UPMC LIFE CHANGING MEDICINE

WOMEN'S CANCER CENTER

Gynecologic Oncology

Mailing Address: PO Box 8700, Harrisburg, PA 17105-8700
Locations: 2035 Technology Parkway, Suite 201, Mechanicsburg, PA 17050
4310 Londonderry Rd, Suite 106 Harrisburg ,PA 17109
www.UPMCPinnacle.com
PN_WomensCancerCenter@upmc.edu

Phone: 717-221-5940
Fax: 717-233-1939

PLEASE ARRIVE 20 MINUTES BEFORE YOUR APPOINTMENT TIME

Our physicians and staff would like to welcome you to our practice.

Enclosed are a few forms for you to complete, as well as directions to our office.

Please bring the following to your appointment:

- A list of all medications you are currently taking, including dosages.
- A list of physicians who are currently involved in your care. Please include their telephone and **fax** numbers, as we will be corresponding with them via fax regarding your care at our office.
- Your current insurance card(s).
- Your email address, or an email address of someone with whom we can communicate regarding your appointments at our office.
- Photo identification

We may be contacting you by phone, prior to your appointment, to obtain a detailed past medical history and other necessary information not included on the enclosed forms.

Your initial appointment with us will include an in depth consultation with the physician, a review of your medical history and the current reports provided to us, and, most likely, a pelvic examination.

You are welcome to have a friend or family member accompany you to your appointment.

We look forward to meeting you, and we appreciate the opportunity to participate in your health care.

Sincerely,

UPMC Pinnacle Women's Cancer Center

Gynecologic Oncologists
Jose E. Misas, M.D. Board Certified ~ Edward E. Podczaski, M.D. Board Certified ~ Sharon A. Fitzgerald, M.D. Board Certified

Thank you for choosing us as your health care provider. We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policy as an essential element in our care and treatment. To assist you, we have adopted the following financial policy. If you have any questions, please feel free to discuss them with our staff.

YOUR INSURANCE

We do participate with most insurers, including many HMO's as well as Blue Shield, Blue Cross and Medicare. It is your responsibility to know if we do participate with your insurance carrier prior to being seen by our physicians. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

For insurances with whom we have an agreement, we will directly bill your insurance company. Any required co-payment that you may have will be collected at the time of your visit. You are responsible for any co-insurance, deductible or
co-payment amount dictated by your insurance.

For insurances with whom we do not participate, we will file an insurance claim for office visits if your insurance plan covers office visits. It is your responsibility to know if your insurance plan does or does not cover office visits.

If your insurance plan does not cover office visits, we require payment at the time of the service.

You will be responsible for any amounts that your insurance carrier deems non-covered. Please be aware that your insurance carrier may consider some of the services provided as non-covered services.

USUAL AND CUSTOMARY FEES

Our practice is committed to providing the best treatment for our patients and we feel that our charges are fair. You are responsible for any amount determined by your insurance company as patient responsibility, regardless of the Insurance Company's determination of usual and customary rates.

TYPES OF PAYMENTS ACCEPTED

We accept personal checks, cash, money orders, Visa, or Mastercard for payment of services. If a check is returned to us for any reason, a $25 fee will be assessed. In addition, personal checks will no longer be accepted for payment on your account.

UNINSURED PATIENTS

Payment in full is expected at the time the service is rendered, unless prior arrangements are made with our Business Office. Professional Fees will be discounted by 40%.

MINOR PATIENTS

For all services rendered to minor patients, the patient's parent or legal guardian is responsible for payment.

Please continue and sign other side

UPMC LIFE CHANGING MEDICINE

UPMC PINNACLE WOMEN'S CANCER CENTER FINANCIAL POLICY

PATIENT IDENTIFICATION

Patient Name:_____

MR Number: _____

Date of Birth: _____

Form 1426-32 (01/19) MR (InD)
Aztec Barcode 201119

FEES FOR COMPLETION OF MISCELLANEOUS INSURANCE FORMS

UPMC Pinnacle Women's Cancer Center is a specialist office. In most cases you will be referred to your primary care physician for completion of insurance forms. In the event that we do complete your form, there is a flat rate of $15.00 (per form) for completion of miscellaneous insurance forms. Additional charges will be added for postage and copies of records. A miscellaneous insurance form is defined as any form not associated with your return to work or with reimbursement of our fees. Examples would be forms associated with loans, mortgages, credit cards and supplemental disability insurances. Payment is required prior to completion of the form.

