



Carrie Jones, ND

Patient Information – BCCP Program

Name: _____
Date of Birth: _____ Age: _____ Gender: F
Address: _____
City/state/zip _____
County: _____
Preferred phone number: _____
Alternate phone: _____
Social Security Number: _____ - _____ - _____
Occupation: _____
Employer: _____

Married ___ Separated ___ Divorced ___
Widowed ___ Single ___ Partnership ___
Dating _____
Live with: Spouse ___ Partner ___ Parents
_____ Children ___ Friends ___ Alone ___
Emergency contact: _____
Phone: _____ relation to you: _____
Who may we thank for referring you?

*Would you like to receive Dr. Jones' newsletters? E-mail: _____

All information is private, will not be sold and has the ability to unsubscribe

Policies: Dr. Jones/BCCP

This program is part of a national early detection program to help low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers.

The pap test, mammogram and related office visit are paid for by American Cancer Society, Susan G. Komen Breast Cancer Foundation, Oregon tribes, and local health departments if you can answer **yes** to the questions below.

- *You are between the ages of 40 and 64? **Initial**
- *You are a resident of Oregon? **Initial**
- *You are without insurance or have a deductible of \$500 or more? **Initial**
- *You make less than 250% of the Federal

Poverty level for your family? **Initial**

Size of Family Unit	250% of Federal Poverty Level	
	Annual Income:	Monthly Income:
1	\$25,525	\$2,127
2	\$34,225	\$2,852
3	\$42,925	\$3,577
4	\$51,625	\$4,302
5	\$60,325	\$5,027
6	\$69,025	\$5,752
7	\$77,725	\$6,477

All pap tests are done in-office while all mammograms are done through Epic Imaging. They have an east and west side location. You will be given a voucher for the mammogram.

The program will not pay for costs already incurred. If you have received your pap test or mammogram already this year, you will not be reimbursed if you did not go through this program. **Initial**

Results of the test are usually sent through the mail however if your address is transient the office may be able to call you. For some results, Dr. Jones may ask you to come back for an office visit which will be paid for by the program.

The pap and mammogram results generally take about a week to come back. If you do not hear from Dr. Jones within 2-3 weeks, please call the office.

Supplements/Vitamins and follow-up treatment are not covered by the program. If you choose to continue care with Dr. Jones outside of your pap test and mammogram, you will have to pay out-of-pocket at the time of visit. **Initial**

If you choose to buy supplements/vitamins at your visit, you will have to pay for these out-of-pocket as they are not included in the cost. **Initial**

Additional lab testing (such as those for anemia, thyroid, cholesterol, blood sugar...etc) are not covered under the Breast and Cervical Care Program. If you are interested in having lab testing, Dr. Jones works with labs that offer significantly discounted rates. **Initial**

Pg _____ Date: _____ Name _____

DOB: _____ Age: _____ Female

Well Woman Intake-BCCP

First day of last menses: _____

Age of menses onset : _____

How often do you get your menses? _____

How long does it last? _____

Are your menses regular? _____

Describe the flow (light/mod/heavy/) _____

Do you clot/have pain? _____

Number of tampons/pad/napkins you use? _____

Do you bleed between menses? _____

Any pre-menstrual sx? _____

Menopausal sx? _____

Do you have any abnormal vaginal sx right now?

*(d/c, itch, burn, odor)? _____

Incontinence/leakage? _____

Are you sexually active? (men/wm/both) _____

Any pain with intercourse? _____

Contraception? _____

*form _____

*if hormonal, # yrs _____

*any problems/complaints? _____

Could you be pregnant? _____

Have you ever had an STI? _____

Work-up:

Date of last pap: _____ N/Abn? _____

*result if Abn: _____

*follow-up? _____

Ever had an abnormal pap? _____

*follow-up? _____

Date of last mammogram? _____ N/Abn? _____

*if Abn, follow-up? _____

Date of last DEXA scan? _____ N/Abn? _____

Do you do self-breast exams? _____

If you have ever been pregnant, how many

Pregnancies: _____ Full term live births: _____

TAB: _____ SAB: _____ living children: _____

Planning a pregnancy in the next 12 mo? _____

Pregnancy History:

If you have ever been pregnant, how many

Pregnancies: _____ Full term live births: _____

TAB: _____ SAB: _____ living children: _____

Planning a pregnancy in the next 12 mo? _____

Lifestyle:

Smoking history? _____

Alcohol use? _____

Caffeine use? _____

Water intake? _____

Experience any of the following recently:

High blood pressure? Yes no unsure

Heart disease? Yes no unsure

High cholesterol? Yes no unsure

Headaches? Yes no unsure

Migraines? Yes no unsure

Abdominal pain? Yes no unsure

Chest pain/SOB? Yes no unsure

Calf/deep leg pain? Yes no unsure

Joint pain? Yes no unsure

Blood sugar problems Yes no unsure

Anemia/blood d/o? Yes no unsure

Eye/vision changes? Yes no unsure

*wear glasses/contacts? _____

Change in BM? Yes no unsure

*#/day _____

*blood/mucus/food? _____

Feeling down or sad lately? Yes no unsure

*for how long? _____

Do you feel safe? Yes no unsure

Do you exercise? What/how often _____

Any history of osteoporosis, relatives with stooping, loss of height, or hip fractures? _____

Have you had height loss? Yes no unsure

Have you broken a bone? Yes no unsure

*what/when? _____

Family or Personal history of:

What _____ who _____ year dx _____ living? _____

Breast Cancer: _____

Colon Cancer: _____

Uterine Cancer: _____

Ovarian Cancer: _____

Prostate Cancer: _____

Other cancers: _____

Heart Dz: _____

Do you have any allergies? _____

Medications: _____

Privacy Notice:

YOUR RIGHTS:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected information. Under the federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or us in, a civil, criminal, or administration action or proceeding, and protected health information is subject to law that prohibits access to protected health information.

You have the right to request a restriction on your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information no be disclosed to family members or friends who may be involved in your care or for notification purposes as described by the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, ie. Electronic.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice becomes effective on or before February 1, 2007

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you have any objections to this form, please speak to your physician.

Signature below is only acknowledgement that you have received and read this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

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