Lona Sasser, D.O.

Mary-Beatrice Squire, M.D.

Lona Sasser, D.O. LLC

Patient Demographic Form

Patient Name: _____ Date of Birth: _____

SS# _____

Address _____

Apt. # _____

City _____ State____ Zip _____

Home # _____ Cell # _____

Language Spoken _____

Marital Status: S M W D Race: B W H O_____

Policy Holder _____

Address _____

Apt. # _____

City _____ State ____ Zip _____

Tel # _____

Relationship _____

Referred by: _____

E-mail for access to the online patient portal

Primary Care Physician _____

Employer _____

Phone _____

Pharmacy _____

Address _____

Phone _____

In case of emergency, notify:

_____ Phone _____

Nearest friend or relative not living with you:

_____ Phone _____

Medical Insurance:

Primary _____

Insured _____D.O.B._____

ID# _____

Group# _____

Medicare # _____

Secondary _____

Insured _____

ID# _____

Group# _____

Assignment of benefits to facilitate the processing of claims - I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Lona Sasser, D.O. LLC. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignor to release all information necessary to secure the payment. Payments MUST be made at the time of each visit, unless prior payment arrangements have been made. A surcharge of 35% will be added to any accounts sent to our collections department.

Consent to Treat – I hereby authorize Lona Sasser, D.O., LLC staff including physicians and medical assistants to render medical care including a medically indicated exam but not limited to a pelvic exam, to fulfill the orders of the physicians, including consultants, and associates.

I have read and understand the above.

Signed: _____ Date: _____

LONA SASSER D.O., LLC

Dr. Lona Sasser D.O. and Dr. Mary-Beatrice Squire MD

FINANCIAL POLICY

Thank you for choosing our practice. We want to make every experience you have with us a positive one. Over the past few years, the practice of medicine has become more complicated for our physicians and patients alike, due to managed care rules and regulations. Because of the growing complexity of the insurance business, we would like to help clarify the relationship between the insurance company, the doctor, and the patient. In an effort to better assist you, we have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the insurance office staff. You will be asked to sign at the end of this form.

UNINSURED PATIENTS If you do not have current health insurance coverage, our policy is to collect payment at the time of service.

CO-PAYMENTS, DEDUCTIBLES, AND CO-INSURANCE A copayment is a set dollar amount you owe for each office visit. Some insurance plans are subject to a deductible and co-insurance. You will be asked to pay your co-payment, deductible, and co-insurance amount at the time of service if your deductible has not been met. We will verify if your deductible has been met with your insurance company prior to your visit. Co-insurance is the amount required by some insurance plans over and above the deductible amount. Our office verifies each patient's financial responsibility with their insurance company but can not guarantee final financial responsibility until claims have been submitted and finalized by the insurance company. ***If your appointment is for a well woman visit but you report a problem that needs to be treated by a physician than your visit may not be covered at 100% and you may receive a bill for a co-pay or deductible.***

LABORATORY AND HOSPITAL FEES Many times it is necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (blood work, culture, etc) is done in our office, the actual test is usually carried out by someone else. This means that you will receive a separate bill from the lab. If you have a question about a bill you receive from a lab, hospital, or outpatient center, please contact them directly to resolve any billing concerns. Please note that *if you have a deductible the hospital or surgical center will require payment of this before the procedure.* Our office is separate from these facilities and we ask that you please contact the hospital or surgical center directly with any billing issues or questions.

OBSTETRICAL PATIENTS- Individual payment plans will be set up for each patient based upon your insurance coverage. Our office policy is to collect all payments by the beginning of the 7th month of pregnancy.

FORMS OF PAYMENT For your convenience, we accept cash, personal checks, MasterCard, Visa, Discover, and American Express. We also offer our patients the option of applying for CareCredit if needed.

ESTIMATION OF SERVICES We will be happy to give you an estimate of fees when this is possible. Please remember that we can only assure you of the exact cost of a procedure on the day of service when the doctor has determined the actual code being used. The estimate of our charges will not include work done by an outside lab or pathology service.

COLLECTION EFFORTS We will make every effort to work with you to make payment arrangements should your bill become outstanding. If all efforts do not bring about a resolution of the account after several attempts, the account balance will be turned over to collections. RETURNED CHECKS- All returned checks will results in a $40 NSF fee which will be applied to your account.

I have read and understand the above completely and agree to comply with the financial policies of this office. My signature authorizes this office to file my claims and assigns to this office all rights, title, and interest to my medical reimbursement benefits under my insurance policy. I understand that my signature also allows this office to release information regarding my visits to my insurance carrier. I understand that I am responsible for my bills in the event the insurance company denies any claims.

_____ _____

Signature of patient (or parent, if patient is a minor) Date

Lona Sasser D.O., LLC
Obstetrics & Gynecology

Lona Sasser D.O., LLC
3111 N. University Drive, Ste. 308
Coral Springs, FL 33065
Tel: (954) 340-1050
Fax: (954) 340-5275
Lona Sasser, D.O.
Mary-Beatrice Squire, M.D.

Name _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism	☐ Back Problems	☐ Ear Problems	☐ Hepatitis - A, B, or C	☐ Measles	☐ Skin Disorder
☐ Allergies	☐ Bleeding Disorder	☐ Eating Disorder	☐ High Blood Pressure	☐ Migraines	☐ Stomach Ulcer
☐ Anemia	☐ Blood Disease	☐ Epilepsy	☐ High Cholesterol	☐ Osteoporosis	☐ Substance Abuse
☐ Anxiety Disorder	☐ Blood Transfusion	☐ Glaucoma	☐ Joint Disorder	☐ Pneumonia	☐ Thyroid Disorder
☐ Arthritis	☐ Cancer	☐ Gout	☐ Kidney Disorder	☐ Polio	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Liver Disorder	☐ Rheumatic Fever	☐ Venereal Disease
☐ AIDS / HIV	☐ Depression	☐ Heart Problems	☐ Lung Disease	☐ Stroke	

Hospitalizations & Surgeries

Reason	Date

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism	☐ Cancer	☐ Joint Disorder
☐ Allergies	☐ Depression	☐ Kidney Disease
☐ Alzheimer's	☐ Diabetes	☐ Liver Disorder
☐ Anemia	☐ Epilepsy	☐ Lung Disease
☐ Anxiety	☐ Genetic Disorder	☐ Migraines
☐ Arthritis	☐ Glaucoma	☐ Psychiatric Disorders
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ AIDS / HIV	☐ Hepatitis	☐ Stroke
☐ Bleeding Disorder	☐ High Cholesterol	☐ Substance Abuse
☐ Blood Disorder	☐ High Blood Pressure	☐ Thyroid Disorder

Details:

Is your mother alive? Yes ____ Current Age ____

No ____ Age at death ____

If your father alive? Yes ____ Current Age ____

No Age at death

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year ____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years ____ # packs / day ____

Do you smoke now?

☐ Yes ☐ No # packs / day ____

Do you use recreational drugs?

☐ Yes ☐ No types? ____ # times / week ____

How much alcohol do you drink per week?

drinks / week ____

How much caffeine do you drink per day?

drinks / day ____

How often do you exercise?

times / week ____

OBGYN History

Have you ever had or do you currently have any of the following?

- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Breast Surgery
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Colposcopy
- ☐ Cryosurgery
- ☐ DES Exposure
- ☐ Extreme Menstrual Pain
- ☐ Fibroids
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Hot Flashes
- ☐ HPV
- ☐ Infertility
- ☐ Irregular Periods / Bleeding
- ☐ Nipple Discharge
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer
- ☐ Painful Intercourse
- ☐ Pelvic Inflammatory Disease
- ☐ Uterine Cancer
- ☐ Urinary Incontinence
- ☐ Yeast Infections - Frequent

Pregnancy History

Please describe any pregnancies you have had.