FEES FOR COPIES

All requests for copies of your medical records must be submitted to us in writing. In addition to the charge for copies, postage fees will be added if applicable. Payment is required prior to completion of your request.

INSURANCE AUTHORIZATION OF ASSIGNMENT

I understand that my signature gives authorization for payment to be made to UPMC Pinnacle Women's Cancer Center on my behalf. My signature also authorizes the release of medical information to the insurer or agency with whom I have coverage that is necessary to pay any claim filed on my behalf for services rendered. In assigned cases, the physician agrees to accept the charge determination of the insurance company as the full charge, and the patient is responsible only for deductible, coinsurance, and non-covered services.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X_____ _____ _____ _____

Signature of Patient/Parent or Guardian if minor | *Printed Name* | *Date* | *Time*

UPMC LIFE CHANGING MEDICINE

UPMC PINNACLE WOMEN'S CANCER CENTER FINANCIAL POLICY

PATIENT IDENTIFICATION

Patient Name:_____

MR Number: _____

Date of Birth: _____

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments. However, unless the personal representative is a licensed physician who is credentialed to provide healthcare services at UPMC, use of UPMC's internal electronic medical record systems to access such medical information is not permitted.

Note that this form is not applicable and cannot be used for UPMC behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to:

- Procedures/services that require informed consent (and withdrawal of consent if applicable);
- Admissions to and discharges from nursing homes or other long-term care facilities;
- Donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy;
- Continuation or withdrawal of life support; and
- For major health care decisions, a formal power of attorney or living will is required.

UPMC

PERSONAL REPRESENTATIVE DESIGNATION FORM

PATIENT IDENTIFICATION

Patient Name _____

MR Number: _____

Date of Birth: _____

This personal representative designation applies to the following UPMC entity/locations:

List all applicable entities:

_____

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:	Patient's Phone:
Patient's Address:		
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues your personal representative may discuss? ☐ YES ☐ NO If yes, please specify:		
Expiration date for this designation *(unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).*		

REQUIRED SIGNATURES:

Personal Representative_____ _____ _____ _____
Signature Printed Name Date Time

Patient_____ _____ _____ _____
Signature Printed Name Date Time

Please return this completed form by mail to: _____

_____

_____

or by fax to:_____

UPMC

PATIENT IDENTIFICATION

PERSONAL REPRESENTATIVE DESIGNATION FORM

UPMC LIFE CHANGING MEDICINE

WOMEN'S CANCER CENTER
NEW PATIENT ROS SHEET

Date of Visit:_____

Name:_____ SSN: _____

DOB: _____ To see Dr. _____

Age:_____ Date of last period:_____ Postmenopausal ☐ YES ☐ NO

Have you had any of the following in the past year?

