Today's Date:_____

HOMETOWN FAMILY MEDICINE
AND WOMEN'S HEALTH

Dr. Scott C. Wyman, MD
Dr. Courtney I. Hathaway, MD
Diana M. Podlecki, PA-C
Jeanne K. Bloom, F.N.P.
Brandi Glibbery F.N.P.

Name: _____

Date of Birth: _____ Social Security Number: _____

Physical Address: _____

Mailing Address: _____

City & State: _____ Zip Code: _____

Phone #: Cell: _____ Other: _____

Email address: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Please indicate whether you would like to have a nurse present during your exam.

Check one and initial.

☐ Requested
☐ Denied

X _____

Referred by: _____

Primary Care Provider (if applicable): _____

Your Preferred Pharmacy: _____

Spouses, Guarantor or Significant Other Information

Name: _____ Date of Birth: _____

Occupation:_____ Employer: _____

Phone #: Home: _____ Cell: _____

May we disclose health/billing information to this person? ☐ Yes ☐ No

Insurance Information

Primary: _____ Secondary: _____
ID#: _____ ID#: _____
Group#: _____ Group#: _____
Subscriber:_____ Subscriber: _____
Subscriber Date of Birth:_____ Subscriber Date of Birth:_____

Authorization to release medical information to insurance company or another physician care for patient. I realize I am responsible for all charges regardless of insurance. I hereby authorize my insurance benefits to be paid directly to Scott C. Wyman, M.D., P.C.

Patient's Signature: _____

OB/GYN- IF APPLICABLE

FAMILY AND PERSONAL HEALTH HISTORY

Please complete the following information as accurate as possible. If you cannot remember specific details, please give the best estimate. Thank you.

Name:	**DOB:**	**Date:**

GYNECOLOGIC HISTORY:

Problems with Menstrual Periods? ☐ No ☐ Yes **Details:** _____

Frequency? (26 days? 28 days?)_____ **Date of Last Menstrual Period**_______________

Age of First Period? _____ **Date of Positive Pregnancy Test** _______________

Date of Last Pap____________

History of Abnormal Pap? ☐ No ☐ Yes

History of Breast Disease? ☐ No ☐ Yes

What is your current method of Contraception? ☐ None ☐ Pill ☐ IUD ☐ Other
Sterilization ☐ No ☐ Yes **Details:**

History of Endometriosis? ☐ No ☐ Yes **What treatments?**

History of Infertility? ☐ No ☐ Yes **What tests and/or treatments?**

HPV Vaccine? ☐ No ☐ Yes **Year:** _____

History of Sexually Transmitted Disease? ☐ No ☐ Chlamydia ☐ Herpes ☐ Genital Warts (HPV) ☐ Gonorrhea ☐ Other:

History of AlcoholAbuse? ☐ No ☐ Yes

OBSTETRIC HISTORY- (Please include miscarriage/abortion history)

Year	City/State	Pregnancy Duration	Hours in Labor	Sex	Birth Weight	Type of Delivery	Complications

SURGICAL HISTORY AND HOSPITALIZATIONS

Year	City/State	Type of Surgery/Reason for Hospitalization	Complications

HEALTH MAINTENANCE

Cholesterol Screening: ☐ No ☐ Yes **Result:** _____ **Date:** _____

Mammogram: ☐ No ☐ Yes **Result:** _____ **Date:** _____

Colonoscopy: ☐ No ☐ Yes **Result:** _____ **Date:** _____

Bone Density Scan: ☐ No ☐ Yes **Result:** _____ **Date:** _____

Tobacco Use: ☐ No ☐ Yes Packs per day_____ Quit?_____ Date_______________
Alcohol Use: ☐ No ☐ Yes Drinks per week._____
Exercise: ☐ Never ☐ 1-3 times a week ☐ 2-4 times a month
Vitamins and/or Calcium Supplements: ☐ No ☐ Yes
Recreational Drug Use: ☐ No ☐ Yes **Have you used or shared needles?** ☐ No ☐ Yes

