



1040 N.W. 22nd Avenue • Suite 330 • Portland, OR 97210 • Phone 503 274-9936 • Fax 503 274-2660
www.CascadeWomensHealth.org

Please Print and Fill out Completely

NAME PATIENT USES:

PATIENT INFORMATION			
PATIENT'S LEGAL NAME: LAST FIRST MI		DATE OF BIRTH:	SOCIAL SECURITY #:
STREET ADDRESS, APT/UNIT #:		CITY AND STATE:	ZIP CODE:
HOME PHONE:		WORK PHONE:	
OK TO LEAVE DETAILED VOICEMAIL? ☐ Y ☐ N		OK TO LEAVE DETAILED VOICEMAIL? ☐ Y ☐ N	
MOBILE PHONE:		TEXT OPT-IN? ☐ Y ☐ N	
OK TO LEAVE DETAILED VOICEMAIL? ☐ Y ☐ N		(YOU WILL RECEIVE AUTOMATED APPOINTMENT REMINDERS)	
PREFERRED PHONE: ☐ HOME ☐ WORK ☐ MOBILE		PATIENT'S EMAIL ADDRESS:	
LEGAL SEX: ☐ FEMALE ☐ MALE ☐ OTHER		SEX ASSIGNED AT BIRTH: ☐ FEMALE ☐ MALE ☐ INTERSEX ☐ UNCERTAIN ☐ UNKNOWN	
GENDER IDENTITY: ☐ FEMALE ☐ MALE ☐ NON-BINARY/GENDERQUEER ☐ OTHER _____			
PRONOUNS: ☐ SHE/HER/HERS ☐ HE/HIM/HIS ☐ THEY/THEM/THEIRS ☐ OTHER: _____			
ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC/LATINO ☐ UNKNOWN ☐ DECLINE		RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC/LATINO ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ WHITE/CAUCASIAN ☐ UNKNOWN ☐ DECLINE ☐ OTHER: _____	
PREFERRED LANGUAGE:	COUNTRY OF ORIGIN: ☐ DECLINE	RELIGION: ☐ DECLINE	MARITAL STATUS: ☐ DIVORCED ☐ DOMESTIC PARTNER ☐ MARRIED ☐ SEPARATED ☐ SIGNIFICANT OTHER ☐ SINGLE ☐ WIDOW ☐ OTHER
PATIENT'S EMPLOYER:		EMPLOYMENT STATUS: ☐ FULL ☐ PART ☐ SELF EMPLOYED ☐ NOT EMPLOYED ☐ RETIRED ☐ ACTIVE MILITARY	STUDENT: ☐ FULL ☐ PART
PRIMARY CARE PHYSICIAN:		ADDRESS:	
PHONE NUMBER:		HOW DID YOU HEAR ABOUT US? ☐ FRIEND/FAMILY ☐ DOCTOR ☐ INSURANCE ☐ YELP ☐ INTERNET SEARCH/GOOGLE	
EMERGENCY CONTACT			
NAME:	RELATIONSHIP:	PHONE NUMBER:	
NAME:	RELATIONSHIP:	PHONE NUMBER:	

(OVER→)

COMPLETE ONLY IF THE PATIENT IS A MINOR

PARENT/GUARDIAN'S NAME:		DATE OF BIRTH:	RELATIONSHIP: ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN ☐ OTHER:
STREET ADDRESS, APT/UNIT #: ☐ SAME AS PATIENT		CITY AND STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:		MOBILE PHONE:
PARENT/GUARDIAN'S NAME:		DATE OF BIRTH:	RELATIONSHIP: ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN ☐ OTHER:
STREET ADDRESS, APT/UNIT #: ☐ SAME AS PATIENT		CITY AND STATE:	ZIP CODE.:
HOME PHONE:	WORK PHONE:		MOBILE PHONE:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:		GROUP NUMBER:	SUBSCRIBER/MEMBER ID:	
POLICY HOLDER'S NAME: ☐ SAME AS PATIENT		DATE OF BIRTH:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:	
STREET ADDRESS, APT/UNIT #: ☐ SAME AS PATIENT		CITY AND STATE:	ZIP CODE:	
SUBSCRIBER'S EMPLOYER:	PHONE NUMBER: ☐ CELL ☐ WORK ☐ HOME		SOCIAL SECURITY NUMBER:	
SECONDARY/SUPPLEMENTAL INSURANCE NAME *:		GROUP NUMBER:	SUBSCRIBER/MEMBER ID:	
POLICY HOLDER'S NAME: ☐ SAME AS PATIENT		DATE OF BIRTH:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:	
STREET ADDRESS, APT/UNIT #: ☐ SAME AS PATIENT		CITY AND STATE:	ZIP CODE:	
SUBSCRIBER'S EMPLOYER:	PHONE NUMBER: ☐ CELL ☐ WORK ☐ HOME		SOCIAL SECURITY NUMBER:	

* WE MAY BE ABLE TO BILL YOUR SECONDARY/SUPPLEMENTAL INSURANCE (PLEASE CHECK WITH RECEPTION DESK FOR CLARIFICATION).

X _____
SIGNATURE OF PATIENT, PARENT
OR LEGALLY RESPONSIBLE PERSON

PRINT NAME

RELATIONSHIP

DATE

(OVER→)

Cascade Women's Health, PC

Patient Health History

Full Name: _____ Date of Birth: _____

What pharmacy do you use? _____

Pharmacy Address _____ Phone# _____

Do you want to have a provider assistant present at the time of your examination? ☐Y ☐N

Reason for your visit today: _____

Current Medications (please list below or attach list):

Supplements:

Allergies to medications/latex/adhesives? ☐Y ☐N (If yes, please list below):

Do you have any dietary restrictions/special diet? ☐Y ☐N (if yes, please list below):

Prior Surgeries? ☐Y ☐N (if yes, please list below):

First day of your last menstrual period? _____ How frequent are your periods? _____

Number of pregnancies: _____ Birth: ☐Y ☐N Miscarriage: ☐Y ☐N Abortion: ☐Y ☐N

Current method of birth control? _____ Are you satisfied with this method? ☐Y ☐N

Date of last pap? _____ Any history of abnormal pap? ☐Y ☐N Date: _____ Result: _____

Date of most recent mammogram? _____ Age when you began having menstrual periods? _____

Have you completed the Gardasil (HPV) vaccination series? ☐Y ☐N

Sexual Orientation: ☐Straight/Heterosexual ☐Gay ☐Lesbian ☐Bisexual ☐Pansexual ☐Queer ☐Asexual

☐Don't Know ☐Questioning ☐Choose not to disclose ☐Something else _____

Sexually active? ☐Yes ☐Not currently ☐Never

Age when you began having sexual relations? _____ Do you have sex with men, women or both? _____

Any new sex partners in the last year? ☐Y ☐N Any history of Sexually Transmitted Diseases or Infections? ☐Y ☐N

Would you like to be screened for Sexually Transmitted Infections (please note: some insurance plans do not cover if only for screening)? ☐Y ☐N

(OVER→)

Full Name:_____ Date of Birth:_____

Do you feel verbally or physically intimidated by your partner or anyone in your household? ☐Y ☐N

Any history of verbal/physical/sexual abuse? ☐Y ☐N

I am: ☐Single ☐Engaged ☐Married ☐Living with partner ☐Divorced ☐Widowed ☐Dating

Past medical history: Have you ever had any of the following?

Abnormal uterine bleeding	N	Y
Abuse	N	Y
Anemia	N	Y
Anesthesia complications	N	Y
Anxiety Disorder	N	Y
Asthma	N	Y
Bladder issue	N	Y
Blood transfusion	N	Y
Breast disease - benign	N	Y
Cancer	N	Y
Deep Vein Thrombosis	N	Y
Depression	N	Y
Excessive alcohol use	N	Y
Endometriosis	N	Y
Eye issue	N	Y
Fibroid uterus	N	Y
GI issue	N	Y
Gestational diabetes	N	Y
Headaches/migraines	N	Y
Heart disease	N	Y

Hepatitis	N	Y
Herpes	N	Y
Elevated blood pressure	N	Y
Infertility	N	Y
Injury/trauma	N	Y
Kidney disease	N	Y
Elevated cholesterol	N	Y
Liver problem	N	Y
Lung disease	N	Y
Neurological issue	N	Y
Pulmonary Embolism	N	Y
Pain	N	Y
Pregnancy complication	N	Y
Skin disorder	N	Y
Sleep disorder	N	Y
Thyroid problems	N	Y
UTI	N	Y
Varicosities	N	Y
Vitamin deficiency	N	Y
Other	N	Y

Please circle all appropriate answers	Parents		Siblings		Maternal Grandparents		Paternal Grandparents		Aunt/Uncle	
Heart attack	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
Stroke	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
Blood clots	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
DVT	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
High BP	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
Diabetes	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
Breast Cancer	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
Ovarian Cancer	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
Other Cancer	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U
Too much bleeding	Mo	Fa	Sis	Bro	GM	GF	GM	GF	A	U

Do you vape? ☐Y ☐N Do you smoke? ☐Y ☐N If yes, how many cigarettes a day?_____

Have you smoked in the past? ☐Y ☐N If yes, how much?_____ Date quit?_____

How many drinks of alcohol do you drink per week? ☐0 ☐Rare ☐1-7 ☐14+

Do you use any other substances? ☐Y ☐N ☐Currently ☐Never Type:_____

(OVER→)

Cascade Women's Health, PC – New Patient Review of Systems

Full Name: _____ Date of Birth: _____

Please check any of the following that you have experienced in the past year:

Menstrual: ☐ Irregular menses or heavy menses ☐ Bleeding between menses ☐ Painful menses
☐ Menstrual headaches

General: ☐ Migraines ☐ Unusual fatigue ☐ Sexual dysfunction ☐ Weight loss ☐ Weight Gain ☐ Cold or heat intolerance ☐ Change in hair growth ☐ Change in sleep ☐ Hot flashes

Breasts: ☐ Lump ☐ Pain ☐ Discharge ☐ Rash

Genital: ☐ Abnormal vaginal discharge ☐ Vaginal or vulvar itching ☐ Vaginal or vulvar rash ☐ Vulvar lump or lesions ☐ Pain with sex ☐ Bleeding with sex

Urinary: ☐ Pain ☐ Burning with urination ☐ Frequency ☐ Loss of urine with cough or sneeze ☐ Blood in urine

GI: ☐ Heartburn ☐ Gas ☐ Nausea or vomiting ☐ Constipation ☐ Loose stools ☐ Bloody or black stools ☐ Hemorrhoids ☐ Abdominal pain

Heart/Lungs: ☐ Racing or fluttering ☐ Chest pain or discomfort ☐ Shortness of breath

Mood/Stress: ☐ Memory change ☐ Frequent crying ☐ Anxiety ☐ Depression ☐ Moodiness ☐ Tension or stress ☐ Considered suicide ☐ Death of family member ☐ Illness of family member ☐ Family conflict ☐ Job problems ☐ Job change ☐ Financial problems ☐ Divorce ☐ Addiction ☐ Eating disorder

Over the past 2 weeks, how often have you been bothered by any of the following problems? (Please check and then total)

1. Little interest or pleasure doing things?

- ☐ 0 - Not at all
- ☐ 1 - Several days
- ☐ 2 - More than half the days
- ☐ 3 - Nearly every day

2. Feeling down, depressed, or hopeless?

- ☐ 0 - Not at all
- ☐ 1 - Several days
- ☐ 2 - More than half the days
- ☐ 3 - Nearly every day

Total: _____

If your total is **2 or more**, please fill out the Patient Health Questionnaire (PHQ-9) on the next page.

If your total is **0-1**, you **do not** need to fill out the PHQ-9.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add up the columns to get your total.

Total: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____
--	---

CREDIT POLICY/ASSIGNMENT OF BENEFITS

Patient Responsibility:

Patients are responsible for all charges resulting from services provided by Cascade Women's Health, P.C. If insured, it is your, the patient's, responsibility to know your insurance coverage and check with your insurance in advance of your appointment to be sure that CWH is in-plan with your network. We encourage every patient to know and understand your policy. Please be aware that some of the treatment plans and office visits may not be covered by your insurance. **If you have any questions regarding coverage, please call your insurance company directly before your visit.**

As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment will be due within 30 days of the first billing, unless financial arrangements have been made. Please note, we are very willing to work with you to create a plan of regular monthly payments if that would be helpful to you.

Copays are due at time of service. We collect from patients whose cards clearly state the amount to be collected. We accept cash, check, and debit/credit cards. We are a specialist office and will collect specialist copays for all visits other than routine.

Minors: The undersigned agrees to be responsible for all balances for services rendered to the minor patient.

Self-Pay Patients:

New patients without insurance: A minimum deposit of **\$150.00** will be collected at the time of visit. The patient or responsible party will then be billed for any balance owing from that visit. All private pay patients will receive a 25% discount on total charges.

Established patients without insurance: A minimum deposit of **\$75.00** will be collected at time of visit. The patient or responsible party will then be billed for any balance owing from that visit. All private pay patients will receive a 25% discount on total charges.

Insurance Billings:

Providing correct insurance information is your responsibility. As a courtesy to you, we will bill your primary insurance company. You will need to bring your current insurance card with you to every appointment. Please call 503.274.9936 x-109 for billing questions. Please leave a detailed message.

Referrals:

If you are required by your insurance company to obtain a referral or prior authorization, it is your responsibility to get one prior to your appointment.

Outside Scheduling:

As a service to you, we will sometimes schedule appointments outside of our office for labs and imaging. It is the patient's responsibility to know which facility is in-plan with your benefits and to let us know. An out-of-plan facility can lead to a reduction in your benefits and an increase in cost for you. All outside services are billed directly by those services, not CWH. Questions related to bills for outside services should be made directly to those entities (labs, imaging, and hospitals).

No Show/Late Cancellation Fee: Your appointment time is reserved just for you. A late cancellation or missed visit/no show leaves a hole in the practitioner's day that could have been filled by another patient. As such, we require 24-hour notice for any cancellations or changes to your appointment. **Patients who provide less than a 24-hour notice, or miss their appointment, will be charged a \$50 cancellation fee.**

Returned check fee:

It is our clinic's policy to charge all patients a **\$35.00** fee for checks that are returned unpaid by the bank.

I hereby authorize Cascade Women's Health, P.C. to release any medical information necessary to process claims with any insurance companies. I also assign Cascade Women's Health, P.C. all payments I am entitled for medical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days (and not set up in a payment plan) may be sent to an outside agency for collection.

I have read and received a copy of the credit policy for Cascade Women's Health, P.C. I accept this policy for services rendered by Cascade Women's Health P.C.

Print your name

Date

Patient Signature (or guardian signature if the patient is a minor)

9/9/2024

HIPAA ACKNOWLEDGMENT AND CONSENT

I understand that **CASCADE WOMEN'S HEALTH, P.C.** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, Claims and related information to insurance companies or others who may be responsible to pay some or all of health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will Handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in them manner described in the Notice of Privacy Practices, and understand that Cascade Women's Health, P.C. is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
------------------------	-------------

-OR-

By: _____ (Patient Representative)	Date: _____
Description of Representative's Authority: _____	

Patient Name: _____

Your Email: _____

Provider: (please circle) Dr. Cohen Dr. Dion Dr. Wentross
Dr. Collins Dr. Holtzman**RISK OF USING EMAIL**

Transmitting patient information by email has a few risks that patients should consider before using email. These include, but are not limited to, the following risks:

- a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b) Email senders can readily misaddress an email.
- c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- d) Employers and on-line services have a right to inspect email transmitted through their systems.
- e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
- f) Email can be used to introduce viruses into computer systems.
- g) Email can be used as evidence in court.
- h) Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

CONDITIONS FOR THE USE OF EMAILS

Providers cannot guarantee, but will use, reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that a specific email will be read and responded to within any specific time.
- b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- c) All email will usually be printed and scanned into the patient medical record.
- d) Office staff may receive and read your messages.
- e) Provider will not forward patient identifiable emails without the patient's prior written consent, except as authorized or required by law.
- f) The patient should not use email for communications regarding sensitive medical information.
- g) Provider is not liable for breach of confidentiality caused by the patient or any third party.
- h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS

To communicate by email the patient shall:

- a) Avoid the use of his/her employer's computer.
- b) Put the patient's name in the body of the email.
- c) Key in the topic (e.g. medical questions, billing question) in the subject line.
- d) Inform provider of changes in his/her email address.
- e) Acknowledge any email received from the Provider.
- f) Take precautions to preserve the confidentiality of the email.
- g) Withdraw consent only by email or written communication to Provider.

Telehealth Consent

Cascade Women's Health PC may ask if you wish to conduct some of your visits through Telehealth consults. A Telehealth visit is a HIPAA-compliant electronic method (via phone or video conferencing), by which your provider will consult with you about your concerns and if appropriate, develop a treatment plan. Telehealth visits will help to minimize need to come to the office. Not all concerns can be addressed in this manner, however.

There are potential risks with the use of this technology that include, but are not limited to:

- interrupted visits due to poor phone or internet connection
- you might be required to make a clinic appointment if the information gathered through the telehealth visit is not sufficient to make an appropriate diagnosis.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and or telehealth between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with me by email or telehealth. If I have any questions, I may inquire with my treating physician.

Patient signature _____

Date _____



Patient No-Show and Late Cancellation Policy

We value your time and strive to provide excellent care to all patients. When an appointment is missed or cancelled late, it prevents another patient from receiving timely medical attention. Please review our policy regarding missed appointments.

Policy Window

- **Notice Required:** Cancellations must be made at least **24 hours** before your scheduled time.
- **Late Arrival:** Arriving late may require rescheduling.

Fees and Penalties

- **Late Cancellation Fee:** A **\$50** fee applies for cancellations under 24 hours.
- **No-Show Fee:** A **\$50** fee applies if you miss an appointment without notifying us.
- **Insurance Coverage:** Please note that insurance companies **do not** cover these fees.
- **Payment Due:** Fees must be paid before booking your next appointment.
- **Dismissal Policy:** Accumulating **three** no-shows or late cancellations within 12 months may result in dismissal from our practice.

Exceptions

- We understand that emergencies, sudden illness, or severe weather happen.
- Please contact our office as soon as possible to let us know what is going on.

I have been informed of this policy and understand.

Patient signature

Date