LISA M. JUKES, M.D., P.A. Date: _____

DEMOGRAPHICS

Full legal name: _____ Date of birth: _____ Social security number: ___-___-_____
Preferred name:_____ Legal sex:_____ Gender Identity:_____
Address: *Apt/Unit* *City* *State* *Zip Code*

_____

Primary phone: _____ Secondary Phone: _____ Email: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Address: *Apt/Unit* *City* *State* *Zip Code*

_____

Primary insurance: _____ Phone number: _____
Member ID number:_____ Group Number:_____
Claims mailing address: _____
Name of Insured: _____ Date of birth: _____ Social security number: ____-___-_____
Address: _____ Phone number: _____
Secondary insurance: _____ Phone number: _____
Member ID number:_____ Group Number:_____
Claims mailing address: _____
Name of Insured: _____ Date of birth: _____ Social security number: ____-___-_____
Address: _____ Phone number: _____

Who is your primary care physician? _____ Phone number: _____
Who were you referred by?_____

We work with Capsule to offer a concierge pharmacy experience and *free* same-day Rx delivery.
Would you be interested in using Capsule for your preferred pharmacy? CAPSULE
☐ Yes ☐ No, another pharmacy: _____

We will automatically enroll you for use of our online patient portal, which may include use of your email address to share practice news, specials, and health education. If you wish to decline, please indicate here: ☐ I DO NOT wish to use the patient portal. Signature: _____

What is your preferred laboratory (circle)? CPL QUEST LAB CORP SETON
**All labs will automatically be sent to CPL or Avero unless otherwise specified. Please note that we do not check insurance benefits or coverage for laboratory services.

REVIEW OF SYMPTOMS

Reason for today's visit: _____

Are you **CURRENTLY** experiencing any of the following symptoms you would like to discuss at today's visit?

☐ Vaginal dryness/itching	☐ Sleep disturbances	☐ Nausea/vomiting
☐ Abnormal vaginal discharge	☐ Depression/sadness	☐ Abdominal pain
☐ Pain with intercourse	☐ Suicidal thoughts	☐ Constipation
☐ Breast problems	☐ Headaches	☐ Diarrhea
☐ Abnormal bleeding	☐ Dizziness	☐ Blood in stool
☐ Memory loss	☐ Cough/cold symptoms	☐ Heartburn
☐ Fatigue	☐ Shortness of breath	☐ Bloating
☐ Weight changes	☐ Chest pain	☐ Urinary incontinence

- ☐ Night sweats/hot flashes
- ☐ Back/joint pain
- ☐ Other: _____
- ☐ Decreased sex drive
- ☐ Change in orgasm ability/intensity

MEDICATIONS

Please list any and all medications you are currently taking. Be sure to include any over-the-counter medications, including those for weight loss, pain relief, antacids, laxatives, and supplements.

Medication	Dosage	Frequency	Do you need a refill?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PERSONAL MEDICAL HISTORY

Do you have a history of any of the following?

☐ Neurologic disease	☐ Stroke	☐ Measles	☐ Migraine Headaches
☐ Thyroid disease	☐ Heart disease	☐ Chickenpox	☐ Depression/anxiety
☐ Lung disease/asthma	☐ High blood pressure	☐ Rheumatic fever	☐ Breast lump
☐ Liver disease/hepatitis	☐ Blood clots	☐ TB/ Pneumonia	☐ Fibrocystic breasts
☐ Bladder/kidney disease	☐ Varicose veins	☐ High cholesterol	☐ Diabetes
☐ Bowel disease	☐ Cancer. If yes, describe:		
☐ Bone/joint disease	☐ Other:		

ALLERGIES

Please list all known drug allergies and reactions: _____

_____

SURGICAL HISTORY

Have you ever had surgery or been hospitalized for an illness? If yes: YES NO

Date	**Type of surgery/illness**	**Location**

FAMILY MEDICAL HISTORY *I am ☐ adopted*

Condition	**Relations (ex: mother, brother x2 , maternal grandfather, paternal grandmother)**	**Living/Deceased**
☐ High Blood Pressure		
☐ Diabetes		
☐ Heart Disease		
☐ Stroke		
☐ Thyroid Disease		
☐ Osteoporosis		
☐ Cancers other than listed on the attached history		
☐ Other:		
Number of siblings: How many brothers? Sisters?		
Number of children: How many sons? Daughters?		

