Name: _____

Who is your Primary Care Physician (PCP)?
Name: _____ **City:** _____ **Phone:** _____

I permit the doctor and staff to discuss my protected health information with and to disclose my protected health information to the following individuals:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Patient Portal from your Physician's office
Your medical information at your fingertips

- Test results
- Medication lists
- Appointments
- AND **MORE!!!**

If you are interested in signing up for Patient Portal, please fill out this form and we will update your information in your account.

You will receive an email from ***FollowMyHealth***, which you will need to validate in order to sign in and register for Patient Portal.

Name: _____ DOB: _____

Email address: _____

Patient Feedback Form

As a patient of Laura A. Katz, M.D., P.C., we would like to thank you for entrusting us with your medical care. Our goal is to continue to provide the best care in a friendly, caring and convenient environment.

If there are any experiences, positive or negative, that you would like to share with us, please take a second to describe them below.

We appreciate your input!

Do you give permission to share this review with vitals.com, Facebook, Healthgrades, and Google? Yes/No

Laura A. Katz, M.D., P.C.

730 N. Macomb St., Suite #324
Monroe, MI 48162
Office: (734) 242-5588
Fax: (734) 242-5144

As a patient in our office, your care is of utmost importance to us. We want you to know that you can reach Dr. Katz at any time of the day or night, regardless to whether the office is open or closed.

During business hours, please call our office and a member of our staff will address any issues you may be having. They will inform Dr. Katz and you will receive an answer by the next business day.

If you are experiencing any issues after hours, you can call the main hospital telephone number at 734-240-8400 and ask to speak with Dr. Katz. They should patch you through to her private cell phone and your concerns will be addressed at that time. We ask that you please **do not wait** to call until the office is open if you are **having any problems**. Please use all these options **before** going to the emergency room.

We hope this helps aid in taking the best care of you and/or your family members. Thank you for your cooperation.

Dr. Katz and Staff

NAME_____DATE_____

WITNESS_____

Laura A. Katz, M.D., P.C.

730 N. Macomb St.,Ste. 324
Monroe, MI 48162
Office: (734) 242-5588

Welcome to our office!

You have been accepted as a patient to the practice of Laura A. Katz, M.D.,P.C. based on the assumption that you have given us an accurate medical and/or pregnancy history so that we can safely care for you in this office environment.

We wish to notify you that if there are additional medical or historical details that would classify you as a more high risk patient, there is a possibility that you could be referred to another physician or a tertiary care center. We want you to receive the best care!

Thank you very much for your time, and for our pregnant patients, congratulations on your new pregnancy!

Sincerely,

Dr. Laura A. Katz and Staff

NAME_____DATE_____

WITNESS_____

Bladder Health Questionnaire

Instructions: Bladder problems can affect the way we live. These problems can include frequent visits to the bathroom, a sudden or strong urge to urinate, accidental loss of urine, blood in your urine, and pain with urination. Please take a minute to answer the questions below about the past four weeks by circling the best response. For questions 1 through 5, write in the number you circle for each question in the box labeled "score." Once you have completed the questionnaire, add your score for questions 1 through 5. The total score will help you and your health care provider decide how serious your bladder problems may be.

Please answer YES or NO to the following questions A and B.

A. Have you noticed any blood in your urine or "pink" urine? ☐ No ☐ Yes

B. Did you have pain with urination? ☐ No ☐ Yes

If you have answered YES to A or B, we recommend that you seek medical attention immediately. If you answered NO to both questions, please continue.

How often in the past four weeks. . .	Not a problem	Less than once a week	1–2 days a week	3–4 days a week	5+ days a week	SCORE
1. Did you wake up at night to urinate two or more times?	0	5	10	15	20	_____
2. Did you have a sudden and uncomfortable feeling you had to urinate soon?	0	5	10	15	20	_____
3. Were you bothered or concerned about bladder control?	0	5	10	15	20	_____
4. Did you lose or leak urine for any reason?	0	5	10	15	20	_____
5. Did you wear a pad or other material to absorb urine you may have lost?	0	5	10	15	20	_____

If your score is over 60, you may **very likely benefit** from care or treatment.

If your score is between 21 and 60, you may **probably benefit** from care or treatment.

If your score is less than 21, you are **less likely** to need treatment.

TOTAL _____

Please discuss these results with your health care provider. Only a health care professional can evaluate or diagnose your bladder health. Effective treatment is available for almost all bladder disorders.

Updated October 2011

Name: _____

DOB: _____

Date: _____

NIDA Drug Screening Tool

Quick Screen

In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Tobacco Products

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Illegal Drugs

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Laura A. Katz, M.D., P.C.
Obstetrics & Gynecology
730 N. Macomb St. STE# 324
Monroe, MI 48162

I, _____, authorize the taking of an identification photograph during my initial consultation with Dr. Laura Katz for the purposes of medical documentation with the understanding such photograph will be kept confidential in my medical records. Initial _____

FRAGRANCE FREE OFFICE AGREEMENT: Initial _____
Due to the severe allergies in Dr. Katz/Dr. Pasko's office, I agree to refrain from wearing ANY scented products (ie: perfume, lotion, body wash, hair products, etc.) to my appointment(s). This includes anyone who accompanies me as well. If I do, I understand I will be asked to reschedule and come back at a later date for safety reasons.

CO-PAY POLICY: Initial _____
All patients who have a preset co-pay amount are required to pay that amount on the day of service. We are required by law and contract to collect from the patient any co-payments by your insurance plan on the date of service. We risk being dropped by the insurance company if co-pays are not collected as agreed upon in our participation contract. All outstanding co-pays must be paid up-to-date. If you have an outstanding balance, it is imperative that you contact the billing department or office manager to discuss payment arrangement as soon as possible.

RETURN CHECK POLICY: Initial _____
For all checks returned from the bank for non-sufficient funds, or for any reason, the following will apply: your account will be charged for the amount of your check and a $35.00 returned check handling fee. We will at that time freeze your account and no longer accept personal checks from you. All further services rendered would have to be paid by cash, Visa or MasterCard. All outstanding charges must be paid up-to-date. If you have an outstanding balance, it is imperative that you contact the billing department or office manager to discuss payment arrangement as soon as possible.

MEDICAL FORMS POLICY: Initial _____
There is a $25.00 fee per form that must be paid at the time medical forms are submitted. The charge would apply to medical forms such as any type of insurance company form or disability form. Please make us aware of urgent deadlines and we will do our best to complete the forms within the time you request. These forms will not be completed during a medical visit. We will forward the forms to the necessary party per your request or you will be notified when they are ready for pick-up.

NO SHOW POLICY: Initial _____
Failure to cancel an appointment within a timely manner will result in a $25.00 charge to you. This fee will be added to your account and will be due immediately upon receipt of notice and before your next appointment. We understand that emergencies arise; however, failure to notify our office within 24 hours that you cannot keep your appointment will be considered a 'no show'. Three 'no shows' may lead to dismissal from our practice. Also, if you are more than15 minutes late for your appointment, you will be rescheduled.

INSURANCE BILLING POLICY: Initial _____
The patient is responsible to know if the medical provider they are scheduled to see is an authorized provider according to their insurance contract. The patient's insurance contract is an agreement between the patient and the insurance company, therefore, if for any reason the insurance contract is not valid or any fees are not covered the patient is responsible for payment of all charges. It is the patient's responsibility to know about all the requirements of the insurance plan. Our 'Patient Insurance Coverage Responsibility Disclaimer' states as follows:

"I understand that it is my responsibility to know if Dr. Laura A. Katz is an authorized provider or is my assigned PCP according to my insurance contract. I realize that my insurance contract is an agreement between my insurance company and me. Therefore, if for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges. I also understand that Dr. Laura A. Katz is required by law and contract to collect from me, on the date of service, any deductible and/or co-payments required by my insurance contract.

I realize I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing, and referral appointments. If prior authorizations are required by my insurance contract for diagnostic testing and specialist appointments, I realize that it is my responsibility to request a referral authorization from Dr. Laura A. Katz. Failure to do so may result in your insurance company denying payment for services and you receiving a bill for services performed."

Signed: _____ **Date :** _____ **Witness:** _____

LAURA A. KATZ, M.D., P.C.
Obstetrics & Gynecology
730 N. Macomb, P.O.B. Suite 228
Monroe, MI 48162

Notice of Privacy Practices

THIS NOTICE, WHICH IS EFFECTIVE AS OF APRIL 7TH, 2003, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The doctor and staff here at Dr. Laura A. Katz, M.D., P.C. believe your medical information should remain confidential. The law requires us to establish office policies that are designed to safeguard your health information. The information contained in this notice constitutes our promise to you that we acknowledge our legal obligation to protect your health information, and it describes you rights concerning our use of your health information.

We will use and disclose your health information for purposes of treatment, payment and/or health care operations.

1. **Treatment** means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. *For example, a consultation follow up letter from a specialist to your primary care physician would be medical information maintained for treatment purposes.*
2. **Payment** means activities undertaken by a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care. *For example, the medical information furnished to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.*
3. **Health Care Operations** includes certain activities of the practice, as well as activities of an organized health care arrangement in which we participate, including: quality assessment and improvement activities, reviews of the competence or qualifications of health care professionals, activities related to underwriting or premium rating of insurance contracts, activities related to legal or accounting services provided to the practice, and business management and planning. *For example, from time to time hospitals and insurance companies will review physicians' clinical skills in order to assure that quality care is being provided. When such reviews are conducted, it is often necessary of the reviewer to randomly select and examine patients' medical records.*

We are permitted or required to disclose limited health information about you, *without your authorization*, in the following circumstances.

1. **As required by law so long as it is limited to the relevant requirements of such law.**
2. **For public health activities**, including the prevention of control of disease, vital statistics and public health investigations.
3. For purposes of making required reports about **victims of abuse, neglect or domestic violence.**
4. **Health oversight activities, including audits**, civil, criminal or administrative investigations, proceedings or actions; inspections; licensure or disciplinary actions.
5. **Judicial and administrative proceedings,** in response to court orders.
6. **Law enforcement purposes** (i.e., report of gunshot wounds; grand jury subpoenas; and information, regarding victims of crime).
7. **To coroners, medical examiners and funeral directors** for purposes of identifying deceased persons or determining cause of death.
8. For **organ and tissue donations,** consistent with applicable laws.
9. **Research,** provided the federal regulations governing research activities that insure the private of your health information are met.
10. To **advert serious threats** to health or safety.
11. **Specialized government functions** regarding military personnel and military veterans, certain national security purposes, and inmates.
12. **Workers' compensation** to the extent necessary to comply with applicable laws
13. **Marketing,** for purposes of appointment reminders, treatment alternatives, or other related benefits and services that may be of interest to you.

Any uses or disclosures other than those noted above require us to obtain your written authorizations, which you may revoke at any time. Any such revocation must be in writing.

You have the following rights with respect to your health information:

1. The right to request restrictions on certain uses of your health information, however we are not required to agree to your request.
2. The right to request, in writing, the manner or method by which we contact you to furnish confidential communications about your health information (i.e., fax, e-mail, voice mail, etc.). You are obligated to notify us, in writing, of any changes to your request.
3. The right to inspect your health information (you are entitled to receive a copy of your health information, except for psychotherapy notes and information compiled in anticipation of or for use in, a civil, criminal, or circumstances, the right to ask us to ament your health information, however we reserve the right to deny your request. If your request to ament is denied, we will provide you with information about the basis of our denial and your right to submit a written statement disagreeing with our denial.
5. The right to receive an accounting of disclosures of your health information, except those disclosures related to treatment, payment or health operations, disclosures that are made to you, disclosures that were made prior to the compliance date.
6. The right to receive a copy of this Notice in writing.

We have the following obligations:

1. We are required by law to maintain the privacy of your health information, and we are required to provide you with a notice of our legal duties and privacy practices.
2. We are required to abide the terms of the notice.
3. We are required to advise you of any changes we make in the terms of our notice of privacy practices. If any changes are made to notice of privacy practices, we will post the revised notice and make a copy of it available on request.

Complaints

If you believe ewe have violated your privacy rights, you make file a written compliant to our Privacy Officer and/or the Secretary of Health and Human Services. There will be no retaliations for filing a complaint.

If you want more information or you believe your rights have been violated, you can contact Our Privacy Officer at the following address 740 N. Macomb St Monroe, Michigan 48162, Attention Saundra Stark. Her telephone number is 734 241 1700. Alternatively, you may wish to contact the federal agency in charge of enforcing patients' privacy rights. That address is: Office for civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, HHS Building, Washington, D.C. 20201.

Acknowledgement

I have read the foregoing Notice of Privacy Practices provided to me by Dr. Laura A. Katz, M.D.,P.C., and I have been given the opportunity to discuss Dr. Laura A Katz's privacy practices. I understand that Dr. Laura A. Katz may, at her discretion, change the terms and conditions of this Notice. Any questions I may have had have been answered to my satisfaction. I understand the content of the Notice of Privacy Practices and I have been provided with a copy of same.

_____ _____

Print name Signature Date Staff initials

The NPP was provided to _____, however he/she did not acknowledge receipt for the following reason: refused did not understand other_____

_____ _____

Staff signature Date

riscover® cancer compass

Does cancer run in your family? Answer these questions about biological (blood) relatives on both sides of your family:

PARENTS **CHILDREN** **AUNTS & UNCLES**
BROTHERS & SISTERS **GRANDCHILDREN** **NIECES & NEPHEWS**
HALF SIBLINGS **GRANDPARENTS**

PATIENT NAME _____

DATE OF BIRTH *(mm/dd/yyyy)* _____

TODAY'S DATE *(mm/dd/yy)* _____

1 *Have you or any of your relatives had* BREAST CANCER?

NO ☐ YES ☐ →

N ☐ Y ☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*
◯ BREAST CANCER ◯ PANCREATIC CANCER ◯ PROSTATE CANCER

N ☐ Y ☐ Do you have any grandparents who are Ashkenazi Jewish?

Have you or any of your relatives been diagnosed with:

N ☐ Y ☐ Breast cancer at age 45 or younger?
N ☐ Y ☐ Male breast cancer?
N ☐ Y ☐ Triple negative breast cancer at age 60 or younger? *these are rare*
N ☐ Y ☐ Two different breast cancers, with the first diagnosed at age 50 or younger?

If **YES** to any, fill out the other side of this form.

2 *Have you or any of your relatives had* LYNCH SYNDROME-RELATED CANCERS? *(see list at right)*

NO ☐ YES ☐ →

N ☐ Y ☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*

LYNCH SYNDROME-RELATED CANCERS
◯ COLORECTAL CANCER ◯ SMALL BOWEL CANCER ◯ URETER CANCER
◯ UTERINE CANCER ◯ BILIARY TRACT CANCER ◯ BRAIN TUMORS
◯ STOMACH CANCER ◯ KIDNEY CANCER ◯ PANCREATIC CANCER

N ☐ Y ☐ Have you or any of your close relatives (parents, children, siblings) been diagnosed with colorectal or uterine cancer at age 49 or younger?

N ☐ Y ☐ Have you or any of your relatives been diagnosed with two different types of Lynch syndrome-related cancers (in the same person)?

If **YES** to any, fill out the other side of this form.

3 *Have you or any of your relatives had* OVARIAN, FALLOPIAN TUBE, *or* PERITONEAL CANCER?

NO ☐ YES ☐ →

If **YES**, fill out the other side of this form.

If you answered **NO** to all the questions, you don't need to fill out the other side.

OFFICE USE ONLY Reviewed by: _____

Are **outlined** questions checked on front side?
☐ Yes → Turn to other side and count the cancers.
☐ No

Are **shaded** questions checked on front or back side?
☐ Yes → Patient likely meets NCCN criteria. → Patient accepted testing?
☐ No

☐ Yes Date drawn: _____
☐ No

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progenity® Prepare for life.

CANCER FAMILY HISTORY

riscover® cancer compass

PATIENT NAME

DATE OF BIRTH *(mm/dd/yyyy)*

Complete this side if you have relatives with these cancers only

- ○ BREAST
- ○ PANCREATIC
- ○ PROSTATE
- ○ OVARIAN
- ○ FALLOPIAN TUBE
- ○ PERITONEAL
- ○ LYNCH SYNDROME-RELATED CANCERS: COLORECTAL, UTERINE, STOMACH, SMALL BOWEL, BILIARY TRACT, KIDNEY, URETER, BRAIN TUMORS

If you have more affected relatives, use the "other" space in each category.

***AVAILABLE TO TEST?**

Tell us if affected relatives are available for testing by writing the appropriate letter code in the box.

N Unavailable due to personal reasons
D Deceased
E Estranged; unable to contact
Y Available for testing

Some health plans require this information to determine eligibility.

Relatives on your mother's side

MOTHER
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

MATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

MATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

MATERNAL GRANDMOTHER
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

MATERNAL GRANDFATHER
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ PROSTATE

OTHER MATERNAL *relationship:* ____
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

Relatives on your father's side

FATHER
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ PROSTATE

PATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

PATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

PATERNAL GRANDMOTHER
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

PATERNAL GRANDFATHER
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ PROSTATE

OTHER PATERNAL *relationship:* ____
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

Relatives that belong to both your mother's and father's sides

YOU
☐ Female ☐ Male
Age diagnosed: ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR CHILD
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR GRANDCHILD
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR SIBLING
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR NIECE/NEPHEW
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

OTHER *relationship:* ____
☐ Female ☐ Male
Age diagnosed: ____ Available to test?* ____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ____
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

OFFICE USE ONLY

If outlined questions are checked on the front, count the affected relatives on the **same side of the family.**

Relatives in the bottom category (**YOU, YOUR SIBLING,** etc.) count on **both sides of the family.**

N ☐ Y ☐ 3 people on the **same side of the family** with ✓**BREAST,** ✓**PANCREATIC,** or ✓**PROSTATE CANCER?**

N ☐ Y ☐ 2 people on the **same side of the family** with ✓**BREAST,** ✓**PANCREATIC,** or ✓**PROSTATE CANCER,** with one person diagnosed with breast cancer at age 50 or younger?

N ☐ Y ☐ 3 people on the **same side of the family** with ✓**LYNCH-RELATED** or ✓**PANCREATIC CANCER?**

N ☐ Y ☐ 2 people on the **same side of the family** with ✓**LYNCH-RELATED** or ✓**PANCREATIC CANCER** with one person diagnosed at age 49 or younger?