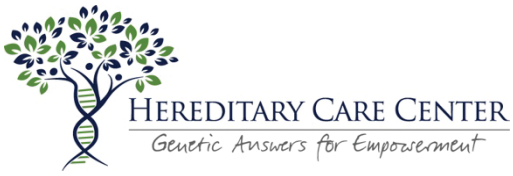

Date: ____/____/_____

Name: _____ **Date of Birth:** ____/____/_____
(first) (middle/maiden) (last)

Address: _____
Street City State Zip

Gender: Male/ Female **Marital Status:** ☐M ☐S ☐W ☐D **Spouse's Name:** _____

E-Mail Address:_____

Home Phone: _____ **Work Phone:**_____ **Cell Phone:** _____

Preferred Contact Method: ☐Home ☐Work ☐Cell Phone

May we leave detailed messages on your voicemail? ☐No ☐Yes: ☐Home ☐Work ☐Cell Phone (check all applicable)

Emergency Contact: Name:_____ Relationship: _____

Phone: _____

Occupation: _____ **Employer:** _____

Employer's Address: _____

Who is your primary care physician: _____ _____
Name Phone

Person Responsible for Payment (If different from patient → ☐Parent ☐Spouse ☐Other):

Name: _____ Home Phone: _____

Address:_____
Street City State Zip

Employer: _____Work Phone: _____

Address: _____
Street City State Zip

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Group #_____ Policy # _____

Copay amount: $_____ Primary Policy Holder:_____ Policy Holder's Birthdate:_____

Relationship to Patient:_____

Secondary Insurance Carrier_____ Group #_____ Policy #_____

Primary Policy Holder: _____ Policy Holder's Birthdate:_____

Relationship to Patient:_____

_____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

AUTHORIZATION TO RELEASE INSURANCE INFORMATION AND TO PAY BENEFITS TO HEREDITARY CARE CENTER: I hereby authorize HEREDITARY CARE CENTER to release any information acquired in the course of my consultation to insurance carriers, third party payors, or others involved in the processing or collection of claims. I hereby assign payment directly to HEREDITARY CARE CENTER for any services performed. This authorization is valid until rescinded in writing or replaced by one of a later date.

SIGNATURE: _____ DATE: _____

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NAME:		AGE:		DATE:	
How did you hear about us?					
Physician or caregiver who referred you?					

PAST MEDICAL HISTORY

Have you ever been diagnosed with colon polyps? ☐NO ☐YES (How many?) _____

Have you ever had cancer? ☐NO ☐YES (What type of cancer?) _____

Have you ever been diagnosed with a precancerous condition? ☐NO ☐YES (please explain)

Race: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black or African American ☐White

☐Hispanic/Latino ☐Non-Hispanic/Latino ☐More than 1 race

ANCESTRY

☐ Western/Northern Europe	☐ Central/Eastern Europe	☐ Near East/ Middle East
☐ Ashkenazi	☐ Africa	☐ Native American
☐ Latin America/Caribbean	☐ Asia	☐ Other

PAST SURGICAL HISTORY (Please include tubal ligation, breast biopsies)

DATE	SURGERY	REASON

SOCIAL HISTORY

Do you smoke? ☐ NO If No, did you smoke in the past? _____ If yes, for how long? _____
When did you quit? _____

☐ YES How much and for how long? _____

Do you drink alcohol? ☐NO ☐YES If Yes, how many drinks per day? _____

Do you exercise regularly? ☐NO ☐YES If yes, how many days per week and how many minutes? _____

HORMONE HISTORY (for women only)

Age of first menstrual period? _____years old

Age at the time of your first live birth? _____ years old or ☐ NA

Age at time of last menstrual period (onset of menopause)? _____ years old

Did you ever use oral contraceptive pills? ☐NO ☐YES If yes, for how many years? _____

If menopausal, did you ever use hormone replacement therapy? ☐NO ☐YES If yes, for how many years? _____

If YES, did you use ☐estrogen only or ☐both estrogen and a progestin (combined)?

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
AND 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
☐	☐	Have **YOU** ever had **Breast Cancer** at any age				
☐	☐	**Ovarian Cancer** in your family at any age				
☐	☐	**Breast Cancer** in your family **before age 50**				
☐	☐	**Bilateral Breast Cancer** in your family at any age				
☐	☐	**THREE OR MORE** relatives on one side of your family with **Breast or Prostate Cancer** at any age				
☐	☐	**Male Breast Cancer** in your family at any age				
☐	☐	**Pancreatic Cancer** in your family at any age				
☐	☐	**Ashkenazi Jewish Ancestry** with **Breast or Pancreatic Cancer** in your family at any age				
☐	☐	**Colon Cancer** in your family **before age 50**				
☐	☐	**Uterine or Endometrial Cancer** in your family **before age 50**				
☐	☐	**THREE OR MORE** relatives on one side of your family with **Colon/Rectal, Uterine/Endometrial,** or **Gastric/Stomach Cancer** at any age				
☐	☐	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: _____

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FINANCIAL POLICY

This is an agreement between Hereditary Care Center, and the Patient named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Hereditary Care Center.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days on the date of the statement.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you have no insurance:

1. You choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees, those charges will be billed directly by the lab.
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

You choose to pay by cash, check, or credit card your co-payment, deductible, and/or any out-of-pocket expenses at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. You agree to pay any portion of the allowed charges not covered by insurance (if we have a contract with your insurance company). If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the monthly statement was sent. The FINANCE CHARGE will be computed at the rate of one and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $.50.

Credit Card Surcharge: NC allows a surcharge on credit card purchases of up to 4%. You may avoid this surcharge by paying with cash or check.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Wake County, North Carolina.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Patient Initials: _____

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Returned checks: There is a fee (currently $35) for any checks returned by the bank. After a returned check, all subsequent payments must be in the form of cash, credit card, cashier's check, or money order; checks will no longer be accepted by the patient.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours notice, a $25 fee may be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their care to another physician.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: **Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.**

Patient's name: _____
please print

Responsible party (If not the patient):

_____

Signature: _____

Co-Signature (if required):_____

Date: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was offered a review of the Hereditary Care Center's Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

Revised April 2016