Women's Cancer Care 

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.**

State and Federal laws require us to maintain the Privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *09/19/2022* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available to you upon your next visit to the office. We reserve the r i ght to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

Your Rights

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our privacy officer at Women's Cancer Care, ATTN: Privacy Officer, 217 Cherokee Rose Lane, Covington, LA 70433, phone (985) 892-2252.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We never market or sell personal information.
  For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site **www.womenscc.com** .

This notice was published and became effective on ___9/19/2022_____**.**

Women's Cancer Care 

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I _____ have received a Copy of this office's Notice of Privacy Practices

Please Print Name: _____

Signature:_____

Date: _____

For Office Use Only

We attempted to-obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

(___) Individual refused to sign

(___) Communication barriers prohibited obtaining the acknowledgement

(___) An emergency situation prevented us from obtaining acknowledgement

(___) Other (Please Specify)

Women's Cancer Care 

Medication Consent Form

By signing below, you will give permission for Women's Cancer Care to access your electronic medication list. Having accurate records of the medications a patient is taking is central to delivering safe, effective clinical care. Knowing exactly which medications and regimens patients use can help Physicians to avoid drug interactions.

_____ I consent to allow my provider to access all of my medication history

_____ I DO NOT consent to allow access to my medication history.

_____ _____

Signature Date

Laboratories

Lab work should be done at the lab specified by your insurance plan. We are not responsible if you choose a lab that is not in network with your Insurance.

_____ _____

Signature Date

Women's Cancer Care 

Patient Privacy

I authorize the physicians and/or administrative and clinical staff of Women's Cancer Care, to disclose general medical information and other protected health information to the following persons and/or entities list below {i.e., spouse, daughter, son, sibling, and caretaker, and close friend, neighbor). If no one is listed below, my protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Women's Cancer Care.

Name	Phone Number	Relationship

Do you authorize the physicians and/or administrative and clinical staff of Women's Cancer Care to disclose lab results on an answering machine and or voicemail?

Yes ☐ No ☐

If yes, please specify at which phone number? _____

If any of the above information changes, I understand that it is my responsibility to notify the office of Women's Cancer Care

Patient Signature: _____Date _____

Women's Cancer Care

Patient Name: _____

Date of Birth:_____

Pharmacy Name/# _____

Date										
Medication, Strength, Daily Dose										

Women's Cancer Care 

Patient Portal Consent Form

The Patient Portal provides a means for you to:

- View and print your medical records

Please read the following policy carefully:

- We are offering the patient portal as a convenience to you at no cost. We do not sell or give away private information, including email addresses without your written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.
- If you are not receiving emails from us, please check your **JUNK** email folder before contacting us.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify Women's Cancer Care if you change your email address or you feel that your Portal account and / or password have been compromised.

To access your account please follow the following steps:

1. You will receive and email from no reply@advancedmd.com. Please click on the URL link inside the email to confirm your subscription to our site.
2. Once confirmed, you can view your account at this web address(add to favorites for quicker access) https://patientportal.advancedmd.com/118344/

Please print all information and sign in the signature field below.

Full Name:_____Date of Birth:_____

Email address: _____

Signature: _____Date:_____

Women's Cancer Care

HEREDITARY CANCER RISK ASSESSMENT

This is a screening tool for the common features of Hereditary Breast/Ovarian and Lynch syndromes

Patient Name: _____Date of Birth:_____

If YOU have been diagnosed with any of these CANCERS, circle yes and indicate the age you were diagnosed:

Yes	Ovarian	Age diagnosed _____	
Yes	Breast	Age diagnosed _____	Was It triple negative (ER/PR/HER2)?
Yes	Pancreatic	Age diagnosed _____	
Yes	Melanoma	Age diagnosed _____	
Yes	Endometrial/Uterine	Age diagnosed _____	
Yes	Colon/Rectal	Age diagnosed _____	
Yes	Other	Age diagnosed _____	

****

Circle the CANCER that any of your FAMILY members have had, indicate the family relation (Parents, Grandparents, Great-Grandparents, Children, Grandchildren, Brothers, Sisters, Half-Brothers/Sisters, Aunts, Uncles, Great-Aunts, Great-Uncles, Nieces, Nephews & 1st Cousins}, and give approximate age of when family member was diagnosed (please do not leave blank).

