Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES
MD LASER SKIN AESTHETICS

Patient Information

Referring Physician: _____ Date: _____

Patient Legal Name: _____ DOB: _____

Local Full Address: _____

Out of State Address: _____

Primary Phone: _____ Secondary Phone: _____ Email: _____

Marital Status: Married ____ Single____ Divorced ____ Widowed: ____ Gender: _____ Social Security Number: _____

Emergency Contact Name and Phone Number: _____
Relationship

Employer Name and Phone Number: _____

Insurance Information

Insurance Company: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Patient: _____Policy Holder DOB: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Cancellation/ No Show Appointment Policy

It is the patient's responsibility to keep their reserved appointments time. Appointments that you book are time we specifically set aside for you. Due to the high demand for appointments, if you do not arrive for your scheduled appointment on time without a 48-hour cancellation notice, you will be responsible for a non-refundable fee. The following fees will be charged for missed appointment or late cancellation:

Scheduled Office Visit: $125.00 **Scheduled In-Office Procedure:** $150

Surgical Procedures: $750.00 **(All surgery cancellations require a 10-day notice)**

ALL RETURNED CHECKS WILL RESULT IN $60.00 ADMINISTRATIVE FEE

Patient Financial Responsibility

We cannot guarantee that we are a participating provider with your insurance. It is the patient's responsibility to know if we are on your provider list. All patients are responsible for office co-pays, deductibles, coinsurance and any non-covered services coinsurance at the time of service, unless is it solely covered, in full, by Medicare or your insurance company. A 3% convenience fee will be added to all credit card payments. All transactions $33.00 or less will have a $1.00 convenience fee.

I have read and understand my financial responsibilities. By signing below, I understand and agree to the policy outlined above.

_____

Patient Name Patient Signature Date

www.WellnessForWomenOfNaples.com
6610 Willow Park Drive, Suite 102 Naples, FL 34109
Ph: 239-262-3100 Fax: 239-262-3101

Acknowledgement of Receipt of Notice of Privacy Practices

Consent for Purpose of Treatment, Payment & Healthcare Operations

I consent to use or disclose my protected health information by Tracye L. Zlobl, M.D., P.A. (DBA-Wellness for Women) for the purpose if diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Wellness for Women.
I understand that diagnosis or treatment of me by Wellness for Women may be conditioned upon my consent as evidenced by my signature on this document.
I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care options. Tracye L. Zlobl, M.D., P.A. / Wellness for Women is not required to agree to the restrictions that I may request. However, if Dr. Zlobl agrees to a restriction that I request, the restriction is binding on the practice.
I have the right to revoke this consent, in writing, at any time, except to the extent that Tracye L. Zlobl, M.D. has taken action in reliance on this consent.
My "protected health information" means heal information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.
I understand that I have the right to review Dr. Tracye Zlobl's notice of privacy practices prior to signing this document.
The Notice of Privacy Practices for Tracye Zlobl M.D. describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations.
A summary of the Notice of Privacy Practices for Wellness for Women is posted in the waiting room.

This Notice of Privacy Practices also describes my rights and the duties of Wellness for Women with respect to my protected health information.
I may obtain a revised Notice of Privacy Practices by contacting Wellness for Women located at 6610 Willow Park Drive Suite 102 Naples, FL 34109.
By signing below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them.

_____ _____

Printed Patient Name and Signature (or legal guardian) Date

Release of Information

Your physician has remote access to the electronic medical record of the **NCH Healthcare System** and can view and testing or treatments provided to you at an NCH facility. Your permission is required to allow your physician remote access to your medical records, in the event you need an emergency room follow up appointment.
I, *(print name here)* _____ with a date of birth of _____
Authorize my physician's office, **Wellness For Women**, remote access to mu NCH electronic medical records (or that of my child under the age of 18) for purposed of care of treatment.
This form is to be retained by the physician and available to NCH upon request.

_____ _____

Signature of Patient Date

www.WellnessForWomenOfNaples.com
6610 Willow Park Drive, Suite 102 Naples, FL 34109
Ph: 239-262-3100 Fax: 239-262-3101

Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES
MD LASER SKIN AESTHETICS

Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge and sexual problems. Pelvic exams – both in the office and while under anesthesia – are also an important part of evaluation for gynecological procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problem, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or history of abnormal pap results, gynecologic cancers or toxic exposures. The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, genital herpes, other sexually transmitted infections including human papilloma virus and early detection of treatable gynecologic conditions before symptoms begin occurring (e.g., vulvar and vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer specific questions.

The potential risks of having a pelvic examination may include (but are not limited to) fear, anxiety, embarrassment, or pain and discomfort.

