COVID SCREENING QUESTIONAIRRE TO BE COMPLETED AT CHECK- IN

PLEASE PRINT LEGIBLY WITH YOUR NAME AND DATE

NAME: _____ DATE: _____

Have you been diagnosed with, or are you currently awaiting tests relating to, a suspected coronavirus (COVID-19) diagnosis? (CIRCLE ONE) YES NO

Have you been in close contact with someone with a confirmed or suspected case of coronavirus (COVID-19) within the last 14 days? (CIRCLE ONE) YES NO

Do you have a fever (greater than 100 degrees F) or symptoms of respiratory illness such as cough, sore throat, difficulty breathing or shortness of breath? (CIRCLE ONE) YES NO

Have you experienced recent loss of taste or smell? (CIRCLE ONE) YES NO

Have you received your COVID-19 vaccine? (CIRCLE ONE) YES NO

If YES, have you received both vaccinations? (CIRCLE ONE) YES NO

Type of vaccine:_____ Date's received:_____

Have you received your Booster? (CIRCLE ONE) YES NO

BRADLEY AXLINE, MD

WELLNESS FOR WOMEN & MEN

Patient Name: _____ Birth Date: _____

Social Security #: _____ Marital Status: S ___M___ D___ W___O___ Sex: F____ M___

Ethnicity: _____ Email:_____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Alt: _____

PRIMARY INSURANCE

Name: _____ ID#: _____ Group#: _____

SECONDARY INSURANCE

Name: _____ ID#: _____ Group#: _____

POLICY HOLDER INFORMATION

Name: _____ Birth Date: _____ Relation:_____

Social Security: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relation: _____

EMPLOYMENT

Employer Name: _____

Occupation: _____ Phone: _____

How did you hear about us? _____

Preferred Pharmacy: _____

Preferred Mail Order Pharmacy:_____

Preferred Compound Pharmacy:_____

Hereby authorize payment directly to the office of Bradley Axline, MD any health insurance benefits otherwise payable to but not to exceed the balance dur for the regular charges for treatment. I understand that I am financially responsible for any outstanding balance and or not covered service by insurance. I also authorize Bradley Axline, MD to release any information required to process claims.

Patient Signature: _____ **Date:** _____

BRADLEY AXLINE, MD
WELLNESS FOR WOMEN & MEN

HEALTH QUESTIONAIRE

Thank you for taking the time to complete this questionnaire. Your current health reflects a wide range of issues vital to helping us better understand and serve your health care needs.

Name:_____DOB_____
Medication Allergies:_____ Other:_____
Medications: Include prescriptions, vitamins/supplements, over the counter, and alternative remedies:
_____
_____

GYNECOLOGIC HEALTH AND HISTORY

Date your last period began:_____ Date of last PAP smear_____ Normal/Abnormal_____
How many days from the start of one period to the next?_____ How many days does the flow last?__
Is the flow light_____ Medium_____ Heavy_____Very Heavy_____ Age at first period_____
Any premenstrual symptoms: ____No _____Yes
Age at first intercourse: _____ Are you sexually active: ____No ____Yes
Do you utilize condoms: ____ No ____ Yes
Do you currently take Birth Control: ____ No ____ Yes If yes what type:_____
Any Menopausal symptoms: ____ No ____ Yes
Irregular cycles:____ Vaginal dryness:____ Problems sleeping:____Hot flashes:____Other:_____
Age at menopause:_____ Are you taking any hormones: ___No ___Yes Type/Dose:_____
Date of last Mammogram:_____Result_____ Where:_____
Date of last Bone Mineral Density:_____ Result:_____ Where:_____
Date of last Colonoscopy:_____ Result:_____ Where:_____

Medical Problems: Have you previously had, or currently have any of the following:

Abnormal Pap Past ( ) Current ( )	**Blood Clots/DVT** Past ( ) Current ( )	**Breast Lump** Past ( ) Current ( )	**Eating Disorder** Past ( ) Current ( )	**Heart Murmur** Past ( ) Current ( )	**Infertility Problems** Past ( ) Current ( )	**Liver Disease** Past ( ) Current ( )	**Thyroid Problems** Past ( ) Current ( )
Heart Disease Past ( ) Current ( )	**Blood Transfusion** Past ( ) Current( )	**Venereal Disease** Past ( ) Current ( )	**Liver Disease** Past ( ) Current ( )	**Hepatitis A, B or C** Past ( ) Current ( )	**Kidney Disease** Past ( ) Current ( )	**Stomach problems/ Ulcers** Past ( ) Current ( )	**Tuberculosis** Past ( ) Current ( )
Asthma/Lung Disease Past ( ) Current ( )	**Bowel Problems** Past ( ) Current ( )	**Depression /Anxiety** Past ( ) Current ( )	**Gonorrhea/ Chlamydia** Past ( ) Current ( )	**HIV/AIDS** Past ( ) Current ( )	**Kidney Infection** Past ( ) Current ( )	**Seizures/ Stroke** Past ( ) Current ( )	**Urine Leakage** Past ( ) Current ( )
Hypertension Past ( ) Current ( )	**Cancer** Past ( ) Current ( )	**Diabetes** Past ( ) Current ( )	**Anemia** Past ( ) Current ( )	**Arthritis** Past ( ) Current ( )	**Fibroids** Past ( ) Current ( )	**Syphilis** Past ( ) Current ( )	**Chest Pain** Past ( ) Current ( )