SOCIAL HISTORY

Do you smoke cigarettes? YES NO **Packs per day:**	Do you use recreational drugs: YES NO **What kind?**
Are you a former smoker: YES NO Packs per day: **When did you quit?**	Do you drink alcohol? YES NO **Drinks per week:**
Do you use e-cigs or vape? YES NO **How often?** **With Nicotine?** YES NO	Do you exercise: YES NO **Times per week:**
What is your occupation:	Employer:
Marital Status: SINGLE MARRIED DIVORCED WIDOW Partner's name:	

MENSTRUAL & GYNECOLOGICAL HISTORY

First day of last menstrual period:	Age at first menstrual period:
Do you have a personal history of? (please circle)	
Fibroids Ovarian cysts Endometriosis Pelvic Inflammatory disease Have you undergone any fertility treatments? _____	
Are you a survivor of sexual abuse or domestic violence?	
Have you received the series of HPV vaccines (Gardasil)? YES NO	
If yes, when was your last injection? Did you complete the series? YES NO	
How would you describe your menstrual cycles? REGULAR IRREGULAR ABSENT	
If absent, why? MENOPAUSAL HYSTERECTOMY NO CYCLE DUE TO BIRTH CONTROL	
Total flow: LIGHT MEDIUM HEAVY How many days does your period last?	

Initials:_____Date:_____

Do you pass any blot clots? YES NO Pain/Cramping: NORMAL SEVERE
Bleeding between periods: YES NO How often do you change pads/tampons on your heaviest days?
Have there been any recent changes to your cycle?
Date of last pap smear and result:
Do you have a history of abnormal pap smears: YES NO If yes, when?
What was the abnormal result? Was treatment/surgery required?

What is your current method of contraception: ORAL CONTRACEPTIVES NUVARING PATCH IUD NEXPLANON CONDOMS ESSURE TUBAL LIGATION VASECTOMY DEPOPROVERA DIAPHRAGM/CERVICAL CAP OTHER:
Do you have a history of sexually transmitted diseases. If yes, explain:
Sexual preference: MEN WOMEN BOTH
Have you been sexually active within the last 12 months? YES NO VIRGINAL
Please circle all that apply: VAGINAL ANAL ORAL

Age of first intercourse:	Number of lifetime sexual partners:

How long have you been with your current partner(s)?
Are you in a sexual relationship with more than one partner? YES NO
Date of last: Mammogram: _____ Result: _____ Colonoscopy: _____ Result: _____ Bone Density: Result:

OBSTETRICAL HISTORY

Total number of pregnancies:	Please list any pregnancy complications:
Number of miscarriages:	
Number of abortions:	
Delivery dates of vaginal births:	
Delivery dates of cesarean sections:	Do you have a history of ectopic pregnancies? If so, describe treatment:_____

IMMUNIZATIONS

Have you had any of the following immunizations?

☐ Shingles	☐ Pneumovax	☐ Flu (this year)

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Has anyone in your family had genetic testing for a hereditary cancer syndrome? (Ex: BRCA or Lynch)? Yes or No

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

Initials:_____Date:_____

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis)
Y	**N**	Breast cancer (please note if it was triple neg)				
Y	**N**	Breast cancer in both breasts OR recurrent				
Y	**N**	Ovarian/fallopian tube cancer				
Y	**N**	Male breast cancer				
Y	**N**	Are you of Jewish descent?				

COLON AND UTERINE CANCER (Colaris)

Y	**N**	Uterine (endometrial) cancer				
Y	**N**	Colon cancer				
Y	**N**	Ovarian, stomach, biliary tract, kidney/urinary tract, brain OR small bowel cancer				
Y	**N**	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	**N**	Prostate Cancer (BRCA)				
Y	**N**	Pancreatic Cancer (Col/BRCA)				
Y	**N**	Melanoma				

Patient's Signature:_____ **Date:** _____

For Office Use Only:

