Patient Prescription Form

NAME:_____

Medication Name	Dosage	Usage (1 pill a day, 3 pills a day)

JAMES A. SIMON, M.D., P.C.

Please update all information, sign, and return. Thank you.

PATIENT INFORMATION	Appt Date	Appt Time	Today's Date	Account #
Patient Name		Marital Status	Email Address	
Street Address	Gender	Home Phone #	Work Phone #	
City, State, Zip		Date of Birth	Cell Phone #	
Primary Physician		Referring Physician	Social Security #	

GUARANTOR/FINANCIALLY RESPONSIBLE PARTY		
Guarantor's Last	First Name MI	Home Phone #
Address	City, State, Zip	Work Phone #
Employer	Employer's Address	

PRIMARY INSURANCE INFORMATION			
Insurance Company	ID #	Group #	
Address	City, State, Zip	Phone #	
Policy Holders Name	Policy Holder Date of Birth	Social Security Number	
Policy Holder's Employer	Patient's Rel. to Ins.	Visit Copayment	Insurance Effective Date

SECONDARY INSURANCE INFORMATION			
Insurance Company	ID #	Group #	
Address	City, State, Zip	Phone #	
Policy Holders Name	Policy Holder Date of Birth	Social Security Number	
Policy Holder's Employer	Patient's Rel. to Ins.		Insurance Effective Date

AUTHORIZED PERSON TO CONTACT FOR BILLING OR RESULTS			
Name:	Phone # :	Name 2:	Phone # :

1. Financial Responsibility

I certify that the information I have provided regarding my insurance coverage is correct and authorize James A Simon MD PC. to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies.

I authorize that payments be made directly to James A Simon MD PC for all medical insurance benefits which are payable under the terms of my insurance policy for the services provided.

I agree to pay any copayments, coinsurance, or deductible as required by my insurance plan for medical care provided to me or my dependent I understand that I am responsible for knowing the terms and regulations of my insurance plan.

I agree to accept full responsibility for payment if my insurance coverage is not verified.

Effective 2/1/2009 I understand that if my account become's delinquent and is sent to collections, I will be responsible for the amount due on my account and all associated processing and collection fees charged by said collection agency.

2. Release of Medical Information For Billing

I hereby authorize James A Simon MD PC to submit a claim to my insurance company, health and welfare fund, Medicare or Medicaid for medical services provided to me or my dependent.

I also authorize James A Simon MD PC provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize James A Simon MD PC to release medical information to my consulting or primary care physician to assist with continuity of my health care. This release will expire one year from the date of my signature below unless I cancel this release in writing prior to that date.

3. Non-Covered Services

I agree to pay for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan.

I Agree to the Above Stated Responsibility and Consent	
Signature of Patient or Legal Guardian	Date

James A. Simon, M.D., P.C.
1850 M Street NW Suite 450 Washington, DC 20036

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations (TPO):
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Computers are located thoughout our practice. Schedules and the patient's proposed treatment are posted on the computer throughout our facility to achieve communication and high quality healthcare.
Your Authorization: In addition to our use of your information for TPO, you may give us written authorization to use your health information or to disclose it for other purposes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, xrays or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We may forward a regular newsletter to our patients and prospective new patients which describe the various services available from our practice.
Required by Law: We may use or disclose your health information when we are required to do so by law. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters or e-mail).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information.) We will charge you a reasonable cost-based fee for expenses such as copies and staff time.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than TPO, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PATIENT OR LEGAL GUARDIAN SIGNATURE

Signature	Date

James A. Simon, MD, PC
Women's Healthcare Across the Lifecycle

1850 M Street, NW Suite 450
Washington, DC 20036

E-Prescription Consent

- **Formulary and benefit transactions**- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that James A. Simon, M.D., P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all the above, I herby provide informed consent to James A.Simon, M.D., P.C. To enroll me in the ePrescribe program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

SIGNATURE_____DATE_____

PRINT NAME_____

DATE OF BIRTH_____

E-MAIL:_____

NAME/ADDRESS/ PHONE NUMBER OF PHARMACY:

_____

Appointment Date: _____

Appointment Time: _____

James A. Simon, M.D., PC

Patient Questionnaire

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Marital Status: _____

How did you hear about us? ❑Friend ❑Yelp ❑Facebook ❑Other Internet Source ❑Physician Referral

Referred by:_____

Address of Referring Physician(s): _____

_____

Allergies: _____

_____

Medications Currently Taking: _____

_____

_____

Reason for today's appointment: (Please check the appropriate statements below)

❑ Routine exam - no problems	❑ Second opinion	❑ Overweight
❑ Bleeding between periods	❑ Irregular periods	❑ Underweight
❑ Stopped having periods	❑ Light periods	❑ Heavy periods
❑ Never had periods	❑ Menopause	❑ Hormone therapy
❑ Premenstrual discomfort	❑ Pelvic pain or cramps	❑ Excess hair growth
❑ Contraception	❑ Cannot get pregnant	❑ Reverse tubal operation
❑ Previous miscarriage(s)	❑ Vaginal infection	❑ Bladder infection
❑ Breast problems	❑ Bone density	❑ Osteoporosis

Any other gynecologic problems or concerns you wish to address today:_____

_____

_____

_____

_____

_____

Please answer the following questions by filling in the blank or by checking "Yes" if it is the appropriate response.

Menstrual History

Age at first menstrual-period	_____	Do You Have:	YES
Starting date of last period	_____	Heavy bleeding	_____
Starting date of period before that one	_____	Bleeding between periods	_____
		Pain with periods	_____
Usual # of days from start of one period to the next	_____	Premenstrual symptoms (bloating, breast soreness,	_____

Bleeding lasts (# of days) _____ fatigue, irritability)
Age at menopause, if applic. _____

Gynecologic History

YES

Date of last pelvic exam: _____
Date of last pap smear: _____; was it abnormal? _____
Have you ever had an abnormal pap smear _____
Date of last mammogram: _____; was it abnormal? _____
Do you have hair growth you consider abnormal? _____
If yes, did you receive treatment? _____
Do you have discharge from your breasts? _____
Have you ever had a tubal infection? _____
If yes, were you treated with antibiotics? _____
History of venereal disease (gonorrhea, syphilis, herpes, chlamydia, etc.)? If so, specify_____ _____
Did your mother take diethyltilbestrol while pregnant with you? _____

Sexual History

Are you sexually active? _____
Frequency of sexual intercourse per week_____
Is intercourse painful? _____
Have you ever been treated for the pain? _____
If yes, describe_____
Do you have any sexual questions or concerns you would like to discuss? _____

_____
_____
_____

Contraceptive History

YES

Are you using a form of birth control? _____
If so, please list:_____
Have you ever used:
Birth control pills: _____
Which types and dates used_____
_____
IUD (intrauterine device) _____
Type_____ Dates used_____
Problems (please list)_____
Diaphragm _____
Condom _____
Other: _____ _____

Obstetrical History

How many times have you been pregnant?_____
If applicable, please describe below:

Premature Births:_____ Miscarriages:_____ Abortions: ___ Living Children:_____

Date	Weeks Preg	(Check appropriate section) Vaginal	C-sect	Miscar	Abort	Complications
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____

Surgical History

Please describe any previous pelvic or abdominal surgery (on the uterus, ovaries, tubes, cervix, or intestines including laparoscopies or appendectomy)

Type of Surgery Year Reason or Diagnosis Complications

_____
_____
_____
_____
_____

List any other surgery:_____
_____
_____
_____

Medical History

Do you have a history of:

- ❑ Emotional Problems
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Kidney Infections
- ❑ Bowel Problems
- ❑ Liver Problems
- ❑ Lung Disease
- ❑ Chronic Cough
- ❑ Visual Disturbances
- ❑ Rheumatic Fever
- Anorexia, Bulimia
- ❑ Ulcers or Stomach Problems
- ❑ Gall Bladder Disease
- ❑ Stroke
- ❑ Kidney Stones
- ❑ Bladder Infections
- ❑ Hepatitis or Jaundice
- ❑ Lung Disease
- ❑ Sinus Problems
- ❑ Difficulty Swallowing
- ❑ Skin Problems, Acne
- ❑ Other:_____
- ❑ Arthritis
- ❑ Easy Bruising
- ❑ Heart Murmur
- ❑ Loss of Urine
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Asthma
- ❑ Seizure Disorders
- ❑ Hearing Problems
- ❑ Cancer

Please list treatments prescribed for items above:_____
_____
_____
_____

Family History

YES

Indicate your ethnic background (i.e. African American, Mediterranean, Eastern European Jewish):_____

Does anyone in your family have a genetic disorder (i.e., cystic fibrosis. sickle cell anemia, Tay-Sachs. thalassemia)? _____
If so, how are they related to you?:_____

Does anyone in your family have mental retardation? _____
If so, how are they related to you?:_____

Does anyone in your family have a birth defect (i.e.. clubfoot, cleft lip and/or palate)? _____
If so, how are they related to you?:_____

Does anyone in your family have a chromosome abnormality (i.e. Down Syndrome, or Mongolism)? _____
If so, how are they related to you?:_____

Is there a family medical history of cancer? _____
If so, what relative and what kind of cancer_____
_____

Is there a family medical history of diabetes? _____

Please list any other medical problems which seem to run in your family or are of concern to you:

_____
_____

Social History

YES

Have you had previous marriages? If so, how many?_____ _____

Have you ever lived or traveled outside of the U.S.?
If so, where?_____

Do you smoke cigarettes now? If yes, how many packs/week?_____ _____
Have you smoked before and stopped? _____
How many years have you smoked in total?_____

Do you drink alcohol? If so, how many glasses/week?_____ _____

Do you use recreational drugs? _____
If so. specify_____

Have you ever worked with toxic chemicals, heavy metals or ionizing radiation? If so, specify_____ _____

How many hours do you exercise each week?_____

Which sports you participate in:_____
_____
_____

Family History Questionnaire

Patient Name: _____ Physician Seeing Today: _____

Date of Birth: _____ Age: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing:
1st Degree Relatives = Mother / Father / Sister / Brother / Children
AND 2nd Degree Relatives = Aunt / Uncle / Grandparent / Niece / Nephew

Have you or any of your relatives had cancer genetic testing? YES NO Explain: _____

Yes/No		BREAST / OVARIAN CANCER (HBOC/BRAC Analysis)	SELF SIBLINGS CHILDREN	MOTHER'S-SIDE	FATHER'S SIDE	Age of Diagnosis
(Y)	N	*EXAMPLE: Breast cancer diagnosed before age 50*		*Mother*		*47*
Y	N	Breast cancer diagnosed before age 50				
Y	N	Ovarian cancer at any age				
Y	N	THREE relatives on the same side of the family with breast cancer at any age (please also include 3rd degree relatives: cousins and great relatives)				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with a breast, ovarian or pancreatic cancer in the family at any age				

Yes/No		COLON / UTERINE CANCER (Lynch Syndrome/Colaris)	SELF SIBLINGS CHILDREN	MOTHER'S SIDE	FATHER'S SIDE	Age of Diagnosis
Y	N	Have YOU been diagnosed with colon or uterine (endometrial) cancer or before age 50				
Y	N	TWO or more relatives on the same side of the family w/ any of the following, one diagnosed before age 50: *Colon, Uterine/Endometrial, Ovarian, Stomach*				
Y	N	THREE or more relatives on the same side of the family w/ any of the following, diagnosed at any age: *Colon, Uterine/Endometrial, Ovarian, Stomach*				

Any other cancer in you or any family members? (*Ex: Prostate, Pancreatic, Melanoma, >10 colon polyps, Brain, Sebaceous Adenomas, etc.*):
Please list RELATIVE, CANCER SITE and AGE of diagnosis:

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☐ Patient is appropriate for hereditary cancer genetic testing ☐ Patient not appropriate

☐ Patient counseled/offered hereditary cancer genetic testing: ☐ ACCEPTED or ☐ DECLINED

HCP Signature: _____ Patient Signature: _____

James A Simon MD, PC

1850 M Street, Suite 450 · Washington, DC 20036
Ph: 202.839.1000 · Fx: 202.436.6150

NEW PATIENT REFERRAL FORM

Patient Name:
Date of Appointment:
Provider being seen:
Purpose of Visit:
Referring Physician: **Address:** **Phone:** **Email:**
Referred by Friend:
Social Media Referral (Circle all that apply): JAS WEBSITE FACEBOOK TWITTER LINKEDIN BLOG
Referred by Other: