

**'Specially for Children Clinical Genetics**

6811 Austin Center Blvd. Ste 400. Austin, TX 78731

Phone: (512) 628-1840 Fax: (512) 628-1841

[www.speciallyforchildren.com](http://www.speciallyforchildren.com)

\_\_\_\_\_, has an appointment with LaDonna Immken, MD and  
Gayle Simpson Patel , CGC on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m

Welcome to 'Specially for Children Clinical Genetics. We hope you will find the following information helpful. You have been referred for genetic counseling because of a personal and/or family history of cancer or a genetic disease. At your appointment we will review your medical and family history. Based on the information you provide we will discuss the availability of genetic testing and the benefits and limitations of testing. Genetic counseling appointments last for approximately 1 hour. Any recommended testing is subject to insurance approval and will be arranged after the visit.

***Please be sure to bring the following information to your visit:***

- 1.) A valid driver's license and insurance card
- 2.) Referral/Authorization provided by your Primary Care Physician
- 3.) Co-Pay: Co-pays and co-insurance deductibles will be collected at the point of service. Please have your form of payment ready/arrangements made, or your appointment will need to be rescheduled for a later date.
- 4.) Please review your family history & be prepared to provide information on both sides of the family.
- 5.) Please complete the entire attached New Patient Packet and bring to your appointment.

**\*\* While we will verify that you have insurance coverage, we can't know the details of each and every insurance policy. Be sure you are familiar with services and procedures that are/are not covered. \*\***

Please allow adequate time to arrive at our location and find parking. You may park in visitor parking for free. Please arrive fifteen (15) minutes early to find parking, and check in at our centralized check-in to complete any needed paperwork. For the benefit of all our patients, our physicians feel it is important to stay ON SCHEDULE. Please be advised that if you are LATE for your appointment, you may be asked to reschedule for a later date. **If you must cancel your appointment, we require at least one business day notice to cancel or you may be charged a \$25 "no-show" fee. Please review our No-Show policy which is attached.**

We look forward to meeting you and would like to thank you for your cooperation. Should you have any questions, feel free to call us at (512) 628-1840. If you would like to submit your new patient packet before the visit you may fax it to (512) 628-1841 or email it to [gsimpson@sfaustin.com](mailto:gsimpson@sfaustin.com) . Thank you.

Sincerely,

***'Specially for Children Clinical Genetics Staff***



## *Hereditary Cancer Risk Assessment Personal and Family History Questionnaire*

**PLEASE COMPLETE THIS FORM ONLY IF YOU ARE BEING REFERRED  
FOR A PERSONAL OR FAMILY HISTORY OF CANCER**

### Background Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
          First                    Middle                    Maiden                    Last

What is your mother's ethnic background? \_\_\_\_\_

What is your father's ethnic background? \_\_\_\_\_

Are any of your relatives of Ashkenazi Jewish descent?    Yes    No

### Medical History

How is your health in general? \_\_\_\_\_

Have you ever been diagnosed with cancer?    Yes    No

<u>Age</u>	<u>Cancer Type</u>	<u>Treatment (Circle all that apply)</u>		
_____	_____	Surgery	Chemotherapy	Radiation
_____	_____	Surgery	Chemotherapy	Radiation
_____	_____	Surgery	Chemotherapy	Radiation

What medications are you currently taking? \_\_\_\_\_

Have you ever had any other types of surgery?    Yes    No

If yes, describe: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Do you see any other physicians regularly?    Yes    No

<u>Name</u>	<u>Specialty</u>
_____	_____
_____	_____
_____	_____
_____	_____

**Medical History- WOMEN ONLY**

Age at first period \_\_\_\_\_ Age at first birth \_\_\_\_\_  
 Number of Children \_\_\_\_\_ Number of Miscarriages \_\_\_\_\_  
 Number of Still births \_\_\_\_\_ Age menopause began \_\_\_\_\_

Have you ever had a breast biopsy?  Yes  No  
 If yes, how many? \_\_\_\_\_  
 If yes, at what age(s)? \_\_\_\_\_  
 Did the biopsy show atypical hyperplasia?  Yes  No  Unknown  
 Did the biopsy show DCIS or LCIS?  Yes  No  Unknown

Have you had a hysterectomy (removal of uterus)?  Yes  No  
 If yes, at what age? \_\_\_\_\_ Reason \_\_\_\_\_

Have you had an oophorectomy (removal of ovaries)?  Yes  No  
 If yes, at what age? \_\_\_\_\_ Reason \_\_\_\_\_

**Cancer Screening History**

<b>Women</b>					
	<i>Screening Test</i>	<i>Most Recent</i>	<i>How Often</i>	<i>Age Started</i>	<i>Comments</i>
	Self Breast Exams				
	Clinical Breast Exams				
	Mammograms				
	Breast MRI				
	PAP Smear				
	CA 125 Blood Test				
	Transvaginal Ultrasound				
	Other:				
<b>Men</b>					
	<i>Screening Test</i>	<i>Most Recent</i>	<i>How Often</i>	<i>Age Started</i>	<i>Comments</i>
	Digital Rectal Exam				
	PSA Blood Test				
	Other:				
<b>Men and Women</b>					
	<i>Screening Test</i>	<i>Most Recent</i>	<i>How Often</i>	<i>Age Started</i>	<i>Comments</i>
	Colonoscopy				
	Sigmoidoscopy				
	Endoscopy				
	Other:				

**FAMILY HISTORY QUESTIONNAIRE**

**Please read these instructions before beginning the Family History Questionnaire**

- Please list all relatives
- Only include blood relatives of yourself
  - not adopted or married-in individuals
  - include half siblings
- Please write n/a in fields that are not applicable to a relative.
- Please consult other family members, if necessary, to increase the accuracy of this information.
- If you run out of room please attach an additional page.

<b>Your Parents</b>					
<b>Name</b>	<b>Age</b>	<b>Age at Death</b>	<b>Type of Cancer or General Health</b>	<b>Age at Diagnosis</b>	
<b>Your Children</b>					
<b>Name</b>	<b>Sex</b>	<b>Age</b>	<b>Age at Death</b>	<b>Type of Cancer or General Health</b>	<b>Age at Diagnosis</b>
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
<b>Your Brothers and Sisters</b>					
<b>Name</b>	<b>Sex</b>	<b>Age</b>	<b>Age at Death</b>	<b>Type of Cancer or General Health</b>	<b>Age at Diagnosis</b>
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				







# 'Specially for Children Notice of Privacy Practices

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### Understanding Your Health Record/Information

This notice describes the practices of 'Specially for Children (SFC) and that of its physicians with respect to your protected health information created while you are a patient at SFC. SFC physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, SFC physicians may share medical information with each other for treatment, payment or healthcare operations described in this notice.

We create a record of the care and services you receive at SFC. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at SFC.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

### Your Health Information Rights

Although your health record is the physical property of SFC, the information belongs to you. You have the right to:

- Inspect and request a copy of your health record as provided by law;
- Request communications of your health information by alternative means or at alternative locations. We will accommodate reasonable requests;
- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of certain disclosures of your health information as provided by law;
- Obtain a paper copy of this notice of information practices upon request from the SFC Privacy Officer at 1301 Barbara Jordan Blvd, Suite 200; Austin, Texas 78723. A copy of this notice may also be obtained from the SFC website at [www.speciallyforchildren.com](http://www.speciallyforchildren.com)

You may exercise your rights set forth in this notice, by providing a written request to the Revenue Integrity Manager at 'Specially for Children, 1301 Barbara Jordan Blvd, Suite 200; Austin, Texas 78723. You may also provide the written request via email to: [ComplianceCommittee@sfscaustin.com](mailto:ComplianceCommittee@sfscaustin.com).

### Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at SFC and on the SFC website at [www.speciallyforchildren.com](http://www.speciallyforchildren.com)
- We will not use or disclose your health information without your written authorization, except as described in this notice or permitted by law.

Examples of Disclosures of Health Information for Treatment, Payment and Health Care Operations and as Otherwise Allowed by Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories:

### Treatment

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at SFC. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your primary care physician or a subsequent health-care provider information about your particular condition so that they may treat you for other medical conditions, if any.

### Payment

For example: We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. The information on or accompanying the bill will include medical information that identifies you, a description of the medical services provided to you, your diagnosis, and other information that your insurer or HMO needs to approve payment to us.

### Health Care Operations

For example: We are permitted to use and disclose the information in your medical record for the purposes of health care operations, which are activities that support this practice and assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

Your health information will also be used as otherwise allowed by law. The following are some examples of how we may use and disclose medical information about you.

**Business Associates:** There are some services provided in our organization through contacts with business associates. Examples include certain lab tests, answering services, transcription services, and copy services. To protect your health information, however, we require business associates to take the appropriate measures to safeguard your information.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition.

**Research:** We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Funeral Directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**Organ Procurement Organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Communications for Treatment and Health Care Operations:** We may contact you by telephone or mail to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

**Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits, goods, and services provided by SFC that may be of interest to you.

**Fund Raising:** We may contact you as part of a fund-raising effort.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers' Compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Public Health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse, Neglect or Domestic Violence:** As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

**Judicial, Administrative and Law Enforcement Purposes:** Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes. This may include disclosures to avert a serious threat to you or a third party's health or safety as well as victims of crime or criminal conduct at the Covered Entity.

**Military, National Security and Intelligence Activities, Protection of the President:** We may disclose health information about you for specialized government functions such as separation or discharge from military service, authorized national security and intelligence activities, as well as authorized activities for the provision of protection services for the President of the United States, other authorized government officials, or foreign heads of state.

**Required or Allowed by Law:** We will disclose medical information about you when required or allowed to do so by federal, state or local law.

### Other Uses of Your Health Information:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose your medical information, you may cancel that permission, in writing, at any time. If you cancel your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission.

### For More Information or to Report a Problem

If you have questions regarding your privacy rights and would like additional information, you may contact the 'Specially for Children Revenue Integrity Manager at 512-628-1933 or [ComplianceCommittee@sfscaustin.com](mailto:ComplianceCommittee@sfscaustin.com)

If you believe your privacy rights have been violated, you may file a written complaint with the 'Specially for Children Revenue Integrity Manager at 1301 Barbara Jordan Blvd, Suite 200; Austin, Texas 78723 or [ComplianceCommittee@sfscaustin.com](mailto:ComplianceCommittee@sfscaustin.com) You may also file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.



**'Specially For Children  
Authorization for Release of Health Information**

I hereby authorize 'Specially For Children to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immunodeficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

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Print Patient Name	Date of Birth	Social Security Number
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Date(s) of Service for Records Being Requested (Be Specific)	Name of Physician, from whom Records are being requested
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Description of Health Information to be released:

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Consultation	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Lab Report	<input type="checkbox"/> X-ray Report	<input type="checkbox"/> EKG
<input type="checkbox"/> Emergency Record	<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Other: (specify) _____

Purpose of Disclosure:

<input type="checkbox"/> Attorney/Legal	<input type="checkbox"/> Continued Patient Care
<input type="checkbox"/> Commercial Insurance	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Other: (specify) _____	

**Release my protected health information (referenced above) to the following physician/person/facility/entity:**

Name:

Dr. LaDonna Immken  
'Specially for Children Clinical Genetics  
6811 Austin Center Blvd. Ste. 400 Austin, Texas 78731  
[www.speciallyforchildren.com](http://www.speciallyforchildren.com)  
512-628-1840 (phone) 512-628-1841 (fax)

I understand that this authorization will expire within one year from the date of this authorization. \_\_\_\_\_  
Initial/Date

I understand that I may revoke this authorization by requesting a written revocation of authorization that can be obtained by calling/writing to the phone number/address listed at the bottom of this page. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I also understand that 'Specially for Children will provide this information 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

**Signature for Authorization:**

\_\_\_\_\_  
Patient or Patient Representative Name

\_\_\_\_\_  
Signature of Patient or Patient Representative Name

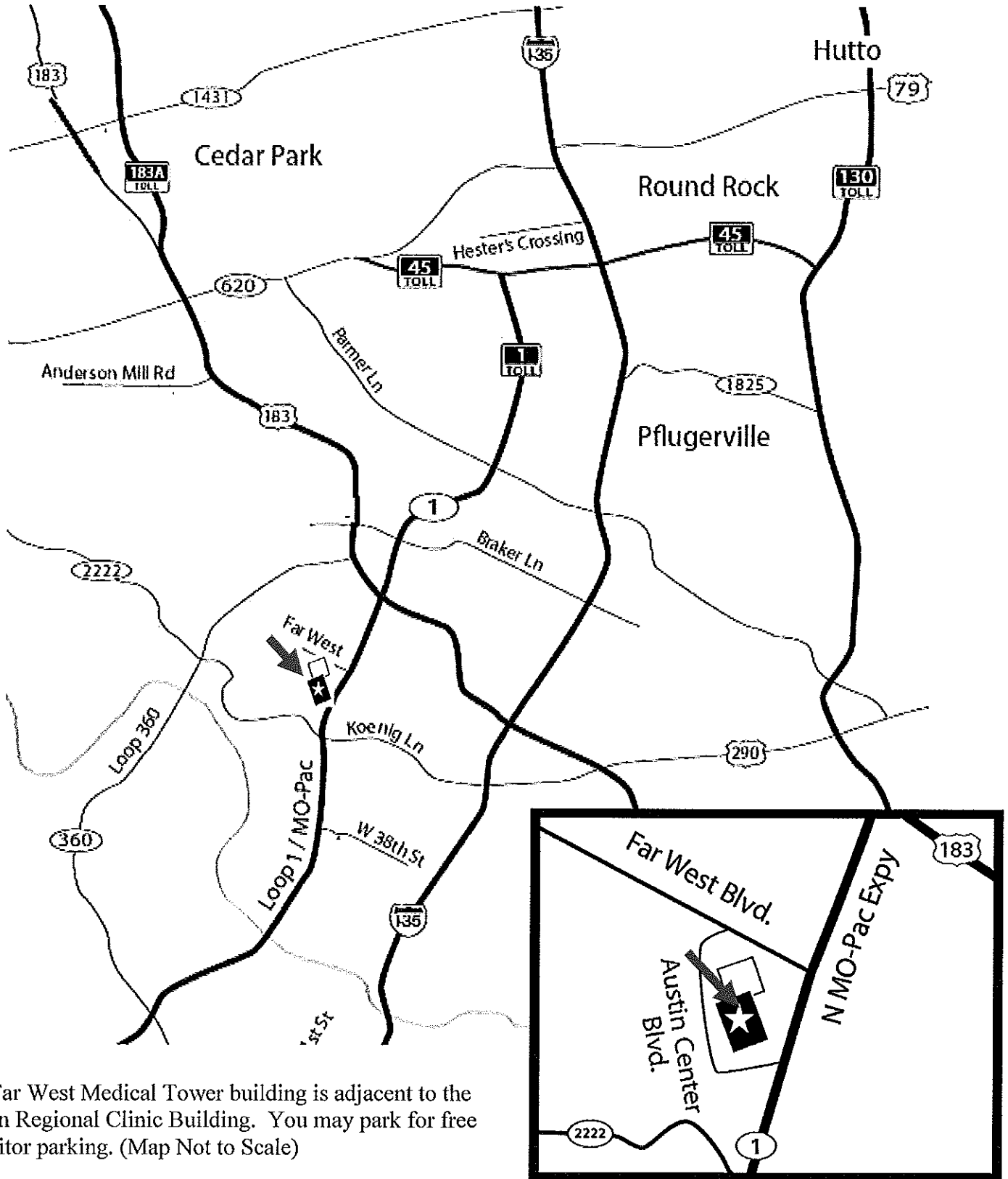
\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Or, Legal Authority (attach supporting documentation)





*'Specially for Children Clinical Genetics  
Far West Medical Tower Building  
6811 Austin Center Blvd. Ste 400  
Austin, Texas 78731  
512-628-1840 phone 512-628-1841 fax  
[www.speciallyforchildren.com](http://www.speciallyforchildren.com)*



The Far West Medical Tower building is adjacent to the Austin Regional Clinic Building. You may park for free in visitor parking. (Map Not to Scale)