Wendy K. Corning, MD, FACOG **Review of Systems** **Today's date: _____**

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: _____

Name of your Primary Care Physician: _____ Last seen? _____

Date last menstrual period started (or year) _____ Frequency_____ Length of period_____

Are you having period problems? Pain_____ Bleeding Problems_____ Clotting_____ Other _____

If yes please explain: _____

In the last year have you been seen by other doctors or at the Emergency Room? When and why:

_____

Give us the month and year of your last -- PLEASE FILL IN ALL DATES, PLACE N/A IF YOU HAVE NOT HAD ONE

Mammogram _____Cholesterol/Lipids _____Bone Density/DEXA _____Colonoscopy _____

Have you had other recent labs or x-rays? When and Why: _____

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		Hot flashes
Eyes		Recent changes in vision				
Head, ears, nose, throat		Hay fever or allergies		Problems w/teeth/gums		Sinus pain/congestion
Breasts Indicate Left or Right Breast		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		Vaginal Itching
		Urinary leakage		Urinary retention		Vaginal discharge
		Urgency		Painful intercourse		Vaginal odor
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						

Have you started taking any new medications or stopped taking any medications since your last appointment with us? If so, indicate when and why. Please list: _____

_____

_____

Many medications have a generic that is the same as the brand name.

If Dr. Corning or the nurse practitioner feel 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?

Medication requests: What medications would you like us to refill today? _____

_____

Preferred pharmacy: _____

Additional Problems/Concerns: _____

_____

UPDATE SOCIAL HISTORY: Please answer the following questions.

Tobacco Use: Yes____ No _____ In past ____ If current smoker: Packs/day _____ How long? _____

Alcohol Use: Drinks/week _____

Recreational Drug Use: Yes ____ No _____ What drug/drugs? _____

Have you ever been sexually active? Yes _____ No _____

Are you currently sexually active? Yes _____ No _____

Have you changed or had new sexual partners in the last year? Yes _____ No _____

Have you had more than 4 lifetime sexual partners? Yes _____ No _____

Do you want STD testing? Yes____ No____

What are your preferred pronouns? She/her____ He/his____ They/them____

Do you perform self-breast exams? Yes____ No_____ If yes, how frequently? _____

Have you had the Gardasil/HPV vaccine? Yes ____ No____ If yes, when? _____ Have you done all 3? _____

New guidelines for the HPV vaccine are ages 9-46. If you fall in this range, and have not had it, do you want this vaccine? Yes _____ No ____ Want to talk to the doctor about this _____

IMMUNIZATION HISTORY: (Please list 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 – Gardasil (3 doses)		Covid-19	
Td/Tdap (1 booster Tdap, Td every 10 yrs) (Tetanus, Diphtheria, Pertussis)			

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,

Your insurance is Medicare, and you are scheduled for an "annual exam" today. Unfortunately, under Medicare, Gynecologists CANNOT be your Primary Care Provider and we can no longer do "annual exams". Only your Primary Care Physician can do a Medicare Annual Exam. As your Gynecologist, Medicare ONLY allows us to do a Breast exam, Pelvic exam and a Pap once every 2 years, unless you have a high-risk condition. Medicare does not allow us to do ANYTHING else at that visit. We CANNOT address problems, we CANNOT do a head to toe exam. We can refill stable medications but cannot do any medicine changes or discuss medications. We CAN always continue to see you for gynecology problems on a different day.

Unfortunately, you also HAVE to have a Primary Care Provider for us to be able to see you today, under Medicare guidelines.

In order for us and you to follow these Medicare rules, you now have 4 options today….Please choose only one.

____#1 I just want a Breast, Pap and Pelvic exam every 2 years which Medicare will pay for. My last exam that was paid by Medicare was 2 years ago or more or this is my first exam under Medicare. If I am incorrect regarding this and it was less than 2 years ago, I understand I still may have to pay for this exam and it will be $100.00

____#2 I want just a Breast, Pap and Pelvic exam, but I want this exam every year. I know that every other year I will have to pay $100.00 for the exam, at the time of service.

____#3 I want an exam every 2 years, but I want a full head to toe exam, (like I used to get!) which includes discussing problems, medication issues, etc. Medicare will pay $100.00 for this exam. Medicare or any supplemental insurance will NEVER pay for the remainder of this exam. I will pay $100.00 today for the other portion of the exam.

____#4 I want a full, head to toe exam every year, which includes discussing problems, medications, etc. Payment for this will vary every other year. The year Medicare pays a portion of this, the fee you are responsible for will be $100.00. The year Medicare does not pay any portion of this, the fee you are responsible for will be $200.00. This fee will be collected at the time of service.

____#5 I have gynecological problems which I wish to discuss today, so I will reschedule my Breast, Pap and Pelvic exam for another day.

My Primary Care Physician is: _____

Patient Signature: _____ Date: _____

Medicare DOES pay for your screening mammogram every year and you can continue to schedule this through our office.

A. Notifier: Wendy Kinsey Corning, M.D, LLC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Medicare Pap Smear Collection (Q0091)	Limited to once every 2 years (23 months)	$59
Medicare Pelvic and Breast Exam (G0101)	Limited to once every 2 years (23 months)	$59

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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