NTGO
an Oncology Medical Home

Dear Patient,

We are an Oncology Medical Home (OMH) whose focus is on gynecologic cancers and complex gynecologic issues. Due to the complexity of your diagnosis, your primary care physician has referred you to us. As an OMH we keep our patients informed and involved in their care. No matter your diagnosis, we will not alter our commitment to you nor to our mission of providing quality care at the lowest cost from friendly and compassionate staff. More information about an Oncology Medical Home can be found on our website.

Prior to your first appointment, a nurse navigator will call to provide you with their name and direct phone number. In the coming days and months to follow, should you be uncertain which staff member should assist you with your question or need, your nurse navigator can always be reached to help facilitate this for you.

Included in this packet is your new patient paperwork. Please complete **all documents** prior to your appointment and arrive with these documents, your driver's license, and insurance card, no less than thirty (30) minutes prior to your appointment time. This additional time will provide the front desk the opportunity to transfer this important information into your electronic chart. Educational information, appointment information, and many of your healthcare records can be accessed through our online patient portal at www.seeyourchart.com. If you did not access your new patient paperwork through this valuable patient portal, please call and provide your nurse navigator with an email address.

NTGO has three locations. Below is a grid showing where your physician's clinics are throughout the week. Because office locations may provide different services, be sure you are certain of the location of any future appointments.

	Alan Muñoz, M.D.	Thomas Heffernan, M.D.	Arlene Garcia-Soto, M.D.
Monday	Dallas		
Tuesday		Dallas	Presbyterian Plano
Wednesday	Presbyterian Plano		Dallas
Thursday	Dallas	Medical Center of Plano	
Friday		Medical Center of Plano	

Visit our website at **www.northtxgynonc.com** for location addresses

Welcome **to North Texas Gynecologic Oncology**

At your first appointment, bring:

- Driver's License
- Insurance Card
- New Patient Packet, completed

Arrive 30 minutes prior to appointment time

Patient Financial Responsibility

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Thank you for choosing North Texas Gynecologic Oncology to serve your healthcare needs. Our physicians and staff look forward to providing excellent care to you and will work hard toward keeping the financial portion of your visit clear, up-to-date and concise. To better understand how you can assist us in accomplishing this goal, please read the information below.

1. **INSURANCE CARDS**: Please be prepared to show the receptionist your ***current*** insurance card each time you come to our office so we can verify our system contains up-to-date information.
2. **COPAYMENTS, DEDUCTIBLES and CO-INSURANCE BALANCES**: Many insurance companies require a copayment for each date of service. NTGO has a contractual obligation with your insurance company to collect this copayment. ***If your insurance plan requires you to pay a copayment, co-insurance and/or deductible, please be prepared to do so at the time of service unless other arrangements have been made.*** Once your claim is filed, the insurance company will pay the portion of the claim they are contractually obligated to pay and the balance will be the responsibility of the insured. You will receive a monthly statement showing your balance as of the date the statement was printed. If your next appointment at our office is prior to the due date, you can choose to pay your balance in our office. Alternatively, you can pay your balance by mailing us a check or using the online feature at northtxgynonc.com.
3. **CHANGES IN INSURANCE**: Insurance plans can change during the year due to employers changing plans or employees changing jobs. ***Should your insurance plan change, please contact the business office immediately. In the event you undergo chemotherapy treatment, please understand that an insurance company may take a couple of weeks to approve a treatment.*** If we are not given ample notification of a change in insurance, your treatment could be delayed or you could be financially responsible for any unpaid services.
4. **COBRA:** If you should lose your insurance and are planning on converting to a COBRA plan, please notify us immediately to avoid potential delays in your office visit, surgery or treatment.
5. **INSURANCE CORRESPONDANCE**: Information received in the mail from your insurance company should always be responded to quickly and completely. Failure to respond to an insurance inquiry may delay payment of services. Should you need help in understanding or completing the inquiries, please ask to speak with someone in our business office.
6. **Referrals and Authorizations**: Please be aware your insurance plan may require a referral or authorization for us to provide services to you. If you do not provide this information to us prior to your appointment, our office will be unable to bill your insurance company for services provided and you will be held responsible for them.
7. **PAYMENT PLANS**: If you are unable to pay your statement in full each month, a payment plan may be approved for you. If it is determined you are in need of a payment plan, please honor your payment agreement to avoid potential visit, surgery or treatment delays.
8. **MEDICARE INFORMATION AVAILABLE**: If you are eligible for Medicare, or will become eligible in the coming year, please ask someone in our business office for additional information on the benefits of enrolling in Medicare even if you and your spouse are currently working and receiving commercial insurance.
9. **ABN**: In the event your insurance company does not cover certain services recommended by our physicians, you may be requested to sign an ABN (Advanced Beneficiary Notice) and pay for these services out of pocket.
10. **UNDERSTANDING YOUR INSURANCE**: The business office will work diligently towards making the financial part of your treatment go smoothly; however, it is important for you, as the patient, to understand your policy and coverage as services not covered by your insurance are your financial responsibility.
11. **SELF-PAY**: Self-pay patients should be prepared to pay the full office visit amount, including any additional services performed during the office visit, at the time of check out.
12. **RETURN CHECK FEE**: A $25.00 return check fee will be added to your balance for any non-paid payment received.
13. **REFUNDS**: Refunds are issued when an overpayment has been identified. If you feel a refund is due, please contact us.

By signing below, you indicate you have been made aware of your financial responsibilities.

_____ _____ _____

PATIENT NAME PATIENT SIGNATURE DATE

_____ _____

STAFF INITIALS DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

NTGO
an Oncology Medical Home

PATIENT NAME _____ **DATE OF BIRTH** _____

I hereby authorize NTGO to release copies of my medical records to _____ .

I hereby authorize _____ to release information and my medical records to NTGO.

Restrictions: (none if left blank)

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the information to be released contains any information about HIV/AIDS, an additional HIPAA release of medical information may be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.

COMMUNICATION PREFERENCES

(Indicate all that apply)

	Leave message with **detailed information**	Leave message with **call-back number only**
Home Phone	☐	☐
Cell Phone	☐	☐
Work Phone	☐	☐

_____ _____

PATIENT / REPRESENTATIVE SIGNATURE TODAY'S DATE

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____

RELATIONSHIP TO PATIENT

NORTH TEXAS GYNECOLOGIC ONCOLOGY

12200 Park Central Drive, Suite 410, Dallas, Texas 75251

p 972.490.5970 | *f* 972.490.5632 | www.northtxgynonc.com

Alan K Munoz, MD
Thomas P Heffernan, MD
Arlene E Garcia-Soto, MD
Jane L Yau, MD

MEDICAL HISTORY

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PATIENT NAME _____ **DATE OF BIRTH** _____

☐ **New Patient** ☐ **Established Patient Update** **TODAY'S DATE**_____

PAST MEDICAL HISTORY — *Indicate any of the following that apply*

☐ Underactive Thyroid (Hypothyroidism)	☐ High Cholesterol (Hyperlipidemia)	☐ Diabetes	☐ Coronary Artery Disease
☐ Heart Attack (Myocardial Infarction)	☐ Peripheral Vascular Disease	☐ Congestive Heart Failure	☐ Atrial Fibrillation
☐ Deep Vein Thrombosis	☐ Pulmonary Embolism	☐ High Blood Pressure (Hypertension)	☐ COPD
☐ Asthma	☐ Osteoporosis	☐ Lumbar Disk Disease	☐ Frequent Urinary Infections
☐ Renal Failure ☐ Dialysis	☐ Kidney Stones	☐ Upper or Lower GI Bleed	☐ Fibrocystic Breast Disease
☐ Ulcerative Colitis	☐ Crohn's Disease	☐ Irritable Bowel Syndrome	☐ Cirrhosis
☐ Hepatitis	☐ Seizure Disorder	☐ CVA (Stroke)	☐ TIA (Transient Ischemic Attack)
☐ Peripheral Neuropathy	☐ Depression	☐ Schizophrenia	☐ Bipolar Disorder
☐ Rheumatoid Arthritis	☐ Auto Immune Disorder(s) _____		☐ HIV / AIDS
☐ HPV	☐ Herpes	☐ Gonorrhea / Chlamydia	☐ Syphilis

GENETIC TESTING? Have you or a family member ever had Genetic Testing? ☐ Yes ☐ No

