# BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

## NEW PATIENT VISIT

**DATE:**

| Name (First, Middle Initial, Last): | Age: | DOB : |
|---|---|---|
| | | |

**Referred by?** _____

**What brings you to the office today?**

_____

_____

_____

**History of Gynecologic Problems:**

- ☐ Abnormal Paps
- ☐ Abdominal Pain
- ☐ Chlamydia
- ☐ Abdominal Pain
- ☐ Frequent UTIs
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Herpes
- ☐ HPV
- ☐ Heavy Periods
- ☐ Infertility
- ☐ Menorrhagia
- ☐ Menopausal Problems
- ☐ Prolapse
- ☐ Pelvic Pain
- ☐ Pelvic Infections
- ☐ PMS
- ☐ Stress Incontinence
- ☐ Overactive Bladder
- ☐ Other Gynecological History: _____

**Pregnancies**

| Year | Type of Birth (Vaginal/C-Section) | Location/Hospital | Gestation (Weeks) | Complications |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Last Menstrual Period:** _____ **How often:** _____ **Days of flow:** ___ **Amount of flow:** _____

**Using Contraception?** ☐ **No** ☐ **Yes** **What kind?** _____ **For how long?** _____

**Last Pelvic Exam (Date):** _____ **Location:** _____

**Last Mammogram (Date):** _____ **Location:** _____

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

# NEW PATIENT VISIT – PAGE 2

| Name: | Date: |
|---|---|
| | |

**List all Illnesses:**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**List all Surgeries:**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**List all medications and dosages including over-the-counter:**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**Allergies:** ☐ No ☐ Yes If Yes, List:

1. _____
2. _____
3. _____

**Family History**

| | |
|---|---|
| Mother's Age: | Medical Issues: |
| Father's Age: | Medical Issues: |
| Brother's Age: | Medical Issues: |
| Brother's Age: | Medical Issues: |
| Sister's Age: | Medical Issues: |
| Sister's Age: | Medical Issues: |
| Additional: | |

**Social History**

| |
|---|
| ☐ Non-Smoker ☐ Smoker—How Many Packs/Day? _____ |
| ☐ Non-Drinker ☐ Occasional/Social ☐ Frequent/Regular |
| Recreational Drug Use? ☐ Yes ☐ No |
| Exercise: ☐ None ☐ 1-2 times/week ☐ 3 or more times/week |
| Sexually Active? ☐ No ☐ Yes Length of time with current partner: _____ |
| Marital Status: ☐ Single ☐ Married – How long: _____<br>☐ Divorced ☐ In a Relationship – How long: _____ |

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

# NEW PATIENT VISIT – PAGE 3

| Name: | Date: |
|---|---|
| | |

**Review of Systems: Please check the boxes of any symptoms you are currently experiencing.**

| | | | | |
|---|---|---|---|---|
| Head/Eyes | ☐ Headache | ☐ Hearing Problems | ☐ Visual Problems | |
| Endocrine | ☐ Excess Thirst<br>☐ Increased Appetite | ☐ Heat Intolerance<br>☐ Decreased Appetite | ☐ Cold Intolerance | |
| Cardiovascular | ☐ Chest Pain | ☐ Shortness of Breath | ☐ Palpitations | |
| Gastrointestinal | ☐ Diarrhea<br>☐ Vomiting | ☐ Constipation<br>☐ Abdominal Pain | ☐ Nausea<br>☐ Blood in Stool | |
| Genitourinary | ☐ Dysuria<br>☐ Incontinence | ☐ Frequency<br>☐ Blood in Urine | ☐ Urgency | |
| Musculoskeletal | ☐ Muscle Swelling | ☐ Muscle Pain | ☐ Joint Swelling | ☐ Joint Pain |
| Psychological | ☐ Depression<br>☐ Mood Instability | ☐ Crying Spells<br>☐ Attention Problems | ☐ Sleep Disturbance | ☐ Anxiety |

