PATIENT/INSURANCE CONTACT FORM

Laida N. Casanova, M.D., LLC

Patient Name: _____ Home Phone: _____

Home Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____ Cell / Cellular: _____

Email: _____

Date of Birth: _____

Husband/Partner's Occupation & Employer: _____

Patient's Occupation & Employer: _____ Social Security #: _____

Emergency Contact: _____ Marital Status: _____

Phone Number: _____ Primary Doctor: _____

Pharmacy: _____ Referred by: _____

****

INSURANCE INFORMATION: MUST BE FILLED OUT BY THE PATIENT

(ALL NEEDED INFORMATION IS LOCATED ON THE FRONT & BACK OF INSURANCE CARD)

Name of Insurance: _____ Customer Service Number: _____

Claims Address: _____ Policy or I.D. Number: _____

Group #: _____ Company by which Insurance is Through: _____

Primary Holder of the Insurance plan: _____ **Holder's Date of Birth**: _____ **Relation to Patient**: _____

2nd Insurance (*if applicable*): _____ Customer Service Number: _____

Claims Address: _____ Policy or I.D. Number: _____

Group #: _____ Company by which Insurance is Through: _____

Primary Holder of the Insurance plan: _____ **Holder's Date of Birth**: _____ **Relation to Patient**: _____

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We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to s.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments from claims of medical malpractice. This notice pursuant Florida Law.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Laida N. Casanova, M.D.,Inc. of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payer for services rendered by Dr. Laida N.Casanova. I understand that I am financially responsible to Laida N. Casanova, M.D., LLC for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

PATIENT'S / GUARANTOR'S SIGNATURE: _____ **DATE**: _____

Laida N. Casanova, MD, LLC
11040 N. Kendall Dr, Suite C100, Miami, FL, 33176,
Telephone: (305) 596-9979 ~ Fax: (305) 598-0063

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

Notice of Privacy Acknowledgement

Laida N. Casanova, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

LAIDA N. CASANOVA, M.D., LLC

FINANCIAL POLICY

Thank you for choosing Laida N. Casanova, M.D., LLC, as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND DEDUCTABLES ARE DUE AT THE TIME SERVICES ARE RENDERED
WE ACCEPT CASH, VISA, MASTERCARD, AND DISCOVER

INSURANCE: We will bill your insurance company for your visits as a courtesy to you. Due to the difficulty of obtaining payment from your insurance plan, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify their medical benefits and/or limitations prior to their visit(s) and that we are a participating provider of your insurance plan. If we are not providers, are out-of-network, or a benefit is not covered, you will be responsible for any and/or all of the balance for the service(s) rendered.

HMO/REFERRALS: It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires one for your visit. It is the Patients' responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and were required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent of the guardian accompanying the minor is responsible for any payments before service(s).

COLLECTIONS: Should your account become a collection problem, the patient/debtor assumes all costs of collection, including but not limited to the collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

NON-COVERED SERVICES: You will be responsible for payment of services "Not Covered" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.

BY SIGNING BELOW, I HAVE READ, FULLY UNDERSTAND AND ACCEPT THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH. LAIDA N. CASANOVA, M.D., LLC HAS THE RIGHT TO REFUSE PROVIDING SERVICE IF THE TERMS OF THIS CONTRACT ARE NOT ACCEPTED.

Patient /
Responsible Party Signature: _____ Date_____

Patient Name Print: _____

Kendall Oaks * 11040 N. Kendall Drive * Suite 100 * Miami * Florida * 33176
Tel: (305) 596-9979 * Fax: (305) 598-0063

Kendall Oaks Professional Center
11040 N Kendall Drive, Suite C-100
Miami, Florida. 33176
Phone: (305) 596-9979
Fax: (305) 598-0063

DATE: _____

NAME: _____ AGE: _____ D.O.B. _____
ADDRESS _____ PHONE: _____
OCCUPATION _____ INSURANCE _____
PLEASE CHECK ONE: SINGLE_____ MARRIED _____ WIDOW _____ DIVORCED _____
PRESENT COMPLAIS: If you have a problem, please describe it. What is it? How long have you had it? _____
_____
_____
HAVE YOU CONSULTED ANYONE FOR THIS? _____ DATE: _____
NAME _____ ADDRESS: _____
DESCRIBE PREVIOUS TREATMENT _____

Last Menstrual Period: _____ ***Last Mammogram:*** _____ ***Last Bone Density:*** _____
Last Pap Smear: _____

