Courtney Hunt, MD, PC

5111 N Scottsdale Rd, Ste 150
Scottsdale, AZ 85250
(480) 970-1937 Phone (480) 970-1938 Fax

General Medical History

Patient name:_____DOB: _____

Primary care physician:_____Who sent patient: _____

Reason for visit: (please list all symptoms and pertinent information):

_____

_____

_____

Past Medical History _____ _____

_____

Past surgeries:

_____

_____

When was your last:

Blood Test: _____ Colonoscopy: _____ Pap smear: _____

Bone Density Test: _____ EKG: _____ Rectal Exam: _____

Chest X-Ray: _____ Mammogram: _____ Stress Test: _____

Height: _____ Weight: _____

History of heart attack: _____

List all medications/supplements you are taking including dosage: _____

_____

List any allergies: _____

Any diseases or illnesses that run in your family (including deceased family members and relationship):

_____

Tobacco use: Yes No

Alcohol use: Yes No

Drug use: Yes No

I am:

- ☐ Married
- ☐ Divorced
- ☐ Single

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Preventive

Blood Test: _____ Chest X-Ray: _____

Bone Density Test: _____ EKG: _____

Colonoscopy: _____ Stress Test: _____

Rectal Exam: _____

Male Health History

Describe any history of prostate abnormality: _____

_____

Preventative tests I have had within the past 12 months:

PSA Results: _____

Digital Rectal Results: _____

I have had the following medical conditions:

- ☐ Heart Attack
- ☐ Clotting disorder/Blood clots
- ☐ Bone loss/Osteoporosis
- ☐ History of use of anabolic steroids
- ☐ Prostatic Hypertrophy
- ☐ Prostate Enlargement
- ☐ Erectile Dysfunction
- ☐ Severe Sleep Apnea
- ☐ Liver Disease
- ☐ Coronary Artery Disease/High Cholesterol

I have had the following surgeries:

- ☐ Prostatectomy
- ☐ Surgery for Testicular Cancer
- ☐ Thyroid Surgery
- ☐ Vasectomy

How is your libido? _____

If you have a partner, how is their libido? _____

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Diet and Nutritional Information

Please describe what you eat on a typical day:

Breakfast:_____

Lunch:_____

Dinner _____

Snack: _____

Water intake (ounces per day):_____ Coffee intake (ounces per day): _____

Other beverages: _____

Exercise information:

Days per week: _____

Minutes per day: ____

Type of exercise: _____

Bedtime: _____

Wake Time: _____

How much sunshine do you get daily? _____

How much time do you spend watching TV? _____

How much computer/phone/tablet screen time daily? _____

If you feel sick, can you see yourself well? In what time frame? _____

Please list 3-5 goals:

_____

_____

_____

_____

_____

Review of Systems Form

*Please check all that apply

Please initial if NONE apply _____

Constitutional

- Weight Loss
- Weight Gain
- Fever
- Fatigue
- Other: _____

Eyes/Nose/Mouth

- Vision Change
- Use of Glasses/Contacts
- Itchy Ears
- Enamel Problems on Teeth
- Difficulty Detecting Smells
- Other: _____

Cardiovascular

- Chest Pain
- Palpitations
- Shortness of Breath
- Edema
- Other: _____

Gastrointestinal

- Diarrhea
- Bloody Stool
- Constipation
- Pain
- Bloating
- Other: _____

Genitourinary

- Hematuria (blood in urine)
- Dysuria (painful urination)
- Urinary Urgency
- Urinary Frequency
- Incontinent
- Other: _____

Skin / Breast

- Mastalgia (breast pain)
- Discharge
- Masses
- Rash
- Scabs or Bumps on Scalp
- Ulcers
- Hair Thinning
- Other: _____

Neurological

- Syncope
- Seizures
- Numbness/Tingling
- Trouble Walking
- Weakness
- Other: _____
- If so, where?

  _____

  _____

Psychiatric

- Depression
- Crying
- Anxiety
- Attention Problems
- Brain Fog
- Other: _____

Endocrine

- Diabetes
- Hypothyroid
- Hyperthyroid
- Other: _____

Hemat / Lymph

- Bruises
- Bleeding
- Other: _____

Updated 8/29/18

natera™ | Empower™ Hereditary cancer test

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:

Family History Questionnaire

Please answer the following questions to the best of your knowledge to help your care team understand cancer patterns in your family. For more information, text EMPOWER to 484848.

Select Yes/No and enter information in the accompanying boxes of the same row. Family members include parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings.

