BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

ANNUAL VISIT

Name: ______________________________ **Date:** ________________ **DOB:** ___________________

What brings you to the office today?

____

____

____

Last Menstrual Period: _______ **How often:** ________ **Days of flow:** ___**Amount of flow:** ________
Describe pain with period: ____

Using Contraception? ☐ **No** ☐ **Yes** **What kind?** ___________________ **For how long?** ______

List all Illnesses:
1. _________________________________ 4. _________________________________
2. _________________________________ 5. _________________________________
3. _________________________________ 6. _________________________________

List all Surgeries:
1. _________________________________ 4. _________________________________
2. _________________________________ 5. _________________________________
3. _________________________________ 6. _________________________________

Hospitalizations since last office visit: Yes ____ **No** ____
If Yes, please describe: ____

Allergies: ☐ **None**
1. _________________________________
2. _________________________________
3. _________________________________
4. _________________________________

List all medications and dosages including over-the-counter:
1. _________________________________ 4. _________________________________
2. _________________________________ 5. _________________________________
3. _________________________________ 6. _________________________________

Family History

Mother's Age:	Medical Issues:
Father's Age:	Medical Issues:
Brother's Age:	Medical Issues:
Brother's Age:	Medical Issues:
Sister's Age:	Medical Issues:
Sister's Age:	Medical Issues:
Additional information:	

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

ANNUAL VISIT – PAGE 2

Name: ______________________________ **Date:** ________________

Social History

☐ Non-Smoker ☐ Smoker – How many packs/day? _____
☐ Non-Drinker ☐ Occasional/Social ☐ Frequent/Regular
Recreational Drug Use? ☐ Yes ☐ No
Exercise: ☐ None ☐ 1-2 times/week ☐ 3 or more times/week
Sexually Active? ☐ No ☐Yes Length of time with current partner: __________________
Marital Status: ☐ Single ☐ Married – How long: ________ ☐ Divorced ☐ In a Relationship – How long: ______________

Review of Systems: Please check the boxes of any symptoms you are currently experiencing.

Head/Eyes	☐ Headache	☐ Hearing Problems	☐ Visual Problems	
Endocrine	☐ Excess Thirst ☐ Increased Appetite	☐ Heat Intolerance ☐ Decreased Appetite	☐ Cold Intolerance	
Cardiovascular	☐ Chest Pain	☐ Shortness of Breath	☐ Palpitations	
Gastrointestinal	☐ Diarrhea ☐ Vomiting	☐ Constipation ☐ Abdominal Pain	☐ Nausea ☐ Blood in Stool	
Genitourinary	☐ Dysuria ☐ Incontinence	☐ Frequency ☐ Blood in Urine	☐ Urgency	
Musculoskeletal	☐ Muscle Swelling	☐ Muscle Pain	☐ Joint Swelling	☐ Joint Pain
Psychological	☐ Depression ☐ Mood Instability	☐ Crying Spells ☐ Attention Problems	☐ Sleep Disturbance	☐ Anxiety

Last Mammogram (Date): ____________________ **Location:** ______________________________

Topics for Today's Visit (check all that you wish to discuss):

Prevention		Infectious Disease/Cancer	
Alcohol screening & counseling		Gonorrhea & Chlamydia	
Aspirin use		Hepatitis B	
Blood pressure		Hepatitis C	
Contraception		HIV risk assessment	
Depression		HIV testing	
Diabetes		Immunizations	
Folic acid supplementation		Latent tuberculosis	
Healthful diet and activity		STI prevention	
Interpersonal violence		Syphilis	
Lipid screening		Breast cancer	
Obesity		Cervical cancer	
Osteoporosis		Colon cancer	
Prevention of falls		Lung cancer	
Statin use		Medications to reduce breast cancer	
Substance use		Risk assessment for BRCA testing	
Tobacco screening & counseling		Skin cancer	
Urinary incontinence			

BLOSSOM

GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

MARJORIE A. CHORNESS, MD FACOG

Today's date	Social Security #	DOB: / /

PATIENT INFORMATION

Last Name	First	MI	Address

City/State	Zip Code	Home #	Cell #

Employer	Employer Address	Work #	Pharmacy #

Email Address	Primary Care Physician

Marital Status	Employed	Student
❑ S- Single ❑ M- Married ❑ D-Divorced ❑ X- Separated ❑ W- Widow	❑ FT ❑ PT ❑ R- Retired ❑ Self ❑ N- None	❑ FT ❑ PT

INSURANCE INFORMATION (We must have this information in order to file your insurance)

Primary Insurance Co:

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	ID #	Group #	Co-Pay $
Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other	

Subscriber's Employer	Employer Address	Employer Phone #

Secondary Insurance Co:

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	ID #	Group #	Co- Pay $
Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other	

Subscriber's Employer	Employer Address	Employer Phone #

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize BLOSSOM Gynecology, Wellness & Infertility (Dr. Marjorie Chorness) to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. **As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility.**