BRADLEY AXLINE, MD

HOSPITALIZATIONS OR OPERATIONS

Year	Diagnosis/Operation	Hospital

History of problems with Anesthesia?_____

Have you had Breast implants/Plastic surgery?_____ Where:_____

Have you had Botox/Juvederm in the past? _____No _____Yes Last treatment:_____

FAMILY HISTORY

If you are adopted do you know your family history? No _____ Yes_____

Please check any family problems:

Arthritis Mother ( ) Father ( ) Other ( )	**Bowel Disease** Mother ( ) Father ( ) Other ( )	**Heart Attack** Mother ( ) Father ( ) Other ( )	**Kidney Disease** Mother ( ) Father ( ) Other ( )	**Stroke** Mother ( ) Father ( ) Other ( )	**Psychiatric Illness** Mother ( ) Father ( ) Other ( )
Alcohol/Drug Abuse Mother ( ) Father ( ) Other ( )	**High Cholesterol** Mother ( ) Father ( ) Other ( )	**Heart Disease** Mother ( ) Father ( ) Other ( )	**Liver Disease** Mother ( ) Father ( ) Other ( )	**Osteoporosis** Mother ( ) Father ( ) Other ( )	**Seizures** Mother ( ) Father ( ) Other ( )
Birth Defects Mother ( ) Father ( ) Other ( )	**Hypertension** Mother ( ) Father ( ) Other ( )	**Diabetes** Mother ( ) Father ( ) Other ( )	**Lung Disease** Mother ( ) Father ( ) Other ( )	**Blood Clots/DVT** Mother ( ) Father ( ) Other ( )	**Other Disease** Mother ( ) Father ( ) Other ( )

Any other significant family history:_____

Have you ever been tested for HIV? ____No ____Yes When:_____

What is your mental image of your body? (Plump, thin, normal)_____ Ideal weight:_____

Have you been diagnosed with an eating disorder or feel you have an eating problem? ____No ____Yes

Are you on any diet restrictions or have any special diet preferences?_____

Do you exercise?____No ____Yes How often:_____ Activity:_____

What is your stress level on a 1 to 10 scale?____ What do you do to relieve stress?_____

SOCIAL HISTORY

Tobacco use: Current_____ Past_____ Packs/day_____ How long_____

Alcohol use: None:____ Drinks per day:____ Per week:_____ Per month:____ Caffeine per day:_____

Street Drug use: None:_____ Drug:_____ How often?_____

Have you been in an abusive situation or relationship?___No ___Yes

Emotional_____ Physical_____ Sexual_____

Do you feel safe in your current relationship? _____No _____Yes

natera | Empower™ Hereditary cancer test

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:

Family History Questionnaire

Please answer the following questions to the best of your knowledge to help your care team understand cancer patterns in your family. For more information, text EMPOWER to 484848.

Select Yes/No and enter information in the accompanying boxes of the same row. Family members include parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings.

Please complete the following for you and your family members:		Age at diagnosis	Enter family member and age at diagnosis		
		You	Siblings/Children	Mother's side	Father's side
Example:	Breast cancer ☒ Y ☐ N	Age 46	Daughter, 23 Sister, 52	Aunt, #1 63 Aunt, #2 48	Grandma, 81
1.	Breast cancer < age 50 ☐ Y ☐ N				
2.	Either colon cancer or uterine cancer < age 50 ☐ Y ☐ N				
3.	Triple negative breast cancer ≤ age 60 ☐ Y ☐ N				
4.	Two or more breast cancers in the same person (first diagnosis ≤ age 50) ☐ Y ☐ N				
5.	Two or more colon and/or uterine cancers in the same person ☐ Y ☐ N				
6.	Two family members with breast, colon or uterine cancer (one ≤ age 50) ☐ Y ☐ N				
7.	Three or more family members from the same side with breast cancer ☐ Y ☐ N				
8.	Three or more family members with colon and/or uterine cancer ☐ Y ☐ N				
9.	Ovarian cancer ☐ Y ☐ N Pancreatic cancer ☐ Y ☐ N Male breast cancer ☐ Y ☐ N 10 or more precancerous colorectal polyps ☐ Y ☐ N				
10.	Ashkenazi Jewish **AND** breast cancer or prostate cancer ☐ Y ☐ N				
11.	You or a close family member has a known gene mutation. Please list _____ ☐ Y ☐ N				
12.	Other cancers not listed above ☐ Y ☐ N _____				
13.	Other concern about your cancer risk ☐ Y ☐ N	Please explain:			

