Consent for accessing Prescription Benefit History

This consent allows Dr. Wendy Corning permission to obtain drug information during the time of your office visit. This information is obtained via secure access from community pharmacies, patient medication claim history from payers, and pharmacy benefit managers.

- ☐ Yes, consent given. (All medications prescribed, by any provider that had pharmacy claims filed against patient insurance will be retrieved)
- ☐ No consent given.
- ☐ Prescriber (Only medications prescribed by the requesting physicians will be retrieved if pharmacy claims have been filed)
- ☐ Parent/Guardian consent on behalf of a minor for prescriber to receive the medication history from any prescriber
- ☐ Parent/Guardian consent on behalf of a minor for prescriber to only receive the medication history this prescriber prescribed

(We recommend consenting to this as it allows us to make sure all your medications and dosages are correct).

_____ _____

Signature of patient (or legal guardian) **Date**

_____ _____

Print patient's name **(Print name of legal guardian)**

Financial Agreement and Authorization for Treatment

PAYMENT POLICY

We take Cash, Checks, Money Orders, Debit Cards, and Visa and Mastercard Credit cards. Patients without insurance are required to pay in full at the time of service. We require insurance co-payments to be paid at the time of service. Since insurance deductibles and co-insurance are often not known at the time of service, we will bill you for these after your insurance has paid. However, we reserve the right to collect known deductibles and co-insurance at the time of service.

We will process insurance claims for office procedures or surgery, however, please be aware that you, the patient, are responsible for the bill. Prompt payment of any amounts due after your insurance has paid is necessary to remain a patient of this practice. If your account is sent to collections, you will not be able to remain a patient of this practice, even if the amount is eventually paid in full. In addition, any patient who files bankruptcy and lists Wendy Kinsey Corning, M.D., LLC as a debtor will no longer be seen by this office.

Accounts that are delinquent after 90 days may be subject to collection and all costs involved, including, but not limited to, attorney fees, court costs, and judgment interest, and will be considered patient responsibility. Any legal action will be filed in the Monroe County Court system.

I hereby authorize payment of medical benefits to Wendy Kinsey Corning, M.D., LLC for services furnished to me by my provider. I further agree to pay all co-pays, deductibles, non-covered services or charges considered above usual and customary (non-contracted carriers only) by my insurance company.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Wendy Kinsey Corning, M.D., LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Wendy Kinsey Corning, M.D., LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wendy Kinsey Corning, M.D., LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wendy Kinsey Corning, M.D., LLC's Privacy Officer at 383 S Park Ridge Rd, Suite 102, Bloomington, IN 47401.

With this consent, Wendy Kinsey Corning, M.D., LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls, pertaining to my clinical care, including laboratory results among others. Wendy Kinsey Corning, M.D., LLC may also mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient information.

I have the right to request that Wendy Kinsey Corning, M.D., LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Wendy Kinsey Corning, M.D., LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wendy Kinsey Corning, M.D., LLC may decline to provide treatment to me. (Patients under 18 years of age will need a parent or guardian signature authorizing treatment and consenting to financial responsibility.)

_____ _____

Signature of Patient (or Legal Guardian) Date

_____ _____

Print Patient's Name (Print Name of Legal Guardian)

Wendy Kinsey Corning, MD, FACOG

383 S. Park Ridge Road, Suite 102
Bloomington, Indiana 47401
Phone: 812-330-5250 ○ Fax: 812-602-0089

Personal Release of Information

Date:	SSN:
Patient Name:	Birth Date:
Address:	Phone:

I authorize Dr. Wendy K. Corning and her staff to release information to the following people:

I understand that this release pertains to my entire medical and financial record, and that Dr. Corning or her staff cannot maintain detailed release restrictions. In addition, the individuals named may be informed of my appointments for treatment with Dr. Corning or any other practitioner if the visit was arranged by Dr. Corning or her staff.

This request is effective until the end of the calendar year or until I revoke it in writing.

