Dear ____________________________,

Thank you for your interest in the Clinical Genetics Service. I look forward to working with you to evaluate your risk for breast cancer and/or hereditary cancers and to develop approaches to reduce your risks for 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 and bring it 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 bring a copy of the test result to 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 at the end of the appointment via a blood sample. 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.ambyrgen.com/patient
Patient Demographic & Consent Form

First Name: _________________________ Middle Initial _____ Last Name: ____________________________

DOB: _______/_______/________  SS#: _______ - _______ - _______

Address: _________________________________  City: ____________________  State: _______  Zip Code: ___________

Phone Numbers

Home: (_____) _____________________________  Home         Mobile         Work         E-Mail

Mobile: (_____) ____________________________  Marital Status: ________________

Work: (_____) _____________________________  Email: ______________________@______________

Occupation: ________________________________  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)

<table>
<thead>
<tr>
<th>RELATIVE</th>
<th>First Name</th>
<th>Alive (Age)</th>
<th>Deceased (Age)</th>
<th>Cancer – Y/N</th>
<th>Type</th>
<th>AGE at DIAGNOSIS</th>
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**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**

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

<table>
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<tr>
<th>Employment Status:</th>
<th>Employed</th>
<th>Retired</th>
<th>Disabled</th>
<th>Occupation (if employed):</th>
</tr>
</thead>
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<tr>
<td>Marital Status:</td>
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<td>Education:</td>
</tr>
</tbody>
</table>

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, when did you discontinue use?
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 □ Progestosterone 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:
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: ____________________________________________________________________