PAST MEDICAL HISTORY

HYPERTENSION	YES___ NO___	ANEMIA	YES___ NO___	BLEEDING TENDENCIES	YES___ NO___
TUBERCULOSIS	YES___ NO___	PHLEBITIS	YES___ NO___	RESPIRATORY DISEASE	YES___ NO___
HEPATITIS	YES___ NO___	THYROID DISEASE	YES___ NO___	MIGRAINE HEADACHES	YES___ NO___
EPILEPSY	YES___ NO___	CANCER	YES___ NO___	CHRONIC KIDNEY DISEASE	YES___ NO___
DIABETES	YES___ NO___	VENEREAL DISEASE	YES___ NO___	YELLOW JAUNDICE	YES___ NO___

IF **"YES"** PLEASE DESCRIBE _____
ALLERGIES _____

MEDICATIONS-List all medications you are taking (dosage and frequency)- include over the counter drugs _____
_____

HOSPITAL ADMISSIONS- List those operations and serious illness, which required hospitalization (excluding pregnancy)

REASON FOR ADMISSION_____ YEAR _____
HOSPITAL _____
REASON FOR ADMISSION_____ YEAR _____
HOSPITAL _____
REASON FOR ADMISSION_____ YEAR_____
HOSPITAL_____
REASON FOR ADMISSION_____ YEAR_____
HOSPITAL_____

ANY OF THE FOLLOWING IN GRANDSPARENTS, UNCLES, AUNTS, RELATIVES:

BREAST CANCER _____
DIABETES _____
UTERINE CANCER _____
RECTAL OR COLON CANCER _____
OTHER FAMILIAR DISEASES _____

OBSTETRICAL HISTORY- Number of times:
Pregnancy_____ Premature Babies_____ Miscarriages_____ Abortions_____ Living Children _____

YEAR	WEEKS PREGNANCY	WEIGHT	SEX	TYPE OF DELIVERY	COMPLICATIONS

SOCIAL HISTORY
SMOKING_____ CIG/DAY/YR_____ ALCOHOL_____ OZ/WK COFFEE_____ CUP/DAY _____
STREET DRUGS_____ HISTORY OF DOMESTIC ABUSE YES_____ NO_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

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

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagn
For example: Colorectal cancer	none	—	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 y
BREAST AND OVARIAN CANCER								
Breast cancer (male or female)								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic or prostate cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Colon/rectal, uterine/endometrial, ovarian, stomach/gastric, kidney/urinary tract, biliary tract, small bowel, pancreas, brain, and sebaceous adenomas								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com

Pelvic Health Survey

Today's Date: _____

Patient's Name: _____ 1. Age: ____ 2. Sex: □Female □Male

Bladder (check one):

3. How often do you leak urine (check one box)?
   - 0 □ Never
   - 1 □ About once a week or less often
   - 2 □ Two or three times a week
   - 3 □ About once a day
   - 4 □ Several times a day
   - 5 □ All the time

4. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? Check one box.
   - 0 □ None
   - 2 □ A small amount
   - 4 □ A moderate amount
   - 6 □ A large amount

5. Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

ICIQ score: sum 3+4+5= _____

6. When does urine leak? (Please check all that apply to you.)
   - □ Never—urine does not leak
   - □ Leaks before you can get to the toilet
   - □ Leaks when you cough or sneeze
   - □ Leaks when you are asleep
   - □ Leaks when you are physically active/exercising
   - □ Leaks when you have finished urinating and are dressed
   - □ Leaks for no obvious reason
   - □ Leaks all the time

Do you wear diapers, pads, or panty liners because of leaking? □Yes □No

Are you bothered by the number of times per day you have to empty your bladder? □Yes □No

Do you wake up at night to empty your bladder? □Yes □No

If Yes, How many times? _____

Do you feel you have to rush to the toilet to avoid an accidental leak? □Yes □No

Bowel:

1) Do you accidentally leak stool? □Yes □No
2) Do you have to strain to have bowel movements? □Yes □No
3) Do you pass gas when you do not want to? □Yes □No

Gynecological:

1) Do you experience pelvic pain? □Yes □No
2) Do/did you experience pain with intercourse? □Yes □No
3) Do you have a feeling of a "ball" in your vagina? □Yes □No
4) Hysterectomy? □Yes □No
5) Vaginal Dryness? □Yes □No
6) # of Vaginal Deliveries _____
7) # of Cesarean Sections _____