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: _____ ☐ 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 ☐ Increased Appetite	☐ Heat Intolerance ☐ Decreased Appetite	☐ Cold Intolerance	
Cardiovascular	☐ Chest Pain	☐ Shortness of Breath	☐ Palpitations	
Gastrointestinal	☐ Diarrhea ☐ Vomiting	☐ Constipation ☐ Abdominal Pain	☐ Nausea ☐ Blood in Stool	
Genitourinary	☐ Dysuria ☐ Incontinence	☐ Frequency ☐ Blood in Urine	☐ Urgency	
Musculoskeletal	☐ Muscle Swelling	☐ Muscle Pain	☐ Joint Swelling	☐ Joint Pain
Psychological	☐ Depression ☐ Mood Instability	☐ Crying Spells ☐ 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 ☐ S- Single ☐ M- Married ☐ D-Divorced ☐ X- Separated ☐ W- Widow	Employed ☐ FT ☐ PT ☐ R- Retired ☐ Self ☐ N- None		Student ☐ 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* _____

MC/lh 7/2/18

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 #

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.*

Family history questionnaire

MyRisk®
Hereditary Cancer Test

Personal information

Patient name	Date of birth	Healthcare provider	Today's date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.** For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.

Do you have personal history of:	Yes (Y) / No (N)	Which cancer?	Age at diagnosis?
Breast, ovarian, colon, rectal or pancreatic cancer at any age	☐ Yes ☐ No		
Uterine cancer at 64 or younger	☐ Yes ☐ No		

Do you have family history of:	Yes (Y) / No (N)	Maternal (M) Paternal (P)	Which relative?	Age at diagnosis?
Breast cancer at 50 or younger	☐ Yes ☐ No	☐ M ☐ P		
Two different breast cancers in one relative at any age	☐ Yes ☐ No	☐ M ☐ P		
Three breast cancers in relatives on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Ovarian cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Male breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Triple negative breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Pancreatic cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Colon cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Uterine cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Three colon and/or uterine cancers on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Do you have family history of other cancers?	List them here:			
Have you or anyone in your family had genetic testing for hereditary cancer?	Who?		What gene?	Result?

Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature	Date
Healthcare provider signature	Date

Office use only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No / ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with MyRisk® / ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk®

☐ COLARIS® PLUS with MyRisk® / ☐ COLARIS AP® PLUS with MyRisk® / ☐ Single site testing / ☐ MyRisk® Update Test

☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

Myriad genetics

Myriad Genetics / 320 Wakara Way, Salt Lake City, UT 84108

Cuestionario sobre el historial familiar de cáncer

MyRisk®
Hereditary Cancer Test

Información personal

Nombre del paciente	Fecha de nacimiento	Proveedor de atención médica	Fecha de hoy

Instrucciones: Su historial de cáncer personal y familiar es importante para proporcionarle la mejor atención posible. Por favor complete la siguiente tabla con su información personal y familiar de cáncer. Los siguientes parientes familiares se deben considerar: **padres, hermanos, hermanas, medios-hermanos, medias-hermanas, hijos, hijas, abuelos, nietos, tíos, tías, sobrinos y sobrinas de ambos lados de la familia.** Para los tipos de cáncer que llevan una notación de "pariente de primer grado", solo los padres, hermanos, hermanas, hijos e hijas deben ser considerados.

Tienes antecedentes personales de:	¿Sí (S) o No (N)?	¿Cuál cáncer?	¿Edad cuando recibió el diagnóstico?
Cáncer de mama, de ovario, de colon, de recto, o de páncreas diagnosticado a cualquier edad	☐ S ☐ N		
Cáncer de útero a los 64 años de edad o antes	☐ S ☐ N		

Tienes antecedentes familiares de:	¿Sí (S) o No (N)?	¿Cuál pariente?	¿Cuál pariente?	¿Edad cuando recibió el diagnóstico?
Cáncer de mama antes de o a la edad de 50	☐ S ☐ N	☐ M ☐ P		
Dos diagnósticos diferentes de cáncer de mama a cualquier edad en un pariente	☐ S ☐ N	☐ M ☐ P		
Tres casos de cáncer de mama a cualquier edad en parientes del mismo lado de la familia	☐ S ☐ N	☐ M ☐ P		
Cáncer de ovario a cualquier edad	☐ S ☐ N	☐ M ☐ P		
Hombre con cáncer de mama a cualquier edad	☐ S ☐ N	☐ M ☐ P		
Cáncer de mama triple negativo a cualquier edad	☐ S ☐ N	☐ M ☐ P		
Ascendencia judía askenazí con cáncer de mama a cualquier edad	☐ S ☐ N	☐ M ☐ P		
Cáncer de páncreas a cualquier edad (pariente de primer grado)	☐ S ☐ N	☐ M ☐ P		
Cáncer de próstata metastásico o de alto riesgo a cualquier edad (pariente de primer grado)	☐ S ☐ N	☐ M ☐ P		
Cáncer de colon antes de o a la edad de 49 (pariente de primer grado)	☐ S ☐ N	☐ M ☐ P		
Cáncer de útero (matriz) antes de o a la edad de 49 (pariente de primer grado)	☐ S ☐ N	☐ M ☐ P		
Tres casos de cáncer de colon y/o cáncer de útero (matriz) a cualquier edad en parientes del mismo lado de la familia	☐ S ☐ N	☐ M ☐ P		
¿Tienes antecedentes familiares de otros tipos de cáncer?	Escriba los otros tipos de cáncer aquí:			
¿Usted o alguien de su familia se ha realizado pruebas genéticas sobre el cáncer hereditario?	¿Quién?	¿Qué gen o genes?	¿Cuál fue el resultado?	

Revisión de la evaluación del riesgo de cáncer (para completar después de la discusión con su proveedor de atención médica)

Firma del paciente	Fecha
Firma del proveedor de atención médica	Fecha

Office use only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No / ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with MyRisk® / ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk®

☐ COLARIS® PLUS with MyRisk® / ☐ COLARIS AP® PLUS with MyRisk® / ☐ Single site testing / ☐ MyRisk® Update Test

☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

Myriad genetics

Myriad Genetics / 320 Wakara Way, Salt Lake City, UT 84108

Name_____ DOB_____ Date _____

Menopause Rating Scale

Which of the following symptoms apply to you at this time?

	None	mild	moderate	severe	extremely severe	how long?
1. Hot flashes Times per day? _____	☐	☐	☐	☐	☐	_____
2. Night sweats Times per night? _____	☐	☐	☐	☐	☐	_____
3. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐	_____
4. Sleep problems (difficulty falling asleep, difficulty sleeping through the night, waking up early)	☐	☐	☐	☐	☐	_____
5. Depressive mood	☐	☐	☐	☐	☐	_____
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐	_____
6. Mood swings	☐	☐	☐	☐	☐	_____
7. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐	_____
8. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐	_____
9. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐	_____
10. Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐	_____
11. Vaginal dryness or burning, difficulty with sexual intercourse)	☐	☐	☐	☐	☐	_____
12. Joint and muscular discomfort	☐	☐	☐	☐	☐	_____
13. Weight Gain How much? _____	☐	☐	☐	☐	☐	

Are you currently using hormone replacement therapy? ___Yes ___No Used in the past? ___Yes ___No

If yes, what type (cream, pellet, patch, ring, etc) and for how long? _____

_____

Physician notes: _____

_____

MC/as 8/7/12

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