CURRENT MEDICATIONS

No Medications ☐

(PLEASE USE THE BACK OF THIS PAGE FOR MORE ROOM IF NEEDED)

Medications	Dosage	Frequency	Prescribing Physician

MEDICAL ALLERGIES

No Known Allergies ☐

Medication	Reaction

PERSONAL & FAMILY HISTORY: (SELF, FAMILY MEMBER, AND ANY DETAILS YOU CAN REMEMBER)

***Are you Adopted? ☐ No ☐ Yes**

History	Family If yes, who?	Self	Details
High Blood Pressure or vascular disease (High Cholesterol, Varicose Veins, Blood Clots in Legs)			
Heart Disease (Irregular beats, Heart Attack, Valve Issues, etc.)			
Pulmonary Disease (Asthma, Emphysema, COPD, TB)			
Diabetes (Type 1 or Type 2, Insulin treatment)			
Thyroid Disease (Underactive, Overactive, Goiters, Graves' Disease,)			
Gastrointestinal Disease (Hepatitis, Gallbladder problems, Acid Reflux, Crohns .)			
Kidney and Bladder Problems (Infections, Stones, Bladder Control Problems)			
Neurological Problems (Migraines, Seizures, Strokes, Paralysis)			
Hematologic (Blood**) Disease** (Anemia, Leukemia, Clotting Problems)			
Musculoskeletal Problems (Arthritis, Joint or Spine problems, Osteoporosis)			
Emotional or Psychiatric Problems (PMS, Anxiety, Depression, Bipolar, Suicide)			
Female Cancers (Breast, Cervix, Uterus, Ovaries)			
Genetic (inherited**) or Congenital Diseases** (Down Syndrome, Cystic Fibrosis, Hemophilia)			
Other Autoimmune disease such as lupus etc.)			

HAVE YOU HAD ANY GENETIC SCREENING OR DIAGNOSIS OF:

	Yes	No		Yes	No
Age Over 35	☐	☐	**Muscular Dystrophy**	☐	☐
Thalassemia (Italian, Greek, Mediterranean, Or Asian Background)	☐	☐	**Cystic Fibrosis**	☐	☐
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)	☐	☐	**Huntington Chorea**	☐	☐
Congenital Heart Defect	☐	☐	**Learning disability/Cognitive delay/Autism** (if yes was person for Fragile X)	☐	☐
Down Syndrome	☐	☐	**Other Inherited Genetic or Chromosomal Disorder**	☐	☐
Tay-Sachs (EG, Jewish, Cajun, French Canadian)	☐	☐	**Maternal Metabolic Disorder** (E.G. Insulin-Dependent Diabetes, PKU)	☐	☐
Sickle cell Disease or Trait (African)	☐	☐	**Patient or Baby's Father had a Child with Birth Defects** (Not Listed)	☐	☐
Hemophilia	☐	☐	**Recurrent Pregnancy Loss, or a Stillbirth**	☐	☐

PERSONAL HISTORY

	Yes	No		Yes	No
History of Domestic Violence	☐	☐	**Perpetrator Relation:**		
Perpetrator in the Home	☐	☐	**Restraining Order in Place**	☐	☐

SEXUAL PRACTICES

	Yes	No		
Sexually Active	☐	☐	**Orientation Homo, Hetero, or Bi-Sexual**	
Practice Safe Sex	☐	☐	**Number of Current Partners**	
Gender Identity:			**Number of Partners you have been with in your lifetime**	

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name:

DOB:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

Patient Name: _____

Personal and Family History Questionnaire for Hereditary Cancer Risk Assessment

Your Personal & Family History of Cancer is Important to Provide You with the Best Care Possible

Please mark "Yes" or "No" below if there is a personal or family history of any of the following cancers.

If yes, indicated family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces and nephew.

Personal and Family History Have you or your family members been diagnosed with any of the following:	Y	N	YOU Age	SIBLINGS / CHILDREN Family Member and Age	MOTHER'S SIDE Family Member and Age	FATHER'S SIDE Family Member and Age
EXAMPLE: Breast cancer	X	○	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	○	○				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○	○				
2 relatives with **breast cancer**, one at age 50 or younger	○	○				
Ovarian cancer at any age	○	○				
Triple Negative Breast cancer at age 60 or younger	○	○				
3 or more of these cancers on same side of the family at any age: **pancreatic, breast**, or **aggressive prostate**	○	○				
Male **breast cancer** at any age	○	○				
Jewish ancestry with **breast cancer** at any age	○	○				
Jewish ancestry with **pancreatic cancer** and one relative with **breast, ovarian, pancreatic** OR **aggressive prostate cancer**	○	○				
10 or more **pre-cancerous colon polyps** found in 1 person throughout their lifetime. Total number_____	○	○				
Colorectal or **Uterine (endometrial) cancer** before age 50	○	○				
TWO individuals in my family (myself included): at least 1 with **colorectal *or* uterine (endometrial) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	○	○				
THREE OR MORE individuals in my family (myself included) with a **Lynch-associated* cancer** at any age, with at least 1 being a colorectal or uterine (endometrial) cancer	○	○				

Have you or a family member had genetic testing for a **BRCA, Lynch or polyposis mutation**?	○	○	If yes, who in your family had testing, when, and if known, where?:

OFFICE USE ONLY

- Does patient meet: 1. NCCN guidelines for HBOC? ○ Y ○ N 2. NCCN guidelines for (A)FAP? ○ Y ○ N 3. SGO guidelines for Lynch syndrome? ○ Y ○ N
- Genetic testing recommended? ○ Y ○ N
- If YES, which test? ○ BRAC*Analysis*® with Myriad myRisk™ ○ COLARIS® with Myriad myRisk™ ○ COLARIS*AP*® with Myriad myRisk™ ○ Multi-Site with Reflex Myriad myRisk™ ○ Single Site _____
- Provide rationale for recommendation: ○ Guidelines met ○ Other (please specify): _____
- Patient accepts same day genetic testing: ○ Y ○ N
- Patient advised to schedule follow-up appointment: ○ Y ○ N

PROVIDER'S SIGNATURE:	TODAY'S DATE:

HOMETOWN FAMILY MEDICINE AND WOMEN'S HEALTH

EMERGENCY CONTACT RELEASE OF INFORMATION

Emergency Contact Form / HIPAA In case of an emergency, who should we contact on your behalf?

1. _____relationship: _____Ph: _____

2. _____relationship: _____Ph: _____

3. Do you have a living will or advance directive? Yes ☐ No ☐

Does the document specify someone to have medical power of attorney (POA) for your affairs (ie; someone designated to make decisions about your care and consent to procedures if you are unable to)? Yes ☐ No ☐

Named POA: _____

Has this individual actively assumed the role as your decision maker or POA? Yes ☐ No ☐

Do you give our office permission to discuss your medical condition and information about your care with any family members or close friends? Yes ☐ No ☐

If yes, please provide names and contact information below if known:

☐ Same as #1 listed above.

☐ Same as #2 listed above.

□ Name: _____relationship:_____Ph: _____

□Name: _____relationship:_____Ph: _____

□ Name:_____relationship:_____Ph:_____

The phone number listed as your primary phone in our records is the one we will use for appointment reminders, to convey results of your labwork, or to contact you regarding billing issues. Please notify our receptionist in the event of a change in your primary contact number.

Is there an alternate number that we may try if we need to contact you regarding a schedule change or appointment reminder? _____□ cell □work □ landline □family member _____

May we leave personal information on your answering machine or voicemail? Yes ☐ No ☐

May we use your email to contact you, give appointment reminders, or send medical info? Yes ☐ No ☐

X_____ Date_____

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Financial Policy

Thank you for choosing our practice. We are committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our Patient Financial Policies is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Financial Obligations:

Missed or cancelled appointments:

There will be a $50 - $100 fee for missed appointments or appointments without a 24-hour cancellation notice depending on the length of appointment cancelled or missed. This charge cannot be billed to your insurance; therefore, it will be solely your responsibility. After 3 consecutive missed appointments or late cancellations, you may be dismissed from our practice.

Returned Checks:

The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. It is expected that the insufficient funds and returned check fee is paid immediately upon notification from us or your financial institution. Your account may be placed on a cash only basis following any returned check until the practice deems you are no longer a financial risk.

Self-Pay Accounts:

Self-pay accounts are patients without insurance coverage and are required to pay in full at the time of service. At time-of-service payments may not always be accurate and if so the discrepancy on billed charges will be reflected on your next statement.

Medical Insurance Accounts:

We will bill your primary, secondary, and/or tertiary insurance companies as a courtesy to you. To properly bill your insurance companies, we require that you disclose all insurance information in a timely manner. All insurance information must be provided to us within 30 days of your appointment. Failure to do so will result in charges being your full responsibility without insurance involvement. If you provide us with inaccurate insurance information and you fail to provide us with updated information within 30 days, the charges will be your responsibility. If due to your inability to give us accurate insurance information we receive claim denials referencing timely filing with your insurance company, you will be held responsible for payment of the denied charges.

Insurance is a contract between you and your insurance company. Every insurance plan has copays, deductibles, and coinsurance obligations that their members must meet. We make every effort to get your general medical health benefits and with this information provided our office has its expectations of you as our patient. We expect you to pay your contracted copays, deductibles, and coinsurance at time services are rendered on the estimated charges. We do our best to estimate but if our estimate does not include services that were provided, we will bill those in addition to the prepaid estimated charges to your insurance. Once all charges have been processed by your insurance any balance that remains will be your responsibility to pay. We do not take responsibility for knowing your contract verbatim with your insurance. It is your responsibility to know whether we are preferred in network providers, what your policy considers in terms of covered, non-covered and experimental or investigational procedures. If we are out of network with your insurance company, you will be required to pay the above usual and customary allowances on all charges. If your insurance

company issues you payment for our services, you are required to pay us in full for those services you were paid. Ultimately it is the insurance company that makes the final determination of your eligibility and benefits once they receive the insurance claim and process it according to your plan. If we have exhausted all our efforts in collecting from your insurance and payment is delayed over 90 days you agree to take full responsibility for all charges that are delinquent on your account.

We will not fraudulently change diagnoses from the supporting documentation for a better outcome from your insurance company.

Outstanding Balance Policy:

It is our office's policy to have you place a credit/debit card on file for any outstanding balances. (Please reference Credit/Debit Card Policy for details). Our office policy is that all accounts are paid for within 90 days. If your account is 60 days past due your account will be entering the collections process if payment is not received when you are contacted via phone on your outstanding account. If your account balance is not paid one week from the date of the call your account will be sent to our Third-Party Collections Agency. When your account is turned over you will not only be responsible for your balance with us but fees that accumulate from the first delinquent date. The collection agency determines these fees and once your account is turned over you will be sent to them to discuss your debt. Once your account is turned over to the collection agency you will be considered discharged from our practice until financial obligations have been met and satisfied. If financial obligations are met, it will be at the discretion of the providers whether they will welcome you back into the practice as a cash pay only client. All outstanding balances prior to assignment to Third Party Collections Agency will be subject to a monthly late payment fee of $25 and 1.5% monthly interest charge on the running balance by our practice.

Referrals and Authorizations:

We may sometimes perform services that your insurance company may need prior approval on. As a courtesy we will try to get prior approval for services that in general most insurance companies may require prior approval for such as infertility treatment and surgical procedures requiring hospital setting. However, it is not our responsibility, nor will we take responsibility if prior approval was needed for services rendered that were not obtained. It is your responsibility as the policy holder to take the steps necessary to inquire about treatment prior approval requirements. If such services are provided and are denied for prior approval all charges will be your responsibility. We always want you to be actively involved in knowing your insurance benefits.

Sometimes we work with Third Party Vendors that may not be in network with your insurance plan. We advise you to ask who we work with regarding lab & pathology processing, preventative services that are outsourced and surgical facilities as well as providers who may be involved in the operating room.

