# The Whole Woman, PLLC

Amy M. Bruton, MD

## Male New Patient Information Form

Name: _____ Age: _____ DOB: _____ DOS: _____

Referring Physician: _____ Primary care physician: _____

Trying to conceive? No ☐ Yes ☐ If so how long? _____ (years and months)
Date last PSA: _____ Result: _____
Date last colonoscopy: _____ Result: _____ Recommended f/u: _____ (years)
Date last bone density: _____ Result: _____

Social History:

Alcohol use: yes no type: _____ #/day: _____ #/week: _____
Caffeine use: yes no type: _____ #/day: _____ #/week: _____
Tobacco use: yes no type: _____ #/day: _____
Recreational drug use ever: yes no type: _____
Recreational drug use current: yes no type: _____ how often: _____
Regular exercise: yes no type: _____ days/week: _____
Occupation: _____

Marital status: M S W D (circle all that apply) Years together: _____
Partner's name: _____ Age: _____ Occupation: _____

General Symptoms: (circle if current problem)

| | | | |
|---|---|---|---|
| Weight gain >10 lbs | Vision problems | Fatigue | Depression |
| Weight loss > 10 lbs | Diarrhea | Clumsiness | Food cravings |
| Nausea/Vomiting | Allergies | Constipation | Food intolerance |
| Bowel cramping | Acid reflux | Low sugar | Dry eyes |
| Memory problems | Brittle nails | Dry hair | Hair loss |
| Numbness hands/feet | Headache | Joint pain | Muscle pain/ache |
| Heat intolerance | Mouth sores | Tongue sores | Dry skin |
| Cold intolerance | Easy bruising | Insomnia | Cough/breathing problems |
| Blood in stool | Dizziness | Fainting | Easy bleeding |
| Intestinal cramping | Palpitations | Excessive thirst | Chest pain |

Other: _____

Name: DOB: DOS:

Medical History:

Eyes:_____ Nose:_____
Ears:_____ Thyroid:_____
Neurologic:_____ Heart:_____
Lungs:_____ Skin:_____
Gastrointestinal:_____ Blood:_____
Liver:_____ Kidney:_____
Bladder:_____ Mental:_____
Autoimmune:_____ Infections:_____
Cancer:_____ Diabetes (type and years):_____

Other:_____

Surgical History (include surgery, date, and where performed): _____

_____

_____

Family History (include chronic illness, cancer, genetic disorder, bleeding/clotting disorder, pregnancy/gyn problems, etc.):

Maternal grandmother: _____ Maternal grandfather:_____

Paternal grandmother:_____ Paternal grandfather:_____

Mother:_____ Father:_____

Sisters:_____

Brothers:_____

Children:_____

Aunts:_____

Uncles:_____

Ancestral Background: (certain illness and genetic disorders are more common in particular ancestral backgrounds):

☐ African ☐ French Canadian ☐ Latin American ☐ Ashkenazi Jewish
☐ Mediterranean ☐ Native American ☐ Caribbean ☐ Sephardic Jewish
☐ Asian ☐ Indian ☐ Other:_____

Do you use natural family planning: yes no type:_____

Name: DOB: DOS:

Current Medications (include prescription, over-the-counter, vitamins, and supplements):

| Medication | Dose/Frequency | Reason for using |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Allergies (include medication and reaction):

# The Whole Woman, PLLC

**FINANCIAL POLICY**

**APPOINTMENTS**

The keeping of regular appointments is crucial to successful therapy. As schedule permits, we will work out a convenient time for you for these appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you.

***PLEASE INITIAL EACH ONE*** ***(Do not check off)***

_____ **Our policy is to charge for missed appointments or appointments canceled with less than 24 business hours notice of the reserved appointment. You will be billed $150 directly for this time.**

**PAYMENT OF FEES**

_____ **The Whole Woman does not participate with any insurance plan nor do we file on your behalf.** We will provide you with all necessary paperwork to assist you in filing with your insurance company. Payment to The Whole Woman is to be made in full at the time of service. We accept cash, check, and credit cards. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a $25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. This process includes the addition of a thirty-three and one-third (33 1/3) percent attorney fee to your unpaid balance. Service may be interrupted until payment is made.