**Please write the names of the medications/prescriptions you need at today's visit.**

| |
|---|
| |
| |
| |
| |
| |
| |

**Topics for Today's Visit (check all that you wish to discuss):**

| Prevention | | Infectious Disease/Cancer | |
|---|---|---|---|
| Alcohol screening & counseling | | Gonorrhea & Chlamydia | |
| Aspirin use | | Hepatitis B | |
| Blood pressure | | Hepatitis C | |
| Contraception | | HIV risk assessment | |
| Depression | | HIV testing | |
| Diabetes | | Immunizations | |
| Folic acid supplementation | | Latent tuberculosis | |
| Healthful diet and activity | | STI prevention | |
| Interpersonal violence | | Syphilis | |
| Lipid screening | | Breast cancer | |
| Obesity | | Cervical cancer | |
| Osteoporosis | | Colon cancer | |
| Prevention of falls | | Lung cancer | |
| Statin use | | Medications to reduce breast cancer | |
| Substance use | | Risk assessment for BRCA testing | |
| Tobacco screening & counseling | | Skin cancer | |
| Urinary incontinence | | | |

**Thank You!**

# BLOSSOM

## GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

MARJORIE A. CHORNESS, MD FACOG

| Today's date | Social Security # | DOB: / / |
|---|---|---|

## *PATIENT INFORMATION*

| Last Name | First | MI | Address |
|---|---|---|---|
| | | | |

| City/State | Zip Code | Home # | Cell # |
|---|---|---|---|
| | | | |

| Employer | Employer Address | Work # | Pharmacy # |
|---|---|---|---|
| | | | |

| Email Address | Primary Care Physician |
|---|---|
| | |

| Marital Status | Employed | Student |
|---|---|---|
| ☐ S- Single ☐ M- Married ☐ D-Divorced<br>☐ X- Separated ☐ W- Widow | ☐ FT ☐ PT ☐ R- Retired<br>☐ Self ☐ N- None | ☐ FT ☐ PT |

## INSURANCE INFORMATION (We must have this information in order to file your insurance)

### Primary Insurance Co:

| Subscriber's Name | Subscriber's S.S. # | Subscriber's Birth date / / | ID # | Group # | Co-Pay $ |
|---|---|---|---|---|---|
| | | | | | |

| Patient's relationship to subscriber | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other |
|---|---|---|---|---|

| Subscriber's Employer | Employer Address | Employer Phone # |
|---|---|---|
| | | |

### Secondary Insurance Co:

| Subscriber's Name | Subscriber's S.S. # | Subscriber's Birth date / / | ID # | Group # | Co- Pay $ |
|---|---|---|---|---|---|
| | | | | | |

| Patient's relationship to subscriber | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other |
|---|---|---|---|---|

| Subscriber's Employer | Employer Address | Employer Phone # |
|---|---|---|
| | | |

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize BLOSSOM Gynecology, Wellness & Infertility (Dr. Marjorie Chorness) to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility.

*Patient/Guardian signature* *Date*

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

*children*

| NAME | AGE | NAME | AGE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## PERSONAL INTERESTS

## LEVEL OF EDUCATION

☐ High School ☐ College 1 2 3 4 ☐ Post Graduate ☐ Other

## PATIENT CONTACT PREFERENCES

I give Blossom Gynecology, Wellness & Infertility, P.A. permission to contact me in the following way:

| | | | |
|---|---|---|---|
| Home Phone | ☐ Yes ☐ No | Cell Phone | ☐ Yes ☐ No |
| Work Phone | ☐ Yes ☐ No | E-Mail | ☐ Yes ☐ No |
| | | E-Mail Address: _____ | |

With the following information:

| | | | |
|---|---|---|---|
| Appointment Information | ☐ Yes ☐ No | Prescription Information | ☐ Yes ☐ No |
| Lab Results | ☐ Yes ☐ No | Insurance/Billing | ☐ Yes ☐ No |

## EMERGENCY CONTACT

| Name | Relationship | Home # | Cell # | Work # |
|---|---|---|---|---|
| | | | | |

MC/lh 7/2/18

# BLOSSOM GYNECOLOGY, WELLNESS AND INFERTILITY, PA

## Authorization for Use and Disclosure of Protected Health Information

I hereby authorize BLOSSOM GYNECOLOGY, WELLNESS AND INFERTILITY, PA to use and/or disclose my protected health information as described below to

**(name and address of recipient)**_____

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying BLOSSOM GYNECOLOGY, WELLNESS AND INFERTILITY, PA.in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) BLOSSOM GYNECOLOGY, WELLNESS AND INFERTILITY, PA agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

**Type of Information to Be Disclosed**

| | | |
|---|---|---|
| Entire Medical Record | Most Recent 5 Year History | Radiology Reports |
| Office Chart Notes | All Hospital Records | Operative Reports |
| Billing Statements | Transcribed Hospital Reports | |
| Dental Records | History and Physical Exam | Other _____ |
| Laboratory Reports | Emergency and Urgent Care Records | |
| Pathology Reports | Medical Records for Continuity of Care | |
| Consultation | Diagnostic Imaging Reports | |
| Discharge Summary | Emergency Room Reports | |

In addition, I authorize that this will include health information relating to (check if applicable):

HIV/AIDS infection  Drug/Alcohol abuse  Genetic Testing

This authorization will expire 365 days from the date of signing.

**Patient Name:**

_____

_____ _____

**Signature of Patient or Legal Representative**  **Date**

_____

**Printed Name of Patient's Representative (*if applicable*)**

**Relationship to Patient (*if applicable*)**
Parent or guardian of unemancipated minor
Court appointed guardian
Executor or administrator of decedent's estate
Power of Attorney

_____ _____

**Signature of Witness**  **Date**

# BLOSSOM GYNECOLOGY, WELLNESS AND INFERTILITY, PA

## Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient DOB: _____

I hereby acknowledge that I have received a copy of Blossom Gynecology, Wellness and Infertility, PA Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient's Representative (*if applicable*)

**Relationship to Patient (*if applicable*)**
Parent or guardian of unemancipated minor
Court appointed guardian
Executor or administrator of decedent's estate
Power of Attorney

---

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

Patient/representative refused to sign
Emergency situation prevented us from obtaining acknowledgement at this time
(will attempt again at a later date)
Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

_____

_____

Other (Specify)

_____

_____

_____

_____

_____

**Marjorie A. Chorness, MD FACOG**
**420 The Parkway, Suite C**
**Greer, SC 29650**
**Tel: (864) 662-5000**

# PATIENT CONSENT FOR TREATMENT

I have requested medical and/or surgical services from Blossom Gynecology & Infertility, P.A. ("Blossom Gynecology") and by signing below, I voluntarily consent to treatment by Blossom Gynecology personnel, including any physician and/or any other designee who may be involved in performing evaluation, lab tests (which may include using drug screens and testing for HIV or other sexually transmitted diseases), physical exam, ultrasound, biopsy, administration of medication, and procedures. This consent will remain in place until I revoke the consent in writing or until the law states that it has expired. Any action taken in reliance on this consent prior to the revocation or expiration of this consent will remain valid.

I understand that I have the right to speak with the physician before any treatment or procedure, and I have been offered the opportunity to ask any questions about the care I may or may not elect to receive. I am aware that the practice of medicine, surgery, and gynecology is NOT an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result of any treatment. I understand and agree that Blossom Gynecology may, at its sole discretion, terminate the physician patient relationship in the event that I fail to follow physician orders that are critical to my care and well-being. Failure to follow physician orders includes, but is not limited to, failing to keep scheduled appointments with Blossom Gynecology; failing to keep appointments for lab draws; failing to take prescribed medications; failing to attend imaging appointments, including, but not limited to mammograms and pelvic ultrasounds; and, failing to attend medical appointments when referred outside of the Blossom Gynecology.

Blossom Gynecology is an office-based gynecology practice that does not provide emergency or hospital services. I understand that if I require hospitalization, inpatient services, or specialized services beyond the scope of Blossom Gynecology's practice, Blossom Gynecology will refer me to a different physician for further treatment. If I require immediate hospital or emergency care, Blossom Gynecology will send me to a hospital emergency department or direct me to call 911.

Blossom Gynecology is at times involved in health care education, and I agree that unless I specifically request otherwise, at times, care, examination, and treatment may be delivered by students or medical personnel in training who are under the supervision of a physician.

I understand and agree that my treatment or procedure may be photographed and/or videotaped. I understand that these materials will be used for medical, scientific, or education purposes provided my identity is not revealed by the pictures or by descriptive accompanying text. I understand and agree not to photograph, videotape, audiotape, record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, AND THEY HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAD IT READ AND EXPLAINED TO ME. I UNDERSTAND THIS FORM AND I HEREBY AGREE TO ALL TERMS AND CONDITIONS SET FORTH ABOVE. I VOLUNTARILY CONSENT TO ALLOW BLOSSOM GYNECOLOGY, ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF ITS PHYSICIANS, AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN MY CARE TO PERFORM TREATMENT.

_____ Patient Signature Date _____

_____ Witness Signature Date _____

_____ Parent/Guardian Signature* Date _____

**Parent/Guardian's signature is not required if the patient is 16 years old or above and the procedure does not involve an operation in accordance with S.C. Code Ann. 63-5-340.*

# Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to you and your family members. Next to each statement, please list the RELATIONSHIP TO YOU AND AGE OF DIAGNOSIS. You and the following family members should be considered:

***Mother Father Sister Brother Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather***

Each Statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of Hereditary Breast and Ovarian Cancer Syndrome and Lynch Syndrome. Share this information with your health care professional to help determine you hereditary cancer risk.

| | | COLON AND UTERINE CANCER | SELF | FAMILY MEMBER | | AGE AT DIAGNOSIS |
|---|---|---|---|---|---|---|
| | | | | MOTHER'S SIDE | FATHER'S SIDE | |
| Y | N | Uterine (endometrial) Cancer before age 50 | | | | |
| Y | N | Colorectal Cancer before age 50 | | | | |
| Y | N | Ovarian cancer | | | | |
| Y | N | Two or more Lynch Syndrome Cancers (colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenoma) | | | | |

| | | BREAST AND OVARIAN CANCER | SELF | FAMILY MEMBER | | AGE AT DIAGNOSIS |
|---|---|---|---|---|---|---|
| | | | | MOTHER'S SIDE | FATHER'S SIDE | |
| Y | N | Breast Cancer at 50 or younger | | | | |
| Y | N | Ovarian Cancer | | | | |
| Y | N | Two primary (unrelated) breast cancers in the same person or on the same side of the family | | | | |
| Y | N | Male Breast Cancer | | | | |
| Y | N | Triple Negative Breast Cancer + (ER-, PR-, HER2- pathology) diagnosed before age 60 | | | | |
| Y | N | Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family | | | | |
| Y | N | Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family | | | | |

Is there any other cancer in you or any family members not provided above? If yes, provide relationship and age of diagnosis:

_____

Have you or any family members ever been tested for hereditary cancer? If yes, please explain:

_____

Patient's signature: _____ Date: _____

**FOR OFFICE USE ONLY**

- o Candidate for further risk assessment and/or genetic testing
- o Information given to patient for review
- o Patient Offered genetic testing: (circle one) Accepted Declined

*Lynch Syndrome – related cancers include colorectal, uterine (endometrial), ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas.
+For a better understanding of triple negative breast cancer, please ask your provider.

BLOSSOM GYNECOLOGY, WELLNESS AND INFERTILITY, P.A. FINANCIAL POLICY

Thank you for choosing Blossom Gynecology, Wellness & Infertility, P.A. as your healthcare provider. We are committed to building a successful and long-term physician-patient relationship.

**Insurance:** A valid photo ID/Drivers License and active insurance card must be presented at the time of your visit. Our office is in network with most major insurance carriers. However, it is the patient's responsibility to understand the coverage details of the policy and to verify we are participating providers. Deductibles, co-insurances and co-pays, as outlined by your policy, are due at time of service. If your insurance was inactive at the time of your visit, your will be responsible for the total cost.

**Non-Covered Services:** Patients are advised to be aware of tests/services that are not covered by insurance to avoid unexpected charges. Insurance companies do not always agree with physicians on what tests/services are medically advised. It is the patient's responsibility to know what is or is not covered by their policy. If you have any questions regarding if services are or are not covered, please contact your insurance company. Elective, cosmetic, or aesthetic procedures will be the patient's financial responsibility.

**Healthy Connections.** We accept Healthy Blue and First Choice/Select Health Care. Your office visits will be billed to your Medicaid carrier.

**Well Woman Exams/Additional Charges:** These exams include preventive care only. Any problem not included in an established list of topics provided for you that is addressed during a Well Woman visit, is considered a **separate service**, must be billed to insurance, and may generate a charge collected at the time of your visit.

**Collection Policy:** Should your account become past due, the patient/guarantor of the account is responsible for outstanding balances. Any questions regarding balances can be emailed to patientaccounts@blossomgyn.com. If the balance is not paid within 45 days of the date of service, we reserve the right to forward the account to a third party collection agency. The patient/guarantor of the account will assume all costs of collection, interest, and legal fees, up to 50% of the account balance. In the event the account is no longer current, medical services may be discontinued.

**Payment Arrangements:** If you are unable to pay your balance in full, please contact our office immediately to set up a payment arrangement and avoid collection action.

**Administrative/Medication Renewal/Missed Visit Fees:** A $40.00 fee will be charged when requesting medication renewals outside of a scheduled appointment or when prior authorization on a medication is required. A **$40.00** fee will be charged for letters/forms the office completes on your behalf. Unless cancelled/rescheduled 24 hours prior to your visit, there is a **$40.00** fee for missed appointments.

MC/vp(1/1/2024)

**Lab Services:** Quest, Labcorp and Myriad provide the lab services. Charges for these services are handled directly by billing departments associated with these companies. If do not have insurance, make sure they are aware. Any questions regarding lab charges should be directed to the billing phone number provided by these companies.

By signing below, I understand and agree to the financial policy as outlined above. I consent to receiving emails, text messages and phone contact regarding financial matters.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient/Guardian Printed Name E-mail Address

## PREVENTATIVE WELL WOMAN EXAMS

Annual Well Woman Exams provide an opportunity to speak with a knowledgeable physician about your health and lifestyle. Gynecological visits are also beneficial because they can help identify early detection of treatable conditions and provide solutions for issues like abnormal paps, breast masses, abnormal mammograms, pelvic pain, bleeding problems, vaginitis, frequent urinary tract infections, PMS, infertility, peri menopausal symptoms, menopause transition symptoms, and post menopausal issues, among others. Depending on your age and health needs, your doctor will likely perform a number of tests or examination techniques that comprise the Well Woman Exam:

- A pelvic exam: the doctor uses a speculum to look at and check the vulva, vagina, and cervix; and then checks your internal reproductive organs (uterus and ovaries) with a gloved hand.
- A Pap test (Cervical Cancer screening): the doctor uses a small brush to collect cells from your cervix. This test usually begins at the age of 21 and is repeated based on your age and medical history.
- STI screening (if indicated)
- A breast exam

Your doctor may also recommend additional health screening that may include the following:

- Blood or urine tests
- Cholesterol screening
- Diabetes screening
- Breast cancer screening (Mammogram)
- Osteoporosis screening (DEXA/bone scan)
- Colorectal cancer screening (i.e. colonoscopy)
- Pelvic Ultrasound

These exams include preventive care only. Any problem not included in an established list of topics provided for you is considered a **separate service**, must be billed to insurance, and may generate a charge collected at the time of your visit.

Date_____

Name_____

Signature_____

MC/mc(1/1/2024)