# of Pregnancies	# of Full Term	# of Miscarriages	# of Abortions

Were there any complications associated with any of your pregnancies?

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Are you currently pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No

Do you need birth control or contraceptive advice?

☐ Yes ☐ No

What method of birth control do you use?

Menstrual History

When was the first day of your last period?

How often does your period occur?

How long does your period last?

Is your period regular?

☐ Yes ☐ No

What age were you when you had your first period?

What age were you at menopause?

Health Exams & Procedures

Please check and date all you have had.

	Month & Year	Results
☐ Blood Sugar - Fasting		
☐ Breast Self Exam		
☐ Cholesterol Test		
☐ Colonoscopy		
☐ CT / CAT Scan		
☐ Dexascan (Bone Density)		
☐ EKG		
☐ Echocardiogram		
☐ Fecal Occult Blood Test		
☐ Mammogram		
☐ MRI		
☐ Pap Smear		
☐ Physical Exam		
☐ Cardiac Stress Test		
☐ Ultrasound		

Pharmacy Name _____ **Phone number** _____ **City** _____

Mary-Beatrice Squire, M.D. Lona Sasser, D.O. Jose Berthe, M.D.

3111 N. University Drive, Suite 308
Coral Springs, FL 33065
(954) 340-1050

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have the right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand my request that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations must be in writing. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement to this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

PLEASE FILL OUT BOTH SIDES OF THE PAPER→

Mary-Beatrice Squire, M.D. Lona Sasser, D.O. Jose Berthe, M.D.

Lona Sasser, D.O. LLC

Patients' rights of disclosures: In general, HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of the health information be made by alternative means.

I, _____, wish to be contacted in the following manner:

Home:

☐ Ok to leave a detailed message

☐ Leave a message with callback number only

Cell Phone:

☐ Ok to leave a detailed message

☐ Leave a message with callback number only

Work:

☐ Ok to leave a detailed message

☐ Leave a message with callback number only

Written communication:

☐ Ok to mail to home

☐ Ok to fax to home fax # _____

☐ Ok to fax to work fax # _____

List all persons in your household who, in your absence, may make requests on your behalf; and with whom we may speak to regarding your medical information.

Name **Relationship**

_____

_____

_____

_____

Patient Signature: _____ **Date**: _____

PLEASE FILL OUT BOTH SIDES OF THE PAPER→

Cancer Family History Questionnaire

Personal Information

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

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

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, indicate 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, nephews, and half-siblings.

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	☒ Y ○ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	○ Y ○ N				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○ Y ○ N				
2 or more people on the same side of my family (can include me) with **breast cancer**, one at age 50 or younger	○ Y ○ N				
Ovarian (peritoneal/fallopian tube) cancer at any age	○ Y ○ N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	○ Y ○ N				
3 or more of these cancers on same side of my family at any age: **pancreatic, breast,** or **aggressive prostate*** *Gleason Score ≥7	○ Y ○ N				
Male **breast cancer** at any age	○ Y ○ N				
Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age	○ Y ○ N				
Pancreatic cancer or aggressive prostate cancer and one relative with **breast cancer at age 50 or younger**	○ Y ○ N				
20 or more **colon/rectal polyps** found in 1 person throughout their lifetime. Specify number_____	○ Y ○ N				
Colon/rectal or **Endometrial (uterine) cancer** before age 50	○ Y ○ N				
Personal history of **Endometrial (uterine) cancer** at any age‡	○ Y ○ N				
TWO individuals on the same side of my family (can include me): at least 1 with **colon/rectal *or* endometrial (uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	○ Y ○ N				
THREE OR MORE individuals on the same side of my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a colon/rectal or **endometrial (uterine) cancer**	○ Y ○ N				

‡ $PREMM_{(1,2,6)}$ Score ≥ 5%
* Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).

Have you or a family member had genetic testing for a **hereditary cancer syndrome?**	○ Y ○ N	If yes, Who?_____ What gene(s)?_____ What was the result? _____

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

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only

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

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

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

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