NEW PATIENT INTAKE FORM **NAME: _____**

Reason for Your Visit: _____ **Date of Birth: _____**

Email: _____ **Social Security #: _____**

Emergency Contact/Relationship: _____ **Emergency Contact #: _____**

Local Pharmacy: _____ **Primary Care Physician: _____**

Drug Allergies: _____

CHRONIC MEDICAL PROBLEMS	PAST SURGICAL HISTORY	DATE	PERSONAL/FAMILY HISTORY Family Member/Self
			Bladder Cancer Y/N
			Breast Cancer Y/N
			Heart Attack Y/N
			Gynecologic Cancer Y/N
			Colon Cancer Y/N
			Diabetes Y/N
			Glaucoma Y/N
			High Blood Pressure Y/N
			Thyroid Disease Y/N
			Other Y/N

CURRENT MEDICATIONS/DOSE	CURRENT MEDICATIONS/DOSE

RISK ASSESSMENT/SOCIAL HISTORY

ALCOHOL? YES/NO HOW OFTEN? _____

TOBACCO? YES/NO NEVER/FORMER/CURRENT

PACKS PER DAY? _____ YEARS? _____

VAPING? YES/NO YEARS? _____

ILLICIT DRUG USE? YES/NO HOW OFTEN? _____

CAFFIENE INTAKE? YES/NO HOW MANY OZ? _____

DEPRESSION/ANXIETY? YES/NO

HISTORY OF SEXUALLY TREASMITTED DISEASE? YES/NO

CURRENT OR HISTORY OF DOMESTIC VIOLENCE? YES/NO

OF PREGNANCIES? _____ # OF BIRTHS? _____

of Cesarean? _____ # of Vaginal Births? _____

MARITAL STATUS: Married/Single/Divorced/Widow

OCCUPATION: _____

EDUCATION: Jr High/High School/College/other

REGLIGIOUS PREFERENCE: _____

ADVANCED DIRECTIVE/LIVING WILL? YES/NO

HEALTHCARE POWER OF ATTORNEY? YES/NO

IF Yes, NAME OF POA? _____

PATIENT SIGNATURE: _____ **DATE: _____**

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security #: _____

I, above named patient, authorize the following using or disclosing party:

Provider/Practice:

Provider Phone: _____ **Provider Fax: _____**

To use or disclose the following health information (checked below):

_____ All of my health information

_____ Most Recent Office notes or office notes related to a specific date_____

_____ Radiology Records

_____ Lab Results/Urine Cultures

_____Operative notes

The above-named party may disclose this health information to the following recipient:

Cooke's Continence Center and Urogynecology

Shannon Cooke, WHNP-BC

330-C Pelham Road Suite B Greenville, SC 29615

Phone: 864-412-8424 **Fax: 864-412-8012**

This authorization does not have an end date however I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance payment. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPPA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing this authorization and that I may have the right to refuse to sign this authorization.

A copy of this authorization was offered to me and is as valid as the original.

Signature of Patient: _____ **Date:** _____

CANCELLATION/NO SHOW POLICY

COOKE'S CONTINENCE CENTER

Thank you for trusting your medical care to Cooke's Continence Center. When you schedule an appointment with Shannon Cooke, we set aside individualized time to provide you with the highest quality care. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Should you need to cancel or reschedule an appointment, please contact our office at 864-412-8424 as soon as possible and NO LATER than 24 hours prior to your scheduled appointment. Of note, a 48 hour notice of cancellation is needed for testing. This policy gives us time to reschedule other patients who may be waiting for an appointment. Please see our Cancellation/No Show policy below:

- Established patients who fail to show to their appointment or cancel an appointment without a 24 hour notice, will be charged a $25.00 fee that must be paid prior to rescheduling an appointment.
- If a second No Show or Cancellation of an appointment occurs without a 24hour notice, it will be at Cooke's Continence Center's discretion to dismiss the patient from the practice.
- New Patients who fail to cancel without a 24hour notice or no shows for a new patient appointment, will be charged $50.00. This fee will need to be paid prior to rescheduling the new patient appointment.
- If a patient is more than 10 minutes late for the scheduled appointment, the appointment will be rescheduled and a $25.00 late show for the appointment will be charged.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy remains in effect. It is ultimately YOUR responsibility to manage your appointments and healthcare.

The above fees are charged to the patient and **NOT** covered by insurance companies.

I have read and understand Cooke's Continence Center's policy for appointment cancellations, no show appointments and late show appointments and agree to the above terms.

Patient Signature _____ Date _____

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COOKE'S CONTINENCE CENTER

Financial Policy

In effort to hold costs down, your payment/balance/co-pay is due when services are rendered.

As a courtesy to our patients who have insurance coverage, we will be happy to file your claim electronically. Your deductible and copayment are due at the time of service. The patient is ultimately responsible for all remaining balances for care provided.

Claims to secondary insurance carriers are also filed for patients as a courtesy. The remaining balance after the primary carrier's payment is the patient's responsibility if the secondary insurance does not make a full payment of the balance.

Patients without insurance coverage are responsible for payment for services rendered prior to office visit or treatments. Self pay amounts are available to those patients who inquire.

Cooke's Continence Center is not a Medicaid provider. It is the patient's responsibility to notify Cooke's Continence Center upfront if Medicaid is part of your insurance plan(s). Therefore, if you haveany sort of Medicare-Medicaidcommercial plan or a Medicaid secondary plan, the patient will be responsible as a self pay patient and/or will be responsible for any remaining balance which is not covered by Medicaid as Medicaid will NOT be billed by Cooke's Continence Center.

I acknowledge that I am responsible for a $25.00 fee for no show appointments or late cancellation appointments (less than 24hour notice) that will be my responsibility to pay. This fee will NOT be billed to my insurance company. This policy does not include the late cancellation fee or no show fee ($150) specific for Urodynamic testing, which is in a separate agreement.

Bymy signature below I acknowledge receipt of the Financial Agreement for Cooke's Continence Center.

Consent to Assess and Treat

I understand that I am receiving care at Cooke's Continence Center from Shannon Cooke, Women's Health Nurse Practitioner and staff. As the patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after know the risks involved. This consent form is to simply obtain your permission to perform the necessary evaluation necessary to indentify the appropriate treatment and/or procedure for any identified condition(s). I am aware that Cooke's Continence Center does not provide emergency care outside of posted office hours. Therefore, I am aware that outside of office hours, I will need to seek alternative emergency care.

By my signature below I acknowledge receipt of the Consent to Treat for Cooke's Continence Center.

HIPAA

I have been provided the appropriate information regarding HIPPA Compliance and Protected Health Information (PHI). Protected Health Information may be disclosed or used for treatment, payment or health care operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

By my signature below I acknowledge the receipt of the HIPPA/PHI Information at Cooke's Continence Center

_____ _____

Patient or Legally Authorized Individual Signature **Date**

_____

Printed Name