Linda C. Evans M.D., L.L.C.

Yearly History Form 2016

Today's Date:_____

Patient Information:

Patient Name:_____ SS#:_____ Date of Birth:_____

Address:_____ City:_____ ST:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email: _____

Preferred Method of Appointment Reminders: ☐ Voice Call ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Emergency Contact: Name:_____ Phone:_____

Ok to leave results on the following phone:

Home: ☐ YES ☐ NO Cell: ☐ YES ☐ NO Work: ☐ YES ☐ NO

☐ Do not leave results on phone

Results will be called to phone indicated above and a message will be left unless you specify an alternate number; normal pap results will not be called.
If you have an alternate number, please list here:_____

Patient Signature: _____ Date: _____

Were you referred here? ☐ YES ☐ NO If so, by who?_____

Primary Insurance Information:

Company:_____ Policy Holder:_____ Policy Holder SSN:____-___-_____

Insurance ID Number:_____ Relationship to Patient:_____

Patient Acknowledgement of Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I have been provided with the opportunity to read/review a copy of the Disclosure of Health Care Information by the office of Dr. Linda C. Evans, MD. I have also been notified of the opportunity to receive a copy of this Disclosure upon request.

Signature: _____ Date: _____

**A copy of the HIPAA policy will be provided at your request

Consent to Treat

I have read and understand the information above and have supplied all necessary medical information. I consent to evaluation and medically necessary treatment by the professional staff of Linda Evans, MD, LLC and/or Premiere Center for Health and Wellness. No guarantee is being made to me about the results of treatment. I understand that this consent will remain in effect until revoked by me in writing.

We routinely test for sexually transmitted diseases in patients 25 years of age and younger. I understand that sexually transmitted diseases are reportable by Ohio state law and if my results are positive, they will be reported to the Department of Health. (If you do not wanted to be tested, please inform the staff)

It is Ohio state law to check an OARRS (Ohio prescribing report) when receiving ongoing therapy with one or more controlled substances, and I consent to have this report run if applicable to my treatment.
I also understand that my prescription benefits and history of prescriptions dispensed by other physicians will routinely be accessed in order to enhance safe and complete treatment.

Signature:_____ Date:_____

Linda C. Evans, MD, LLC

Financial Guidelines

Our office is required by contract with your chosen insurance carrier to file claims according to the service we provide you. There are 2 general types of office visits:

1. **Routine, Well Woman, Preventative, or Yearly Visit:** These visits are to prevent health problems and recommend age appropriate screening tests. A preventative visit is **NOT** a visit to discuss problems you may be having. Problems addressed or prescriptions filled may result in additional visit fees. A preventative visit is only covered once a year with your insurance company. If the claim is denied for any reason, you will be responsible for the cost of the visit.

2. **Problem Visit:** These visits are to address symptoms or complaints that may signify the need for diagnosis or treatment. They may be for an illness or to follow up with a medical condition. These visits will be focused on the problems you have indicated, and may or may not include a physical examination.

Your coverage for these visits is determined by your insurance provider. It is your responsibility to know what services are covered and what services are not.

If you wish to have your visit limited to a type 1 visit, it is your responsibility to inform the provider at the beginning of your visit. If the visit expands outside of the scope of a preventative visit, you will be billed for the visit in accordance with your insurance policy guidelines.

We bill upfront at our office. This means we will contact your insurance provider based on the most recent information you have given us to verify active benefits and possible payments due. This may be a copayment or apply towards your deductible depending on your specific policy. We make every effort to calculate your responsibility before your visit, however this is not a guarantee, but an estimate and you may receive an additional bill from our office. In the event of an out-patient procedure this does not include facility charges such as hospital stays, administered anesthesia, radiology, pathology and or laboratory services. We will make every effort to help you maximize your insurance coverage, but we must bill according to national billing guidelines. We cannot change billed codes or amounts unless it was a coding error. Changing a billing code or amount after submission is considered insurance fraud.

We 'assign benefits' to our office which means your insurance will pay us if we are in network. For out of network patients, benefits are assigned to you individually which means the insurance company will reimburse you directly, not our office. If you have an out of network insurance provider you are responsible for payment in full upfront. This does not guarantee you will not get a bill after your claim is processed.

You should receive an EOB or estimation of benefits from your insurance company in the mail after your appointment. This is simply a statement of what we submitted to your insurance for a particular date of service and a statement of what your insurance company will be paying our office. This does not necessarily mean you will get a bill from our office, but it is possible that you will.

Laboratory testing may be ordered at your visit. The laboratories we use have their own billing practices and labs performed by them are billed by their office, not ours. If you receive a bill from PathGroup, Medical Diagnostic Laboratories (MDL), or Myriad, please contact their offices in regard to payment as we will not be able to answer any questions you have about their bills.

Payment Methods: Our office accepts cash, Visa, MasterCard, Discover and personal checks for those in good standing. We do not accept American Express. There is a returned check fee of $40. This does not include any other expenses your bank may apply.

Delinquent Accounts: Patient accounts that are severely past due will be sent to a third party collections agency and reported to the credit bureau. These patients cannot be seen at our office until accounts are brought current. These patients may also incur extra expenses from the collections agency.

By signing, you have read and understand the terms of our office.

Signature:_____ Date:_____

LINDA C. EVANS M.D., L.L.C.
Service Agreement Options

Services provided to you today (at your office visit) and notification of lab results from tests performed **today** are provided as part of the office visit. The official policy is **we do not provide services over the telephone.** This includes prescription refills, pre-cert for medication and/or procedure, medication changes, and letters/notes for school, work, insurance coverage, etc. This policy is necessary because of the large number of telephone requests for services every day.

For those patients who would like the convenience of certain telephone services, our office has created a service agreement. The agreement is designed so that the office can continue to provide this type of service without having to make an office appointment. This agreement would be beneficial for the following patients:

- Students who are away at college and may need to change or restart birth control
- Patients who receive multiple prescriptions during the year
- Patients who are on hormone replacement that may need to be adjusted through the year
- Patients who anticipate an insurance change which may require obtaining new prescriptions
- Patients having surgery and would likely need disability or other insurance forms completed
- Refilling a controlled substance **requires an office visit**.

The service agreement is completely elective and only available during the visit for your annual exam. Patients who choose not to participate in the service agreement will be required to come to the office for services, or pay individually for completion of forms, letters, and prescription refills.

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

[ ] I wish to participate in this service agreement. I understand that it is for routine uncomplicated requests such as those listed above. I understand that I will need to schedule an appointment for an office visit if I have a medical problem.

[ ] I choose a 1 year service agreement for $30.00 which will expire one year from the date of my signature below.

[ ] I choose a 2 year service agreement for $50.00 which will expire two years from the date of my signature below.

[ ] I choose not to participate in this service agreement and will come into the office for an appointment every time I need a duplicate prescription, a medication change, or any other service.

I have read and understand the above information.

Patient Signature: _____ Date: _____

2015 Medical History

Date of last pap:_____ Was it normal? ☐ Yes ☐ No ☐ N/A

Have you ever had an abnormal pap? ☐ Yes ☐ No Date if applicable:_____

Please list any medical illnesses you have had:_____

_____

Have you had a hysterectomy(removal of your uterus)? ☐ Yes ☐ No If yes, date:_____

Was the surgery: ☐ Abdominal ☐ Laparoscopic ☐ Vaginal Have you had your ovaries removed? ☐ Yes ☐ No / ☐ One ☐ Both

Please list all surgeries you have had:

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Any family history of:

☐ Breast Cancer: Who_____ Age_____ ☐ Colon Cancer: Who_____ Age_____

☐ Ovarian Cancer: Who_____ Age_____ ☐ Uterine Cancer: Who_____ Age_____

☐ Other Cancer: Type_____ Who_____ Age_____

☐ Heart attack younger than 60: Who_____ Age_____

☐ Substance Abuse or addiction: Who_____

Number of pregnancies:_____ Number of living children:_____ Number of adopted children:_____

Number of vaginal deliveries:_____ Dates:_____ Number of C-sections:_____ Dates:_____

Have you ever received hormone replacement therapy (oral, patch, or pellet)? ☐ Yes ☐ No

If yes: Last treatment date:_____ Where:_____ Type:_____

Preventative Information

For preventative well woman care, Dr. Evans recommends the following:

Menopausal women have a bone density study for osteoporosis: Have you had a bone density study? ☐ Yes ☐ No ☐ N/A
Date of last bone density study:_____ Was it normal? ☐ Yes ☐ No ☐ N/A

Age 20 and older perform regular monthly self-breast exams: Do you perform monthly self-breast exams? ☐ Yes ☐ No ☐ N/A

Age 40 and older have an annual mammogram: Have you had a mammogram? ☐ Yes ☐ No ☐ N/A
Date of last MMG:_____ Was it normal? ☐ Yes ☐ No ☐ N/A

Age 40-50 have a yearly stool test for blood (can obtain from PCP): Have you had a stool test for blood? ☐ Yes ☐ No ☐ N/A

Age 50 and older have a colonoscopy to evaluate for colon cancer: Have you had a colonoscopy? ☐ Yes ☐ No ☐ N/A
Date of last colonoscopy:_____ Would you like a referral for one? ☐ Yes ☐ No

Age 50 and Older: Do you have at least 1 ovary? ☐ Yes ☐ No ☐ N/A

If you are over 50 and have at least 1 ovary, you are a candidate for an ovarian cancer screening. This involves taking a blood sample to measure the level of CA-125 (Cancer Antigen 125). We offer this testing through Premiere Center for Health and Wellness, which is not contracted with ANY insurance company.

☐ I have read the information about the optional CA-125 testing and would like to Have it performed. I understand there is an associated fee of $75.

☐ I would like to have a prescription written to have a CA-125 performed at a lab so my insurance company will be billed. I understand that if it is not covered by my plan I will be billed approximately $150 by the lab.

☐ I prefer not have the CA-125 test performed.

Patient Signature_____ Date:_____

Linda C. Evans M.D., L.L.C.

Review of Symptoms

Patient Name: _____ Acct: _____ Date: _____

Today's appointment is for: ☐ Annual ☐ Problem _____ ☐ Lab visit

Please explain issues you would like to discuss with the provider today:_____

Preferred Pharmacy: _____

Primary Care Physician:_____ May we release information to this physician? ☐Yes ☐No

Do you use tobacco products? ☐ Yes ☐ No Type:_____ Amount:_____ Do you wear a seatbelt? ☐Yes ☐No

In the past 12 months, have you consumed more than 6 alcoholic drinks on one occasion? ☐Yes ☐No

Method of Birth Control: ☐ Pills ☐ NuvaRing ☐ Tubal ☐ Hysterectomy ☐ Abstinence ☐ IUD

☐ Female Partner ☐ Withdrawal ☐ Condoms ☐ Depo Provera ☐ Menopause ☐ Vasectomy

☐ Natural Family Planning ☐ other _____

Medication List - List ALL medications prescribed by our office AND other providers: (if not taking any, please write none)

Medication	Dosage	Reason for taking	Refill?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Over the counter meds, vitamins & supplements: _____

Please list all allergies to medication & reaction(s):_____

Have you had a period in the last year? ☐ Yes ☐ No When was your last period? _____

Does your period occur monthly? ☐ Yes ☐ No Are your periods abnormally heavy? ☐ Yes ☐ No

Are your periods painful? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Domestic Partner

Please indicate if you are experiencing any of the following:

Fatigue	☐ Yes ☐ No	Blood in Stool	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No	Nausea	☐ Yes ☐ No	Rage	☐ Yes ☐ No
Weight gain	☐ Yes ☐ No	Urinary Issues	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Headache	☐ Yes ☐ No	Lack of Sexual Drive	☐ Yes ☐ No	Acne	☐ Yes ☐ No
Nipple Discharge	☐ Yes ☐ No	Painful Intercourse	☐ Yes ☐ No	Hair Loss	☐ Yes ☐ No
Breast Tenderness	☐ Yes ☐ No	Compulsive Behavior	☐ Yes ☐ No	Excessive Hair Growth	☐ Yes ☐ No
Hemorrhoids	☐ Yes ☐ No	Sleep Difficulty	☐ Yes ☐ No		

Any new medical conditions and/or surgeries in the past 2 years? _____

Patient Signature: _____ Date:_____

FEMALE MENOPAUSE SYMPTOM ASSESSMENT

PATIENT NAME _____ DATE _____

What was the first day of your last period? Date _____ or _____ > 1 year

Please rate your menopausal/premenopausal symptoms below: (0 no symptoms-5 severe symptoms)

Difficulty falling asleep	0	1	2	3	4	5
Difficulty staying asleep	0	1	2	3	4	5
Hot flashes	0	1	2	3	4	5
Night sweats	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Moodiness	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Lack of a sense of well-being	0	1	2	3	4	5
Excessive Fatigue	0	1	2	3	4	5
Weight gain	0	1	2	3	4	5
Difficulty losing weight despite regular exercise	0	1	2	3	4	5
Inability to concentrate	0	1	2	3	4	5
Inability to multi-task	0	1	2	3	4	5
Forgetfulness	0	1	2	3	4	5
Lack of interest in sex	0	1	2	3	4	5
Lack of ability to respond sexually	0	1	2	3	4	5
Pain with intercourse	0	1	2	3	4	5
Vaginal Dryness	0	1	2	3	4	5
Hormonal headaches	0	1	2	3	4	5
PMS Symptoms	0	1	2	3	4	5
Joint Pain	0	1	2	3	4	5
Muscle Pain/Weakness	0	1	2	3	4	5
Dry Eye	0	1	2	3	4	5
Hair Loss	0	1	2	3	4	5
Other	0	1	2	3	4	5
TOTAL						