Pap Smear - Date_____ Normal ☐ YES ☐ NO

Mammogram - Date_____ Normal ☐ YES ☐ NO

Colorectal Screening - Date _____ Normal ☐ YES ☐ NO

Reason for visit: _____

Specific issues you would like to address today: _____

Allergies: _____

Pharmacy: _____

CONSTITUTIONAL	YES	NO	SKIN	YES	NO	HEENT	YES	NO
APPETITE CHANGE			BREAST LUMP			MOUTH SORES		
FATIGUE			BREAST PAIN			NOSEBLEEDS		
FEVER/CHILLS			SKIN LESIONS			RINGING IN THE EARS		
EARLY FULLNESS WITH EATING			NIPPLE DISCHARGE			TROUBLE SWALLOWING		
HEADACHES			RASH			BLURRED VISION		
UNEXPECTED WEIGHT CHANGE			**CARDIOVASCULAR**	**YES**	**NO**	DOUBLE VISION		
RESPIRATORY	**YES**	**NO**	CHEST PAIN			**GASTROINTESTINAL**	**YES**	**NO**
COUGH			PAIN IN LEGS WITH WALKING			BLOATING		
COUGHING UP BLOOD			IRREGULAR HEARTBEAT			ABDOMINAL PAIN		
SHORTNESS OF BREATH			LEG/FEET/ANKLE SWELLING			ABDOMINAL SWELLING		
WHEEZING			SHORT OF BREATH WITH LYING FLAT			BLOOD IN STOOL		
GENITOURINARY	**YES**	**NO**	PALPITATIONS			CONSTIPATION		
DIFFICULTY URINATING			PINS AND NEEDLES IN TOES			DIARRHEA		
PAIN WITH INTERCOURSE			**NEUROLOGICAL**	**YES**	**NO**	NAUSEA		
PAIN WITH URINATION			BALANCE CHANGE			VOMITING		
BLOOD IN URINE			LIGHTHEADEDNESS			**SKIN/BREAST**	**YES**	**NO**
INCONTINENCE			MEMORY LOSS			BREAST LUMP		
LEAKAGE OF URINE			NUMBNESS			BREAST PAIN		
PELVIC PAIN			SEIZURES			SKIN LESIONS		
VAGINAL PAIN			FAINTING			NIPPLE DISCHARGE		
VAGINAL BLEEDING			VERTIGO			RASH		
			EXTREMITY WEAKNESS					

PSYCHIATRIC	YES	NO	HEMATOLOGIC	YES	NO	MUSCULOSKELETAL	YES	NO
DEPRESSED MOOD			EASY BRUISING/BLEEDING			ARTHRITIS/JOINT PAIN		
INSOMNIA			SWOLLEN LYMPH NODES			DIFFICULTY WALKING		
THOUGHTS OF HURTING YOURSELF						MUSCLE PAIN		
ANXIOUS MOOD						MUSCLE WEAKNESS		

PHYSICIANS

Primary Care Physician _____

Referring Physician _____

Cardiologist _____

Other _____

TELL US ABOUT ANY PAIN YOU MAY BE HAVING *(CIRCLE THE APPROPRIATE RESPONSE)*

NONE	MILD		MODERATE				SEVERE			
0	1	2	3	4	5	6	7	8	9	10
										
NO PAIN	**MILD** Pain is present but does not limit activity.		**UNCOMFORTABLE TROUBLESOME** Can do most activities with rest periods.		**MISERABLE DISTRESSING** Unable to do some activities because of pain.		**INTENSE HORRIBLE** Unable to do most activities because of pain.		**WORST PAIN UNBEARABLE** Unable to do any activities because of pain.	

Patient's Signature:_____ Date:_____

FOR STAFF COMPLETION

HT_____ WT_____ B/P_____ PULSE_____

RESP RATE_____ PMHX_____ DOCTORS_____ INS_____

Physician's Signature:_____ Date:_____

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MEDICAL HISTORY

NAME_____ SS#_____ DOB _____
Condition being addressed at Women's Cancer Center_____
_____
Primary Care Physician_____ Phone # _____

MEDICATION LIST

DRUG	MG DOSE	#/DAY	DRUG	MG DOSE	#/DAY

MEDICAL CONDITIONS

SURGERY HISTORY

YEAR	TYPE	HOSPITAL	YEAR	TYPE	HOSPITAL

MEDICATION ALLERGIES

Are you allergic to Latex? ☐ YES ☐ NO Shell Fish? ☐ YES ☐ NO

MEDICATION	REACTION	MEDICATION	REACTION

FAMILY HISTORY *of Cancer/Heart Disease/Genetic Disease?*

FAMILY MEMBER	MATERNAL/PATERNAL	DISEASE *(If Cancer, what kind?)*

SOCIAL HISTORY

Marital Status _____ Spouse/Partner Name _____
Do you Smoke?_____ If yes- # years_____ Quit? How long ago?_____
Do you drink Alcohol? _____ If Yes- how many drinks _____ per day/week/month
Do you use Street Drugs? _____ If Yes what drug(s)?_____
Any history of drug or alcohol dependency?_____
Do you work? ☐ YES ☐ NO Occupation _____ Employer _____
(We may call you prior to your appointment to review this information)