

Women's Health Assessment

Name _____ E-mail Address _____
 Age _____ Date of Birth _____ Referring Physician _____
 Primary Care Physician _____ OB/GYN _____

Who were you referred by / how did you hear about us?

Self Doctor Friend/Family Member _____ Other _____

Height _____ Weight _____ Blood Pressure _____ (taken during assessment)

Are you comfortable with your current weight? No Yes

What would you consider an ideal weight for you? _____ Date of last physical _____

Past Medical History

Have you been diagnosed/treated for:

	No	Yes		No	Yes
Cancer - Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	STD /HIV	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol problem	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

List Surgeries / Pertinent Hospitalizations

Have you had any of the following tests performed?

	No	Yes	Date / Year of Test
Mammography	<input type="checkbox"/>	<input type="checkbox"/>	
PAP smear	<input type="checkbox"/>	<input type="checkbox"/>	
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Bone density	<input type="checkbox"/>	<input type="checkbox"/>	

OB/GYN History

How many children do you have? _____ How many pregnancies have you had? _____

Have you had any interrupted pregnancies? No Yes _____

Have you had a hysterectomy? No Yes Date of surgery _____

Have your ovaries been removed? No Yes

Have you had a tubal ligation? No Yes

Have you ever used oral contraceptives? No Yes Any problems? No Yes
 If YES, describe any problem(s) _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? No Yes If YES, please explain (such as age when this occurred, symptoms, etc ...)

Are you still having menstrual cycles? No Yes
 When was your last period? _____ How often? _____
 How many days of flow? _____ Bleeding between cycles? No Yes
 Do you have, or did you ever have, Premenstrual Syndrome (PMS)? No Yes
 If YES, explain symptoms: _____
 If menopausal, have you had any spotting or bleeding? No Yes

Pertinent Family History

Has anyone in your family been diagnosed/treated for:

	No	Yes	Relationship(s)
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Fibrocystic breast	<input type="checkbox"/>	<input type="checkbox"/>	
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	

Lifestyle

How many alcoholic drinks do you consume per week? _____ Type of drink _____

How much caffeine do you consume per day? _____

How many diet beverages do you consume per day? _____

Do you smoke? No Yes How much per day? _____ If quit, when? _____

Do you feel you eat healthy? No Yes _____

Do you follow a special diet? No Yes _____

Do you feel your diet is excessive in: Carbohydrates Proteins Fats

Do you exercise? No Yes Number of times per week _____ Type _____

Are you interested in increasing? No Yes Type _____

Marital Status: Married to _____ Significant other _____

Single Divorced Widowed

Education _____ Occupation _____

Stress

Do you feel stress in your life? No Yes

If YES, please rank the source with 1 being the most stressful.

Physical/health related	
Relationship(s)	
Job related	
Emotional	
Other _____	

Do you feel stress from any relationships (spouse, kids, family, coworkers, and friends) in your life? No Yes

Please explain who / what are the issues: _____

Have you considered counseling? No Yes Would you consider counseling? No Yes

List Nutritional/Natural Supplements
<input type="checkbox"/> vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
<input type="checkbox"/> minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
<input type="checkbox"/> herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, etc.)
<input type="checkbox"/> enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
<input type="checkbox"/> nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)
<input type="checkbox"/> others (glucosamine, antihistamines, antacids, etc.)
List: _____ _____

List Hormones Previously Taken	Date Started	Date Stopped	Reason
_____	_____	_____	_____
_____	_____	_____	_____

List Prescription Medications		
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Medication Allergies _____

External Self

Are you generally comfortable with your appearance? No Yes

If NO, what are your areas of concern? _____

Are you routinely using a skin care regimen and/or makeup? No Yes

Are you interested in a complimentary consult with an esthetician (skin care specialist) regarding options for skin rejuvenation/maintenance products? No Yes

Are you interested in information or visiting with someone regarding:

- Facial rejuvenation? No Yes
- Body rejuvenation? No Yes
- Dental rejuvenation? No Yes
- Hair style options? No Yes

CHECK the degree of severity for any symptoms that apply to you:

	mild	moderate	severe		mild	moderate	severe
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy/irregular menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harder to reach climax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body aches/joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breakthrough bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin/hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fuzzy thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any additional comments or concerns: _____

Patient Signature _____

Date _____

Financial Policy

This is an agreement between Kurtis Waters, MD, PA, as creditor, and the patient/debtor named on this form. In this agreement, the words "you," "your," and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Kurtis Waters, MD, PA.

By executing this agreement, you are agreeing to pay for all services that are received.

Benefits:

- It is patient responsibility to verify any and all coverage, eligibility, and benefit levels per their individual insurance policy(s). We are unable to quote any benefits and/or allowed amounts for your visit. Please contact your insurance company directly with any policy concerns.

Policy for non-insured medically necessary procedures:

- Payment in full is due on the date that services are rendered.
- Patient will receive a 40% discount of normal fee rates for same day payment.
- Payment types accepted are: cash, check, Visa, MasterCard, Discover, or Care Credit.

Policy for patients with contracted insurance companies:

- If we are contracted with your insurance company, we must follow our contract and their requirements.
- Any co-pays required by your insurance company must be paid at the time of service. This is an insurance requirement per your policy.
- It is the insurance company that makes the final determination of your eligibility.
- If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral may result in a lower payment from your insurance company.
- You agree to pay any portion not covered by your insurance.
- We are currently contracted with the following insurance companies: BCBS MN and its affiliates, Medica (including Select Care, Labor Care, and United Healthcare), Medicare and Medicare Replacement plans, Minnesota Medical Assistance, Ucare, and Health Partners.

Policy for patients with non-contracted insurance companies:

- Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will submit your charges to your insurance as a courtesy to you.
- Any co-pays required by your insurance company must be paid at the time of service. This is an insurance requirement per your policy.
- It is the insurance company that makes the final determination of your eligibility.

- If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral may result in a lower payment from your insurance company.
- You agree to pay any portion not covered by your insurance.
- We are currently NOT contracted with the following insurance companies: Preferred One and its affiliates, Cigna, Aetna, and other commercial carriers.

Financial Policy continues on next page

Revised 08/01/2008

initial_____

Policy for Cosmetic Procedures:

- Payment in full is required on the date of service for all injections and cosmetic consultations. No same day discount applies as cosmetic procedures are already set at a discounted rate.
- Payment for a scheduled cosmetic surgery must be received 14 days prior to the date of surgery. If this payment is received after that date, surgery may be rescheduled from 14 days of receipt of payment.
- Payment types accepted are: cash, check, Visa, MasterCard, Discover, or Care Credit.

Statements:

- You will receive a statement on any remaining balance directly after we receive notification from your insurance company.
- BALANCE IN FULL is due upon receipt of statement.
- Payment options include: cash, check, Visa, MasterCard, Discover, or Care Credit.

Returned Checks:

- Any checks returned by your financial institution will be assessed a fee of \$25.00.

Past due accounts:

- If your account becomes past due, we will take any and all necessary steps to collect this debt. If we refer your account to an outside collection agency, all future correspondence regarding that debt will need to be made directly through the collection agency.
- We reserve the right to cancel your privileges to make charges against your account at any time due to delinquent balances.
- If a balance remains unpaid, any future care you may need by our office could be affected.

Waiver of confidentiality:

- You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date:

- Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible Party: _____
(If not the patient)

Signature: _____ Date: _____

**AUTHORIZATION FOR RELEASE OF INFORMATION
AND FINANCIAL RESPONSIBILITY**

RECORD RELEASE: I authorize Kurtis Waters MD, PA to release medical information about me to my insurance carriers, the Social Security Administration or its intermediaries/carriers, Centers for Medicare & Medicaid Services (CMS) and its agents for purposes of payment, and to referring physicians and other providers involved in my care.