Cancer	Mother or Father's Side	Relationship	Age Diagnosed
Ovarian	_____	_____	_____
Breast	_____	_____	_____
Pancreatic	_____	_____	_____
Prostate	_____	_____	_____
Melanoma	_____	_____	_____
Endometrial/Uterine	_____	_____	_____
Colon/Rectal	_____	_____	_____
Stomach/Small bowel/Biliary tract	_____	_____	_____
Urinary tract/Kidney cancer	_____	_____	_____
Sebaceous adenomas	_____	_____	_____
Other	_____	_____	_____

Do you have Jewish Ancestry (Central or Eastern European)? Yes or No

Patient Signature_____ Date_____

****

Patient offered genetic testing: Accepted _____ Declined_____ Reason for Decline_____

Healthcare Provider Signature_____ Date_____

Women's Cancer Care

Request for Medical Records

Patricia Braly, M.D.

Heather Simon, WHNP

Date: _____

TO: _____

_____

_____

I hereby authorize you to release to: Women's Cancer Care any information including the records of any treatment or examination rendered to me.

Thank you.

Patient Name: _____

Date of Birth: _____

Social Security #_____

Signature: _____

Witness:_____

Please return records to: Women's Cancer Care, 606 W. 12th St., Covington, LA 70433

If you have any questions or need further assistance, please call (985) 892-2252

Women's Cancer Care Patient Financial Agreement

Thank you for selecting Women's Cancer Care. We believe clear financial policies are a foundation of creating a positive relationship between provider and patient. Please read carefully through the following document and let our staff know if you have any questions or concerns.

At Women's Cancer Care, we participate with a wide array of managed care and commercial insurance plans. Please ask our staff if you wish to confirm participation with your insurance plan. Women's Cancer Care will submit a claim form for services rendered to your insurance company on your behalf. You have assigned payment for services to Women's Cancer Care during registration; we will alert you of any patient responsibility portions and work with you to establish a payment plan if necessary.

We ask for payment of patient responsible portions at the time of service based on benefit structures as summarized in the table below:

Insurance Type	**Patient Payment Responsibilities**
Medicare	Please bring all insurance cards with you to your first visit. If you have a secondary insurance, we will submit claims to Medicare and your secondary and no payment is required during the visit for covered services. If you do not have a secondary insurance we may ask for your deductible and/or co-insurance amounts at check out. If a non-covered services is provided you will be informed as such and asked to pay for that service at check out.
Medicaid	Please bring your insurance card to EACH visit. You will be asked to pay any relevant copays at each visit at check in.
BCBS	Please bring your insurance card to your first visit. We will submit a claim to your insurer and send you a bill for any remaining amount (co-insurance and deductible) after we receive notice of payment from BCBS. We will ask for any copays at check in.
HMO and PPO plans we participate with	Please bring your insurance card and referral (if required) to your first visit. We will ask for any copays at check in. We may collect coinsurance and deductible amounts at check out.
HMO and PPO plans we do not participate with	As a convenience to you we will submit a claim to your insurer. You will be responsible for any remaining balances including copay, coinsurance, deductible and balance due. We may ask for payment of these balances at the visit after verifying benefits.
Workers Compensation	We require proof of an open claim prior to scheduling an appointment. Please bring any and all paperwork from your employer and/or case manager to your visits. We will submit a claim on your behalf.

_____

Initial and Date

Auto Insurance (Auto Accident)	We require proof of an open claim prior to scheduling an appointment. Please bring us the name of your claims adjuster and any and all paperwork relevant to your claim. We will submit a claim on your behalf.
Self Pay	Patients are asked to pay for services as they are rendered. Please ask to speak to our Billing Specialist regarding payment plans and options as well as qualification for financial need discounts.

