Parveen S. Vahora MD PA
9332 State Road 54, Suite 403
Trinity, FL 34655

Welcome:
Your appointment is on _____, at _____.

Please plan to arrive at least 20 minutes before your appointment so we can finalize your information. If you are going to be more than 15 minutes late for your appointment, please call the office as soon as possible so we can find a more convenient time for you to see the physician.
Please complete the enclosed forms and bring them and following items that apply to you:

□ **All of your current Insurance Cards.**

□ **Your driver's license or other photo ID.**

Please note originals of these must be brought with you in order to comply with the Red Flags/Identity Theft Program. If you do not bring these you will not be seen for your visit. Also if the address on your photo ID is different from your current address, you need to bring a copy of an utility bill or other correspondence showing your current address.

□ A list of your current medications.

□ Notes or letters from your other physicians or the physician who sent you here.

□ Copies of any lab or test results or imaging studies including any ultrasound reports.

□ Authorization and referral – if this is required by your insurance company. Must be received in the office 7 days prior to your visit.

□ If you have Insurance through the Health Exchange/Marketplace – proof of payment of 3 months of your premium.

Please keep in mind:
If your insurances plan requires an authorization, please obtain an authorization number. Appointments will be rescheduled if an authorization is not received 7 business days prior to your visit. We are unable to see you if you do not have an authorization. It is your responsibility to know your insurance coverage.
If your health insurance requires a co-pay or deductible or co-insurance, please be prepared to pay that amount when you check in. We would be happy to provide you with the information regarding your insurance coverage and responsibility.
If your insurance is a PPO/EPO/POS or you have a plan that has a deductible, you will be required to have a credit card on file. If you do not have a credit card we will require a check on file or cash deposit on your account prior to you being seen by the our practice.
If you currently do not have a health insurance plan, or we are not contracted with your insurance plan, **payment in full is due at the time of service.**

Thank you for choosing our practice. We look forward to taking care of your healthcare needs.

I _____ HAVE READ AND UNDERSTAND THE PROVISIONS LISTED ABOVE.

SIGNATURE of Patient or Legal Guardian **DATE**

Parveen S. Vahora, MD PA

Patient Information Sheet

Today's Date: _____ □ New □ Established □ Updated **Account #**: _____

PATIENT: _____
Last Name First Name Middle

Social Security Number: _____ **DOB:** _____ **Age:** _____

Marital Status: □ S □ M □ D □ W □ SEP Ht: _____ Wt: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Secondary Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Employed By: _____ **Work Phone:** _____

Address: _____

Spouse or Parent Name: _____ Relationship: _____

Notify in Case of Emergency: _____ Relationship: _____

Address: _____

Phone #: _____ Referred By: _____

PHYSICIAN INFORMATION:

Referring Physician: _____ **Other (specify):** _____

Family Physician: _____ **Phone:** _____

Pharmacy: _____ **Phone:** _____

Insurance Information:

Insurance: _____ **Policy #:** _____ **Group #:** _____

Is the insurance listed above your primary Insurance? □ YES □ NO

Do you have **Medicare**? □ YES □ NO **Medicare #:** _____

Is **Medicare** your Primary or Secondary Insurance? □ PRIMARY □ SECONDARY

Secondary Insurance:_____ **Policy #:** _____ **Group #:** _____

Who is the Subscriber? □Self □Other (Please complete below):

Name: _____ DOB: _____ SSN: _____

Relationship: _____ Phone Number: _____

Address: _____

Medication List

****This is now required by Government Regulations under the new Health Law*****

Patient Name/DOB: _____

My Primary Care Physician is: _____

The following are a list of all the current Medications/Vitamins/Herbal supplements, I am currently taking.
(If none please write that):

	Name	Directions	Additional Info
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

_____ _____

Signature Date

Parveen S. Vahora, MD PA

PERMISSION TO TREAT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Parveen S. Vahora, MD PA deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by **Parveen S. Vahora, MD PA**. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits related to services.

I hereby authorize **Parveen S. Vahora, MD PA** to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) Insurance Carrier(s)/Medicare to make payments directly to **Parveen S. Vahora, MD PA** for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any changes incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers may not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

PRIVACY NOTICE

I have received a copy the HIIPA Privacy Notice.

DESIGNATED RELATIVE

I authorize Discussion on My General Medical Condition and Diagnosis (including treatment, payment and health care operations) with: ( ) Spouse ( ) Children ( ) Other _____

Please list the family members or significant others, if any, whom we may inform about your medical condition, and in case of an emergency:

Name: _____ Relationship: _____Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____

Messages May Be Left on My Answering Machine Regarding My Health & Appointment Made: ( ) Yes ( ) No.

Patients Name (print):_____SS#:_____

Witness: _____ Relationship: _____

Signature: _____ Date: _____

PATIENT GYNECOLOGICAL & MEDICAL HISTORY

PATIENT NAME: _____DOB: _____AGE:_____ DATE OF VISIT_____

SENT BY DR.: _____Reason for today's visit: _____ _____

Check all that apply. If it is a family Member, please note relationship (i.e. father, sister, etc.)

	Patient	Family		Patient	Family		Patient	Family
BLOOD TRANSFUSIONS			BOWEL PROBLEMS			ABNORMAL PAP		
HIGH CHOLESTEROL			THYROID DISEASE			SYPHILIS		
HIGH BLOOD PRESSURE			IMMUNE SYSTEM DISORDER			BACTERIAL VAGINOSIS		
STROKE			LYMPH SYSTEM DISORDER			BLEEDING AFTER INTERCOURSE		
MIGRAINE HEADACHES			LUNG DISEASE			BREAST PROBLEMS		
BLOOD CLOTS			ASTHMA			CHLAMYDIA/GONORRHEA		
HEART DISEASE			KIDNEY/BLADDER PROBLEMS			CONDYLOMA		
HEART MURMUR			LIVERR/GALLBLADDER PROBLEMS			DES EXPOSURE		
HEART PALPITATIONS			SEIZURE DISORDER			DOUCHING		
BLEEDING DISORDER			VARICOSE VEINS/PHLEBITIS			ENDOMETRIOSIS		
ANEMIA			ARTHRITIS			GENITAL HERPES		
DIABETES			MENTAL DISABILITIES			INFERTILITY		
BREAST CANCER			BIRTH DEFECTS			LOSS OF URINE		
OVARIAN CANCER			WEIGHT PROBLEMS			OVARIAN CYSTS		
COLON CANCER			CAFFEINE USE			PELVIC OR TUBUAL INFECTIONS		
OTHER CANCERS			OTHER SUBSTANCE USE			PELVIC PROLAPSE		
RADIATION TREATMENTS			TRICHOMONAS			RECURRENT YEAST		
ULCERS/STOMACH PROBLEMS			ABNORMAL MAMMOGRAM			UTERINE FIBROIDS		
Other Medical Information:								

MENSTRUAL – CONTRACEPTIVE HISTORY (Check if present)

Age at Onset: Cycle: Length: Date of Last Menstrual Period:

HEAVY PERIODS		NATURAL FAMILY PLANNING		STERILIZATION DATE:	
FREQUENT PERIODS		BARRIER		IUD	
SPOTTING BETWEEN PERIODS		DEPO PROVERA INJECTION		CURRENT METHOD:	
PAINFUL PERIODS		NORPLANT		LAST DATE USED:	
PMS		ORAL CONTRACEPTIVES			

Last Pap: _____Results: _____Last Mammogram: _____Results: _____ Last Bone Density _____ Results: ____

PREGNANCY HISTORY

Specify number of: Pregnancies: Children born alive: Miscarriages:
Abortions: Ectopic: Date of last delivery:
# of Vaginal deliveries: # of Cesarean deliveries:

SEXUAL HISTORY (Check all the apply)

Are you sexually active? □ Yes □ No Frequency: Questions:
□ Unprotected Intercourse □ Pain with Intercourse □ Anorgasmia □ Multiple Partners
□ Physical/Sexual Abuse □ Other:

SOCIAL HISTORY

□ Married No. of years: No. of times: □ Single □ Separated □ Divorced □ Widowed
Do you SMOKE? □ YES □ NO If yes, how much?
How much ALCOHOL do you drink? Do you use STREET DRUGS? □ YES □ NO
Do you exercise regularly? □ YES □ NO If yes, describe: _____

ALLERGIES TO MEDICATIONS:

PRESCRIPTIONS - OVER THE COUNTER MEDICATIONS:

□ See List

PREVIOUS HOSPITALIZATIONS OR SURGERIES (Other than childbirths)

OFFICE FINANCIAL POLICY 2018

PARVEEN S. VAHORA, MD, P.A.

Our goal is to provide and maintain a good physician–patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve this objective.

Please read carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- ❑ On arrival, please check in at the front desk **AND** present your **current** insurance card at every visit. You will be asked to sign and date the accuracy of the face sheet that is pre-printed. If **ANY** information is incorrect, please provide the correct information. This is your verification of the accurate insurance and consent to bill them on your behalf. You are responsible for ensuring that all information is correct, including the insurance information.
- ❑ There will be a $25 charge for all scheduled appointments that are missed, without informing the office, within 24 hours.
- ❑ IF THE INSURANCE INFORMATION THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND IT WILL BE YOUR RESPONSIBILITY TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
- ❑ According to your benefit plan, you are responsible for any and all copayments, deductibles and coinsurances. **ALL** copayments and deductibles will be collected at check-in.
- ❑ It is your responsibility to understand your benefit plan. It is important for you to know if a written referral or authorization is required by your plan to see a specialist, usually HMO plans require one. If preauthorization is required, it must be received by our office 7 days prior to the office visit/procedure/surgery. IT IS YOUR RESPONSIBILITY TO OBTAIN THE AUTHORIZATION.
- ❑ All Health Exchange plans/market place HMO plans require authorizations for all visits and procedures. Proof of payment of the 3 premiums and current eligibility is required prior to any visits for all Health Exchange Plans.
- ❑ Patient balances are billed immediately upon receipt of your insurance's plan explanation of benefits (EOB).
- ❑ If previous arrangements have **NOT** been made with our billing office, any account with an outstanding balance greater than 45 days will be charged a $10.00 re-bill fee and may be charged to a credit card.
- ❑ A $45.00 fee will be charged for any checks returned for insufficient funds.
- ❑ We charge $1.00 per page to copy or send medical records. These will be processed once the payment is made, in a timely fashion)
- ❑ All scheduled surgeries require a 1 week cancellation notice. The cancellation fee of $100 will be charged to your account.
- ❑ All applicable insurance deductibles & coinsurance amounts for an office visit/procedure or surgery will be collected, **PRIOR** to the service.
- ❑ Please note that not **ALL** plans cover all services. In the event your insurance determines a service is "NOT" covered, you will be responsible for that charge.
- ❑ You must check your insurance plan to find out if any and all prescribed medications are covered on your prescription plan. Prior Authorizations for medications will not be done. It is your responsibility to provide us list of covered medications if there is an issue.

I have read and understand the financial policy for PARVEEN S. VAHORA, MD, PA and agree to comply and accept the responsibility for any payment that becomes due as outlined.

_____ _____

Patient Printed Name DATE

_____

Patient Signature

Notice of Privacy Practices for Protected Health Information (HIPPA)

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information." Please Review It Carefully!

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you; within our office, we restrict the disclosure of this information to doctors, nurses, technicians, insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- **When required by law**
- **Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)**
- **Health oversight activities (audits, investigations, inspections)**
- **Judicial and administrative proceedings (court order)**
- **Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)**
- **Deceased person information to coroners, medical examiners, funeral directors.**
- **Organ or tissue donation**
- **Research, provided authorization is IRB-approved or privacy board-approved**
- **Emergencies or to avert serious threat to health or safety**
- **Specialized government functions (military, inmates)**
- **Workers compensation**
- **Disaster relief**

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights

You Have The Right To:

- **Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy for your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.**
- **Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this within a written request to amend your chart directed to our office. We must respond within 60 days.**
- **Receive an accounting of any disclosures made from your record over the last six years, starting April 13, 2003. You can get this with a written request directed to our office. We must respond within 60 days.**
- **Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above. You may revoke or restrict consent.**
- **Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.**
- **Receive a copy of this notice by printing it or a written request directed to this office, and a copy of this notice will be given with all new patient packets.**

We may contact you for appointment reminders and we may provide you with information about health-related or product benefits and services. Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPPA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our <u>PRIVACY OFFICER</u> AT:

Parveen S. Vahora, M.D. PA
9332 State Road 54 Suite 403 Trinity, FL 34655
Phone: (727) 376-1536 Fax: (727) 376-1539

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.
Updated Jan 2018

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	ENDOMETRIAL (UTERINE) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON/RECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*
If Yes, Who?_____ What gene(s)?_____ What was the result? _____

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed at/under age 50
- ☐ Ovarian (peritoneal/fallopian tube) cancer at any age
- ☐ Two or more primary breast cancers ‡
- ☐ Male breast cancer at any age
- ☐ Triple Negative Breast Cancer (ER-, PR-, HER2-Pathology)
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

‡ In the same individual or on the same side of the family

§ HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer (Gleason Score ≥7)

Lynch Syndrome - Red Flags*

An individual with a personal history of any of the following:

- ☐ Colon/rectal and/or endometrial cancer before age 50
- ☐ MSI High histology on a colon/rectal or endometrial tumor before age 60¶
- ☐ Abnormal MSI/IHC tumor test result (colon/rectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

An individual with a family history of any of the following:

- ☐ A first-or second-degree relative with colon/rectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

¶ MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern

*** Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*

^ Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only:

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If YES, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update ☐ Other:_____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____