Chan Soon-Shiong Medical Center at Windber

Windber GYN Associates, 600 Somerset Ave 4th FL, Windber, PA 15963
Telephone: 814-467-3176 Fax: 814-467-3177

Office Hours:
Monday – Friday
8:30am – 4:00pm

YOUR NEXT APPOINTMENT IS WITH:

GREG WHORRAL, MD

NICOLE ENEDY, CRNP

MANDY ELBAYLY, CRNP

DATE: _____

TIME: _____

Office Location: 4th Floor Medical Arts Building, CSS Medical Center at Windber

PLEASE NOTE THE FOLLOWING POLICIES:

1. Prescriptions will only be filled during business hours. **Refills on prescriptions are not considered to be urgent calls. Please allow 72 hours for refills.**
2. We ask that you be 15 minutes early for your appointment. **Late arrivals may be asked to be rescheduled.**
3. Please call a day in advance to cancel your appointment. **Failure to call and cancel an appointment may result in a $40 no show fee.**
4. **We ask that you avoid wearing perfume to your appointment for the consideration of staff and other patients.**

Appointments may run behind. Your patience is appreciated.

To access your medical information online, please visit the NEW WindberCare Patient Portal:

https://windbercareportal.meditech.cloud/

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The providers request that you please fill out this paperwork prior to your appointment. Not doing so may result in your appointment being rescheduled or delayed. You must arrive 30 minutes prior to your appointment time.

Date: _____

Patient Name: _____ Birth Date: _____ Age: _____

***ALLERGIES** (and the reaction you had) to ANY medicines, latex, shellfish, x-ray dyes, iodine, or nuts:
_____ **Check:** ☐ NO ALLERGIES
_____

Last Pap Smear Date: _____ Location: _____
Last Mammogram Date: _____ Location: _____
Last Colonoscopy Date: _____ Location: _____
Last Bone Density Test (Dexa Scan) Date: _____ Location: _____

Have you received one or more injections of the HPV Vaccine (Gardasil)? ☐ Yes or ☐ No (check answer)
If yes, how many injections have you received?: _____
If yes, when did you receive the Gardisil Vaccine (Please provide dates if known): _____

Previous Pregnancies:
# of total pregnancies: _____ # of living children: _____ # of abortions: _____ # of miscarriages: _____
# of ectopics: _____ # of vaginal births: _____ # of C-sections: _____
Any complications: _____

Gynecologic information:
Periods began at age: _____ Periods come every _____ days and the menstrual flow lasts _____ days
First day of your ***last*** menstrual period: _____

Menstrual Abnormalities (please check):

PMS:	**Cramps:**	**Flow:**
☐ None / Mild	☐ None / Mild	☐ Light
☐ Moderate	☐ Moderate	☐ Medium
☐ Extreme	☐ Extreme	☐ Heavy

Currently sexually active?: ☐ Yes or ☐ No Onset of sexual activity (age): _____

# of partners within the last 6 months: _____ # of total partners: _____

Are you sexually active with ☐ men, ☐ women or ☐ both? (check answer)

Are you ☐ Married, ☐ Single, ☐ Divorced, ☐ Widowed, ☐ Separated? (check answer)

Are you currently or have you been a victim of abuse? ☐ Yes or ☐ No (check answer)

Type of contraception (please check):
☐ Birth Control Pills ☐ Tubal Ligation ☐ Diaphragm ☐ Vasectomy ☐ IUD ☐ Condoms
☐ Depo Provera ☐ Nexplanon ☐ Nuva Ring ☐ **None**

Have you ever had an abnormal pap smear? ☐ Yes or ☐ No If so, when? _____

What treatment, if any, was needed? _____

Have you ever had any of the following sexually transmitted infections (STIs)? **Please Check**:
☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ HPV ☐ Genital Warts ☐ **None of these**

Medical/Surgical Information:

Smoke: ☐ Y or ☐ N Former Smoker: ☐ Y or ☐ N	How many: # pack(s) per:
Drink: ☐ Y or ☐ N	How much: # drink(s) per:
Illicit drugs: ☐ Y or ☐ N	How much:
Exercise: ☐ Y or ☐ N	☐ Minimal ☐ Moderate

NAME: _____ **Date of Birth:** _____

Previous surgeries/procedures (please list dates if known):

☐ D&C	☐ LEEP, Colposcopy, Cryosurgery	☐ List All other NON-GYN Surgeries:
☐ Hysterectomy	☐ Bladder surgery/Vaginal Repair	_____
☐ Surgery on Ovaries	☐ Laparoscopy	_____
☐ Laparotomy	☐ Endometrial Biopsy	_____

PERSONAL Medical History:

	Current	Past		Current	Past		Current	Past
☐ Diabetes	☐	☐	☐ Autoimmune Disease	☐	☐	Cancer:		
☐ Heart Disease	☐	☐	☐ Bleeding Tendency	☐	☐	☐ Breast	☐	☐
☐ High Blood Pressure	☐	☐	☐ Kidney Disease	☐	☐	☐ Ovarian	☐	☐
☐ Stroke	☐	☐	☐ Blood Clots in legs/lungs	☐	☐	☐ Uterine	☐	☐
☐ Thyroid Disease	☐	☐	☐ Anxiety	☐	☐	☐ Cervical	☐	☐
☐ High Cholesterol	☐	☐	☐ Depression	☐	☐	☐ Vulva	☐	☐
☐ Osteoporosis	☐	☐	☐ Congenital Anomalies	☐	☐	☐ Colorectal	☐	☐
☐ Mental Retardation	☐	☐	☐ Infertility	☐	☐	Other Cancer: _____		
☐ DES Exposure	☐	☐				_____		
						_____		

Please use this space for any conditions not listed above: _____

_____

Are you CURRENTLY suffering from any of the following:

☐ Headache	☐ Hearing loss	☐ Nausea	☐ Joint pain
☐ Passing out	☐ Dry mouth	☐ Vomiting	☐ Muscle weakness
☐ Fever	☐ Nipple discharge	☐ Diarrhea	☐ Easy bruising
☐ Tiredness	☐ Breast mass	☐ Constipation	☐ Excessive bleeding
☐ Swollen glands	☐ Cough	☐ Blood in stool	☐ Depression
☐ Weight change	☐ Difficulty breathing	☐ Painful urination	☐ Anxiety
☐ Rash	☐ Chest pain	☐ Urinary frequency	☐ Mood Changes
☐ Blurry vision	☐ Palpitations	☐ Urinary incontinence	☐ Excessive Thirst
☐ Sore throat	☐ Lack of appetite	☐ Inability to empty bladder	☐ Hives
			☐ Other: _____
			_____

FAMILY Medical History (Mom, Dad, Brother, Sister, your own Children):

☐ Diabetes Who: _____
☐ Heart Disease Who: _____
☐ High Blood Pressure Who: _____
☐ Stroke Who: _____
☐ Osteoporosis Who: _____
☐ Mental Retardation Who: _____
☐ DES Exposure Who: _____
☐ Autoimmune Disease Who: _____
☐ Bleeding Tendency Who: _____
☐ Blood Clots in legs/lungs Who: _____
☐ Congenital Anomalies Who: _____
☐ Kidney Disease Who: _____
☐ Other: _____

Who in your family, mom, dad, brother, sister, your own children, grandparents, aunts, uncles, and/or cousins have had <u>any cancer</u>:

Paternal = your father's side= **P**
Maternal = your mother's side = **M**

Please indicate **P**aternal or **M**aternal as referenced above.

Cancer: Please Be Specific.

☐ Breast Who: _____
☐ Ovarian Who: _____
☐ Uterine Who: _____
☐ Cervical Who: _____
☐ Vulva Who: _____
☐ Colorectal Who: _____
☐ Other Cancer: _____

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Medication List

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

A Current Medication List Helps Prevent Errors:

Medication Name, Strength *Include OTC Meds* *Vitamins, Herbs, Supplements*	Dosage (mg,ml, etc)	How and When to Use (daily, at bedtime, etc)	Who prescribes this to you and why do you take these medications?

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Patient name: (Last)_____ (First) _____(Middle)_____

Birth date: _____ SSN#: _____ Maiden/Other Name: _____

Marital status (please check): ☐Married, ☐Single, ☐Divorced, ☐Widowed, ☐Separated

Email address: _____Do you have an Advance Directive (e.g. living will)? ☐Yes or ☐No

Race (please check): ☐White, ☐Hispanic, ☐Black/African Amer., ☐Amer. Indian/Alaskan Native, ☐Native Hawaiian, ☐Asian ☐Other:_____

Phone number: Home: _____ Cell: _____ Work: _____

Best method of contact during the day (please check): ☐Home ☐Cell ☐Work

Address: _____

Employment status (please check): ☐Employed, ☐Full-Time Student, ☐Part-Time Student, ☐Retired, ☐Self-Employed, ☐Unemployed, ☐Homemaker

Employer: _____ Occupation: _____

Emergency contact: _____ Relationship: _____ Phone Number: _____

Who is your primary care physician? _____ Phone Number: _____

Local Pharmacy: _____ Location: _____ Mail Order Pharmacy:_____

RESPONSIBLE PARTY INFORMATION: If patient is Responsible Party, please check here and skip to next section: □