Please complete the following for you and your family members:		Age at diagnosis	Enter family member and age at diagnosis		
		You	Siblings/Children	Mother's side	Father's side
Example: Breast cancer	☒ Y ☐ N	Age 46	Daughter, 23 Sister, 52	Aunt, #1 63 Aunt, #2 48	Grandma, 81
1. Breast cancer ≤ age 45 **OR** breast cancer ≤ age 50 with unknown family history	☐ Y ☐ N				
2. Either colon cancer or uterine cancer < age 50	☐ Y ☐ N				
3. Triple negative breast cancer ≤ age 60	☐ Y ☐ N				
4. Two or more breast cancers in the same person (first diagnosis ≤ age 50)	☐ Y ☐ N				
5. Two or more colon and/or uterine cancers in the same person	☐ Y ☐ N				
6. Two family members with breast, colon or uterine cancer (one ≤ age 50)	☐ Y ☐ N				
7. Three or more family members from the same side with breast cancer	☐ Y ☐ N				
8. Three or more family members with colon and/or uterine cancer	☐ Y ☐ N				
9. Ovarian cancer **OR** pancreatic cancer **OR** male breast cancer **OR** 10 or more precancerous colorectal polyps	☐ Y ☐ N				
10. Ashkenazi Jewish **AND** breast cancer or high-grade prostate cancer	☐ Y ☐ N				
11. You or a close family member has a known gene mutation. Please list _____	☐ Y ☐ N				
12. Other cancers not listed above _____	☐ Y ☐ N				
13. Other concern about your cancer risk	☐ Y ☐ N	Please explain:			

If you have never been diagnosed with breast cancer, please complete the following questions.

1. Height (ft/in) _____ **2.** Weight (lbs)_____ **3.** Have you had children? ☐**Y** ☐**N** How old were you when you had your first child?_____

4. Approximate age at first menstrual period?_____ **5.** Have you gone through menopause? ☐**Y** ☐**N** ☐**Ongoing** If yes, at approximately what age?_____

6. Are you of Ashkenazi Jewish descent? ☐**Y** ☐**N** ☐**I don't know**

7. Have you ever used hormone replacement therapy? ☐**Y** ☐**N** If yes, when? Start date_____ Ongoing? ☐**Y** ☐**N** End date_____

If yes, what type? ☐ **Estrogen** ☐ **Progesterone** ☐ **Combined**

8. How many sisters do you have?_____ Daughters?_____ Maternal aunts?_____ Paternal aunts?_____ ☐ **I don't know**

9. Have you ever had a breast biopsy? ☐**Y** ☐**N** If yes, what was the result? ☐ **Hyperplasia** ☐ **Atypical hyperplasia** ☐ **LCIS** ☐ **I don't know**

Signatures

Patient Name	Patient Signature	Date
Provider Name	**Provider Signature**	**Date**

For Office Use Only

A 'Yes' answer to any of questions 1–11 indicates your patient may meet criteria for hereditary cancer testing.

Patient offered hereditary cancer genetic testing (check all that apply)

☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**

201 Industrial Road, Suite 410 | San Carlos, CA 94070 | www.natera.com | 1.650.249.9090

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

CELL #: (_____)_____-_____ **OTHER #:** (_____)_____-_____ **EMAIL ADDRESS:** _____

DATE OF BIRTH:_____/_____/_____ **SOCIAL SECURITY NUMBER:** ---------- _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER **SEX:** (circle one) FEMALE MALE

RACE/ ETHNICITY: _____

PATIENT'S EMPLOYER: _____ WORK PHONE#: _____

INSURANCE INFORMATION (For Lab Purposes)

While our office does not take insurance, we can submit lab orders or pathology through your insurance as a courtesy.

PRIMARY INSURANCE COMPANY:_____**COVERAGE EFFECTIVE DATE:**_____

CLAIMS ADDRESS:_____**PHONE:** _____

CONTRACT (ID#) NUMBER:_____**SUBSCRIBER'S NAME:** _____

GROUP NUMBER:_____ **GROUP NAME:** _____

SECONDARY INSURANCE COMPANY:_____**COVERAGE EFFECTIVE DATE:** _____

CLAIMS ADDRESS:_____**PHONE:** _____

SUBSCRIBER ID #:_____**SUBSCRIBE'S NAME:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle) SELF SPOUSE CHILD OTHER INSURED'S DATE OF BIRTH: _____

GROUP NUMBER:_____**GROUP NAME:** _____

All patients must complete our patient form before being seen by the provider. It is your duty as a patient to notify us of any changes of address, phone number, or insurance. We will need a copy of your driver's license. If you change insurance companies and do not supply us with updated information, labwork and pathology may not be billed through your current insurance and you will be responsible for contacting the laboratory to correct this.

PATIENT SIGNATURE:_____**DATE:**_____

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Credit Card Policy and Authorization

Patient Name:_____ Date of Birth:_____

Courtney Hunt, MD PC requires that all patients keep a credit card on file. This card will only be charged under the following conditions.

