PACIFIC GYNECOLOGY SURGICAL GROUP
Leslie S. Kardos, M.D.
2100 Webster St., Ste 518 | San Francisco, CA 94115
Phone: 415.426.7859 | Fax: 415.426.7805

OFFICE POLICIES

Dear Patients,

Thank you for your continued support of our practice. We would like to take this opportunity to inform you about our policies.

INSURANCE: There are numerous insurance plans available. Therefore, it is impossible for our staff to know the covered benefits of each plan. It is your responsibility to know and understand the policies and benefits of you plan. This includes referrals, authorizations, co-payments, deductibles covered hospitals, labs and x-ray facilities.

In order for us to bill your insurance, you must provide us with a copy of your current insurance card at the time of service. Failure to provide any necessary insurance information for billing will require you to pay for your visit at the time of service.

APPOINTMENTS: To allow us to provide quality care and prompt service, we request that you cancel any appointments that you cannot make at least 24 hours prior to your appointment. Failure to cancel appointments will result in a $50 missed appointment fee. Failure to cancel any surgeries or procedures with 72 hours of your scheduled appointment will result in $100 fee. Please call (415) 202-1509 to cancel appointments or to leave a message after business hours.

CO-PAYMENTS: All co-payments are required at the time of service or we many need to reschedule you appointment.

COPY OF RECORDS: There is a $25.00 charge for each copy of medical records. Please complete a request for medical records and allow 7 – 10 days to process your request.

COMPLETION OF FORMS: There is a $15.00 charge for completion of all applications and form; such as disability and insurance forms.

PRESCRIPTIONS: There is a 24 hour turnaround time for all prescription refill requests. If you need a prescription refilled before the weekend, please call ahead to allow us time to process your request.

I acknowledge that I have read and understand the policies listed above.

Patient Name: _____ Date: _____

Signature: _____

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Welcome to our office! We are committed to providing you with the best care possible. We encourage you to ask questions and communicate openly with us. Please assist us by providing the following information. All information is confidential and is only released with your consent.

PATIENT REGISTRATION FORM

DATE OF APPT:	TIME OF APPT:	APPT PROVIDER:			
NAME:		MRN:	DOB:		SEX:
ADDRESS:	*Street*	*City/State*		*Zip*	

MARITAL STATUS
☐ Single ☐ Married ☐ Widowed ☐ Divorced

PRIMARY LANGUAGE:
{PriLang}

ETHNICITY
☐ Hispanic or Latino ☐ Non Hispanic
☐ Decline

RACE
☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ White ☐ Other ☐ Decline

PHONE #:	Primary:	Secondary:	E-mail Addr:	
	Circle one: *Home* / *Cell* / *Work*	Circle one: *Home* / *Cell* / *Work*		

Is it okay to leave a message: ☐ Yes or ☐ No

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS:

INSURANCE INFORMATION
(Please give your insurance card to the receptionist)

Guarantor Account:	Relationship to Patient:	Address (if different):	Home Phone No: ( )
Occupation:	Employer:	Employer Address:	Employer Phone No:
Primary Insurance:			Effective Date:

Subscriber's Name:	Subscriber's SSN:	Birth Date:	Group No:	Policy No.:	Co-Payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (if applicable):	Subscriber Name:	Group No:	Policy No:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE #:
RELATIONSHIP:	

PREFERRED PHARMACY
PHARMACY NAME:
PHARMACY ADDRESS:
PHARMACY TELEPHONE NUMBER:

REFERRING PHYSICIAN:	PCP**:**

Would you like to receive visit summaries? ☐ YES ☐ NO

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that this is not a guarantee of payment and that I am financially responsible for any balance. I also authorize Pacific Gynecology Surgical Group, Inc or my insurance company to release any information required to process my claims.

Our office will bill your insurance. You are responsible for the deductible, share of cost, co-payment at time of visit, and any costs not a benefit of your plan. If you do not have insurance we would appreciate payment at the time of your visit.
Our staff is available if you have any questions. I authorize payment of medical benefits be made directly to the physician provider for services rendered. I authorize my doctor to release any medical or other information necessary to the party who accepts assignment. I authorize use of information from this form to bill my insurance companies.

I have received a copy of this medical practice's Notice of Privacy Practices. I understand that a copy of the current privacy notice will be posted in the reception area and that a copy of any updated or amended Notice of Privacy will be available at each appointment.

DATE	SIGNATURE NAME	PATIENT / GUARANTOR SIGNATURE

Family History Questionnaire for Common Hereditary Cancer Syndromes

DOB: **Age:** **Phone:**

Height: **Weight:** **Age of First Period:** **Age you delivered your first child:**

Are you Menopausal ? Yes *(at Age _____)* or No **Have you ever used Hormone Replacement Therapy?** Yes or No

Adopted: Yes or No **Has anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No**

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.

Example: Colon Cancer *Brother 36 yrs* *Aunt 44 yrs* *Grandfather 65 yrs*

BREAST AND OVARIAN CANCER

			You (age of diagnosis)	Siblings/Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	Breast Cancer				
Y	N	Breast Cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian Cancer				
Y	N	Male breast cancer				
Y	N	Are you of Ashkenazi Jewish decent				

COLON AND UTERINE CANCER

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

OTHER CANCERS

Y	N	Prostate Cancer				
Y	N	Pancreatic Cancer				
Y	N	Melanoma				

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY

Patient offered hereditary cancer testing?

□ YES (ACCEPTED / DECLINED) □ NO HEALTH CARE PROVIDER SIGNATURE: _____

HBOC – Personal or Family History (Derived from NCCN)

One person with: (out to 2nd degree)

-Breast Cancer (diagnosed ≤ 45)
-Ovarian CA, any age
-Male breast CA, any age
-Bilateral breast CA (1st cancer dx'd ≤ 50)
-Triple negative Breast CA (dx'd ≤60)

Two persons with: (out to 2nd degree)

-Breast Cancer (at least 1 dx'd ≤ 50)

Three persons with: (out of 2nd degree)

Combination breast/pancreatic/aggressive prostate cancer at any age.

NOTE:

A. Lower threshold for testing in Ashkenazi Jewish individuals.
B. 3rd degree blood relative with breast cancer and/or ovarian cancer with 2 or more close blood relatives with breast cancer (at least 1 breast cancer dx'd at or under age 50) and/or ovarian cancer.
C. Limited family structure (fewer that 2 female 1st or 2nd degree relatives living past age 45)

Lynch*-Personal or Family History (Derived from SGO)

One person One person with: (out to 2nd degree)

-Endometrial or Colorectal Cancer (1diagnosed ≤ 50)
-CRC, endo, or ovarian cancer along with another Lynch associated cancer in the same individual (2 primaries, any age)

2 persons:

1 person with later onset (≥ 50) endo or CRC and 1 person with an early onset (≤ 50) other Lynch-related cancer

Three persons with: (out of 2nd degree)

-Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Endo, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/renal pelvis, biliary tract, sebaceous adenomas.

Pacific Gynecology Surgical Group, Inc is committed to your health and cancer prevention. To best serve you, we need a detailed personal and a family cancer history. Please fill out the back of this form. If you have questions please ask the medical assistant or your provider.

If you filled this out with the last 6 months and nothing has changed you do not need to fill it out again. Just SIGN and indicate as such on the back of this form.

THANK YOU!