Patient Information

Social Security # _____ Birth Date _____ Age _____

Last Name _____ Legal First Name _____ M.I. _____ Maiden or Nickname _____

Address _____

Apartment # _____ E-mail Address _____

City _____ State _____ Zip _____

Home Phone # (___) _____ - _____ Work Phone # (_____) _____ - _____ Ext. _____

Can we call you at home? Yes / No (Please circle one) Cell # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Patient's Employer Information

Employer's Name _____ Patient's Occupation _____

Address _____ If Student: ☐ Full time ☐ Part time

City _____ State _____ Zip _____

Insurance Information - Primary / Secondary / Other

Please Give Your Insurance Cards To The Receptionist

Do you have health insurance? Yes / No (Please circle one)

Primary Insurance
Company Name _____ Address _____

Policy No. _____ Group No. _____ Who is the subscriber for the primary insurance: ☐ Self ☐ Parent ☐ Spouse ☐ Other _____

Secondary Insurance
Company Name _____ Address _____

Policy No. _____ Group No. _____ Who is the subscriber for the secondary insurance: ☐ Self ☐ Parent ☐ Spouse ☐ Other _____

Subscriber's Information

Subscriber's Name _____ Subscriber's Birth Date _____

Subscriber's SS# _____ Employer's Phone # (___) _____ - _____

Subscriber's Employer _____

Subscriber's Employer's Address _____

City _____ State _____ Zip _____

Emergency Information

Please list the nearest living relative /friend other than your spouse/parent.

In case of an emergency, we may contact: _____

Phone # (_____) _____ - _____ Relationship to Patient _____

Other

Primary Care Physician: _____ Referred by: _____

Payment Is Expected At Time of Service

I will be paying by CASH / CHECK / CREDIT CARD (Please circle one)

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to the Lifeline Medical Associates, LLC, its successors and assigns or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due to services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to the Lifeline Medical Associates, LLC, its successors and assigns and any individual it may designate for any balance not covered by insurance.

_____ _____
Signature of Patient or Parent of Minor Date

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Lifeline Medical Associates for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient's Signature Date

LIFELINE MEDICAL ASSOCIATES, LLC
WOMEN'S HEALTHCARE IS OUR LIFE'S WORK.
COMPREHENSIVE CARE CENTER

Yashica Shah, MD Steven Haskel, MD Samra Khalid, DO Diana Huang, MD
Elana Grann, MSN APN Elizabeth Colaiocco, APN BC

Patient Name: _____ Date of Birth: _____

Payment of Services

Payment is due in full at the time of service. Please understand that your insurance card is not a guarantee of payment. You are ultimately responsible to the practice for payment on all services regardless of insurance coverage. Additionally, it is your responsibility to confirm coverage for all services with your insurance provider. We cannot verify coverage of services for each individual plan and are not responsible for services provided, recommended, or prescribed that are not covered by your insurance.

All copays are due at the time of service. This office performs a courtesy appointment confirmation of all appointments the day before. Please be aware that there is a **$25.00 fee** for not cancelling an appointment. **No exceptions!**

Reporting Results Policy

It is our mission to provide you with the best possible care. Part of the quality care includes getting all test results to you in an efficient and timely manner. In some cases, you will be asked to schedule a follow up appointment to review results. If you do not need a follow up appointment, DO NOT ASSUME that "no news is good news".

We make every effort to contact you regarding test results. Yet, sometimes, we come across obstacles; we have an incorrect phone number, your voice mailbox is full, or there are technical difficulties with the fax machine, printer, etc. If we have ordered blood work or imaging for you, and you have not heard from our office within 2 weeks after it was completed, please call our office to review results.

Signature: _____ Date: _____

LIFELINE MEDICAL ASSOCIATES, LLC
WOMEN'S HEALTHCARE IS OUR LIFE'S WORK.
COMPREHENSIVE CARE CENTER

Privacy Policy and Consent

Protecting your privacy is important to us. If you would like us to discuss your personal medical information with anyone other than yourself, your written consent is required by law. Please specify below whom you give permission for us to disclose your information with.

I, _____, give consent for the Comprehensive Care Center to share my personal medical information with the following people:

1. _____ relationship: _____ phone number: _____
2. _____ relationship: _____ phone number: _____

☐ NO ONE

Is it okay for our staff to leave voice messages on your phone regarding appointments, results or other information?

☐ YES; you may leave messages about test results and other information on my voicemail.

☐ NO; please only leave messages regarding appointments. Do not leave personal health information such as test results.

☐ NO; please do not leave any messages on my voicemail.

We offer an email program through our corporate office as a way to efficiently communicate results and answer questions. We offer these services through a program called Patient Portal. If you would like to participate in this email program, please provide the front desk with your email address below. By consenting to have access to Patient Portal, you understand that your personal medical information will be included in email. We are not responsible for privacy breaches if other people have access to your email account.

Email address: _____

In order to ensure you get the best possible care, some of your personal medical information may be shared with other providers who request access to your records. If there is specific confidential information that you do not want shared, please be sure to notify us. As long as this information is not critical to providing you with proper treatment, we will make every effort to ensure your privacy.

Signature: _____ Date: _____

LIFELINE MEDICAL ASSOCIATES, LLC
WOMEN'S HEALTHCARE IS OUR LIFE'S WORK.
COMPREHENSIVE CARE CENTER

Name: _____ Date of Birth: _____

Primary Care Provider: _____ Pharmacy: _____

Referred By: _____

MEDICAL HISTORY (Please select all that apply)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cholesterol
- ☐ Diabetes
- ☐ GERD
- ☐ Headaches with Aura
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraine
- ☐ Osteopenia
- ☐ Seizures
- ☐ Thyroid Imbalance
- ☐ Other: _____

List any medications including dosage and frequency. Please also list any herbs, vitamins and supplements:

_____ _____
_____ _____
_____ _____
_____ _____

SURGICAL HISTORY: (Please include dates and any complications)

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: (Please also list your allergic reactions)

_____ _____
_____ _____
_____ _____
_____ _____

MENSTRUAL HISTORY:

- How old were you at the onset of your first period? _____
- When was the first day of your last menstrual period? _____
- If menopausal, what age did you have menopause? _____
- Are your menses regular? ☐ Yes ☐ No
- Any bleeding between periods? ☐ Yes ☐ No
- How many days apart are your periods? _____
- How many days do you bleed for? _____
- The flow is: ☐ light ☐ medium ☐ heavy
- Are the periods painful? ☐ Yes ☐ Mild, but relieved with medication ☐ No

GYNECOLOGICAL HISTORY:

- When was your last pap smear? _____ Was it normal? ☐ Yes ☐ No
- Have you ever had an abnormal pap smear before? ☐ Yes ☐ No
- Have you ever had any of the following? (Please select all that apply)
  - ☐ Chlamydia
  - ☐ Fibroid Uterus
  - ☐ Genital Herpes
  - ☐ Gonorrhea
  - ☐ GYN surgery
  - ☐ HIV
  - ☐ HPV / Abnormal Pap
  - ☐ Ovarian Cyst
  - ☐ Polyp in Uterus or Cervix
  - ☐ Syphilis
  - ☐ Other: _____
- Are you currently sexually active? ☐ Yes ☐ No Method of contraception? _____
- Age of first intercourse? _____ How many sexual partners have you had? _____
- Which contraceptives have you used in the past? _____
- If you are under 26, have you received the Gardasil vaccination? ☐ Yes, injections completed ☐ No, none completed ☐ 1 or 2 out of the 3 injections completed ☐ What's Gardasil?
- When was your last mammogram? _____ Was it normal? ☐ Yes ☐ No ☐ N/A
- When was your last colonoscopy? _____ Was it normal? ☐ Yes ☐ No ☐ N/A
- When was your last DEXA scan (bone density test)? _____
  What was the result? _____

OBSTETRICAL HISTORY:

- How many times have you been pregnant? _____
- How many: Full term deliveries (>37 weeks)? _____
  Preterm deliveries (24-36 weeks)? _____ Miscarriages? _____
  Abortions? _____ Ectopic pregnancies? _____
- How many living children do you have? _____

Please fill out the following chart concerning all pregnancy history.

Date	Weeks of Gestation	Vaginal or c-section	Any complications?	Hospital of Delivery	Doctor who delivered	Birth weight	Sex of baby

FAMILY HISTORY:

Does anyone in your family have a history of any of the following? (If yes, please list family member and age of diagnosis.)