Patient Signature Date Witness Signature Date

Wendy Kinsey Corning, MD, FACOG

383 S. Park Ridge Road, Suite 102
Bloomington, Indiana 47401
Phone: 812-330-5250 ○ Fax: 812-602-0089

Dear Patient:

You are scheduled for an annual exam. An annual exam consists of **Wellness Issues Only**. It is a head-to-toe physical exam, including a pelvic and breast exam and the collection of a Pap test. We will arrange for age-appropriate routine testing such as a mammogram, screening blood work such as cholesterol, or follow-up blood work such as thyroid levels to monitor known problems. This exam may include minor problems such as uncomplicated infections, STD screening, and contraception changes, refills or medications, or any changes of medications, etc.

However, an annual exam **Does Not** include prolonged consideration of medical conditions. **These Are Problem-Focused Visits And Will Be Billed As Such**. These are issues including but not limited to detailed discussions of contraceptive options, evaluating pain, heavy periods, PMS, bladder-control problems, menopausal concerns, detailed questions about hormone therapy, reviewing blood work or biopsies, etc. Sometimes, a significant problem may be found during an annual exam. The additional time to evaluate a new problem found on exam is also not part of an annual exam. **This means that there may be two (2) separate charges to the insurance for the single exam. One for the Wellness and one for the Problem Focused Issue. ALL Problem Focused Visits Are Subject To Co-pays & Deductibles Set Up By Your Insurance.**

It is the practice of this office to file claims with insurance that accurately reflect the services rendered. This means that your insurance may be billed for both an annual exam and a problem-focused visit/exam. Most insurance companies cover both services on the same day. **However, If You Do Not Have A Co-Payment For Wellness Visits, You May Have One For A Problem-Focused Visit Rendered On The Same Day.**

If you have significant problems at the time your annual exam is scheduled, it may also be necessary to postpone either the annual or the problem-focused visit and do them separately. Dr. Wendy Corning may have other patients scheduled immediately after your appointment, and it would not be fair to those patients to have their visits delayed excessively. We may also be aware that your insurance company will not pay for both services on the same day. In that case, we will ask you to schedule another appointment.

I have read the above and agree to the policies of Wendy Kinsey Corning, MD. LLC

_____ _____

Signature Date

_____

Printed Name

Wendy K. Corning, MD, FACOG **Gynecologic Medical History Form** **Today's date**_____

_____Please complete All 4 Pages_____

Name **Date of Birth**

Your answers on this form will help your clinician understand your medical concerns and conditions better.
Best estimates are fine if you cannot remember specific details.

REASON FOR YOUR VISIT: _____

_____

In the last year have you had any MRI's, CT Scans, Ultrasounds, or Lab work we should obtain? Where? Did you bring any results with you today? _____

_____

Additional Problems/Concerns: _____

_____

CURRENT MEDICATIONS: Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Date Started	Prescribing MD/NP

(Please record additional items on back)

Many medications have a generic that is the same as the brand name. If Dr. Corning or the nurse practitioner feels the generic is the same, are you okay with her prescribing the generic? __ Yes to generic __ No (Brand Only)
Do you prefer prescriptions in a __ 30 day supply or a __ 90 day supply? Preferred pharmacy_____

ALLERGIES OR REACTIONS TO MEDICINES/FOODS/OTHER AGENTS/ENVIRONMENTAL:

Allergen (Drugs, food, environment)	Reaction or Side Effect

WOMEN'S GYNECOLOGIC HISTORY:

# pregnancies	# deliveries vaginal__ C-section__	# abortions	# miscarriages
1st day (date) most recent period:		Frequency of periods:	
Age at first period:		Length of each period:	
Current birth control method (you or partner):		Are you happy with your birth control?	

PERSONAL MEDICAL HISTORY:

How would you rate your general health?	Poor	Fair	Good	Excellent

Health Maintenance Screening Tests		
Cholesterol Screening (last)	Date	Results
Mammogram (last)	Date	Results
Ever abnormal? Yes No	Details:	
Pap smear (last)	Date	Results
Ever abnormal? Yes No	Details:	
Stool test for blood (last)	Date	Results
Sigmoidoscopy or Colonoscopy (last)	Date	Results
DEXA (bone density test)(last)	Date	Result

PERSONAL ILLNESSES OR HEALTH PROBLEMS: Please indicate (√) whether you have had any of the following problems and the approximate date of illness or diagnosis.

√	Illness/Problem (date)	√	Illness/Problem (date)	√	Illness/Problem (date)
	Arthritis/other Rheumatologic Disease		Headaches		Intestinal (GERD, IBS, Ulcers, Crohn's)
	Neurologic problems		Heart Disease/Heart Attack		Lung (Asthma, Chronic Bronchitis, COPD, Emphysema)
	Cardiovascular bleeding/Clotting problems		Heart valve replacement		Gynecological Cancers (ovary, uterus, tubes, cervix, etc.)
	Depression/Anxiety		High Blood Pressure		Muscular problems
	Diabetes		High cholesterol		Thyroid (hypo-, hyper-, Goiter)
	Any Other (please list)				

SOCIAL HISTORY: Please circle or check (√) the answer.

Current Occupation:					**Exercise Regularly:** Yes No How often? How long (minutes)? If no, why?		
Marital Status	Divorced	Domestic Partner			Married	Single	Widowed
Sexual Activity Are you sexually active?	Not Currently	Yes	No		Current sex partners:	Male	Female
More than 4 sexual partners in your lifetime?		Yes	No		Have you had sexually transmitted diseases (STDs)?	Yes	No
Have you changed sexual partners since your last exam?		Yes	No		Other concerns?	Yes	No
Interested in being screened for sexually transmitted diseases?		Yes	No		What are your preferred pronouns? She/her____ He/his____ They/them____		
Alcohol Use	Yes No	Drinks per week:			Is alcohol a concern for you or others?	Yes	No
Drug Use	Do you use recreational drugs?	Yes	No		Have you ever used needles?	Yes	No
Tobacco Use	Never___	Quit: ___ Date			Current Smoker: ____ Packs/day____ # of years____		
Other Tobacco:					Are you interested in quitting?	Yes	No
Safety: Is violence at home a concern for you?		Yes	No		Have you ever been abused?	Yes	No

REVIEW OF BODY SYSTEMS: Please check (√) any current problems you have on the list below.

Constitutional		Chills		Fatigue		Weight gain
		Excessive thirst		Fever		Weight loss
		Excessive urination		Night Sweats		
Eyes		Recent changes in vision				
Head, ears, nose, throat		Hay fever or allergies		Problems w/teeth/gums		Sinus pain/congestion
Breasts		Changes in skin		Discharge		Lumps
		Pain				
Cardiovascular		Chest pain		Palpitations		
Respiratory		Cough		Shortness of breath		Wheezing
Gastrointestinal		Abdominal pain		Bowel changes		Nausea
		Bloating		Constipation		Rectal bleeding
		Blood in stools		Diarrhea		Vomiting
Genitourinary/ Gynecological		Urinary frequency		Pain with urination		Urinary retention
		Blood in urine		Sexual dysfunction		Vaginal discharge
		Urinary incontinence		Urgency		
Skin		Changes to existing skin lesions or moles				Rash
Neurological		Dizzy/lightheaded		Headaches		
Psychiatric		Anxiety		Depression		Difficulty sleeping
Heme-Lymphatics		Bleeding disorder		Unexplained lumps		
Others not mentioned above						

SURGICAL HISTORY: (Please list all prior operations and dates – record additional items on back):

Year	Illness or Operation	Complications

IMMUNIZATION HISTORY: (Please all vaccines. Include your best estimate of month and year.)

Vaccine	Date	Vaccine	Date
Influenza (1 dose annually)		Meningococcal (meningitis)	
Varicella (Chicken Pox) (2 doses)		Pneumovax (pneumonia) (age 65)	
Measles, mumps, rubella (1 or 2 doses)		Zoster (Shingles) (1 dose age 60)	
HPV – Gardisil (3 doses)		Covid-19	
Td/Tdap (1 booster Tdap, Td every 10 yrs) (Tetanus, Diphtheria, Pertussis)			

FAMILY HISTORY: Please indicate (√) below significant medical problems of immediate family members (parents, siblings, paternal/maternal grandparents, paternal/maternal aunts/uncles).

	Medical Condition	Relationship		Medical Condition	Relationship
	Arthritis			Breast cancer	
	Blood clots			Cervical cancer	
	Diabetes			Colon cancer	
	Elevated cholesterol			Ovarian cancer	
	Heart disease			Uterine cancer	
	High blood pressure			Other cancer :	
	Stroke				
	Other not mentioned:				