If you have never been diagnosed with breast cancer, please complete the following questions.

1. Height (ft/in) _____ **2.** Weight (lbs) _____ **3.** Have you had children? ☐**Y** ☐**N** How old were you when you had your first child? _____

4. Approximate age at first menstrual period? _____ **5.** Have you gone through menopause? ☐**Y** ☐**N** ☐**Ongoing** If yes, at approximately what age? _____

6. Are you of Ashkenazi Jewish descent? ☐**Y** ☐**N** ☐**I don't know**

7. Have you ever used hormone replacement therapy? ☐**Y** ☐**N** ☐**Ongoing** If yes, when? Start date _____ End date _____

If yes, what type? ☐ **Estrogen** ☐ **Progesterone** ☐ **Combined** ☐ **I don't know**

8. How many sisters do you have? ____ Daughters? ____ Maternal aunts? ____ Paternal aunts? ____ Maternal half-sisters? ____ Paternal half-sisters? ____

9. Have you ever had a breast biopsy? ☐**Y** ☐**N** If yes, what was the result? ☐ **Hyperplasia** ☐ **Atypical hyperplasia** ☐ **LCIS** ☐ **I don't know**

Signatures

Patient Name	Patient Signature	Date
Provider Name	**Provider Signature**	**Date**

For Office Use Only

A 'Yes' answer to any of questions 1–11 indicates your patient may meet criteria for hereditary cancer testing.

Patient offered hereditary cancer genetic testing (check all that apply)

☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**

  201 Industrial Road, Suite 410 | San Carlos, CA 94070 | www.natera.com | 1.650.249.9090

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OBSTETRIC HEALTH AND HISTORY

Are you currently pregnant:_____ No _____ Yes How many weeks:_____
Childs Father's name and phone number:_____
Have you been seen by another OBGYN for this pregnancy:_____ If yes, name of doctor:_____
Have you recently traveled outside of the country:____No _____Yes
Have you been exposed to Covid or the Zika virus: _____ No _____Yes
Pregnancies- Total number:_____Miscarriages:_____Abortions:_____Number of living children:_____

Please list your past pregnancies:

Month/ Year	Hours in labor	Infant weight	Sex	Problems/Complications	Weeks pregnant	Vaginal/ C-Section	Anesthesia	Hospital

BRADLEY AXLINE, MD

WELLNESS FOR WOMEN & MEN

Privacy Practice Acknowledgement

I have received and/ or reviewed the Notice of Privacy Practice; I understand a copy will be provided to me upon request.

Patient Record of Disclosures

I authorize Bradley Axline, MD to share my protected health information with the individual(s) below:

This would include any medical information and/ or any financial billing information.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I wish to be contacted in the following matter:

Phone: _____

☐ Ok to leave message with detailed information

☐ Leave message with call back number ONLY

Written Communication (test results/billing information)

☐ Ok to mail to home address (different from above) _____

Electronic Communication

☐ Ok to email me at my personal email address _____

Signature: _____ Date: _____

BRADLEY AXLINE, MD
WELLNESS FOR WOMEN & MEN

Payment Policy

Insured: All patients for Dr. Axline are to pay their co-pay at time of service. If you're unable to do so your appointment will be rescheduled. Our billing will submit claims to your commercial insurance companies, Medicare, and Medicaid. We do not participate with **Affordable Care Act**. If patient has an unmet deductible we will collect the contracted rate at time of service and invoice patient any remaining balance after claim is processed by insurance carrier. If unable to pay the contracted rate at time of service your appointment will be rescheduled. If insurance carrier pays more than anticipated refunds will be issued for any credit balances.

Self-pay: All patients for Dr. Axline will have to pay the amount for visit at time of service. If you come in for an initial visit and don't have insurance but then apply for Medicaid we will collect the amount for service and will not refund you the amount.

Collection Policy: All patients for Dr. Axline will receive monthly statements for any unpaid balances. Accounts past due more than 30 days will receive a series of collection letters and phone calls. If payment has not been received or a payment plan established by the Final Notice is sent to accounts will be turned over to an outside collection agency and will be reported to a national credit reporting services. This information will be retained and the individual's credit record for a period of seven (7) years.

NO SHOW/CANCELLED APPOINTMENTS OR SURGERYS: If you are unable to keep a scheduled appointment, please let us know **24 HOURS** prior to your scheduled appointment and **72 HOURS** prior to your scheduled surgery or in office procedure. A NO SHOW OR CANCELLED APPOINTMENT will generate a $35 fee for an office visit or Telehealths/$250 for a scheduled surgery or in office procedure**. If you are scheduled for an ESSURE procedure and you cancel the procedure we will generate a $250 fee.** Three NO SHOWS may require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled.

Medical Records: If you request for your medical records to be transferred to another Doctors office the fee is $25 for the first 20 pages and .50 cents thereafter.

Family Medical Leave Act: If you need Dr. Axline to fill out FMLA paperwork there is a fee of $25 each.

After hours answering service is only for emergency. If you call after business hours for a non-emergency matter you will be charged $25.

_____ _____

Patient/Guarantor Signature Date

_____ _____

HIPPA NOTICE OF PRIVACY PRACTICE

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.

OUR OBLIGATION

We are required by law to:

Maintain the privacy of protected health information (PHI)

Give you this notice of our legal duties and privacy practices regarding health information about you

Follow the terms of our notice that is currently in effect

PHI includes information that we create or receive about your past, present, or future health condition, the provision of health care to you, or the payment for health care provided to you. In general, we may not use or share anymore PHI than is necessary to accomplish our purpose.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the way we may use and disclose health information that identifies you. Except for the following purposes, we will use and disclose Health Information only with you written permission. You may revoke such permission at any time by writing to our Practice Administrator.

Treatment: We may use and disclose PHI for you treatment and to provide you with treatment-related healthcare services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside the office, who are involved in your medical care and need the information to provide you with medical are.

Payment: we may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. We may also share PHI with billing companies and companies that process our health care claims.

Health Care Options: We may use and disclose PHI for health care operation purposes. These uses and disclosure are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may also share information with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

You have the following rights regarding health information we have about you:

Your right to request limits on our use of PHI: You may ask that we limit how we use and share your PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situation. You cannot limit the uses and reports that we legally required or allowed to make. To request a restriction, you must make your request in writing to the Practice Administrator.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Your right to review and get a copy of PHI: you may view or obtain a copy of your PHI. Your request must be in writing. We will reply to you within 30 days of your request. If you request a copy of your PHI, we may charge a fee. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost advance.

Your rights to a list of the reports we have made: You have the right to get a list of the parties to whom we have reported your PHI. The list will not include reports for treatment, payments, or health care operation; reports you have previously authorized: reports made directly to you or your family; reports mad for national security purposes; reports to corrections or law enforcement personnel.

We will respond to your request within 60 days: We will include the reports made in the last six years unless you request a shorter time. The list will include the date of each report, the identity of the person (s) receiving the report, the type of information reported, and the reason for the report.

You're right to correct or update your PHI: If you feel that there is mistake in your PHI, or that important information is missing, you may request a correction.

I have received and understood Notice of Privacy Practice:

Print Name **Date**

Signature **Relation**

INFORMED CONSENT FOR TELEHEALTH
Bradley Axline, MD

This Informed Consent for Telehealth contains important information focusing on providing healthcare services using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us and will remain valid unless revoked.

Benefits and Risks of Telehealth

Telehealth refers to providing certain medical services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care as the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person treatment and telehealth, as well as some risks. For example:

Risks to confidentiality

As telehealth sessions take place outside of your doctor's office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important; however, for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in the appointment only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology

There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of telehealth services. The nature of electronic communications technologies, however, is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth).

Fees

The same fee rates will apply for telehealth as apply for in-person therapy. Some insurers are waiving co-pays during this time. It is important that you contact your insurer to determine if there are applicable co-pays or fees which you are responsible for. Insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic therapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telehealth sessions in order to determine whether these sessions will be covered.

Your signature below indicates agreement with its terms and conditions.

_____ _____

Patient Date

_____ _____

Provider Date

Communicator Automated Messaging Preferences

Please **circle** preferred communication method for each listed

Health Notifications	Email	Phone	Text Message	None
Appointments	Email	Phone	Text Message	None
Announcements	Email	Phone	Text Message	None
Billing	Email	Phone	Text Message	None