

Donna Claypool, NP
13359 Isle Drive, Suite 1
Baxter, MN 56425
218-454-8888

Thank you for scheduling an appointment with Donna Claypool, NP on _____ at _____ for a comprehensive women's health assessment. Enclosed you will find a packet of information that needs to be completed for your upcoming appointment. Included in the packet is:

- ✓ An Informed Consent Form regarding the services you will be receiving.
- ✓ A Women's Health Assessment form that needs to be completed prior to arrival for your appointment.
- ✓ A demographic and insurance information form. If laboratory testing is needed, the tests will be ordered and submitted to your insurance company by Kurtis Waters, MD. The information on this form is needed to successfully submit the laboratory charges.

If you have any further questions or need to reschedule your appointment, please feel free to contact our office at 218-454-8888.

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1, Baxter, MN 56425
(This information is necessary for our files & will be considered confidential)

PATIENT'S FULL NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ SEX: M F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL _____

PRIMARY PHONE # TO CONTACT YOU: _____

ALTERNATE PHONE #: _____

ALTERNATE PHONE #: _____

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ CONTACT INFO: _____

WOULD YOU LIKE TO HEAR ABOUT UPCOMING SEMINARS, PROMOTIONS, AND SPECIALS

____yes ____no

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE _____

ID # _____ GROUP # _____

POLICY HOLDER (IF OTHER THAN PATIENT):

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE _____

ID # _____ GROUP # _____

POLICY HOLDER (IF OTHER THAN PATIENT):

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled; to be made on my behalf to Kurtis Waters MD, PA for any services furnished me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance.

This facility does not deny any benefits or service because of race, color, national origin, age gender, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill.

Signature _____

Date _____

(Legal Guardian if minor)

Women's Health Assessment

Name _____ E-mail Address _____
 Age _____ Date of Birth _____ Referring Physician _____
 Primary Care Physician _____ OB/GYN _____

Who were you referred by / how did you hear about us?

Self Doctor Friend/Family Member _____ Other _____

Height _____ Weight _____ Blood Pressure _____ (taken during assessment)

Are you comfortable with your current weight? No Yes

What would you consider an ideal weight for you? _____ Date of last physical _____

Past Medical History

Have you been diagnosed/treated for:

	No	Yes		No	Yes
Cancer - Type _____	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding problems	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		Allergy	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>		Blood clots	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		STD /HIV	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Alcohol problem	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		Other _____	<input type="checkbox"/>

List Surgeries / Pertinent Hospitalizations

Have you had any of the following tests performed?

	No	Yes	Date / Year of Test
Mammography	<input type="checkbox"/>	<input type="checkbox"/>	
PAP smear	<input type="checkbox"/>	<input type="checkbox"/>	
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Bone density	<input type="checkbox"/>	<input type="checkbox"/>	

OB/GYN History

How many children do you have? _____ How many pregnancies have you had? _____

Have you had any interrupted pregnancies? No Yes _____

Have you had a hysterectomy? No Yes Date of surgery _____

Have your ovaries been removed? No Yes

Have you had a tubal ligation? No Yes

Have you ever used oral contraceptives? No Yes Any problems? No Yes
 If YES, describe any problem(s) _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?
 No Yes If YES, please explain (such as age when this occurred, symptoms, etc ...)

Are you still having menstrual cycles? No Yes
 When was your last period? _____ How often? _____
 How many days of flow? _____ Bleeding between cycles? No Yes
 Do you have, or did you ever have, Premenstrual Syndrome (PMS)? No Yes
 If YES, explain symptoms: _____
 If menopausal, have you had any spotting or bleeding? No Yes

Pertinent Family History

Has anyone in your family been diagnosed/treated for:

	No	Yes	Relationship(s)
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Fibrocystic breast	<input type="checkbox"/>	<input type="checkbox"/>	
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	

Lifestyle

How many alcoholic drinks do you consume per week? _____ Type of drink _____
 How much caffeine do you consume per day? _____
 How many diet beverages do you consume per day? _____
 Do you smoke? No Yes How much per day? _____ If quit, when? _____
 Do you feel you eat healthy? No Yes _____
 Do you follow a special diet? No Yes _____
 Do you feel your diet is excessive in: Carbohydrates Proteins Fats
 Do you exercise? No Yes Number of times per week _____ Type _____
 Are you interested in increasing? No Yes Type _____

Marital Status: Married to _____ Significant other _____
 Single Divorced Widowed
 Education _____ Occupation _____

Stress

Do you feel stress in your life? No Yes

If YES, please rank the source with 1 being the most stressful.

Physical/health related	
Relationship(s)	
Job related	
Emotional	
Other _____	

Do you feel stress from any relationships (spouse, kids, family, coworkers, and friends) in your life? No Yes

Please explain who / what are the issues: _____

Have you considered counseling? No Yes Would you consider counseling? No Yes

List Nutritional/Natural Supplements
<input type="checkbox"/> vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
<input type="checkbox"/> minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
<input type="checkbox"/> herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, etc.)
<input type="checkbox"/> enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
<input type="checkbox"/> nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)
<input type="checkbox"/> others (glucosamine, antihistamines, antacids, etc.)
List: _____

List Hormones Previously Taken	Date Started	Date Stopped	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Prescription Medications

List Medication Allergies _____

External Self

Are you generally comfortable with your appearance? No Yes

If NO, what are your areas of concern? _____

Are you routinely using a skin care regimen and/or makeup? No Yes

Are you interested in a complimentary consult with an esthetician (skin care specialist) regarding options for skin rejuvenation/maintenance products? No Yes

Are you interested in information or visiting with someone regarding:

Facial rejuvenation? No Yes

Body rejuvenation? No Yes

Dental rejuvenation? No Yes

Hair style options? No Yes

CHECK the degree of severity for any symptoms that apply to you:

	mild	moderate	severe		mild	moderate	severe
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy/irregular menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harder to reach climax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body aches/joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breakthrough bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin/hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fuzzy thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any additional comments or concerns: _____

Patient Signature _____

Date _____

Donna Claypool, NP
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Informed Consent Form

Your signature on the bottom of this form signifies that you understand that the comprehensive women's health assessment and subsequent follow-up appointments cannot be submitted by our office to your insurance policy as there is no code that correctly conveys the services that you are receiving. Your decision to have this service rendered and your signature below indicate an understanding that the procedure will not be submitted to your insurance company and is in no way covered under any insurance obligations by Kurtis Waters, MD PA.

If additional laboratory testing is needed, tests will be ordered by Dr. Kurtis Waters and will be submitted to your insurance company. Reimbursement for such tests would be made according to your individual insurance coverage. Please contact your insurance company directly if verification of coverage is needed.

Payment in full for services rendered is due on the date of service. You understand that you may submit your paid receipt to your individual medical reimbursement plan. Any reimbursement from the above plan is a direct agreement between you and your benefit administrator.

Patient Name

Date

Patient Signature

Estimated Costs for Services

Insurances may or may not cover many of the services involved in a Woman's Health Assessment and Treatment plan. We want to be forthright on any potential costs of the services involved as many patients have high deductible plans and health saving accounts they must be attentive to. Please understand that not everything listed below is required on every patient. We pride ourselves on trying to deliver these services at the lowest cost possible and at the same time, we understand that everything can add up. We know your investment **in you** will be well worth it!

Initial Consult

\$320 at time of visit (other clinics range from \$450-1600 for similar services)

(Receipt can be submitted by patient to insurance or Health Savings Plan but many insurances do not cover as there is no insurance code for this type/level of service)

Initial F/U(1 month)

Included in cost of Initial Consult

Additional F/U (3months, 6months, yearly)

\$120 at time of visit

(Receipt can be submitted by patient to insurance or Health Savings Plan)

Salivary tests

Can Range from \$250-550

(Can be submitted to insurance by clinic)

Blood tests

Can Range from \$100-600

(Can be submitted to insurance by clinic)

Neutraceuticals/supplements

Daily supplements, Omega 3, Liver detox, Adrenal Adaptagens typically cost about \$1/day

(Can be submitted by patient to insurance or Health Savings Plan)

Compounded Hormones and/or other Prescriptions

Many of compounded prescriptions can range from \$40-100+/month. Once individual dosages have been established, some of the compounded prescriptions can be combined to make it more cost effective. Typical combination cream averages \$40-70/month.

(Very few insurance companies cover compounded prescriptions, can be submitted by patient to insurance or Health Savings Plan)

Other

Preventive health screenings are required through your primary care physician and/or gynecologist (mammogram, bone density test, colonoscopy, etc). Covered by insurance.

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1, Baxter, MN 56425

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

1. Kurtis Waters MD, PA is permitted to make uses and disclosures of **protected health information** (PHI) for treatment, payment, and health care operations, as described in the following examples:
 - a. For treatment – (e.g., to discuss your PHI with other healthcare providers)
 - b. For payment – (e.g., to submit information to your insurance company)
 - c. For health care operations – (e.g., to send the minimum necessary of your PHI to other healthcare providers as appropriate)
2. Kurtis Waters MD, PA is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Minnesota state law, when more stringent than federal law, will be followed.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Kurtis Waters MD, PA may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
5. The individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. Kurtis Waters MD, PA is not required to agree to a requested restriction, however.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.
 - f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. Kurtis Waters MD, PA is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
7. Kurtis Waters MD, PA is required to abide by the terms of the Notice currently in effect.
8. Kurtis Waters MD, PA reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Kurtis Waters MD, PA will provide individuals or patients with a revised Notice on request in person or by mail after an official public notification in the Brainerd Daily Dispatch.
10. Individuals may complain to Kurtis Waters MD, PA and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated by calling or writing and requesting a complaint form.
11. Kurtis Waters MD, PA contact person for matters relating to complaints is:

Call:

Privacy Officer @ 218-454-8888

Or **Write** to:

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1
Baxter, MN 56425

12. This Notice is first in effect 12/1/2007.

**Kurtis Waters MD, PA
13359 Isle Drive, Suite 1
Baxter, MN 56425
218-454-8888**

I hereby acknowledge that I have received a copy of Kurtis Waters MD, PA Notice of Privacy Practices.

Signature

Date:_____

Optional:

Email address:_____@_____

This address is considered part of your **protected health information**, and will be used by Kurtis Waters MD, PA only for your benefit.