Responsible party name: (Last) _____ (First) _____ (Middle)_____

Social Security Number: _____ Date of birth: _____ Patient relationship:_____

Phone Number: Home: _____ Cell: _____ Work: _____

Address: _____

PRIMARY INSURANCE INFORMATION: If patient has no insurance, please check here and skip to bottom of page □

Name of insured: _____ Patient relationship to insured: _____

Insured Date of birth: _____ Insured Social Security Number: _____

Insurance company: _____ Subscriber ID (Policy Number): _____Group ID: _____

SECONDARY INSURANCE INFORMATION: If patient has no secondary insurance, please check here and skip to bottom of page□

Name of Insured: _____ Patient relationship to insured: _____

Insured Date of Birth: _____ Insured Social Security Number: _____

Insurance company: _____ Subscriber ID (Policy Number): _____Group ID: _____

PLEASE HAVE INSURANCE CARDS AND PHOTO ID AVAILABLE AT CHECK IN

I AGREE THAT THE INFORMATION SUPPLIED ON THIS FORM IS ACCURATE AND UP-TO-DATE. I UNDERSTAND THAT I AM RESPONSIBLE FOR UPDATING THE ABOVE INFORMATION AS SOON AS IT CHANGES. THIS ALLOWS NOT ONLY ACCURATE BILLING BUT ALSO TIMELY NOTIFICATION OF MEDICAL RESULTS OR TREATMENTS.

My signature below verifies my receipt of the Patient Rights and Responsibilities notice.

Patient (or Guardian) Signature: _____ Date: _____

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Request for Special Permission of Protected Health Information

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

Message Authorization:

If we need to contact you, may we leave a message at your:

Home Phone Number ☐ No ☐ Yes

Cell Phone Number ☐ No ☐ Yes

Work Phone Number ☐ No ☐ Yes

Request for Special Permission:

I understand that my health care provider may use or disclose my Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations. My health care provider may also disclose information to someone involved in my care or the payment for my care, such as family member or friend.

I hereby permit the health care provider to disclose this information to the following person:

Persons Name: _____ **Relationship to Patient: _____**

_____ _____

Signature of patient or his/her authorized representative **Date**

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APPOINTMENT SCHEDULING:

Effective August 1, 2008, it is the policy of Windber GYN Associates that when a patients presents for a scheduled appointment, the patient will be escorted to the examination room alone.

ROUTINE APPOINTMENT:

Appointments are scheduled based on the next available provider, in order that you and our other patients are seen as soon as possible. Deferring your appointment until a specific provider is available is not in your best interest.

Effective June 1, 2016, if you are unable to keep an appointment please call to cancel at least 24 hours prior to the scheduled time or a no show fee of $40 will be assessed to you. If you are more than 10 minutes late for an appointment (due to physician scheduling) you may be asked to reschedule.

Only urgent calls should be made after hours or on weekends.

PRESCRIPTION REFILLS:

Please call for prescription refills during regular office hours.
Please allow 72 hours for refills.

FEES AND INSURANCE:

Effective April 1, 2015, please bring your insurance information and photo ID with you for **every** office visit. Insurance co-payments, deductibles, and fees for non-covered services will be collected at the time of your visit or we will gladly reschedule your appointment. All Disability Forms or Family Medical Leave Act (FMLA) forms are $5 per form and must be paid in full prior to completion; these forms take 10 days for completion.

We accept cash, check and major credit and debit cards.

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Office Policy Guidelines and Notifications for Windber GYN Associates

New Patients:

- You must arrive 30 MINUTES prior to scheduled appointment time.
- You must have a current photo ID and insurance card with you.
- A new patient packet will be mailed to you prior to your appointment time. We ask that you return this information prior to your appointment, either by mail, fax, or hand delivered. If this is a hardship or timing of scheduled appointment does not allow this*, YOU MUST HAVE THESE PAPERS COMPLETED WHEN* YOU *ARRIVE.* If you arrive *WITHOUT COMPLETED FORMS*, you will be asked to *RESCHEDULE YOUR APPOINTMENT*.
- If an individual fails to arrive prepared for 2 new patient appointments, no further appointments will be made.

Established patients:

- Please arrive ***15 minutes*** prior to scheduled appointment time. You must have a current photo ID and insurance card with you. Failure to arrive prior to your appointment time will result in unnecessary delays.
- If you arrive more than ***10 MINUTES LATE*** for your appointment, you will be rescheduled.

General Notifications:

- Please give 24 hours notice of cancellations. If advanced notice is not given, you will be charged the standard $40.00 no show fee.
- There is a charge of $40.00 for "no show" appointments. Three inexcusable "no show" appointments will result in dismissal from the practice.
- There is a $5.00 fee for any FMLA forms or disability forms that need completed.
- We require 72 hour notice for medication refills. Nurse calls are prioritized according to nature of call and patient needs for the day. We make every attempt to address calls as quickly as possible, but are unable to guarantee time frames of response. If unable to wait for a response, please go to nearest emergency room if needed for evaluation.
- Test results can be viewed on the patient portal: http://gynportal.mysecurechart.com. Patients will be called with abnormal test results that need to be addressed.
- Due to the nature of this practice, any patient who presents to our office will be escorted alone to the examination room. Anyone accompanying the patient will be asked to remain seated in the waiting room until called for.
- Thank you for your understanding. We hope to build a strong relationship with you and provide the best care possible!

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Payment Policy

Thank you for choosing us as your gynecological care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this Payment Policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you.

1) ***Insurance***. We participate in ***most*** insurance plans, including Medicare. If you are ***not*** insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. ***Knowing your insurance benefits is your responsibility***. Please contact your insurance company with any questions you may have regarding your coverage.

2) ***Co-payments and deductibles***. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3) ***Non-covered services***. Please be aware that some—and perhaps all—of the services you received may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be responsible for the balance of these services. If you have medicare, you must sign an Advanced Beneficiary Notice (ABN) prior to being seen for your exam.

4) ***Proof of Insurance***. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

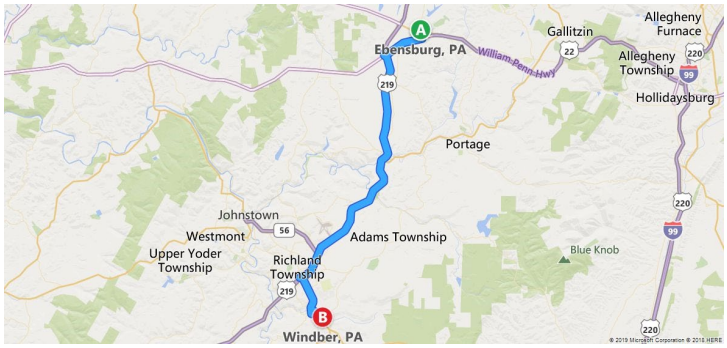
5) ***Claims submission***. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

6) ***Coverage changes***. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will automatically be billed to you.

7) ***Nonpayment***. If your account is 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Further more, delinquent accounts can result in being discharged from the practice. If this is to occur, you will be notified by certified/return receipt US postal mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our Payment Policy. Please let us know if you have any questions or concerns.



From 160 (Portage/Ebensburg)

From Ebensburg/Portage, please take Rte 160 in to Windber. Go to the stop light after the Windber Recreational Park on Rte160. At that light, make a right hand turn on to Somerset Ave. Go down three blocks to the 7th Street intersection. On your right is the CSSIMMW building. Please make a right on to 7th Street and continue to the second parking lot on your left hand side, Parking Lot E. Please park in this parking lot and enter CSSMCW either by sidewalk in to the far corner door, or to the double doors on 3rd floor and turn to your right and take the elevator to the 4th floor and turn right, the office is at the end of this hallway.

From Somerset Route 219

Depart 31W PA 281 S/ W Main St toward N Ankeny Ave, Turn left onto S Ankeny Ave; Turn left onto PA- 31E/ PA-281 N/ W Patriot St and then immediately turn left onto PA 601/ S Center Ave Pass the GETGO. Take ramp for US 219 North toward Johnstown, Take ramp right for PA 56 East toward Windber. Turn left onto PA 56 Scalp Ave Pass Dairy Queen in Richland. Take ramp right for PA 601 toward Pain/Scalp Level. Turn right onto PA 601 Main St, Turn Right onto Bedford St to Graham Ave/under the railroad bridge, Keep straight onto Graham Ave. The streets are numbered and you will turn Left onto 7th St by St Elizabeth Ann Seton Church. Go straight up the hill to Somerset Ave, stay on 7th Street until you pass parking lot F, then in middle of hill Turn Left into Parking Lot E, across from the one way street. Windber GYN Associates in on the 4th FL, walk the sidewalk in to corner door. Or enter the double doors and go up elevator from 3rd fl to 4th FL, step on to the right down hallway.

When you turn on to 7th Street, please go up one block to Somerset Avenue. You will now see Chan-Soon Shiong Medical Center at Windber(CSSMCW) on your left and Chan-Soon Shiong Institute of Molecular Medicine at Windber(CSSIMMW) on your right. Go straight through the intersection and continue on 7th Street. Immediately on your left hand side there will be a parking Lot F, continue up the hill to the next parking Lot E on your left hand side. Please park in this parking lot and enter the CSSMCW at this location. As you enter, you may walk the sidewalk into the far corner on to 4th fl, or walk into the double doors on 3rd floor and turn to your right and take the elevator to the 4th floor and turn right, the office is at the end of this hallway.