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluate information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this patient consent form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____ _____

Patient Signature Date

www.WellnessForWomenOfNaples.com
Tracye L. Zlobl, M.D. Amy G. Votta, MSN, APRN
6610 Willow Park Drive, Suite 102 Naples, FL 34109
Ph: 239-262-3100 Fax: 239-262-3101

Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES
MD LASER SKIN AESTHETICS

Portal System and Prescription Refills

Our goal for using the Portal is to create an efficient system for patient-provider communication.

We will be utilizing a patient portal to provide you with your results. This is also an efficient system if you have a question. This system is not to be used to treat symptoms or report emergencies. Messages will be checked only during normal business hours.

Please do not call the office for your test results – you will be referred to check the Portal. For hormone results either you will be scheduled for a follow up or the results will be posted to the portal. If you do not sign up for the portal you need to schedule an office visit to review your results.

You will be contacted about any significant abnormal results as soon as it has been reviewed by your Provider.

Refill requests must be made through your pharmacy. We are "E-prescribing". If we receive duplicate requests from the patient and the pharmacy it will slow response time. When your refills expire, your pharmacy will offer to contact the office or request they do so on your behalf. Please allow 72 hours from time of request for response or refill. Prescriptions for controlled medications (ex. Testosterone, anxiety and sleeping medications) expire every six months and require an office visit for refills.

We appreciate your cooperation and thank you for using the patient portal. By signing below, you acknowledge the purpose of the portal and the office policy on refills and results.

_____ _____

Printed patient name Patient Signature Date

_____

Email address

www.WellnessForWomenOfNaples.com
Tracye L. Zlobl, M.D. Amy G. Votta, MSN, APRN
6610 Willow Park Drive, Suite 102 Naples, FL 34109
Ph: 239-262-3100 Fax: 239-262-3101

Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES
MD LASER SKIN AESTHETICS

CONTACT CONSENT FORM

Date: _____

Initial one line below

_____ I **DO NOT** give Wellness For Women permission to discuss pap, pathology, lab results, or any other health information with anyone other than myself.

_____ I **DO** give Wellness For Women permission to discuss pap, pathology, lab results or any other health information with the following person (s):

_____ _____

Name **Relationship**

Initial one line below

_____ I **DO NOT** give Wellness For Women permission to leave detailed messages on my answering machine/ voicemail regarding pap, pathology and lab results.

_____ I **DO** give Wellness For Women permission to leave detailed messages on my answering machine/ voicemail regarding pap, pathology and lab results. The following number should be called:

_____

Phone Number

POLICY

If at any time you wish to change the above information, it is your responsibility to notify the office and to complete a new Contact Consent Form. By signing below, you acknowledge the Wellness For Women Contact Consent Form Policy.

_____ _____

Printed Name **Signature** **Date**

www.WellnessForWomenOfNaples.com
Tracye L. Zlobl, M.D. Amy G. Votta, MSN, APRN
6610 Willow Park Drive, Suite 102 Naples, FL 34109
Ph: 239-262-3100 Fax: 239-262-3101

Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES
MD LASER SKIN AESTHETICS

Date: _____ **PROTECTED HEALTH INFORMATION** Referred by: _____

Name: _____ Preferred Name: _____ Date of Birth: _____ Age: _____

Reason for visit: _____ ☐ Routine GYN Care ☐ Problem Visit

Preferred Pharmacy and location: _____

Personal History	**YES**	**NO**		**YES**	**NO**
Anemia	☐	☐	Heart Murmur	☐	☐
Anxiety	☐	☐	Heart Disease	☐	☐
Arthritis	☐	☐	Herpes	☐	☐
Artificial Heart Valve	☐	☐	High Blood Pressure	☐	☐
Atrial Fibrillation (AFIB)	☐	☐	HIV/ AIDS	☐	☐
Asthma	☐	☐	HPV/ Warts	☐	☐
Blood Transfusion	☐	☐	Kidney/ Urinary Infections	☐	☐
Bowel Trouble	☐	☐	Migraines	☐	☐
Breast Cancer	☐	☐	Mood Disorders	☐	☐
Cancer: _____	☐	☐	Osteopenia	☐	☐
Crohn's	☐	☐	Osteoporosis	☐	☐
Colitis	☐	☐	Pneumonia	☐	☐
Chicken Pox	☐	☐	Rheumatic Fever	☐	☐
Chlamydia	☐	☐	Sexually Transmitted Infections	☐	☐
Depression	☐	☐	Stroke	☐	☐
DVT (blood clots)	☐	☐	Syphilis	☐	☐
Diabetes	☐	☐	Tuberculosis (TB)	☐	☐
Eating Disorder	☐	☐	Thyroid Disease	☐	☐
Fracture	☐	☐	Ulcers	☐	☐
Glaucoma	☐	☐	Do you have a history of **other** Illnesses or injuries? _____		
Gonorrhea	☐	☐	_____		
Headaches	☐	☐	_____		

When was your last Test or Immunization?

	DATE		DATE
Bone Density (DEXA)		COVID-19 Vaccine	
Colonoscopy/ Endoscopy		Mammogram	
Flu Vaccine		Last Pap Smear	
Gardasil Vaccine		History of abnormal pap	
Shingles Vaccine		☐ LEEP ☐ CRYO	

Surgical Procedures and Hospitalizations:

_____
_____
_____

List <u>current medications with strength and dosage</u>, including natural/herbal, over the counter medications, vitamins and minerals:

_____
_____
_____
_____
_____
_____

Drug Allergies:

_____
_____

Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES
MD LASER SKIN AESTHETICS

Family History	YES	NO	Which Blood Relative	Maternal/Paternal	Age
Hereditary Cancers:	☐	☐	_____	_____	_____
Breast Cancer	☐	☐	_____	_____	_____
Colorectal Cancer	☐	☐	_____	_____	_____
Endometrial Cancer	☐	☐	_____	_____	_____
Gastric Cancer	☐	☐	_____	_____	_____
Melanoma Cancer	☐	☐	_____	_____	_____
Ovarian Cancer	☐	☐	_____	_____	_____
Pancreatic Cancer	☐	☐	_____	_____	_____
Prostate Cancer	☐	☐	_____	_____	_____
Other: _____	☐	☐	_____	_____	_____
Depression	☐	☐	_____	_____	_____
DVT (blood clots)	☐	☐	_____	_____	_____
Anxiety	☐	☐	_____	_____	_____
Diabetes	☐	☐	_____	_____	_____
Heart Disease	☐	☐	_____	_____	_____
High Blood Pressure	☐	☐	_____	_____	_____
High Cholesterol	☐	☐	_____	_____	_____
Stroke	☐	☐	_____	_____	_____
Other: _____					

Your Personal Social History

Do you have a calcium rich diet? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No If yes, how many times per week? _____

Do you smoke? ☐ Yes ☐ No If yes, packs per day _____ how many years? _____ Quit smoking? ☐ Yes ☐ No if yes, when did you stop? _____

Do you vape nicotine? ☐ Yes ☐ No If yes, what nicotine dosage? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, drinks per day _____ Drinks per week _____

Illicit drug use? ☐ Yes ☐ No ☐ Previously If yes or previously, type of drug use _____ Frequency _____

Do you have a history of abuse? ☐ Yes ☐ No If yes, ☐ Physical ☐ Emotional ☐ Sexual

Partnership status: ☐ Married ☐ Single ☐ Engaged ☐ Divorced ☐ Widowed ☐ Significant other

Occupation: _____

Your Obstetric History

	Number		Number
Total # of pregnancies		Total # of abortions/terminations	
Total # of full-term births		Total # of living children	
Total # of premature deliveries (<37 weeks)		Total # of vaginal deliveries	
Total # of miscarriages		Total # of C-Sections	

Wellness for Women
GYNECOLOGY FOR WOMEN OF ALL AGES
MD LASER SKIN AESTHETICS

Your Gynecologic History

Are you menopausal? ☐ Yes ☐ No If yes, age when menopause started: _____

Are bothered by menopause symptoms? ☐ Yes ☐ No If yes, what are your symptoms?

_____

_____

If you still get a menstrual cycle: Do you use birth control? ☐ Yes ☐ No If yes, what type of birth control do you use? _____

☐ Birth control patch (name) _____ ☐ IUD (type and date inserted) _____

☐ Birth control pill (name) _____ ☐ Natural family planning method

☐ Condoms ☐ Nuva Ring ☐ Contraceptive Foam/Jelly ☐ Depo Provera ☐ Diaphragm ☐ Vasectomy ☐ Withdrawal

☐ None ☐ Other

What age did you begin menstruation? _____ How many days are there from the start of your period to the start of your next period? _____

How many days does your period last? _____ Flow of period: ☐ Light ☐ Moderate ☐ Heavy

Do you have menstrual cramps? ☐ Yes ☐ No If yes, ☐ Mild ☐ Moderate ☐ Severe

Do you have break through bleeding? ☐ Yes ☐ No ☐ Not applicable Date of last period: _____

Do you have bothersome urinary urgency or leaking? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Age of first intercourse: _____

Any new sexual partners in the last year? ☐ Yes ☐ No

Do you have sex with: ☐ Men ☐ Women ☐ Both

Lifetime sexual partners: ☐ One ☐ Less than 5 ☐ More than 5

Are you have any pain related to sexual function? ☐ Yes ☐ No If yes, what? _____

Are you bothered by decreased level of sexual desire or interest? ☐ Yes ☐ No

www.WellnessForWomenOfNaples.com
Tracye L. Zlobl, M.D. Amy G. Votta, MSN, APRN
6610 Willow Park Drive, Suite 102 Naples, FL 34109
Ph: 239-262-3100 Fax: 239-262-3101