; Type: _____ Maternal Grandfather: ___ A ___ D; Type: _____
Siblings: ___ A ___ D; Type: _____ Paternal Grandmother: ___ A ___ D; Type: _____
Children: ___ A ___ D; Type: _____ Paternal Grandfather: ___ A ___ D; Type: _____

Gynecological History:

Last pap smear:_____ Any abnormal pap smears:_____
Last mammogram:_____ Any abnormal mammograms:_____
Are you sexually active? ___ Yes ___ No ___ Heterosexual ___ Homosexual ___ Bisexual
Are you in an abusive relationship? _____ Have you been sexually abused? _____

Gardasil Vaccines Completed: _____ of 3

THE CENTER FOR GYNECOLOGY AND RESTORATIVE MEDICINE
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Patient History Form (Page 3)

Name:_____

Date:_____

REVIEW OF SYSTEMS:

Do you now or have you had any problems related to the following symptoms?

Constitutional Symptoms			**Eyes**		
Fever/chills	☐Y	☐N	Glasses/contacts?	☐Y	☐N
Headache	☐Y	☐N	Blurred vision	☐Y	☐N
Weight loss/gain	☐Y	☐N	Double vision	☐Y	☐N
Ear/Nose Throat			**Cardiovascular**		
Sore throat	☐Y	☐N	Chest pain	☐Y	☐N
Chronic Sinusitis	☐Y	☐N	Palpitations	☐Y	☐N
Difficult swallowing	☐Y	☐N	Varicose veins	☐Y	☐N
Respiratory			**Hematological/Lymphatic**		
Wheezing	☐Y	☐N	Excess bruising	☐Y	☐N
Coughing	☐Y	☐N	AIDs/HIV	☐Y	☐N
Short of breath	☐Y	☐N	Swollen glands	☐Y	☐N
Breast			**Musculoskeletal**		
Breast pain	☐Y	☐N	Back pain	☐Y	☐N
Nipple discharge	☐Y	☐N	Neck pain	☐Y	☐N
Itchy nipples	☐Y	☐N	Joint pain	☐Y	☐N
Gastrointestinal			**Genitourtinary**		
Constipation	☐Y	☐N	Blood in urine	☐Y	☐N
Diarrhea	☐Y	☐N	Painful urination	☐Y	☐N
Bloating	☐Y	☐N	Urinary frequency	☐Y	☐N
Neurological			**Endocrine**		
Numbness	☐Y	☐N	Tired/sluggish	☐Y	☐N
Memory lapses	☐Y	☐N	Excess thirst	☐Y	☐N
Dizziness	☐Y	☐N	Cold extremities	☐Y	☐N
Integumentary/Skin			**Emotional**		
Acne	☐Y	☐N	Depression	☐Y	☐N
Dry skin	☐Y	☐N	Anxiety	☐Y	☐N
Rashes/boils	☐Y	☐N	Stress	☐Y	☐N

FINANCIAL POLICY

The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have regarding the information noted below.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

CREDIT CARD POLICY: We are requesting that you supply our office with your credit card information that will be securely kept on file for payment of all services and fees which would also include a no show/late cancellation fee if warranted per our missed appointments policy as described below.

MISSED APPOINTMENTS: Unless cancelled 48 hours in advance, there is a **$50.00** fee for missed appointments that will be charged to the credit card on file. Please help us serve you and others better by keeping scheduled appointments. When you do not call to cancel or reschedule your appointment, you may be preventing other patients from getting much needed medical treatment.

PROOF OF INSURANCE: If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

NON-COVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a **$50.00** NSF fee from the office.

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

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

_____ _____

Patient Name Date

_____

Patient/Responsible Party Signature

MALPRACTICE

"Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Dr. Michelle M. Starke has decided to not 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 judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

This is to certify that I have read and understood the information above.

_____ _____

Patient Name and Signature Date

The Center for Gynecology and Restorative Medicine
Michelle Starke, MD, LLC

Notice of Privacy Acknowledgment and Consent for the Purposes of Treatment, Payment and Health Care Operations

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), 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.

I hereby consent to the use or disclosure of my protected health information by Michelle Starke, MD, LLC (the "provider") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the provider. I understand that diagnosis or treatment of me by the provider may be conditioned upon my consent as evidenced by my signature on this consent.

I understand I have the right to request a restriction as to how my protected heath information is used or disclosed to carry out treatment, payment, or health care operations of the practice. The provider is not required to agree to the restrictions that I may request. However, if the provider agrees to a restriction that I request, the restriction is binding on the provider and all physicians associated with the provider.

I have the right to revoke this consent in writing, at any time, except to the extent provider has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or health care clearing house. This protected health information related to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have the right to question any therapy proposed and/or provided by the provider and that all my questions will be answered prior to receiving treatment. I understand that I have not been and will not be given a guarantee of beneficial or specific results.

I acknowledge that among those who attend to me are medical, nursing or other health care personnel who are in training. I consent to their presence and participation in my evaluation and treatment as part of their education and training. I acknowledge that such personnel may not be employees of the provider. I consent to such personnel who are in training having access to my medical records regardless of whether I am present or whether such personnel have even seen me.

_____
Patient Name or Legal Guardian (print)

_____ _____
Patient Signature Date

Communication by Email, Text Message, and Other Non-Secure Means

Patient Name: _____ Date: _____

Email Address: _____ Mobile Number: _____

It may become useful during the course of treatment to communicate by email, text messages (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with our office there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate with our office. Third parties on the Internet such as server administrators and others who monitor Internet traffic.

If there are people in your life that you do not want accessing these communications, please talk with our office about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to the office of **Michelle M. Starke, MC, LLC** to use unsecured email and/or mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of your appointments with a provider in our office
- Information related to billing and payment
- Personal information as initiated by me, to which this office may respond

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

Patient Signature Date

Pelvic Health Survey

Name: _____ Date: _____

Bladder:
How often do you leak urine? Check one box.

- ☐ 0. Never
- ☐ 1. About once a week or less often
- ☐ 2. Two to three times a week
- ☐ 3. About once a day
- ☐ 4. Several times a day
- ☐ 5. All the time

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

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 (Do not write. For office use only): _____

When does urine leak?

- ○ 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? ○ Y / N ○
Are you bothered by the number of times per day that you have to empty your bladder? ○ Y / N ○
Do you wake up at night to empty your bladder? ○ Y / N ○
If yes, how many times? _____
Do you feel you have to rush to the toilet to avoid an accidental leak? ○ Y / N ○

Bowel:
Do you accidentally leak stool? ○ Y / N ○
Do you have to strain to have a bowel movement? ○ Y / N ○
Do you pass gas when you do not want to? ○ Y / N ○

Gynecological:
Do you experience pelvic pain? ○ Y / N ○
Do/did you experience pelvic pain with intercourse? ○ Y / N ○
Do you have a feeling of a "ball" in your vagina? ○ Y / N ○
Hysterectomy? ○ Y / N ○
Vaginal Dryness? ○ Y / N ○
Number of vaginal deliveries _____
Number of Cesarean Sections_____

Michelle M. Starke, MD, LLC
The Center for Gynecology & Restorative Medicine

Hereditary Cancer Questionnaire

Name: _____ Date: _____

Have you or any of your relatives ever been tested for a hereditary cancer syndrome? (Ex: BRCA/Colaris) ☐ Y / N ☐

Do you have any Ashkenazi Jewish Ancestry? (Eastern European) ☐ Y / N ☐

Have you ever been diagnosed with cancer? ☐ Y / N ☐

If yes, which type of cancer were you diagnosed with? _____

Has anyone in your family been diagnosed with cancer? (Parents, Grandparents, Aunts, Uncles, Siblings, or Children)

Family Member	**Age at Diagnosis**
Breast Cancer: _____	_____
_____	_____
Ovarian Cancer: _____	_____
_____	_____
Colon Cancer: _____	_____
_____	_____
Uterine Cancer: _____	_____
_____	_____
Other Cancers: _____	_____
_____	_____

----------For Office Use Only----------

- Genetic testing offered: Accepted or Declined
- Information/Brochure Provided to patient
- Patient does not have risk factors

HCP Signature: _____