- Breast Cancer ☐ No ☐ Yes _____
- Colon Cancer ☐ No ☐ Yes _____
- Ovarian Cancer ☐ No ☐ Yes _____
- Uterine Cancer ☐ No ☐ Yes _____
- Does anyone in your family have a history of blood clots? ☐ No ☐ Yes _____

SOCIAL HISTORY:

- Are you: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
- Sexual preferences: ☐ Men ☐ Women ☐ Both
- Do you have a history of domestic violence? ☐ No ☐ Yes
  Do you feel safe in your current living environment? ☐ No ☐ Yes
- Describe your alcohol intake: ☐ Never ☐ Socially ☐ Frequently ☐ Problematic
- Any tobacco use? ☐ Never ☐ Current, ____ # of cigarettes per day
  ☐ Former, Quit at age: _____ Age Started: _____
- Any recreational drug use? ☐ Never ☐ Currently using _____
  ☐ Former, Quit at age: _____ Age Started: _____
- Do you exercise? ☐ Regularly ☐ Sometimes ☐ Rarely ☐ No
  If yes, what is your routine? _____
- Describe your diet: ☐ Balanced ☐ Vegetarian ☐ Needs improvement
- What is your occupation? _____
- Highest level of education completed? _____

Lifeline Medical Associates

Patient's Name: _____
Date Of Birth: _____
Today's Date: _____

Reason for today's visit (chief complaint): _____
In the past *48 hours*, have you had *any* of the following? (Please check all that apply.)

Yes	No		Yes	No	
		Constitutional			**Genitourinary**
		Fever			Pain with Urination
		Chills/Rigors			Blood in Urine
		Neurological			Frequent Urination
		Headaches			Frequent Urination at Night
		Blurred Vision			Urinary Incontinence
		Dizziness			**Reproductive**
		Numbness/Tingling			Breast/Nipple Pain
		Cardiac			Breast Discharge
		Swelling			Breast Lump
		Chest Pain			Breast Skin Changes
		Palpitations			Painful Menses
		Respiratory			Frequent Menses
		Dyspnea/Difficulty Breathing			Heavy Menses
		Chronic Cough			**Hematological/Lymph**
		Gastrointestinal			Swollen Lymph Nodes
		Constipation			Easy Bleeding/Bruising
		Diarrhea			**Psychosocial**
		Nausea			Anxiety
		Vomiting			Depression
		Abdominal Pain			Suicidal Thoughts/Ideations
		Musculoskeletal			
		Chronic Joint/Back Pain			

Cancer Family History Questionnaire

PERSONAL INFORMATION			
Patient Name		Date of Birth	Age
Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider	

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents,Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

	COLON AND ENDOMETRIAL CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
O Y O N	Colon/rectal cancer at age 50 or younger			
O Y O N	Endometrial (*Uterine*) cancer at age 50 or younger			
O Y O N	Two or more Lynch syndrome cancers(colon/rectal,endometrial/uterine,ovarian,stomach) same side of the family (one diagnosed at age 50 or younger)			
O Y O N	Three or more Lynch syndrome cancers *(colon/rectal,endometrial/uterine,ovarian, stomach)* on the same side of the family *(at any age)*			

(*Lynch syndrome cancers: colon/rectal, endometrial/uterine, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, or sebaceous adenomas)

	BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
O Y O N	Breast cancer at age 50 or younger			
O Y O N	Ovarian *(Peritoneal/Fallopian tube)* cancer at any age			
O Y O N	Two or more primary *(unrelated)* breast cancers in the same person or on the same side of the family			
O Y O N	Male breast cancer at any age			
O Y O N	Triple negative breast cancer *(ER-, PR-, HER2- pathology)*			
O Y O N	Three or more HBOC-associated cancers at any age in the same person or on the same side of the family (HBOC-associated cancers include breast [including DCIS], ovarian, pancreatic, and aggressive prostate cancer**)			
O Y O N	Pancreatic cancer or aggressive prostate cancer**, AND one relative with breast cancer at age 50 or younger			
O Y O N	Ashkenazi Jewish ancestry with breast or pancreatic cancer at any age			

(** Gleason Score ≥ 7)

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)	
Patient's Signature	Date
Health Care Provider's Signature	Date

Office Use Only

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

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

myriad.

Lifeline Medical Associates

Transforming Women's Healthcare
www.LMA-LLC.com

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at **lma-llc.com** or calling the Privacy Officer at **973-316-6760**

Some examples of Protected Health Information include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need: We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures" every 12 months, except for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

PATIENT RIGHTS CONTINUED

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 973-316-6760, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003 Revised: March 25, 2013

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Lifeline Medical Associates

Transforming Women's Healthcare
www.LMA-LLC.com