Clinical Genetics Service
Helping You and Your Family Reduce Your Risk

Aaron G. Margulies MD
Compassionate surgical care you can trust

Your TELEHEALTH appointment is _____ at _____AM/PM

Your paperwork is due back to our office by _____

North Office Location	**West Office Location**	**Jefferson City Location**	**Newport Location**
7714 Conner Road Suite 107 Knoxville, TN 37849	Tennova Turkey Creek Medical Center 10810 Parkside Drive Suite G-11 Knoxville, TN 37934	Jefferson Memorial 120 Hospital Drive Suite G-50 Jefferson City, TN 37760	Newport Medical 434 Fourth Street Suite 301 Newport, TN 37821

Dear_____,

Thank you for your interest in the Clinical Genetics Service. I look forward to working with you on our **TELEHEALTH VISIT** to evaluate your risk for breast cancer and to develop approaches to reduce your risk for breast cancer. Our service also includes risk assessment for those with breast cancer, ovarian cancer, colorectal cancer, uterine cancer, and other cancers to assess the role genetics may play in cancer development.

In an effort to expedite your visit, please complete the attached questionnaire packet with copy of front and back of insurance cards and driver's license and mail/email or fax it to Imelda prior to your appointment. In addition, if you or anyone in your family has already pursued hereditary cancer genetic testing, it is very important that you send a copy of the test result before your appointment, if possible. If appointment not scheduled above, I will contact you to schedule an appointment convenient for you.

During your visit, we will review your personal and family history and your lifestyle questionnaire to assess whether a hereditary cancer syndrome may explain some of the cancers in your family. We will discuss the basic genetics of hereditary breast and ovarian cancer syndrome (HBOC), Lynch syndrome, and other cancer syndromes as appropriate and discuss strategies for an individualized healthcare plan for cancer risk reduction. If genetic testing is indicated, then testing can be initiated after the appointment via a saliva sample (Special Saliva collection kit to be mailed to your home.)
Insurance coverage and the testing laboratory's pre-authorization process will be discussed at your appointment.

Early Detection and Risk Reduction are our Key Goals in the Clinical Genetics Service.

If your insurance requires a referral from your primary care physician, then please ensure that a referral is completed prior to scheduling your appointment. All other charges will be filed with your insurance.

****If Imelda has emailed you a link to a family pedigree website, CRA Health, then please complete the online questionnaire two days before your scheduled appointment. ****

If you have any questions or need further assistance, please give me a call at **865-692-1602.**
I look forward to meeting with you soon.

Sincerely,
Imelda G. Margulies, MSN, FNP- BC
Director, Clinical Genetics Service

Email: ImeldaFNP@AaronMD.com FAX: (865) 692-1619
Websites to View: www.aaronmd.com; www.mysupport360.com; www.ambrygen.com/patient

Patient Demographic & Consent Form

First Name: _____ Middle Initial_____ Last Name: _____

DOB: _____/_____/_____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Numbers

Home: (_____) _____

Mobile: (_____) _____

Work: (_____) _____

Occupation: _____

Preferred Method of Contact: (Circle One)

Home Mobile Work E-Mail

Marital Status: _____

Email: _____@_____

Employer: _____

Emergency Contacts

1. _____ Relation: _____ Phone: _____

2. _____ Relation: _____ Phone: _____

Do you consent for our office to leave a voice message if needed? **Yes No**

May we contact and share medical information with your emergency contacts if needed? **Yes No**

Would you like an email for sign-up information to Dr. Margulies' blog on Breast Cancer? **Yes No**

Would you like an email invite to register an account on our patient portal? **Yes No**

Which Office is most convenient for you? (Circle One) **Powell Turkey Creek Jefferson City Newport**

How did you hear about our practice? _____

If you are a **Breast Care Patient**, do you give consent for Dr. Margulies to discuss your case with other physicians? **Yes No**

If you are a **Genetics Patient**, do you give consent for our office to release or obtain copies of your genetic testing? **Yes No**

Insurance ***If your insurance carrier through your spouse or someone else please complete the following:**

Name of Insured: _____ DOB: _____ SS#: _____-_____-_____

Treating Physicians: Primary Care Physician: _____ Referring Physician: _____

Medical Oncologist: _____ Radiation Oncologist: _____

Gynecologists: _____

Pharmacy: Name: _____ City: _____ Phone: _____

By signing below, I verify that all the information above is correct. I also verify that I have been offered and have reviewed a copy of the Patient Privacy Notice required by HIPAA and understand my right to privacy as a medical patient of Aaron G. Margulies MD, PLLC.

Patient / Responsible Party Signature: _____ Date: _____

Name: _____ DOB: _____MRN: _____

How many sisters do you have? _____ How many brothers? _____

How many children do you have? _____ Daughters_____ Sons _____

How many sisters does your mother have? _____ How many brothers? _____

How many sisters does your father have? _____ How many brothers? _____

Ethnic background: _____ Ashkenazi Jewish? Y/N

***PLEASE LIST ALL MEMBERS OF YOUR FAMILY ALIVE OR DECEASED (REGARDLESS OF CANCER)**
*Indicate who (including yourself) has had Cancer - **(Especially breast, ovarian, pancreatic, prostate)**

RELATIVE	First Name	Alive (Age)	Deceased (Age)	Cancer – Y/N	Type	AGE at DIAGNOSIS
You						
Daughter						
Daughter						
Son						
Son						
Your Family						
Sister						
Sister						
Brother						
Brother						
Mother						
Father						
Mother's Side						
Grandmother						
Grandfather						
Aunt						
Aunt						
Uncle						
Uncle						
Father's Side						
Grandmother						
Grandfather						
Aunt						
Aunt						
Uncle						
Uncle						

****If you have a large family history of cancer, please list on the back of this sheet additional family members (cousins, etc.) that may provide more accurate information regarding your family history of cancer.**

Hereditary Cancer Genetics Questionnaire **Clinical Genetics Service**

Name: _____ DOB: _____

Reason for Visit: (give a brief description):

Date of Last Breast Imaging: _____ Location:

Do you have dense breast tissue? YES / NO

Medical History / Past Surgeries / Past Breast Surgeries

Have you ever had a colonoscopy? YES / NO If yes, Age of most recent colonoscopy? _____

Colon Polyps: YES / NO If yes, Number of polyps? _____

Previous History of any Breast Biopsies: YES / NO If yes, how many biopsies have you had? _____

If yes, have you ever had Atypia, ADH, or LCIS? _____

Medication Allergies:

☐ NKDA

Daily Medications & Supplements:

Regular Aspirin Usage: YES / NO Regular Ibuprofen Usage: YES / NO

Social History & Risk Calculations

Employment Status: Employed Retired Disabled Occupation (if employed):

Marital Status: Education:

Ashkenazi Jewish Heritage? YES NO

Hispanic? YES NO

Tobacco Use: CURRENTLY IN THE PAST NEVER

If yes, what type do you use? Number of years used?

If currently using, how much per day?

Alcohol Use: YES NO If YES, number of drinks per week?

Exposures to Hazardous Materials: Asbestos Benzene Lead Radiation Sunburn Other: _____

Vegetables: Number of servings per day?

Hours per week of vigorous exercise:

Weight: Height:

Number of Pregnancies: Number of Live Births: Age of First Live Birth:

Age of First Menses: Date of Last Menstrual Cycle: Age Periods Stopped:

Hysterectomy: YES / NO If YES, at what age was this performed?

Ovaries Present: YES / NO If NO, at what age were they removed?

Oral Contraceptive Use: YES / NO

If YES, age when started: _____

If YES, how many years used_____ If YES, when did you discontinue use? _____

Hormone Replacement: □ CURRENTLY □ IN THE PAST □ NEVER

(If yes, what type of hormone? □ Estrogen only □ Progesterone only □ Estrogen & Progesterone

If YES, how many years used_____ If YES, when did you discontinue use? _____

Have you had cancer genetic testing? YES / NO Description:

Has cancer genetic testing been done in the family? YES / NO Description:

Aaron G. Margulies, MD, PLLC

Aaron G. Margulies, MD, FACS

Imelda Margulies, MSN, FNP-BC

FINANCIAL RESPONSIBILITY FORM

At the office of **Aaron G. Margulies, MD, PLLC**, we strive to give you the best possible care. In order to serve this purpose, it is important that our patients understand the process of reimbursement. Please read this Financial Responsibility Form and sign to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as, authorization requirements. This information can be obtained by contacting your insurance carrier.

We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payment due will be yours.

***If you have any changes in your insurance coverage you must notify us prior to your appointment.**

DEDUCTIBLES, COINSURANCE AND COPAYMENTS

The deductible is determined by your individual contract with your insurance carrier. You are responsible for your deductibles, copayments, and coinsurance. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay deductibles, coinsurance and copayments, when this applies.

NON-COVERED SERVICES AND MEDICAL NECESSITY

All patients are responsible for account balances if their insurance carrier denies payment for services rendered because they were stated as “non-covered services” or deemed as “medically unnecessary.” To avoid this, please check with your insurance carrier prior to receiving any treatment or services.

By signing below, I authorize the release of any medical information necessary to process insurance claims filed to my insurance carrier on my behalf or on the behalf of my dependents. I authorize payment for medical benefits to be made directly to my physician for services rendered at the office of **Aaron G. Margulies, MD, PLLC**.

I certify that I have read the above disclosure statements, understand my responsibilities, and agree to the terms written above.

Patient / Responsible Party Signature _____Date_____

Patient / Responsible Party Name (Please Print) _____

Relation to Patient: _____