_____ **I have received a copy of the basic fee schedule.**
Our fee schedule is also available on our website, *thewholewomannc.com*

_____ **I am not a Medicare or Medicaid patient.**
By signing this, you are informing our office that you are not a Medicare or Medicaid patient. If you are a Medicare or Medicaid patient, please inform our front desk staff.

**REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS**

_____ **Any reports or professional consultations involving time beyond that of the regular appointment will be billed at a prorated charge for the professional time involved.**

_____**We will charge for telephone, email and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate.**

**READ CAREFULLY AND SIGN**

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

_____ _____

Signature of Patient / Responsible Party Date

*7509 Six Forks Road * Suite 101 * Raleigh, North Carolina 27615*
*Tel: 919-900-7222 * Fax: 919-900-8864*

The Whole Woman, PLLC
Amy M Bruton, MD

## Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Printed name of patient_____

Patient's representative & relationship _____

## Receiving health information

Please be made fully aware that **a cell phone or a computer** is **not a secure and private line**. If you choose to communicate with The Whole Woman, PLLC (henceforth TWW) or any of their providers or staff by such means you agree to hold harmless TWW and their providers and staff. You further agree to allow the providers and staff of TWW to contact you via cell phone or computer. And you agree to receive confidential detailed messages on your telephone voicemail.

## Cancellation Policy

We ask for a 48-hour notice and **require a 24-hour notice (at least 1 business day)** for appointment cancellation. We understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies outside of your control (i.e. life happens). If you are unable to keep your appointment, please notify us as soon as possible. If this happens after hours leave a message with the answering service, as email, at this time, is not checked frequently. **Do Not** cancel your appointment through the portal.

## Missed Appointment / No Show Policy

1st no show/ late cancellation = $150.00 fee

2nd no show/ late cancellation = $150.00 fee and possible dismissal from the practice.

## Arrival for Appointments

Please arrive 5 to 10 minutes prior to your appointment time to ensure punctual treatment. Please take the time to print and fill out paperwork from the website and have it with you when you arrive. Our office, in turn, will do our best to minimize your wait time. We do not double book appointments. We strive to take appropriate time with each patient, those who are late or are unprepared may have a shortened appointment so the next patient will not be inconvenienced.

I have read, understand and agree to hold harmless TWW, and abide by the above policies.

Signature_____ Date _____/_____/_____

For Office Use Only:
I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to for the following reason:

__Language Barrier __Read later and return __Patient objects
__Patient cannot read __Unable to sign __Other_____

# *The Whole Woman, PLLC*

Amy M. Bruton, MD

Patient Information Sheet

Name_____
First Middle Last preferred

Phone Home_____ Cell_____ Work_____
*please indicate preferred number

Email address_____

Address_____ City_____ State_____ Zip_____

Month/Day/Year of birth____/ ____/ ____ Profession_____

Employment Status: Full-Time/Part-Time/Unemployed/Student Employer_____

Marital Status: Single/Married/Divorced/Widowed/Separated Spouse/Partner_____

Parent/Gaurdian (for minors/disabled)_____ Phone_____

Emergency Contact_____ Phone_____

Contacts relationship to patient_____

Primary Care_____ Referring Physician_____

How did you learn about us? _____

## Pharmacy Preference

Pharmacy Name_____ Phone_____

Compounding Pharmacy_____ Phone_____

**Next page**

**Insurance** (in case needed for prior authorization or for other testing covered by plan)

Primary Insurance

Name of insurance _____ Employer_____

Name of insured_____ Insured's date of birth _____/_____/_____

Relationship to patient Self/Spouse/Parent

Secondary Insurance

Name of company_____ Employer_____

Name of insured_____ Insured's date of birth _____/_____/_____

Relationship to patient Self/Spouse/Parent

## Patient Consent

The Whole Woman, PLLC (hence forth TWW) will only use your health care information for the following reasons:

Treatment: TWW will use your health care information to make decisions about the provision, coordination or management of your healthcare, including but not limited to, analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. By signing this you acknowledge that you understand that treatment for any and or all of your conditions will be based upon the information which you provide. You are accepting full responsibility should you provide inaccurate, incomplete, or misleading information. You hereby certify that the identifying information, address, and telephone information provided are correct and agree to inform TWW and it's staff if and when such information changes or becomes outdated. You agree that TWW and staff cannot contact you if you have provided incorrect or illegible information or fail to keep your information up to date and correct. You agree to hold harmless TWW for any lack of communication due to any of the above.

Payment: TWW may need to use or disclose information in our health care record to obtain reimbursement from you. We may also need to disclose information to obtain precertification, preauthorization of services, or reimbursement of non-TWW services. This information may also be used for collection purposes and related healthcare data processing through our system.

Operations: Your health care records may be used in our business planning and development operation, including but not limited to, improvements in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

I do hereby agree to allow my health care information to be used for the purpose of treatment, payment, and operations as outlined above.

_____ _____/_____/_____

Patient Signature Date

# HEREDITARY CANCER RISK ASSESSMENT

**Patient Name:** _____ **Today's Date:** _____

**Your Physician:** _____ **Date of Birth:** _____

**INSTRUCTIONS:** Please circle YES (Y) to any statement below if it applies to YOU or YOUR FAMILY MEMBERS.
Next to each statement, please list the AGE of the person when they were DIAGNOSED with cancer and your relation.
**1st Degree Relatives** = Mother / Father / Sister / Brother / Children
**2nd Degree Relatives** = Aunt / Uncle / Grandparent / Niece / Nephew
**AND 3rd Degree Relatives** = Great Grandparents / 1st Cousins

**1. Have YOU had Genetic Testing for Hereditary Cancer, Previously (BRCA/MyRisk)?**

| | |
|---|---|
| □ **YES** | Approximate year you were tested _____ **Result:** □ Positive □ Negative □ Unknown |
| □ **No** | Proceed to Section 2 - Cancer Family History |

| 2. Yes/No | | CANCER FAMILY HISTORY | YOU SIBLINGS CHILDREN | MOTHER'S SIDE | FATHER'S SIDE | Age at Diagnosis |
|---|---|---|---|---|---|---|
| Y | N | Have **YOU** ever had **Breast Cancer** at any age | | | | |
| Y | N | **Ovarian Cancer** in your family at any age | | | | |
| Y | N | **Breast Cancer** in your family **before age 50** | | | | |
| Y | N | **Bilateral Breast Cancer** in your family at any age | | | | |
| Y | N | **THREE OR MORE** relatives on one side of your famiy with **Breast or Prostate Cancer** at any age | | | | |
| Y | N | **Male Breast Cancer** in your family at any age | | | | |
| Y | N | **Pancreatic Cancer** in your family at any age | | | | |
| Y | N | **Ashkenazi Jewish Ancesetry** with **Breast or Pancreatic Cancer** in your family at any age | | | | |
| Y | N | **Colon Cancer** in your family **before age 50** | | | | |
| Y | N | **Uterine Or Endometrial Cancer** in your family **before age 50** | | | | |
| Y | N | **THREE OR MORE** relatives on one side of your family with **Colon/Rectal, Uterine/Endometrial, or Gastric/Stomach Cancer** at any age | | | | |
| Y | N | Have **YOU** ever had **Uterine or Endometrial Cancer** | | | | |

**FOR OFFICE USE ONLY:**
Did Patient meet criteria for Genetic Education? □ **YES** □ **NO** □ **MORE INFORMATION NEEDED**
If Yes, Patient chose to: □ **ACCEPT** □ **DECLINE High Risk Education:** Reason: _____
If ACCEPTED, Patient: □ **SUBMITTED myRisk** □ **DECLINED Testing:** Reason: _____

PATIENT SIGNATURE: _____ Date: _____

PROVIDER SIGNATURE: _____