CARE FOR WOMEN OB/GYN

ATASCOCITA & KINGWOOD

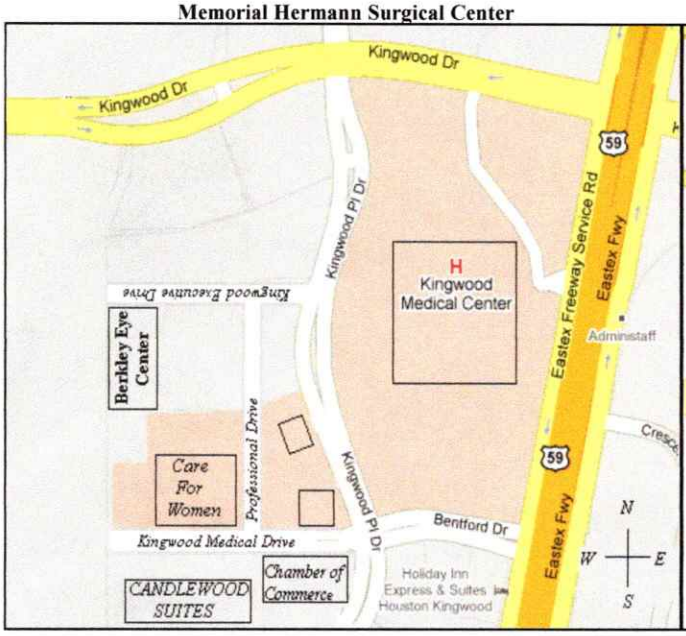
The comprehensive care you need.
The compassion & convenience you deserve.

Please call our office if you need to confirm the date, time and location of your appointment.
281-359-7000
www.careforwomenonline.com

KINGWOOD

Located in the Kingwood Medical Arts Building

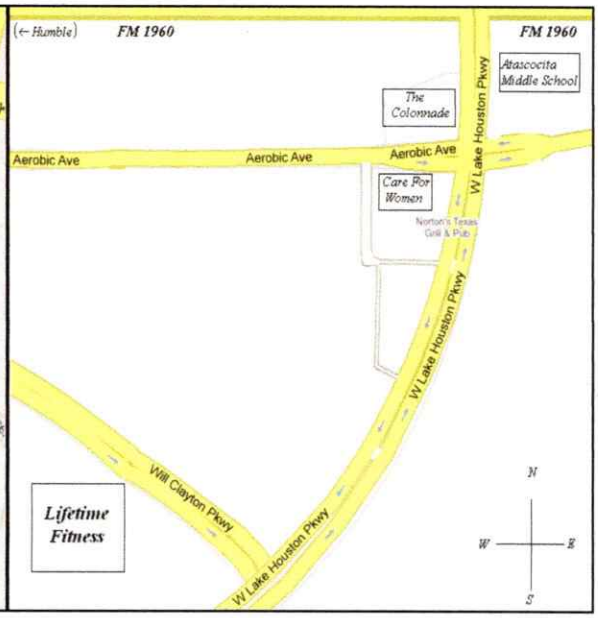
Memorial Hermann Surgical Center



350 Kingwood Medical Drive, Suite 350
Kingwood, TX 77339
Fax: 281-359-5833

ATASCOCITA

Located in <u>Orlean Square</u> close to Iguana Joe's



18321 West Lake Houston Parkway, Suite 100
Humble, TX 77346
Fax: 281-812-4927

****ATTENTION NEW PATIENTS****

You MUST arrive 30 minutes prior to your appointment along with your completed paperwork, insurance card, and picture ID.

Please call our office 24 hours in advance for any reschedules or cancellations, or you risk the possibility of losing your deposit.

Patient Text Message Consent Form

I hereby give my consent for the practice to send Text Messages to my mobile phone for the purpose of health information and appointment reminders. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession.

Should I not be able to keep an appointment I will call the office to cancel.

Printed Name: _____ Date of Birth: _____

Signature: _____

All patients have the right to change their minds and have this service stopped. If you no longer wish to receive these text reminders, please notify reception.

CARE FOR WOMEN

ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that I have been afforded the opportunity to read the CARE FOR WOMEN Notice of Privacy Practices and to have a written copy if requested, as well as to ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

To the Patient:
Please sign and return this copy to be kept in your records.

CARE FOR WOMEN
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer for CARE FOR WOMEN:

Beth Lunn, M.A.
Clinical Manager,
Care for Women
281/359-7000 x114

WHO WILL FOLLOW THIS NOTICE?

All staff and physicians of Care for Women.

We understand that medical information about you and your health is personal, and we are committed to protecting this information. When you receive care at Care for Women, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other healthcare providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing, and continually working, to improve the care rendered.