Payment Options and Expectations

For your convenience, Women's Cancer Care accepts cash, personal check, cashiers check, debit card, and credit card (MasterCard, Visa, Discover and American Express). Should a check you write to Women's Cancer Care not clear, there will be a $25 non-sufficient funds fee assessed to your account. Please note that all copays are due at check in; patients who arrive for their appointment without their copay will be asked to reschedule as we are required to collect this per our agreement with your insurance plan.

Balances not collected at the time of services will be billed to you on a monthly basis. For your convenience, you may pay balances via personal check, cashier check, or credit card. If paying by credit card you can either include credit card information on the return portion of your statement and mail to the office, or you can call the office and our billing specialist will take your credit card information over the phone. If you fail to pay your balance in a timely fashion we reserve the right to send the account to a collection agency. Accounts sent to a collection agency will be assessed an administrative fee based on the size of the balance, up to 25%.

No Show and Cancelled Appointments

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment. If you do not respond to our staff within 24 hours of your appointment your appointment may be given to another patient.

Please be aware that failure to do so will result in a missed appointment fee of $75.00.
After 3 missed appointments (failure to show or call), you may be discharged from care as a direct result of being "noncompliant to treatment."

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated but will help us to help you (and others) achieve a positive outcome.

Initial and Date

If you require surgery

If you require surgery, we will work with you to select a date and review any anticipated financial responsibilities. Our staff can provide you a detailed review of charges and payment requirements and their due date. You may be asked to make a pre-payment to cover the amount of your deductible for surgical care. Please feel free to talk to our staff about payment plans. If you have a special financial situation please allow our staff to work with you. At Women's Cancer Care, we request that all balances be paid within 6 months; as a result, payments plans are structured based on a 6-month timeframe.

We look forward to taking care of your healthcare needs and providing you all information necessary to manage any financial responsibilities. If we can answer any questions please don't hesitate to ask!

Sincerely,

Women's Cancer Care

My signature below constitutes acknowledgement and acceptance of this policy.

Patient Name: _____

Patient or guarantor Signature: _____

Date: _____

Women's Cancer Care

PATIENT INFORMATION

Date:_____

Patient:_____ Occupation:_____

Mailing Address Street:_____ Employer: _____

City/State/Zip:_____ Employer Address:_____

HM#:_____ Cell#_____ City/State/Zip:_____

Email:_____DOB:_____ Work Phone:_____

Marital Status: (Circle) Married Single Divorced Widowed SS#:_____

Referred by: _____ Alternate Contact in case of Emergency/next of kin

Spouse:_____ _____

Spouse Daytime Phone: _____ Phone:_____

GUARANTOR INFORMATION

Guarantor _____ SS#_____ Phone:_____

(W#) _____ Relationship to Patient (circle one) Self Mate/Spouse Parent/Guardian Other

PRIMARY INSURANCE INFORMATION

Insurance Company:_____ Insurance Phone #: _____

Policy #: _____ Group #: _____

Policyholder:_____ DOB:_____ SS#:_____

Employer: _____ Employer Phone: _____

Relationship to Patient (circle one) Self Mate/Spouse Parent/Guardian Other

SECONDARY INSURANCE

Insurance Company:_____ Insurance Phone #: _____

Policy #: _____ Group #: _____

Policyholder:_____ DOB:_____ SS#:_____

Employer: _____ Employer Phone: _____

Relationship to Patient (circle one) Self Mate/Spouse Parent/Guardian Other

I hereby consent to such medical and other treatment deemed appropriate by my treating physician unless I specify direct otherwise. I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient Signature Date

Women's Cancer Care

HEALTH HISTORY

NAME _____ DATE _____

REASON FOR VISIT _____

AGE _____ SEX F ( ) M ( ) MARITAL STATUS S ( ) M ( ) D ( ) W ( ) # OF CHILDREN _____

TYPE OF WORK _____ PRIMARY PHYSICIAN _____

TELL US ABOUT YOUR HEALTH:

Do you have or have you ever had:

☐ High blood pressure ☐ Diabetes (High blood sugar) ☐ Lung disease ☐ Liver disease ☐ Angina

☐ Kidney disease ☐ Heart disease ☐ Heart failure ☐ Sexually transmitted disease

☐ Other _____

Have you ever had surgeries:

☐ Tonsils removed ☐ Adenoids removed ☐ Appendix removed ☐ Gallbladder removed

☐ Other _____

Allergies to medications or substances ☐ Yes ☐ No	Have you ever had blood transfusions? ☐ Yes ☐ No
What? _____	What year? _____

Do you smoke? ☐ Yes ☐ No

If **YES**: How long? _____

How much? _____

If **NO**: Did you ever smoke? ☐ Yes ☐ No

If yes: How long? _____

How much? _____

When did you stop? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If **YES**: How long? _____

How much? _____

If **NO**: Did you ever drink? ☐ Yes ☐ No

If yes: How long? _____

How much? _____

When did you stop? _____

Have you ever used drugs (like marijuana, cocaine, etc.)? ☐ Yes ☐ No

FAMILY HISTORY

Father: ☐ Alive Age _____ State of Health _____

Health problems: ☐ Cancer ☐ High blood pressure ☐ High blood sugar ☐ Heart disease

☐ Deceased Age at death _____

Mother: ☐ Alive Age _____ State of Health _____

Health problems: ☐ Cancer ☐ High blood pressure ☐ High blood sugar ☐ Heart disease

☐ Deceased Age at death _____

Siblings/Children: (Circle)	Alive	Age	Deceased	Age	State of Health
Brother or Sister	☐ Y ☐ N	_____	☐ Y ☐ N	_____	_____
Brother or Sister	☐ Y ☐ N	_____	☐ Y ☐ N	_____	_____
Brother or Sister	☐ Y ☐ N	_____	☐ Y ☐ N	_____	_____
Son or Daughter	☐ Y ☐ N	_____	☐ Y ☐ N	_____	_____
Son or Daughter	☐ Y ☐ N	_____	☐ Y ☐ N	_____	_____

Any blood relatives (grandparents, uncles, aunts, first degree cousins, nieces, and/or nephews) with any of the following:

☐ Cancer ☐ Diabetes (High blood sugar) ☐ High blood pressure ☐ Heart disease ☐ Stroke

☐ Kidney disease ☐ Alcohol or drug addiction

Women's Cancer Care

REVIEW OF SYSTEMS

General
- ☐ Chills
- ☐ Fever
- ☐ Loss of weight
- ☐ Sweats
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headaches (migraines)
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Bleeding Disorders

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Eye
- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision - flashes or halos
- ☐ Glaucoma
- ☐ Eye glasses or contacts
- ☐ Cataracts

Ear
- ☐ Earache
- ☐ Ear discharge
- ☐ Loss of hearing
- ☐ Ringing in ears

Nose
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus problems

Mouth/Throat
- ☐ Bleeding gums
- ☐ Hoarseness

Gastrointestinal
- ☐ Poor appetite
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Pulmonary
- ☐ Asthma
- ☐ Persistent cough
- ☐ Shortness of breath
  - ☐ At rest
  - ☐ On exertion
- ☐ Sputum production
- ☐ Pain in chest
- ☐ Blood in sputum

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Genito-urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Frequent infections
- ☐ Difficulty to urinate

Muscle/Joint/Bone
Pain, weakness, numbness

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulder
- ☐ Arthritis

Neurological
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Numbness

Psychiatric
- ☐ Depression
- ☐ Hospitalization
- ☐ Anxiety
- ☐ Alcohol or drug addiction

Men only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

Women only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

POS® Reorder # 0915491