BRCA/Lynch Testing Indicated?: YES NO

Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED

Follow-up appointment scheduled: YES NO Date of Appointment:_____

One person with (out to 2nd degree):	**BRCA – Personal or Fam. History**	**Lynch Syndrome (Colon/Endo)**
• Breast Cancer at 49 or younger • Ovarian Cancer at any age • Male breast cancer any age • Pancreatic cancer any age • Bilateral Breast at any age • Metastatic prostate cancer at any age • Triple Neg Br.Ca. at 60 or younger • Jewish ancestry w/ovarian, pancreatic or breast cancer any age • Personally affected w/breast cancer at any age	Two persons with (out to 3rd Degree) • 2 Breast Cancers, w 1 ≤ 50 or younger Three Persons with (out to 3rd degree) • Breast and/or Ovarian and/or Pancreatic (any age)/aggressive Prostate	Personally affected with: • Colon or Endometrial at ≤ 64 Family History out to 2nd Degree: • 1 Colon or Endometrial Cancer ≤ 49 • 10+ Colon polyps found in a lifetime • 2 or more Lynch* cancers in the same person • 2 or more Lynch* cancers w/1 dx < 50 *(gastric, ovarian, brain, kidney, small bowel, pancreas, ureter, biliary tract)

INFORMED CONSENT FOR MAMMOGRAMS, BLOOD WORK, GENETIC TESTING, AND VACCINES

Initials:_____Date:_____

Your mammogram, lab work, and/or vaccines may or may not be covered by your insurance plan or Medicare/ Medicaid. **You are responsible for determining insurance coverage for these tests and for any payments to outside laboratories or facilities. Even if these tests are covered, charges may apply towards your copay or deductible. We do not verify coverage or benefits for these services.** Additional tests may also be added at the provider's discretion if abnormal results are returned.

***__**Please note**__: it is our office policy for the pap test to be performed with HPV typing in order to enhance the detection of cervical dysplasia/cancer in patients 30 years of age or above. Pap smears may not need to be collected each year, depending on current recommendations. If you have questions concerning HPV testing, please discuss them with the provider during your visit.

I have read the information above and understand its content. I understand that I may ask questions about testing at any time. I hereby give my consent to have my blood drawn or tissue samples collected for the labs discussed with the provider, or to receive the vaccine(s) recommended.

Print name:_____ Signature:_____ Date:_____

If the patient is a minor (under age 18), this form **__must__** be signed by a parent/guardian/legal representative.
Print Name: _____ Relationship: _____
Signature: _____ Date: _____

Standard Screening Tests:

Screening Blood Work: Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC), Lipid Panel, Thyroid-Stimulating Hormone (TSH), Vitamin D, Vitamin B12, Iron, Ferritin

Other Screening: Pap Smear, Human papillomavirus (HPV), Mammogram, Breast Ultrasound, Bone Density, Hemoglobin A1C

- **Mammogram** screening usually starts at age 40, testing every 1-2 years depending on age and family history. It is our office policy to order 3D mammograms (breast tomosynthesis). Please talk to your imaging facility if you have questions about cost and coverage for this type of screening.
- **Bone Density (DEXA)** screening is recommended every 2-5 years beginning at age 65, with early menopause, or if you are determined to be at increased risk for bone loss.

Additional Testing:

Please read through the following and select any imaging, tests, or vaccines you are potentially interested in today. *If you are unsure about what you would like to have done, your provider will go over your options with you.*

- □ **Hormone Testing:** Follicle-Stimulating Hormone (FSH), Estradiol, Testosterone, etc
- □ **Sexually Transmitted Disease Screening:** Blood work: hepatitis* (A, B, C), RPR (Syphilis), Herpes (simplex I & II); Cervical testing: Gonorrhea, Chlamydia, Trichomonas, Mycoplasma/Ureaplasma
  *The CDC recommends testing for hepatitis C virus for adults born from 1945 to 1965.
- □ **HIV-1 Antibody** (I understand that the performance and results of the HIV antibody test are considered confidential. I understand that the test results in my health record shall not be released without my expressed written permission, except to the individuals and organizations that have been given access by law, who are also required to keep my health information confidential. These include me, my physician, health care facility staff who provide my healthcare or handle specimens of my body fluids or tissues, funeral directors, court of record under lawful order, and the Health and Human Services Department/Travis County Health Department as required by law.)
- □ **Abnormal Bleeding Evaluation:** Human Chorionic Gonadotropin (HCG), Prolactin, FSH, Luteinizing Hormone (LH), Insulin (fasting), CMP, Dehydroepiandrosterone (DHEA), 17-Hydroxy, Free/Total Testosterone, TSH, CBC
- □ **Expanded Cardiac Testing**
- □ **Cystic Fibrosis/Genetic Carrier Testing**
- □ **Ovarian Reserve Testing**
- □ **Prenatal Testing:** OB Panel, Pap Smear, HPV, Gonorrhea, Chlamydia, Trichomonas, Urine Culture, HCQ Quantitative, Optional: Thyroid II Panel, HIV, Varicella, Toxoplasmosis IgG & IgM
- □ **Ova-1 or CA-125** (ovarian tumor markers)
- □ **Familial Hereditary Cancer Testing**
- □ **Gardasil 9 Vaccination**. Gardasil 9 is a series of vaccines that reduces the risk of Human Papillomavirus (HPV) types 16, 18, 31, 33, 45, 52, and 58; precancerous or dysplastic lesions caused by HPV Types 6, 11, 16, 18, 31, 33, 45, 52, and 58; and genital warts caused by HPV Types 6 and 11. It will not protect against diseases due to non-vaccine HPV types, nor does it serve as a substitute for routine cervical cancer screening.

CONFIDENTIAL COMMUNICATIONS REGARDING YOUR HEALTH INFORMATION

The confidentiality of your personal health information is of the utmost importance to our office. Please indicate below any requests for restrictions on how we may communicate your personal health information and/or billing information.

□ I authorize the release of my medical and/or billing information to:

Initials:_____Date:_____

Name(s) of person(s) who are permitted to discuss your personal health information and/or billing information

_____ _____

_____ _____

□ I do not authorize the release of my medical and/or billing information to anyone other than myself.

This authorization will remain valid one year from the date listed below. It is the responsibility of the patient to notify the office of any changes to this information.

Printed name: _____ **Date:** _____

Signature: _____

If the patient is a minor (under 18), this form must be signed by a parent/guardian/legal representative:

Parent/guardian/legal representative signature:_____ Date:_____

CONSENT FOR TREATMENT

I authorize and direct Lisa M. Jukes, M.D. and her providers/mid-level providers (nurse practitioner/physician assistant)/ assistants to perform quality care, including, but not limited to: diagnostic procedures and surgical and medical treatment(s), as may be necessary in their professional judgement.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I acknowledge that, when medically appropriate, I may receive care from a mid-level provider or assistant.

I grant this consent without duress, confusion, or pressure from Lisa M. Jukes, M.D. and/or her staff, associates, or colleagues.

Printed name: _____ **Date:** _____

Signature: _____

If the patient is a minor (under 18), this form must be signed by a parent/guardian/legal representative:

Parent/guardian/legal representative signature:_____ Date:_____

Lisa M. Jukes, M.D., P.A. 5656 Bee Cave Rd, Ste B101, Austin, TX 78746 (512) 301 – 6767

HIPAA NOTICE OF PRIVACY PRACTICES

Effective, April 14th, 2003; Updated January 17th, 2014

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your

Initials:_____Date:_____

protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

1. Use and Disclosure of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. The situations include: as required by law; public health issues as required by law; communicable diseases; health oversight, abuse, or neglect; Food and Drug Administration requirements, legal proceedings, law enforcement, coroner, funeral directors, organ donation, research, military activity and national Security, Worker’s Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department on Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance or on the use or disclosure indicated in the authorization.

2**.Your Rights** Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notification of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.
You have the right to request confidential communications from use by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You have the right to request your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3.Complaints You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your for filing a complaint.**

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Print Name:_____ **Signature:**_____ **Date:**_____

FINANCIAL POLICY

Updated July 29th, 2022

1. **All payments are required at the time services are rendered.** If we are in network with your insurance company your copay, unmet deductible and/or coinsurance must be paid at the time of service. These amounts are only estimates of total financial responsibility and you may still be billed for additional amounts after the claim for your visit has been finalized. Federal law requires that we collect copays at the time of service; otherwise we can be charged with fraudulent business practices. Patients who may have difficulty paying at the time of service should ask about payment options you may be eligible for. All payment arrangements must be made prior to services being rendered.

   It is the patient’s responsibility to know whether or not the provider of service is in network. The agreement with your insurance company is a contract between you and the insurance company. Please call the number on the back of your insurance

card for this information. If we are not in network with your insurance or if you fail to get the necessary referral or authorization to see our providers, you will be responsible for the difference between physician charges and any out-of-network payments. If your plan states that you need a referral to see Dr. Jukes, it is your responsibility to obtain the referral from your primary care physician or insurance carrier, depending on your plan benefits, prior to services being rendered.

Non-preventive concerns addressed at a wellness visit may not be covered in full. While many insurance plans cover well woman exams in full, any existing problems addressed at the same visit may be subject to copays and/or deductibles/coinsurance. Please reference the Preventative vs. New Problem FAQs for further information on what constitutes a problem visit vs. a preventative exam.

Patients are responsible for verifying lab test coverage prior to testing. Some lab tests such as STD or hormone testing, lipid panels, and Vitamin D testing may not be covered by your insurance. Other tests may have a copay or charges towards your deductible or coinsurance. Many screening tests are not covered by Medicare. We do not verify any of this information. You are responsible for any lab fees not paid by your insurance.

If you are undergoing surgery, it may be necessary, at Dr. Jukes' discretion, to use an assistant surgeon to safely complete your surgery. Any assistant surgeon fees not covered by your insurance will be your responsibility.

If you are undergoing surgery, please note that Lisa M. Jukes, M.D. has a financial interest in Stonegate Surgery Center, LP and Arise Austin Medical Center.

Patients without insurance coverage are eligible for a 30% discount off of our usual and customary billed fees. However, to receive this discount, payment must be made in full at the time of service.

2. **A 24 hour cancellation notice is required if you cannot keep your appointment**. There will be a fee of $100.00 applied to your account if we do not receive 24 hours' notice of a cancellation for an office-based appointment. 1 week's notice is required for the following in order to avoid the indicated fee: Pelvic Floor Rehabilitation - $150.00; LEEP, Hysteroscopy, Ablation, or Labiaplasty - $500.00; facility surgeries - $750.00. This fee must be paid in full before the missed appointment can be rescheduled. In addition, accumulating 3 "no-shows" without 24 hour cancellation notice for scheduled appointments will result in termination of the doctor-patient relationship.
3. For any balances on your account, you will receive an invoice requesting the payment that is due. **Please note that a finance charge of 3% will be accrued on any balance left unpaid for more than 45 days.** Failure to pay the outstanding balance will result in your account being sent to a collection agency. We will have no alternative but to terminate the doctor-patient relationship at this point. If your account is turned over to collections and you wish to reestablish care, you will be responsible for payment of the balance as well as a 40% charge to cover the costs of the collections agency. If there are unusual circumstances preventing you from paying your bill, please contact our financial coordinator Bianey at (512) 301 – 6767.
4. Please be aware that there is a $35.00 fee for the release of medical records to a patient. There is no fee for the release of medical records to another physician with written request from the patient. A minimum charge of $20.00 will be assessed for any paperwork to be completed by Dr. Jukes for your employer, school, attorney, etc. The exact fee will depend on the documentation required.
5. We do not accept the following insurance plans: Medicaid, Medicare, and Medicare Managed Care plans; Tricare Humana Military; Humana HMOs; BlueCross BlueShield HMOs; Aetna Advantage Plans (QHP). This is not an exhaustive list.
6. **On-time/paperwork completion policy:** We cannot consider your on time for your appointment until all necessary paperwork is completed in full. Paperwork is required for all new patients as well as yearly for established patients at their annual exams. If you do not have the required paperwork completed in full by the time of your appointment, it is possible that we may have to reschedule your appointment to a later time or different day if no later appointments are available. We reserve the right to charge you the appropriate cancellation fee if we are unable to see you for your appointment due to paperwork delays. You are always welcome to complete your paperwork ahead of time; all of your forms can be found on our website: lisamjukesmd.com.
7. **You may request a copy of this billing policy, an itemized statements of your account, or a written estimate of your out-of-pocket expenses for any service we provide at any time.**

Acknowledgement of Fees:

Returned checks will be subject to a $50.00 handling fee. If a second check is presented and returned, we will request that future visits be paid with cash, credit or debit card.

FMLA/Disability forms: Sharecare Health Data Service handles Family Medical Leave Act/Disability forms. $30 for the first set of forms and $15 for each additional set. Please allow 5-7 business days for completion after your payment has been made. If you have questions regarding the form completion or turnaround time, please contact the form department at (866) 273-4039.

Initials:_____Date:_____

- RX prior Authorization: Our office will not perform any prior authorization for medications that cost less than $35/Month.
- RX Prior Authorization fee: $50 fee for requests to fill out prior authorization form for medications >$35/month.
- After Hours Calls: $35 flat fee for after hour phone calls that are not Gynecology emergencies.

Lab/Prescription policies:

- All lab work will be billed separately by the respective laboratory and is not included in in our charges unless you prefer to private pay for labs at your visit. Any questions regarding bills for lab work should be addressed with the laboratory.

- Please allow 48 hours for refill requests. Refills that are handled afterhours or on weekends will be charged $35.00. Afterhours refill policy is due to excessive weekend non-urgent refill requests.

8. Any questions or complaints regarding our billing policies can be directed to our Financial Coordinator Bianey at (512) 301 – 6767.

Please sign below to acknowledge the understanding of this financial policy and agree to adhere to it.

Print Name:_____ **Signature:**_____ **Date:**_____

Preventative vs New Problem FAQs

Congratulations on scheduling a preventative health visit, a vital step toward better and prolonged health!

Initials:_____Date:_____

A medical evaluation is just as important when you feel healthy as it is when you are ill. Preventative care is health care performed as a precaution **to prevent diseases from developing** or to **detect diseases at early stages**. Preventative care should be an integral part of your annual planning for your health.

Below are frequently asked questions (FAQs) to help you understand how health plans mandate what is considered **"preventative"** and what is considered "**active or ongoing"** health care. These distinctions affect what services your health insurance will cover and what you may be responsible for paying.

What is covered under the preventative care benefit?

Depending on your insurance plan, services defined as "preventative care" are likely to be covered at no cost to you. Preventative care is the periodic routine assessment of your health to avoid future illness.

Those services include:

- A complete review of your personal and family history (this information can guide medical and preventative care)
- A comprehensive physical exam tailored to your age
- All routine CDC recommended vaccinations (as applicable)
- Most routine basic cancer screenings
- Routine preventative blood testing (eg: diabetes and cholesterol screenings)
- Refill of current birth control

What is the difference between preventative care and acute or ongoing care?

Ongoing or acute care involves the diagnosis, treatment, and monitoring of specific diseases and conditions.

Examples of ongoing or acute care include:

- Diagnosing or addressing a new condition that is identified during your physical exam, such as a UTI, yeast infection or breast mass or abnormality.
- Monitoring or treating a condition you already have, such as diabetes or pre-diabetes, which may involve refilling medications. While this can be done at a preventative health visit for your convenience, typical health plans mandate that there be a specific additional charge for these services.
- Some vaccines are routine and others are only needed for specific situations. Vaccines that are not considered routine and are only needed in certain situations. Routine vaccines are usually covered by your health plan.
- Every health plan has certain laboratory tests that it covers 100% and others that are considered non-routine and may be charged to you or as part of your deductible.
- Prescription management for medication other than refill of current birth control

What happens if I come in for a preventative visit and there is a need for a diagnosis and treatment of a new problem or complaint (eg: a urinary tract infection), active management of an ongoing condition (eg: thyroid, depression, fibroids, prolapse), or prescription management request during the same visit?

Initials:_____Date:_____

You may see your provider for a PAP test to screen for cervical cancer (preventative care) but also discuss a new or ongoing health concern such as asthma, or a new condition discovered during your physical (such as a urinary tract infection) in the same visit.

Although the focus of the preventative health visit is keeping your healthy, we make every attempt to address other concerns during your visit, because we understand it is the most logical and convenient time to address your health issues.

Depending on the list of issues you would like to review and your provider's schedule for the day, your doctor might ask you to schedule a visit at a later date.

How will I be billed if the above scenario occurs?

In cases like these, the acute or chronic medical care part of the visit will generate an additional copay or count toward your out of pocket expenses.

Unfortunately, we cannot change this practice. Modern Women's Health contracts with over 50 insurance companies. We apologize for any inconvenience to you and appreciate your understanding that we must follow medical billing guidelines in order to submit claims on your behalf. Any questions related to your benefits should be directed to your insurance company or your employer's Human Resources dept.

Acknowledged: Print Name Signature DOB