



Joseph Gauta, MD, FACOG
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 Emily Clements, DO
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OBSTETRICS | GYNECOLOGY | INFERTILITY | INCONTINENCE

PATIENT HEALTH HISTORY QUESTIONNAIRE

Please complete all 3 pages

Name: _____ Date: _____

Primary Care Doctor _____ Pharmacy Used/Location _____

Doctor's Office Phone #: _____ Referred by: _____

Reason for Visit: _____

ALLERGIES: None

Medication or Substance	Reaction
-------------------------	----------

1. _____
2. _____
3. _____
4. _____

MEDICATIONS: None

Medication	Dosage	Frequency	Reason
------------	--------	-----------	--------

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

FAMILY HISTORY: None:

Age	Heath Problem or cause of death
-----	---------------------------------

- | | | |
|-----------------|-------|-------|
| Father: | _____ | _____ |
| Mother: | _____ | _____ |
| Siblings: | _____ | _____ |
| | _____ | _____ |
| Children: | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| Uncles / Aunts: | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| Grandparents: | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

REPRODUCTIVE & MENSTRUAL HISTORY:

Total # of Pregnancies _____ # Miscarriages _____ # Terminations _____
 # of Full Term _____ # Ectopics _____ # Living children _____
 # Premature _____ # Multiple Births _____

Date of last menstrual period: _____ Flow Amount: _____ Method of birth control: _____
 Regularity: _____ Are you in Menopause: _____ On hormone replacement : _____
 Frequency: _____

GENERAL HEALTH SCREENINGS:

Date of last Pap smear: _____ Date of last Bone Density Scan: _____
 Date of last Colonoscopy: _____ Date of last Mammogram: _____

PAST GYNECOLOGIC HISTORY: (Do you have or have you ever had):

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal PAP Smear | <input type="checkbox"/> Dysplasia | <input type="checkbox"/> Menorrhagia (heavy bleeding) |
| <input type="checkbox"/> Amenorrhea (no menses) | <input type="checkbox"/> Dysfunctional Bleeding | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Anovulation (no ovulation) | <input type="checkbox"/> Ectopic pregnancy | <input type="checkbox"/> Ovarian cyst |
| <input type="checkbox"/> Bartholin's gland cyst | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pelvic adhesions/infections |
| <input type="checkbox"/> Candidiasis (chronic yeast) | <input type="checkbox"/> Fibroid uterus | <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> PMS/PMDD |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Polycystic ovaries (PCOS) |
| <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Herpes Simplex (HSV) | <input type="checkbox"/> Recurrent vaginitis |
| <input type="checkbox"/> Cold Knife Conization | <input type="checkbox"/> Human Papilloma Virus | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cryosurgery | <input type="checkbox"/> Blocked/Dilated Fallopian Tubes | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Cystocele (dropped bladder) | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Uterine polyps |
| <input type="checkbox"/> DES Exposure in utero | <input type="checkbox"/> Infertility | <input type="checkbox"/> Uterine prolapse |
| <input type="checkbox"/> Dyspareunia (painful sex) | <input type="checkbox"/> Irregular Periods | |
| | <input type="checkbox"/> LEEP | |

Comments: _____

PAST MEDICAL HISTORY: (Do you have or have you ever had):

- | | | |
|--|---|--|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cholesterol, elevated | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> GERD / Reflux |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Cancer – Type _____ | <input type="checkbox"/> Hepatitis (A, B, or C) |
| <input type="checkbox"/> Arthritis/RA | <input type="checkbox"/> Congestive Heart Disease | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD (Lung Disease) | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Incontinence (Stress, Urgency, Frequency) |
| <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> DVT (Venous embolism) | <input type="checkbox"/> Interstitial Cystitis |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Fibromyalgia | |

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

PAST MEDICAL HISTORY continued: (Do you have or have you ever had):

- | | | |
|---|--|--|
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Kidney Infection/stone | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Transient ischemic attack (TIA) |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Skin Cancer | |