_______________________________ *Patient/Guardian signature*

_______________________________ *Date*

MC/lh 7/2/18

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

children			
NAME	AGE	NAME	AGE

PERSONAL INTERESTS

LEVEL OF EDUCATION
❒ High School ❒ College 1 2 3 4 ❒ Post Graduate ❒ Other

PATIENT CONTACT PREFERENCES			
I give Blossom Gynecology, Wellness & Infertility, P.A. permission to contact me in the following way:			
Home Phone	❒ Yes ❒ No	Cell Phone	❒ Yes ❒ No
Work Phone	❒ Yes ❒ No	E-Mail	❒ Yes ❒ No
		E-Mail Address: ______________________	

With the following information:			
Appointment Information	❒ Yes ❒ No	Prescription Information	❒ Yes ❒ No
Lab Results	❒ Yes ❒ No	Insurance/Billing	❒ Yes ❒ No

EMERGENCY CONTACT				
Name	Relationship	Home #	Cell #	Work #

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
FINANCIAL POLICY

Thank you for choosing Blossom Gynecology, Wellness & Infertility, P.A. as your healthcare provider. We are committed to building a successful and long-term physician-patient relationship.

Insurance: A valid photo ID and insurance card must be presented at the time of your visit. Our office is in network with most major insurance carriers. However, it is the patient's responsibility to understand the coverage details of the policy and to verify we are participating providers. Deductibles, co-insurances and co-pays, as outlined by your policy, are due at time of service.

Non-Covered Services: Any services that are not covered under your policy will be the patient's financial responsibility. Payment will be due at time of service. Should you have any questions on what services are non-covered, we encourage you to contact your insurance company.

Well Woman Exams: These exams include preventive care only. Any problem or concern addressed during an annual exam is considered a separate service and may be a separate charge.

Collection Policy: Should your account become past due, the guarantor of the account is responsible for resolving all outstanding balances in a timely manner. Any questions regarding balances can be emailed to patientaccounts@blossomgyn.com. If the balance is not paid within 60 days of the date of service, we reserve the right to forward the account to a third party collection agency. The patient/guarantor of the account will assume all costs of collection, including but not limited to, interest and legal fees.

Payment Arrangements: If you are unable to pay your balance in full, please contact our office immediately to set up a payment arrangement and avoid collection action.

Administrative Fees: A $50.00 fee will be charged when requesting medication renewals outside of a scheduled appointment or when prior authorization on a medication is required. A $50.00 fee will be charged for letters/forms the office completes on your behalf.

Missed Appointments: Unless cancelled/rescheduled 24 hours prior to your visit, there is a $50.00 fee for missed appointments.

Lab Services: Quest provides the lab services for our office. Charges for these services are handled directly by Quest's billing department therefore; we are unable to assist you in these matters. Any questions regarding lab charges should be directed to the billing number on your Quest bill.

By signing below, I acknowledge I understood and agreed to the financial policy as outlined above. I consent to receiving emails and phone contact regarding financial matters.

______________________________	______________________
Patient/Guardian Signature	Date
______________________________	______________________
Patient/Guardian Printed Name	E-mail Address

PATIENT CONSENT FOR TREATMENT

I have requested medical and/or surgical services from Blossom Gynecology, Wellness & Infertility, P.A. ("Blossom Gynecology") and by signing below, I voluntarily consent to treatment by Blossom Gynecology personnel, including any physician and/or any other designee who may be involved in performing evaluation, lab tests (which may include urine drug screens and testing for HIV and other sexually transmitted diseases), physical exam, ultrasound, biopsy, administration of medication, photographs, and procedures.

I understand that I have the right to speak with the physician before any treatment or procedure, and I have been offered the opportunity to ask any questions about the care I may or may not elect to receive. I am aware that the practice of medicine, surgery, and gynecology is NOT an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result of any treatment.

Blossom Gynecology is an office-based gynecology practice that does not provide emergency or hospital services. I understand that if I require hospitalization or inpatient services, or specialized services beyond the scope of Blossom Gynecology's practice, Blossom Gynecology will refer me to a different physician for further treatment. If I require immediate hospital or emergency care, Blossom Gynecology will send me to a hospital emergency department or direct me to call 911.

Blossom Gynecology is at times involved in health care education, and I agree that unless I specifically request otherwise; at times, care, examination, and treatment may be delivered by students or medical personnel in training who are under the supervision of a physician.

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, AND THEY HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAD IT READ AND EXPLAINED TO ME. I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW BLOSSOM OBSTETRICS, GYNECOLOGY, & INFERTILITY PHYSICIANS, ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIANS, AND ALL OTHER PERSONNEL, WHICH MAY OTHERWISE BE INVOLVED IN MY CARE TO PERFORM TREATMENT.

________________________________ ____________________
Patient Signature Date

________________________________ ____________________
Witness Signature Date

________________________________ ____________________
Parent/Guardian Signature* Date

**Parent/Guardian's signature is not required if the patient is 16 years old or above and the procedure does not involve an operation in accordance with S.C. Code Ann. § 63-5-340.*

03/01/2019

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
MARJORIE A. CHORNESS, MD FACOG

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Blossom Gynecology, Wellness & Infertility, P.A. to use and/or disclose my protected health information as described below to

(name and address of recipient)____

____

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

____

____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Blossom Gynecology, Wellness & Infertility, P.A. in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Blossom Gynecology, Wellness & Infertility, P.A. agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Entire Medical Record
☐ Office Chart Notes
☐ Billing Statements
☐ Dental Records
☐ Laboratory Reports
☐ Pathology Reports
☐ Consultation
☐ Discharge Summary
☐ Most Recent 5 Year History
☐ All Hospital Records
☐ Transcribed Hospital Reports
☐ History and Physical Exam
☐ Emergency and Urgent Care Records
☐ Medical Records for Continuity of Care
☐ Diagnostic Imaging Reports
☐ Emergency Room Reports
☐ Radiology Reports
☐ Operative Reports
☐ Other ____________________

____

____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Patient Name: ______________________ **Patient ID #:** ______________

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (if applicable)

Relationship to Patient (*if applicable*)
0 Parent or guardian of unemancipated minor
0 Court appointed guardian
0 Executor or administrator of decedent's estate
0 Power of Attorney

____
Printed Name of Patient's Representative (*if applicable*)

____
Signature of Witness

____
Date

MC/lh 6/19/18

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BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
MARJORIE A. CHORNESS, MD FACOG
420 C THE PARKWAY • GREER, SC 29650 864.662.5000 FAX 864.662.5008

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________ **Patient ID #:** ______________

I hereby acknowledge that I have received a copy of Blossom Gynecology, Wellness & Infertility, P.A.s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

______________________________ ______________________

Signature of Patient or Legal Representative **Date**

____

Printed Name of Patient's Representative (*If applicable*)

Relationship to Patient (*If applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____
____
____
____
____

- ☐ Other (Specify)

____
____
____
____
____

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Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: ______________________________

Date of Birth: ______________________________ Date Completed: ________________

Instructions: Please circle Y for those that apply to you and your family members. Next to each statement, please list th RELATIONSHIP TO YOU AND AGE OF DIAGNOSIS. You and the following family members should be considered:

Mother Father Sister Brother Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephe Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

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 th common features of Hereditary Breast and Ovarian Cancer Syndrome and Lynch Syndrome. Share this information with your health care professional to help determine yo hereditary cancer risk.

COLON AND UTERINE CANCER			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Uterine (endometrial) Cancer before age 50				
Y	N	Colorectal Cancer before age 50				
Y	N	Ovarian cancer				
Y	N	Two or more Lynch Syndrome Cancers (colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenoma)				

BREAST AND OVARIAN CANCER			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast Cancer at 50 or younger				
Y	N	Ovarian Cancer				
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family				
Y	N	Male Breast Cancer				
Y	N	Triple Negative Breast Cancer + (ER-, PR-, HER2- pathology) diagnosed before age 60				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				

Is there any other cancer in you or any family members not provided above? If yes, provide relationship and age of diagnosis:

____

Have you or any family members ever been tested for hereditary cancer? If yes, please explain:

____

Patient's signature: ______________________________ Date: ______________________

FOR OFFICE USE ONLY

- Candidate for further risk assessment and/or genetic testing
- Information given to patient for review
- Patient Offered genetic testing: (circle one) Accepted Declined

*Lynch Syndrome – related cancers include colorectal, uterine (endometrial), ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas.
+For a better understanding of triple negative breast cancer, please ask your provider.

Name________________________________ DOB____________ Date ____________

Menopause Rating Scale

Which of the following symptoms apply to you at this time?

	None	mild	moderate	severe	extremely severe	how long?
1. Hot flashes Times per day? ______	☐	☐	☐	☐	☐	______
2. Night sweats Times per night? ______	☐	☐	☐	☐	☐	______
3. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐	______
4. Sleep problems (difficulty falling asleep, difficulty sleeping through the night, waking up early)	☐	☐	☐	☐	☐	______
5. Depressive mood	☐	☐	☐	☐	☐	______
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐	______
6. Mood swings	☐	☐	☐	☐	☐	______
7. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐	______
8. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐	______
9. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐	______
10. Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐	______
11. Vaginal dryness or burning, difficulty with sexual intercourse)	☐	☐	☐	☐	☐	______
12. Joint and muscular discomfort	☐	☐	☐	☐	☐	______
13. Weight Gain How much? _________	☐	☐	☐	☐	☐	

Are you currently using hormone replacement therapy? ___Yes ___No Used in the past? ___Yes ___No

If yes, what type (cream, pellet, patch, ring, etc) and for how long? ________________________________

____

Physician notes: ____

____