This notice tells you the ways we may use and disclose your protected health information (PHI) (also referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

Care for Women employees and physicians shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Care for Women will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use, or disclosure of your unsecured medical information that presents a significant risk of financial, reputational, or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- For Treatment. We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- For Payment. We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run CARE FOR WOMEN in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- Appointment Reminders. We may use and disclose medical information in order to remind you of an appointment. For example, CARE FOR WOMEN may provide a written or telephone reminder that your next appointment with CARE FOR WOMEN is coming up.
- Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- As Required by Law. We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- Sale of Practice. We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- Organ and Tissue Donation. If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Qualified Personnel. We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following activities:
    - To prevent or control disease, injury, or disability. To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

- To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- Lawsuits and Disputes. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If CARE FOR WOMEN determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- Inmates. If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide your treatment.
- Other Uses or Disclosures. Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for CARE FOR WOMEN. If you request a copy of the information, CARE FOR WOMEN may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records. It is the policy of CARE FOR WOMEN to provide your records within 15 days of receipt of a written and signed request from you on CARE FOR WOMEN's designated request form.

  Care for Women may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by CARE FOR WOMEN will review your request and denial. The person conducting the review will not be the person who denied your request. Care for Women will comply with the outcome of the review.

- Right to Amend. If you feel that medical information maintained about you is incorrect or incomplete, you may ask CARE FOR WOMEN to amend the information. You have the right to request an amendment for as long as the information is kept by CARE FOR WOMEN. To request an amendment, your request must be made in writing and submitted to Care for Women. In addition, you must provide a reason that supports your request. Care for Women may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, CARE FOR WOMEN may deny your request if you ask us to amend information that:
  - Was not created by CARE FOR WOMEN, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by CARE FOR WOMEN;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.
  To request this list you must submit your request in writing to Beth Lunn, Clinical Manager. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. CARE FOR WOMEN will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information CARE FOR WOMEN uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Care for Women discloses about you to someone who is involved in your care or the payment for your care. Care for Women is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which CARE FOR WOMEN has been paid out of pocket in full. Should Care for Women agree to your request, CARE FOR WOMEN will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Care for Women. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Care for Women's use and/or disclosure; and (3) to whom you want the limits to apply.
- Right to Request Confidential Communications. You have the right to request that CARE FOR WOMEN communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that CARE FOR WOMEN contact you only at work or by mail. To request that CARE FOR WOMEN communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. CARE FOR WOMEN will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer .

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with CARE FOR WOMEN or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with CARE FOR WOMEN, contact the Privacy Officer at 281/359-7000 x114. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

CARE FOR WOMEN: MEDICAL HISTORY INFORMATION

TODAY'S DATE:_____

Name: Last_____ First_____ Initial____ Age:_____ DOB:_____

Race:_____ Height:_____ Weight:_____ Last Menstrual Period:_____ PCP Name:_____

Last Pap smear taken: _____ Have you ever had a Mammogram? _____ If so when? _____ Where? _____

Are you allergic to any medications? _____ If so what? _____

PHARMACY NAME:_____ADDRESS:_____PHONE:_____

List current medications & dosage you are taking (EX: birth control pills, thyroid, hormones, etc.)
(CONTINUE ON BACK OF THE PAGE IF NEEDED)

1. _____ 3._____
2. _____ 4._____

Birth Control Method: _____

OBSTETRICAL HISTORY

Total Pregnancies _____ Total living children today _____

Full Term_____ Premature_____ Twins_____ Cesarean Section_____ Abortion_____ Miscarriages_____

Year of Birth	Place of Delivery	Sex	Weight	Type of Delivery	Complications

(CONTINUE ON BACK OF THE PAGE IF NEEDED

PREVIOUS MEDICAL HISTORY

Have you been treated by a physician in the last two years? _____ When and what for? _____

Please list ALL medical/cosmetic surgeries you have had and when:

1. _____ 3. _____
2. _____ 4. _____

GYNECOLOGICAL HISTORY

Abnormal Pap .....Y.....N
Sexually Transmitted Disease .....Y.....N
Regular Menstrual Cycle .....Y.....N
Heavy Menses/Painful Menses/PMS .....Y.....N
Endometriosis .....Y.....N
Breast Disease or Surgery .....Y.....N
Problems with Bowel Movement .....Y.....N

Difficulty Getting Pregnant .....Y.....
PCOS/Hirsutism .....Y.....
Menopause .....Y.....
History of Hormone Replacement Therapy .....Y.....
Uterine Fibroids .....Y.....
Urinary Tract Problems .....Y.....
Urinary Incontinence/Leakage .....Y.....

DO YOU HAVE OR HAVE EVER HAD?

Allergy to Local Anesthetics.....Y.....N
Bleeding Tendency.....Y.....N
Blood Transfusion History.....Y.....N
Hepatitis/Jaundice.....Y.....N
Ulcers.....Y.....N
Rheumatic Fever.....Y.....N
Polio.....Y.....N

Cancer.....Y.....N
High Blood Pressure.....Y.....N
Diabetes.....Y.....N
Thyroid Disease.....Y.....N
Liver/Kidney/Lung Disease.....Y.....N
Anemia.....Y.....N
Epilepsy or Seizures.....Y.....N

Chest Pain.....Y.....
Heart Attack/Murmur/Disease.....Y.....
Stroke.....Y.....
Alcohol Use.....Y.....
Illegal Drug Use.....Y.....
Smoke/Use Tobacco.....Y.....

FAMILY HISTORY

On the line after listed condition, write **"O"** for **NO HISTORY.** Write **"M"** for **MOTHER.** Write **"F"** for **FATHER.**

High Blood Pressure _____ Diabetes _____ Heart Disease _____ Blood Clots _____ Twins _____

CONTACT INFORMATION

I wish to be contacted in the following manner with my test results by:

HOME PHONE / CELL PHONE / WORK PHONE / EMAIL (CIRCLE ONE)

CHECK ONE: ____ Leave message with detailed information. ____ Only leave message with call back details.

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND HEREBY AUTHORIZE ANY MEDI
INFORMATION TO BE RELEASED TO CARE FOR WOMEN:

Print Name _____Signature _____

Signature of Patient (Parent or Guardian if patient is a minor)

CARE FOR WOMEN

Patient Information Form and HIPAA Privacy Compliance Patient Questionnaire

PLEASE FILL IN ALL BLANKS AND BRING TO YOUR APPOINTMENT
YOU MUST ALSO BRING YOUR INSURANCE CARD AND PICTURE ID:

Name: _____ **Date:** _____

(Please Print): *Last* *First* *MI*

Home Phone: ( ) _____

Address: _____ **Cell #:** _____

City _____ **State:** _____ **Zip** _____ **Work #:** _____

Employed: Yes ☐ No ☐ Student: Full time ☐ Part Time ☐ **E-Mail Address:** _____

Employer/School: _____ **Date of Birth:** _____
Employer Address: _____ **SS #** _____
City _____ **State:** _____ **Zip** _____ **Driver's License** _____
Occupation: _____ **Marital Status: M ☐ S☐ W☐ D☐ Sep☐**
Billing Address if Different: _____
Address **City** **State** **Zip** **Phone #**

PATIENT'S INSURANCE INFORMATION:
Is your insurance through your employer? **Yes ☐ No ☐** **Employer's Name** _____
Your Insurance Company Name _____ **Insured's Name** _____
Insured's Relationship To You: _____
Group/Policy # _____ **Insured's SS# and Date of Birth:** _____

AUTHORIZATION FOR *CARE FOR WOMEN* TO FILE YOUR INSURANCE

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of government or medical benefits to Care for Women *Patient Signature:* **X** _____ *Date:* _____

HOW DID YOU HEAR ABOUT US? ☐Friend ☐Relative ☐Dr. Referral ☐Yellow Pages ☐Welcome Wagon ☐Ad
Other: _____

HIPAA PRIVACY STATEMENT

All patients have the right to have confidential care provided. All information, medical or social, whether written, spoken, electronic, or computer generated, is to be held in strict confidence (please refer to the Care for Women Compliance Privacy Rules Notice).

If your lab testing is normal, our office may send you a private card notice. If anything is abnormal, our office will notify you by telephone. If you are not notified by phone or mail, please do not assume everything is normal. Call our office if it has been over two weeks since your test.

PATIENT RECORD OF DISCLOSURES

Yes ☐ No ☐ : May we speak to your emergency contact about medical information if you are unable to be reached in a timely manner?

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis.

EMERGENCY CONTACT (other than your Home # or Work #):

Name: _____ **Home Phone #:** _____
Work #: _____ **Other #:** _____ **Cell #:** _____

PLEASE NOTE: WE RESERVE THE RIGHT TO RELEASE MEDICAL INFORMATION IN EMERGENCY SITUATIONS

Your signature below only acknowledges that you have received the above HIPAA Privacy Notice regarding your rights to confidential care:

Signature of Patient or Guardian: X _____ **Date:** _____

( ) Signature declined. The practice made a good faith effort to obtain the patient's written acknowledgement of HIPAA Statement.

FOR STAFF USE ONLY: Date: _____ **Initials** _____

Year: _____

CARE FOR WOMEN

Patient Bill of Rights/Financial Responsibility

1) **I will make every effort to understand the benefits of my insurance plan, even to the extent of calling the benefits coordinator at my place of employment or my insurance carrier.**
2) **I will cooperate with this medical practice to assure prompt payment for all services I (we) receive, including non-covered services.**
3) **I agree to pay a $35 charge for any check that is returned by my bank for any reason.**
4) **If I receive maternity services, I agree to discuss any change of insurance plan with your business office before making the change. Failure may result in denial of payment, which makes the patient financially responsible.**
5) **I agree that this office can only bill for a diagnosis documented in my medical record. Thus, to Care for Women to change a diagnosis for the purpose of securing payment from my insurance carrier may result in an act of fraud.**

× _____ **INITIAL & DATE** ******I understand that Care for Women will only file Medicaid/Texas Health Network for services incurred once verification of coverage is obtained. Temporary ID cards or verbal authorization are not acceptable. Once coverage is verified, Care for Women will file only from that day forward, and for no dates prior to this verification. Any monies due Care for Women for services prior to the verification date are my responsibility***

Please sign below to indicate that you have read and understand the Bill of Rights/Financial Responsibility and HIPAA Privacy Statement.

× _____ **(signature)** _____ **(date)**

Any charges or fees quoted to you by employees or physicians of Care for Women are based on information given to us by your insurance company. The insurance company, emphasizes that it is not a guarantee and that the correct amount due by the patient can not be completely determined until after the claim is processed by them. Therefore, you may owe additional charges after we receive payment by the insurance company, for which you will receive a bill. We regret any inconvenience this may cause.

PATIENT CONSENT FORM
FOR MEDICAL AND/OR SURGICAL TREATMENT

I authorize the physicians at Care for Women to provide medical care including, without limitation, routine diagnostic procedures and medical treatment, which includes any procedures deemed necessary by the attending physician or other physicians or assistants, as may be designated by the physician, for medical care.

I understand that no warranty, guarantee, or assurance has been made by Care for Women with regard to the results of any treatments, examinations, or other medical care.

× _____ **(Signature of Patient)** _____ **(date)**

× _____ **(Witness' Signature)** _____ **(date)**

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN BELOW:

× _____ **(Signature of Patient)** _____ **(date)**

× _____ **(Witness' Signature)** _____ **(date)**

CONCERNING COMPLAINTS: Complaints about your physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
P.O. Box 2018
Austin, TX 78768-2018
For assistance by phone, call: 800-248-4062

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer (male or female)								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic or prostate cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Colon/rectal, uterine/endometrial, ovarian, stomach/gastric, kidney/urinary tract, biliary tract, small bowel, pancreas, brain, and sebaceous adenomas								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com

FHQ/06-13

MYRIAD

NCCN Simplified

One (1st or 2nd degree) relative with:

- **Breast 45 or under** **USPSTF-Breast 49 and under**
- **Ovarian ANY age**
- Male breast any age
- Breast with AJ heritage any age
- Bilateral breast if first diagnosis between 46-50
- Triple negative breast under 60
- **Pancreatic Cancer Any Age**
- **Metastaic Prostate Cancer Any Age**
- **Any personal history of breast cancer**

Two relatives:

- Two instances of breast cancer, one under 50 (one of which is a 1st or 2nd degree relative)
- One instance breast 46-50 (1st or 2nd) with a more distant ovarian (depends on how this ovarian is related to the breast)

Three relatives with:

- Breast and/or pancreatic/prostate/ and/or ovarian at any age (one of which is a 1st or 2nd degree relative)

RELATIVES

1ST DEGREE	2ND DEGREE	3RD DEGREE
MOM/DAD	GRANDMA/GRANDPA	COUSINS
SISTER/BROTHER	AUNTS/UNCLES/NIECES/NEPHEWS	GREAT GRANDPARENTS

LYNCH CRITERIA

Personal History of Colon or Endometrial cancer age 50 or younger
Family History of a 1st degree relative with Colon or Endometrial cancer age 50 or younger
Family History of 2 or more relatives on the same side of the family with Lynch Cancers one of which is diagnosed 50 or younger.(1st, 2nd, and 3rd degree relatives)

CARE FOR WOMEN

The comprehensive care you need.
The compassion & convenience you deserve.

We are asking that you log onto our website and follow the instructions below to enter your personal and medical history through our* <u>secure patient portal</u>. *If you do not have internet access, or if you have problems entering the information, please plan to come ½ hour early for your appointment to enter the information in our office.

Your user name is:_____

Your password is your birthdate: <u>xx/xx/xxxx</u> for example, 05/15/1916

Note: please complete both the online medical history form and the paper one mailed to you. The doctors like to have both.

Instructions: Go to www.careforwomenonline.com

- **Click on Patient Portal button in the upper right-hand corner of the page.**
- **Enter your user ID and Password.**
- **Click Medical Records in red at the top of the page.**
- **Click History in red at the top of the page, and enter all info, clicking the "save" button after each section.**
- **When finished, click Log Out in red at the top of the page.**