Comments: _____

PAST SURGICAL / DIAGNOSTIC HISTORY: None

- | | | |
|--|--|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Knee surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> C/Section # _____ | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> D&C # _____ | <input type="checkbox"/> LASIK (eye correction) |
| <input type="checkbox"/> Breast augmentation | <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> Ovary Removal |
| <input type="checkbox"/> Breast reduction | <input type="checkbox"/> Endometrial ablation | <input type="checkbox"/> Pacemaker implant |
| <input type="checkbox"/> Breast lumpectomy | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Pelvic Floor Rehabilitation |
| <input type="checkbox"/> Breast mastectomy | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Shoulder surgery |
| <input type="checkbox"/> Bladder lift | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> CABG (coronary bypass) | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Cholecystectomy/Gallbladder | <input type="checkbox"/> Hysterectomy (abdominal) | <input type="checkbox"/> Tonsillectomy & Adenoids |
| <input type="checkbox"/> CMG | <input type="checkbox"/> Hysterectomy (vaginal) | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Hysterectomy-laparoscopic | |

Comments: _____

- | | Yes | No | If so, how much? |
|-------------------------------------|--------------------------|--------------------------|------------------|
| Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever smoked? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you drink ? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you smoke marijuana ? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you use recreational drugs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you perform monthly breast exam? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is your diet well balanced? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you use seat belts? | <input type="checkbox"/> | <input type="checkbox"/> | |



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NOTICE OF PRIVACY PRACTICES – REVISED APRIL 14, 2003

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. If you have any questions about this notice, please contact our office Privacy Officer at
1890 SW Health Parkway, Suite 205, Naples, FL 34109 or call (239) 592-1388.

WHO WILL FOLLOW THIS NOTICE:

This notice describes information about privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclosed health information about you and describes your rights and our obligations regarding the disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your plan about treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest or benefit to you.

Health-Related Products or Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (see office address at end of notice) that you do not wish to receive such communications, we will use every effort to not use or disclose your information for these purposes.

You may revoke your **Consent**, at any time by giving us a written notice. Your revocation will be effective when we receive it, but it will not apply to any uses or disclosures which occurred prior to that time.

If you do revoke your **Consent**, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operation, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS:

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security, and Intelligence: If you were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information about you to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring our spouse with you into the exam room during treatment or while your treatment is being discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any other purpose other than those identified in the previous sections without your specific, written **Authorization**. We must obtain your **Authorization** separate from and **Consent** we may have obtained from you. If you give us **Authorization** to use or disclose health information about you, you may revoke that **Authorization** in writing at any time. If you revoke your **Authorization**, but, we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different from the **Authorization** and **Consent** mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed **Consent** and a special written **Authorization** that complies with the law governing HIV or substance abuse.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

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

Right To Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the practice Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing and other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health care information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right To Amend: If you believe that health information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the practice Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect or copy
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request “an accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the practice Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14,2003. Your request should indicate in what form you want the list. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also, have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will make all reasonable efforts to accommodate this request. For example, you may not wish us to contact you at work.

Right to a Paper Copy of This Notice: You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To receive a copy of this notice, contact the practice Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

We will post a summary of the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Security of the Department of Health and Human Services. To file a complaint with our office, contact the practice Privacy Officer. You will not be penalized for filing a complaint.

Thank you for taking the time to read this information.



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Consent for Purpose of Treatment, Payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Especially for Women for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Especially for Women. I understand that diagnosis or treatment of me by Especially for Women may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Especially for Women is not required to agree to the restrictions that I may request. However, if Especially for Women agrees to a restriction that I request, the restriction is binding on Especially for Women's practice. I have the right to revoke this Consent, in writing, at any time, except to the extent that Especially for Women's practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information is information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Notice of Privacy Practices for Especially for Women prior to signing this document.

Notice of Privacy Practices for Especially for Women has been provided to me.

The Notice of Privacy Practices for Especially for Women's practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of Especially for Women's health care operations.

A summary of the Notice of Privacy Practices for Especially for Women is also posted in the waiting room.

This Notice of Privacy Practices for Especially for Women also describes my rights and the duties of Especially for Women's practice with respect to my protected health information.

Especially for Women reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for Especially for Women.

I may obtain a revised Notice of Privacy Practices for Especially For Women by contacting the office of Especially for Women at 1890 SW Health Parkway, Suite 205, Naples, FL 34109 or by calling (239) 592-1388.

Name of Patient (Please Print) Signature of Patient or Representative Date

Name of Representative (Please Print) Employee Initials



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INSURANCE ADVISORY NOTICE

Please be advised that many insurance companies do not cover annual exams, infertility testing, weight control counseling and screening tests, etc.

Especially for Women participate with many insurance plans, and it is impossible for us to know what type of plan you or your company has purchased. It is your responsibility to know what type of coverage, benefits, deductibles and co-payments you have with your insurance plan.

If your visit is for an exam or screening test that is not covered under your plan, you will be billed directly. We cannot change our coding of visits to accommodate your coverage. Incorrect coding is considered fraud and can result in large fines for our office and yourself.

In the event that an outside collections agency is necessary to enforce payment of the account, the patient agrees to pay for all collection fees deemed reasonable.

By signing this document, I am aware that it is my responsibility to know what type of coverage, benefits, deductibles and co-payments my insurance requires and allows. I am aware that I will be billed directly for uncovered services.

Please sign and date below:

Patient signature _____ Date _____

Witness (For office use) _____ Date _____



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MEDICARE QUESTIONNAIRE

MEDICARE SCREENING SERVICES

Medicare does not cover preventative examination services. However, it does cover some of the screening services that are often provided during a preventative visit. The screening services are discussed below.

COLLECTION OF SCREENING PAP SMEAR SPECIMEN

Medicare reimburses for collection of a screening Pap Smear every two years in most cases. A screening Pap Smear is performed in the absence of an illness, disease, or symptoms. This service is reported using HCPCS code Q0091.

HIGH RISK FACTORS FOR CERVICAL CANCER

- Yes No My onset of sexual activity was under 16 years of age.
- Yes No I have had five or more sexual partners in my lifetime.
- Yes No I have a history of sexually transmitted disease.
(PID, Gonorrhea, Chlamydia, Syphilis, Herpes, Warts HPV, or HIV)

HIGH RISK FACTOR FOR VAGINAL CANCER

- Yes No I had prenatal exposure to DES (Diethylstilbestrol)
DES is a drug that was given to many women during pregnancy for nausea or threatened pregnancy loss.

Patient Signature

Date:



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MEDICARE WAIVER OF LIABILITY

Patient Name _____ **Medicare #** _____

Medicare will only pay for services that it determines to be "Reasonable and Necessary" under Section 1862 (A) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. As your provider, I feel that the service listed below is in your medical interest. I believe that, in your case, Medicare is likely to deny payment for this service for the reason(s) stated below:

- 1) Medicare does not usually pay for this many visits or treatments.
- 2) **Medicare usually does not pay for this service.**
- 3) Medicare usually pays for only one rest home visit per month.
- 4) Medicare usually does not pay for this injection.
- 5) Medicare usually does not pay for this many injections.
- 6) Medicare does not pay for this because it is a treatment that has yet to be proven effective.
- 7) Medicare does not pay for this office visit unless it was needed because of an emergency.
- 8) Medicare usually does not pay for like services by more than one doctor during the same time period.
- 9) Medicare usually does not pay for this many services within this period of time.
- 10) Medicare usually does not pay for more than one visit per day.
- 11) Medicare usually does not pay for such an extensive procedure.
- 12) Medicare usually does not pay for like services by more than one doctor of the same or similar specialty.
- 13) Medicare usually does not pay for this equipment.
- 14) **Medicare usually does not pay for this lab test.**

.....

I have been notified by the provider that, in my case, Medicare is likely to deny payment for the service identified below for the reason(s) stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

There **might** be two portions of your exam that will be covered. Your Pap Smear and Screening exam. Medicare only covers these exams every other year.

_____	New Pt. Exam	Routine	\$250.00	Collect
Date	Service	Reason	Charge	Signature
_____	Est. Pt. Exam	Routine	\$190.00	Collect
Date	Service	Reason	Charge	Signature
_____	Screening Exam Only	Routine	\$ 42.00	
Date	Service	Reason	Charge	Signature
_____	Medicare Initial Exam		\$250.00	
Date	Service	Reason	Charge	Signature
_____	Pap Smear	Routine	\$ 70.00	
Date	Service	Reason	Charge	Signature
_____	Hgb **	Routine	\$ 14.00	
Date	Service	Reason	Charge	Signature
_____	Hemocult**	Routine	\$ 11.00	
Date	Service	Reason	Charge	Signature
_____	Urine **	Routine	\$ 12.00	
Date	Service	Reason	Charge	Signature
_____	Blood Sugar**	Routine	\$ 12.00	
Date	Service	Reason	Charge	Signature

****Medicare will be billed for these items, if they do not cover these items we will bill you.**
 Hgb-\$14.00, Hmct-\$11.00, Urine-\$12.00, Blood Sugar-\$12.00 = Lab Total \$49.00



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Patient Name: _____ **Identification Number:** _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	1) Pelvic Screening Exam (includes breast exam)	2) Screening Pap Test	3) Routine Lab ie: urine screen, hemoglobin, blood sugar	4) Misc Lab ie: cultures, biopsy's, tests, supplies ** Welcome to Medicare visit**
Reason Medicare May Not Pay:	Covered service every 24 months. Your last billed pelvic screening will be determined by Medicare	Covered service every 24 months. Your last billed screening pap test will be determined by Medicare.	Routine labs are never a covered benefit for Medicare.	Not all charges are deemed medically necessary by Medicare guidelines *visit done by other provider
Estimated Cost:	\$42.00	\$70.00	\$12 urine screen \$14 hemoglobin \$12 glucose	*\$250.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

OPTION 1. I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the _____ listed above. I understand with this choice I am **not responsible for payment**, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: _____	Date: _____
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
Form CMS-R-131 (03/08)



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OBSTETRICS | GYNECOLOGY | INFERTILITY | INCONTINENCE
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Date: _____ Patient's Name: _____ Insurance Co: _____

ADVANCED BENEFICIARY NOTICE (ABN)

Note: You need to make a choice about receiving these health care items or services.

Your insurance might not pay for the item(s) or service(s) that are described below. Your insurance might not pay for all of your health care costs. Your insurance only pays for covered items and services when their rules are met. The fact that your insurance may not pay for a particular time or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Your health insurance probably won't pay for-**

Items or Services: Routine annual examination including Pap Smear and Lab work.
Services or Supplies as described:
Because: Some Insurance Companies do NOT cover these services.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you may have to pay for them. Before you make any decision about your options, you should:

- Read this entire notice carefully.
- Ask us to explain, if you don't understand, why your insurance might not pay.
- Ask us how much these items or services will cost you (Estimated Cost: _____); in the case you have to pay for them or through other insurance.

PLEASE CHOOSE ONE OPTION, CHECK THE APPROPRIATE BOX, SIGN & DATE YOUR CHOICE

<input type="checkbox"/> Option 1 - YES I want to receive these item, services or supplies. I understand that my insurance will not decide whether to pay unless I receive these items, services or supplies. Please submit my claim to my insurance. "I understand that you may bill me for items, services or supplies and I may have to pay the charges while my insurance is making its decision." If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.
<input type="checkbox"/> Option 2 - NO I have decided not to receive these items or services. I will not receive these items, services or supplies. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

Date: _____ Patient Signature: _____

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to the insurance, your health information on this form may be shared with your insurance company. They will keep your health information that your insurance company sees confidential.