PHOTOGRAPHS: I hereby give permission to my provider or any assistant designated, to take photographs to enhance the medical record and for diagnostic purposes. I understand that they may show them to other health professionals to help with my skin care and for educational purposes for their patients.

ASSIGNMENT OF BENEFITS: I authorize payment of Medical/Medicare benefits to Kurtis Waters MD, PA for any services furnished by this clinic to me. I understand that I am financially responsible for charges not covered by Medicare and/or my insurance carriers.

This authorization also covers charges generated by Kurtis Waters MD, PA for services received at St. Joseph's Medical Center or other medical facilities.

I permit a copy of this authorization to be used in place of the original.

DATE _____

SIGNATURE _____

(Relationship if patient is a minor: _____)

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1, Baxter, MN 56425

**THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS
INFORMATION. PLEASE REVIEW IT CAREFULLY.**

1. Kurtis Waters MD, PA is permitted to make uses and disclosures of **protected health information** (PHI) for treatment, payment, and health care operations, as described in the following examples:
 - a. For treatment – (e.g., to discuss your PHI with other healthcare providers)
 - b. For payment – (e.g., to submit information to your insurance company)
 - c. For health care operations – (e.g., to send the minimum necessary of your PHI to other healthcare providers as appropriate)
2. Kurtis Waters MD, PA is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Minnesota state law, when more stringent than federal law, will be followed.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Kurtis Waters MD, PA may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
5. The individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. Kurtis Waters MD, PA is not required to agree to a requested restriction, however.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.
 - f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. Kurtis Waters MD, PA is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
7. Kurtis Waters MD, PA is required to abide by the terms of the Notice currently in effect.
8. Kurtis Waters MD, PA reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Kurtis Waters MD, PA will provide individuals or patients with a revised Notice on request in person or by mail after an official public notification in the Brainerd Daily Dispatch.
10. Individuals may complain to Kurtis Waters MD, PA and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated by calling or writing and requesting a complaint form.
11. Kurtis Waters MD, PA contact person for matters relating to complaints is:

Call:

Privacy Officer @ 218-454-8888

Or **Write** to:

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1
Baxter, MN 56425

12. This Notice is first in effect 12/1/2007.

**Kurtis Waters MD, PA
13359 Isle Drive, Suite 1
Baxter, MN 56425
218-454-8888**

I hereby acknowledge that I have received a copy of Kurtis Waters MD, PA Notice of Privacy Practices.

Signature

Date: _____

Optional:

Email address: _____ @ _____

This address is considered part of your **protected health information**, and will be used by Kurtis Waters MD, PA only for your benefit.

Estimated Costs for Services

Insurances may or may not cover many of the services involved in a Woman's Health Assessment and Treatment plan. We want to be forthright on the potential costs of the services involved as many patients have high deductible plans and health saving accounts they must be attentive to. We know your investment **in you** will be well worth it!

Initial Consult

\$320

(Can be submitted by patient to insurance or Health Savings Plan)

Initial F/U

Included in cost of Initial Consult

Additional F/U

\$120

(Can be submitted by patient to insurance or Health Savings Plan)

Salivary tests

Can Range from \$250-550

(Can be submitted to insurance by clinic)

Blood tests

Can Range from \$100-600

(Can be submitted to insurance by clinic)

Neutraceuticals/supplements

Daily supplements, Omega 3, Liver detox, Adrenal Adaptagens typically cost about \$1/day

(Can be submitted by patient to insurance or Health Savings Plan)

Compounded Hormones and/or other Prescriptions

Many of compounded prescriptions can range from \$40-100+/-month. Once individual dosages have been established, some of the compounded prescriptions can be combined to make it more cost effective. Typical combination cream averages \$40-70/month.

(Very few insurance companies cover compounded Prescriptions, can be submitted by patient to insurance or Health Savings Plan)

Other

Preventive health screenings are required through your primary care physician and/or gynecologist (mammogram, bone density test, colonoscopy).