By signing below, I understand that if I fail to show up for a scheduled visit, Courtney Hunt, MD PC will attempt to contact me via phone or email. If I do not answer within 24 hours, I agree to allow Courtney Hunt, MD PC to charge my credit card for the $50 no show fee incurred.

Type of Card:____Mastercard_____Visa_____American Express_____Discover

Card Number: _____

Exp Date:_____/_____ Security Code: _____

I hereby acknowledge and agree that Courtney Hunt, MD PC is authorized to charge my account for any outstanding charges.

Patient Signature:_____Date:_____

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Insurance and Financial Policy

Patient Name:_____ Date of Birth: _____

- **Payment is required at the time of service. We do not accept checks.**
- **Laboratory Services -** Please be aware that we order labs, cultures, pap smears, HPV testing, etc based on what we deem best for your health care. Not all of these services may be covered by your insurance plan and we cannot be fully versed on individual insurance plans to assess coverage for these tests. BioReference is the lab we use in this office, unless you direct us to do otherwise. In certain cases, we will send biopsies and other samples to other laboratories for their expertise in gynecological pathology. Questions regarding lab billing should be directed to the laboratory directly.
- **Late Policy/ Missed Visits -** In consideration of maintaining an on-time schedule, we request that you arrive 30 minutes prior to your appointment time in order to fill out any necessary paperwork. Arriving more than 15 minutes late may require us to reschedule your appointment and you will incur a $50 fee. Failure to show for an appointment will result in a $50.00 charge per occurrence. Cancelations are required 24 hours prior to your appointment to avoid being charged.
- **Related/Complimentary Services –** Courtney Hunt, MD PC physicians may have a financial interest in certain complimentary testing, services or supplements provided by our office. Purchase of these products is not a requirement, but may be recommended to compliment the treatment plan put in place by your provider.
- **Discharge from Practice -** Any patient who commits any of the following offenses may be subject to immediate dismissal from the practice; abusive behavior or language, non-compliance with treatment plan, prescription misuse or abuse, multiple missed visits or failure to pay account.
- **Administrative Charges –** Patients may incur, and are responsible for, the payment of additional charges at the discretion of Courtney Hunt, MD PC. The charges may include, but are not limited to the following, and are subject to change at any time.
    - Charge for copying and distribution of medical records $50.00
    - Charge for form completion, including but not limited to, disability, FMLA or forms to satisfy FSA/HSA requirements $50.00
    - Year End Tax Statements $50.00

Patient Signature:_____Date:_____

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Authorization to Release Medical Information

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPPA), in order for your healthcare provider or Courtney Hunt, MD PC staff to discuss your medical history with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give us your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

- I give permission to Courtney Hunt MD, PC and staff to communicate lab results and health information to me through the Patient Health Record (PHR) that is operated by Practice Fusion Electronic Medical Records System. ☐ Yes ☐ No
- I authorize Courtney Hunt MD, PC and staff to leave lab results, appointment information and any other medical information on my voicemail in case I can't be reached.
  ☐ Yes ☐ No
- I give permission to Courtney Hunt MD, PC and staff to email me visit notes, lab and imaging results, and lab and imaging orders. I understand that email is not necessarily a secure method on my end.
  ☐ Yes ☐ No
- I give permission to Courtney Hunt MD, PC and staff to communicate with me via text messaging regarding appointment reminders, scheduling appointments and cancelling appointments.
  ☐ Yes ☐ No
- I authorize Courtney Hunt, MD PC and staff to share my medical information (including but not limited to lab results, appointment times, reasons for visits, imaging results, etc.) with any individual or medical provider below. ☐ Yes ☐ No

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name: _____ Relationship:_____

Patient Signature:_____ Date: _____

Printed Name:_____DOB:_____

Notice of HIPAA Privacy Practices

Courtney A Hunt, MD, PC

Receipt of Written Notice of Privacy Practices
Acknowledgement

I,_____, have received/been offered a copy of Courtney A Hunt, MD, PC's Notice of Privacy Practices.

_____ _____
Patient Name DOB

_____ _____
Patient Signature Date

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____

Phone Number: _____

Address: _____

Relationship: _____

TELEMEDICINE PATIENT CONSENT FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation.
2. NATURE OF THE TELEMEDICINE CONSULT: During the telemedicine consultation:
    a. Details of your health history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
    b. A physical examination of you may take place.
    c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
    d. Video, audio, and/or photo recordings may be taken of you during the procedure(s) or service(s).
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Arizona state law apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Arizona, and that Arizona law shall apply to all disputes.
7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all potential risks, consequences, and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information above.

I agree to participate in a telemedicine consultation for the procedure(s) described above.

SIGNATURE: _____

DATE: _____ TIME: _____