Minors:

The parent(s) or guardian(s) is responsible for full payment of services and will receive the billing statement. Minors must be accompanied by a parent or guardian unless a signed release to treat and financial arrangements have been made prior to services.

Medical Records Copies:

All requests for medical records must be in writing, please allow us 10 business days to complete the request. This is within the legal requirement of the State of Montana. Please be advised that there is an administrative fee of $15 and a fee of $0.50 per page and this is assessed at the discretion of our office and is in accordance with Montana Annotate code.

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Refunds:

If you feel you have a refund coming it is your responsibility to contact our office and request such a refund. Refunds will only be issued after all dates of services have been paid for in full by you or your insurance. If it is deemed, you have a refund coming an audit will be done on your account and a refund check will be issued. If a refund is due to you and payment was made via credit/debit card, please be advised that a 3% fee will be deducted from your refund to cover credit card processing fees. Patients using a CareCredit card, please be advised that a 15% fee will be deducted from your refund due to CareCredit processing fees. Refunds will not be issued if you have upcoming appointments on the schedule.

Cell and Land Line Phone Calls:

By providing a cell or land line phone number you have authorized contact for any activity involving our services to you, including but not limited to the resolution of unpaid account balances. This number will only be used for in-house or any business entity contracted to perform duties resulting from services provided to you by our office.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving services, you are ultimately responsible for payments on your account balance. Our office will not bill any other party.

Authorization to Release Information and Assignment of Medical Benefits:

I hereby authorize Hometown Family Medicine and Women's Health, to treat the below named patient. I authorize the release of medical information necessary to process insurance claims for treatment. Photocopies and electronic signed version of this form or any other form I have signed with the practice are valid as the original and binding. I authorize medical benefits to be paid directly to Scott C. Wyman, M.D., P.C., dba Hometown Family Medicine and Women's Health. I understand that I am financially responsible for any services from this office regardless of insurance coverage. I understand that if I have dependents that also seek medical services with the practice, and I am assigned as the responsible party that I am also under financial obligation for those services as well regardless of insurance coverage.

Printed Patient Name: _____

Signature of Patient (over 18 years of Age): _____

Printed Guardian/Guarantor Name: _____

Signature of Guardian/Guarantor: _____

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Credit/Debit Card Policy

Hometown Family Medicine and Women's Health has implemented a credit card policy for everyday convenience for our patients. What this means to our patients is a worry-free no hassle prompt payment benefit that will alleviate the possibility of our patients receiving a late payment fee and interest charges on the likelihood of your account having an unpaid balance.

Insurance Patients:

It is our desire to collect any copays, deductibles, and coinsurance at time of service prior to submission to your insurance company. If there are other services that are completed that the front desk are unaware of those charges will be billed to you after they have been processed by your insurance. Once your insurance has processed all charges any remaining balance will be charged to your card on file following 3 business days after our courtesy call to you informing you of your balance. We will attempt to leave you a message if you do not call us back your card will be automatically charged. Your receipt with your statement will be emailed to your email on file or mailed to you if there is no email on file.

Self-Pay Patients:

If you do not have insurance, it is expected that full payment will be collected at the time of service on estimated charges. If there are charges that the front desk is unaware of these will show on your next statement. These charges will be charged to your card on file following 3 business days after our courtesy call informing you of your balance. We will attempt to leave you a message if you do not call us back your card will be automatically charged. Your receipt with your statement will be emailed to your email on file or mailed to you if there is no email on file.

No Show and 24-hour cancelations:

If you cancel without 24-hour notice or no show your appointment we reserve the right to charge your card a $50 - $100 fee depending on the appointment this amount will be reflected in your text message reminder.

***** If you should at any time want a different card charged other than the one on file with us it is your responsibility to call us and update that information. If your card on file is expired or does not have sufficient funds to charge your balance and you fail to respond to us your account will be considered delinquent. We reserve the right to charge you a late payment fee of $25 monthly and 1.5% monthly interest charge on all running balances on your account. If you have dependents that we take care of as well the same will apply to their account balances. *****

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CV:
Cardholder ZIP Code (from credit card billing address): _____