PATIENT MEDICAL QUESTIONNAIRE PAGE ONE

We kindly ask you to fill out the following form to update your medical record. Be as complete as possible. *Thank you!*

Today's Date: ________________ Date Of Birth: ________________

Name: ____

Date Of Most Recent SCREENING Tests:

Mammogram:__________ Bone Density:__________ Colonoscopy:__________

Do you have any medical problems? Please list them:

____

____

____

Gynecologic Conditions (Circle all that apply):

1. Abnormal Paps
2. STDs: Gonorrhea Chlamydia Syphillis Herpes HPV
3. Periods: Heavy Periods Painful Periods Fibroids Endometriosis PMS
   Ovarian Cysts Irregular Cycles Infertility Recurrent Miscarriages IVF
4. Cancer of: Breast Ovary Uterus Cervix
5. Vaginal Dryness Painful Sex Vaginal Laxity Urinary Incontinence
6. Surgeries: LEEP of cervix Myomectomy Uterine Ablation Laparoscopy
   Removal of Ovary Bladder lift surgery
   D & C for: Hysterectomy Tubal Ligation C-Section
7. Anything else not mentioned?

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PATIENT MEDICAL QUESTIONNAIRE PAGE TWO

Obstetrical History:

1. How many pregnancies have you had?________________
2. How many abortions have you had?__________________
3. How many full-term deliveries:_______ Preterm deliveries:__________
4. How many miscarriages have you had?________________
5. Any complications related to pregnancy or delivery?________________________________

____

____

Please List All Prior Surgeries (Year and Type of Surgery):

____

____

____

Please list Medications you are currently taking:

____

____

List any Allergies to Medications or Latex:

____

____

Family History: Any diseases run in the family? (abbreviate **M** for mother, **F** for father, **Sib** for Sibling. For extended family, please mark **Maternal** or **Paternal**, for example, **MG** for Maternal Grandmother).

Diabetes____ Heart Disease____ Ovarian Cancer____ Breast Cancer____ Uterine Cancer____

Colon Cancer____ Autoimmune Disease____ Alzheimers/Parkinsons ____

Social Habits:

Smoking: Packs/Week ____ How many years?____ Alcohol: Drinks/Week ____

Drugs: What Kind?____________________ Times/Week ____

Drugs: What Kind?____________________ Times/Week ____

Drugs: What Kind?____________________ Times/Week ____

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PATIENT MEDICAL QUESTIONNAIRE PAGE THREE

Additional History:

What type of work do you do? ______________________________

____

____

What brings you here today? ______________________________

____

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FEMILIFT INFORMATION FORM

Dr. Anita Sadaty is happy to offer her patients a new breakthrough laser technology called ***Femilift*** – an advance in treating vaginal conditions that affect millions of women each year.

Femilift is a laser technology developed by Alma Lasers to address the following vaginal health concerns:

- » **Vaginal Dryness**
- » **Painful Sex**
- » **Vaginal Relaxation & Reduced Sensation**
- » **Urinary Stress Incontinence**
- » **Laxity In The Labia Majora (lack of firmness in the outer labia)**

A virtually painless treatment that delivers fractionated thermal energy to restructure and restore damaged vaginal tissue due to childbirth, age, trauma, menopause, effects of chemotherapy and radiation or hormonal imbalance. By enhancing collagen reformation and revitalizing vaginal mucosa, the Femilift laser can reverse common vaginal health concerns without the need for hormones or surgery.

If you are interested in discussing this with Dr. Sadaty or need more information, please check the box below:

☐ ***YES!*** I would like more information about Femilift

☐ No, I'm not interested at this time

**Unfortunately, this innovative treatment is not covered by insurance, please ask for more details.

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CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I ______________________________ hereby give consent and authorize Dr. Anita Sadaty and her office staff to disclose personal health information to: ____

(Name of Person/Agency Requesting Information)

How may this information be released? Please choose all that apply:

☐ Verbally ☐ Photocopy

Client/Patient:

Full Name: ____

Signature: ___________________________ Date: ____________________

Witness:

Full Name: ____

Signature: ___________________________ Date: ____________________

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PATIENT INFORMATION
EMERGENCY CONTACTS
INSURANCE INFORMATION

Patient Name: ______________________________

Home Phone: ( ) ______________ Work Phone: ( ) ______________

Cell Phone: ( ) ____________ Email: ______________________

Street Address: ______________________________

City: ______________________ State: ______ Zip: ____________

Date of Birth: ______________ Social Security Number: ______________

Occupation: ______________________________

Employer: ______________________________

Referred by: ______________________________

If not referred, how did you hear about Dr. Sadaty? ______________________________

____

EMERGENCY CONTACT INFORMATION:

Name: ______________________________

Relationship: ______________________________

Cell Phone: ( ) __________ Home Phone: ( ) __________ Work Phone: ( ) __________

INSURANCE INFORMATION:

Please provide a copy of the front and back of your Insurance Card or return these forms with your Insurance Card.

Primary Insurance Carrier: ______________________________

ID# ______________________________

Insured Party: ______________________________

Relationship to Patient: ______________________________

Insured Party's Date Of Birth: ______________________________

Secondary Insurance Carrier: ______________________________

ID# ______________________________

Insured Party: ______________________________

Relationship to Patient: ______________________________

Insured Party's Date Of Birth: ______________________

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I, ______________________________, hereby authorize Redefining Health Medical, PC ("RHM") to use and/or disclose my health information, which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, RHM can refuse to treat me.

I have been informed by RHM has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying RHM in writing, but if I revoke my consent, such revocation will not affect any actions that RHM took before receiving my revocation.
I understand that RHM has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.
I understand that I have the right to request RHM to restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations.
I understand that RHM does not have to agree to such restrictions, but that once such restrictions are agreed to, RHM must adhere to such restrictions.

Patient Signature: ________________________________ Date Of Birth: ________________

Printed Name of Patient or Patient Representative: ________________________________

Relationship to patient: ____________________________ Date Signed: ________________

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E-PRESCRIBING INFORMATION FORM

Redefining Health Medical will be using E-Prescribing, an electronic prescription service. Your pharmacy will receive your prescriptions via the Internet.

In order for you to receive prescriptions, you will need to give us your pharmacy information:

Full Name:______________________________ Date Of Birth: ____________

Pharmacy Name:______________________________

Pharmacy Phone Number:______________________________

Pharmacy Address:______________________________
(If you do not know the complete address, please provide the town and/or zip code)

Mail Order Prescription Company:

- ☐ Caremark
- ☐ Medco
- ☐ Express Scripts
- ☐ Cigna Tel-Drug
- ☐ Other

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A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	**E. Reason Medicare May Not Pay:**	**F. Estimated Cost**
G0101 - screening pelvic/breast examination Q0091 - diagnostic pap smear	will deny for frequency allowed once every 2 years	$93.62

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.** ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.