If yes, please complete type of test: BRCA ☐ Positive ☐ Negative

Lynch Syndrome ☐ Positive ☐ Negative

PAST SURGICAL HISTORY — *Indicate any of the following surgeries that apply*

☐ Tonsillectomy	☐ Adenoidectomy	☐ Cataract Surgery	☐ Thyroidectomy
☐ Cervical Disk Fusion	☐ Pacemaker Insertion	☐ Coronary Bypass Stenting	☐ Coronary Artery Bypass Graft
☐ Exploratory Laparotomy	☐ Exploratory Laparoscopy	☐ Appendectomy	☐ Gallbladder Removal (Cholecystectomy)
☐ Removal Spleen (Splenectomy)	☐ Stomach Removal (Partial Gastrectomy)	☐ Surgery for Aneurysm (Aneurysmectomy)	☐ Femoro-Popliteal Bypass
☐ Varicose Vein Stripping	☐ Inguinal Hernia Repair (Inguinal Herniorraphy)	☐ Ventral Hernia Repair (Ventral Herniorraphy)	☐ Hemorrhoidectomy
☐ Hysterectomy – partial, ovaries were NOT removed (ovarian preservation)	☐ Hysterectomy – total, ovaries WERE removed (salpingo oophorectomy)	☐ C-Section	☐ Tubal Ligation (tubes tied)
☐ Organ Transplant	☐ Other:		

PAST CANCER HISTORY — *Indicate any of the following cancers that apply*

☐ None ☐ Breast ☐ Cervix ☐ Ovaries ☐ Uterus ☐ Colon ☐ Lung ☐ Other:

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY

Age of first menstrual period: _____

Age of Menopause (if applicable): _____

Date of Last Menstrual Period: _____

Describe your periods:
☐ Regular
☐ Irregular

Menstrual flow is (was) typically:
☐ Light
☐ Normal
☐ Heavy

HORMONE THERAPY

☐ Never ☐ Current ☐ Previous (date stopped): _____

Number of years used? _____ Type: _____

PATIENT NAME _____ **DATE** _____

CONTRACEPTIVE (birth control)

Oral Contraceptive Methods:

☐ Never ☐ Current ☐ Previous (date stopped): _____

Number of years used? _____ Type: _____

Other Contraceptive Methods: (not including Condoms)

☐ Never ☐ Current ☐ Previous (date stopped): _____

Number of years used? _____ Type: _____

MATERNITY

Number of Pregnancies _____ Number of Births _____ Age at first full-term pregnancy _____

HYSTERECTOMY

Have you had a hysterectomy: ☐ Yes ☐ No *If answered Yes*: Do you have ☐ One *or* ☐ Both ovaries?

Do you still have a cervix? ☐ Yes ☐ No ☐ Unsure

SOCIAL HISTORY

BLOOD TRANSFUSIONS If necessary, will you accept blood during surgery? ☐ Yes ☐ No

TOBACCO use ☐ Never ☐ Current Every day smoker ☐ Current Some Day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Pipe smoker ☐ Chew Tobacco ☐ Moist powdered tobacco ☐ Snuff ☐ E-cigarettes ☐ Former smoker ☐ Previous (date stopped): _____ Number of years used? _____ # packs per day: _____

ALCOHOL use ☐ Never ☐ Occasionally ☐ Previous Number of years? _____

On average, how many drinks per: Day _____ Week _____ Type: ☐ Wine ☐ Beer ☐ Spirits

DRUG use *Do you use illicit drugs?* ☐ Yes ☐ No Type:_____

MARITAL STATUS ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

CHILDREN ☐ No Children ☐ Yes, I have _____ living children

Your OCCUPATION ☐ Retired ☐ Homemaker ☐ Other: _____

FAMILY MEDICAL HISTORY

Mother ☐ Alive, age _____ ☐ Deceased at age _____, cause of death: _____

Father ☐ Alive, age _____ ☐ Deceased at age _____, cause of death: _____

Siblings *Number of:* Living Brothers: ____ Living Sisters: _____ Deceased Siblings: _____

FAMILY CANCER HISTORY

☐ None ☐ Unknown ☐ Breast ☐ Ovarian ☐ Lung ☐ Pancreatic ☐ Colon ☐ Prostate ☐ Thyroid ☐ Melanoma ☐ Neurofibromatosis ☐ Familia Adenomatous Polyposis (FAP) ☐ Other:

FAMILY DISEASE HISTORY

☐ None ☐ Unknown ☐ High Blood Pressure (Hypertension) ☐ Diabetes ☐ Coronary Artery Disease ☐ High Cholesterol (Hyperlipidemia) ☐ Other:

HEALTH MAINTENANCE HISTORY

Colonoscopy ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Mammogram ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Pap Smear ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Have you had a Flu vaccine this year? ☐ NO ☐ YES (date) _____

Have you had a Pneumonia vaccine this year? ☐ NO ☐ YES (date) _____

Have you had the Gardasil vaccine series? ☐ NO ☐ YES (dates) _____ _____ _____

MOOD DISORDERS SCREENING

We offer a screening for mood disorders such as anxiety and depression. If you are experiencing any Psychiatric symptoms, please consider participating in this screening.

☐ I would like to participate in this screening

☐ I decline this screening

PATIENT NAME _____ **DATE** _____

DRUG ALLERGIES — *list any medication allergies below*

	Medication	Reaction
1.		
2.		
3.		

FOOD ALLERGIES — *list any food allergies below*

	Food	Reaction
1.		
2.		
3.		

MEDICATIONS — *list all medications you are currently taking including supplements*

	Name of Drug	Dosage Amount	Frequency Taken
1.		mg or mcg	#____taken_____ times daily or every _____ hours
2.		mg or mcg	#____taken_____ times daily or every _____ hours
3.		mg or mcg	#____taken_____ times daily or every _____ hours
4.		mg or mcg	#____taken_____ times daily or every _____ hours
5.		mg or mcg	#____taken_____ times daily or every _____ hours
6.		mg or mcg	#____taken_____ times daily or every _____ hours
7.		mg or mcg	#____taken_____ times daily or every _____ hours
8.		mg or mcg	#____taken_____ times daily or every _____ hours
9.		mg or mcg	#____taken_____ times daily or every _____ hours
10.		mg or mcg	#____taken_____ times daily or every _____ hours

PHARMACY — *Complete all information of your pharmacy*

Pharmacy Name	Address	Phone#
_____	_____	_____
	_____	

FAMILY HISTORY QUESTIONNAIRE

for Common Hereditary Cancer Syndromes

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PATIENT NAME _____ **DATE OF BIRTH** _____

PATIENT SIGNATURE _____ **TODAY'S DATE** _____

Age at first period_____ Age at first full term pregnancy_____
Have you had a surgical or needle biopsy of the breast? YES NO
If yes, did the biopsy show atypical cells? YES NO UNKNOWN
Are you menopausal? YES NO
Have you ever used Hormone Replacement Therapy? YES NO
Has anyone in your family had genetic testing for a hereditary cancer syndrome? YES NO

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 cousin.

BREAST AND OVARIAN CANCER (BRCA)

			YOU (age of diagnosis)	Siblings/Children (age of diagnosis)	Mother's side (age of diagnosis)	Fathers side (age of diagnosis)
YES	NO	*Example: Colon Cancer*		*Brother at 36*	*Aunt at 44*	*Grandfather at 65 Cousin at 58*
☐	☐	Breast Cancer				
☐	☐	If yes above, was Tamoxifen or Herceptin prescribed?				
☐	☐	Breast cancer in both breasts or multiple primary breast cancers				
☐	☐	Ovarian Cancer				
☐	☐	Male Breast Cancer				
☐	☐	Prostate Cancer (BRCA)				
☐	☐	Pancreatic Cancer (Col/BRCA)				
☐	☐	Melanoma (BRCA)				
☐	☐	Are you of Ashkenazi Jewish decent?				

COLON and UTERINE CANCER (Colaris)

☐	☐	Uterine (endometrial) Cancer				
☐	☐	Colon Cancer				
☐	☐	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer. (Please circle type of cancer)				
☐	☐	Pancreatic Cancer (Col/BRCA)				

For Office Use Only:

Confirmed Triple Negative Status	YES	NO		
Patient meets NCCN criteria for testing	YES	NO		
Patient offered hereditary cancer testing	YES	NO	If Yes: accepted declined	Reason:
Follow-up appointment scheduled	YES	NO	Appt Date:	
Health Care Provider's Signature				Date: