Thank you for choosing Jefferson Center for Women’s Medical Specialties for your care. Our office is located at:

834 Chestnut St.
3rd Floor; Suite 300
Philadelphia, PA 19107
(215) 955-5000

Please note: The entrance to the building is on 9th street between Chestnut and Sansom streets.

In order to provide you with the best possible care, we ask for your cooperation in completing several forms prior to your first visit. Enclosed you will find a patient registration form and medical history questionnaire. Please complete these and bring them with you to your first appointment, please do not mail completed forms to the office. If you are coming for a consultation or a second opinion, you should bring any pertinent operative records and laboratory reports related to your condition. You can also have these mailed or faxed (#1-215-923-1089) to our office prior to the appointment for the doctors to review.

At each office visit, our receptionist will ask you to review your registration information and verify that it is correct. We ask that you bring your insurance card and a form of identification with you to every visit. Please be prepared to pay any co-pay that is your responsibility or to provide us with a referral upon arrival.

If you are unable to keep your appointment, we ask that you call our office within 24 hours so that we may offer this appointment to another patient.

You have scheduled an appointment with:

☐ Candice Carbone, CRNP
☐ Leslie Hughes, CRNP
☐ Rebecca Jackson, MD
☐ Cory Kacergis, CRNP
☐ Cheung Kim, MD
☐ Katherine Lackritz, MD
☐ Lisa Lent, CRNP
☐ Rebecca Mercier, MD
☐ J. Biba Nijjar, MD
☐ Casandra Snader, CRNP
☐ Ryan Sobel, MD
☐ Elisabeth Woodhams, MD
☐ Abigail Wolf, MD

Date of Appointment: __________________________

Time of Appointment: __________________________

If you are not able to keep your appointment, we ask that you call our office to cancel so that we may offer this appointment to another patient. We recommend arriving to the office 15 minutes early to allow for the registration process. Please be advised, we allow a 20 minute grace period for tardiness to your appointment. If you arrive more than 20 minutes after your scheduled appointment time, you will be asked to reschedule your appointment.

Sincerely,

The Physicians of Women’s Medical Specialties
Discounted Parking is available to our patients in the Ben Franklin parking lot, located on Sansom Street between 8th and 9th Streets. The discounted rate is $14.00/day. Please see our front desk staff for a stamp to validate your parking discount.

Discounted parking is also available at the Central Parking lot on Market Street between 8th and 9th Streets. Our front desk staff is happy to provide a discounted parking coupon.

Thank you.
Directions to Jefferson Center for Women’s Medical Specialties

From the Pennsylvania Turnpike
Exit at Valley Forge. Take Rt. 76 East to I-676 East to the 8th Street/Chinatown Exist. Take 8th Street to Walnut Street, then make another right onto 9th Street. The Benjamin Franklin House will be on your right, about 1½ blocks. Parking is on the left across from the building.

From I-95 North of Wilmington
Take Exit 22 Independence Hall/Callowhill Street, following signs for Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left onto 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Benjamin Franklin House will be on your right, about 1½ blocks. Parking is on the left, across from the building.

From I-95 South (from Bucks County)
Take Exit 22 Independence Hall/Callowhill Street, following signs for Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left onto 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Benjamin Franklin House will be on your right, about 1½ blocks. Parking is on the left, across from the building.

From New Jersey Shore Points
Take the Atlantic City Expressway North to Rt. 42 North. Follow signs for the Benjamin Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Benjamin Franklin House will be on your right, about 1½ blocks. Parking is on the left, across from the building.

From Central New Jersey
Routes 70 West and 38 West will take you to the Benjamin Franklin Bridge. Cross over the Benjamin Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Benjamin Franklin House will be on your right, about 1½ blocks. Parking is on the left, across from the building.

From New York
Take the New Jersey Turnpike South to Exit 4 / Rt. 73 North. Take Rt. 73 North to Rt. 38 West. Follow Rt. 38 West to the Benjamin Franklin Bridge. Cross over the Benjamin Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Benjamin Franklin House will be on your right, about 1½ blocks. Parking is on the left, across from the building.
University Physicians

Street Direction

Emergency Entrance

Valet Parking

Parking Garages/Lots

I. Jefferson Hospital for Neuroscience Garage
8th and 9th Sts. between Locust and Walnut Sts.

J. Walnut Street Theater Lot
819 Walnut St.

K. Central Parking System
Open lot between 8th and 9th Streets on Market St.

10th & Chestnut St. Garage
Entrances on 10th St. and on Sansom St.

Central Parking System (Eglin)
open lot between 11th and 12th Sansom St.

Central Parking System (Eglin)
th and Sansom St.

right Parking Garage
h St. between Sansom l Walnut Sts

B. Girard Square Parking
1120 Clover St., between Chestnut and Ludlow Sts.

F. The Auto Park at Gallery Mall
10th St. between Arch and Filbert Sts.

G. Philadelphia Parking Authority Garage
10th and Ludlow Sts.

H. Wills Eye Hospital—Walnut Towers Garage
8th and 9th Sts. between Locust and Walnut Sts.

L Jefferson Hospital for Neuroscience Garage
8th and 9th Sts. between Locust and Walnut Sts.

K. Central Parking System
Open lot between 8th and 9th Streets on Market St.

I. Jefferson Hospital for Neuroscience Garage
8th and 9th Sts. between Locust and Walnut Sts.

J. Walnut Street Theater Lot
819 Walnut St.

K. Central Parking System
Open lot between 8th and 9th Streets on Market St.

L Jefferson Hospital for Neuroscience Garage
8th and 9th Sts. between Locust and Walnut Sts.
Jefferson University Physicians ("JUP") is participating in the Medicare and Medicaid Electronic Health Record Incentive Program ("Program"). The federal government requires us to record specific demographic information about all of our patients. We are asking you to provide the demographic information below for Program purposes. Please check the appropriate boxes below. Only one entry in each section can be chosen.

1. Language:
   - [ ] English
   - [ ] Other (Please List)

2. Race:
   - [ ] African American or Black
   - [ ] American Indian or Alaska Native
   - [ ] Asian
   - [ ] Caucasian or White
   - [ ] Native Hawaiian or Other Pacific Islander
   - [ ] Unknown
   - [ ] Declined

3. Ethnicity:
   - [ ] Hispanic or Latino
   - [ ] Non-Hispanic or Non-Latino
   - [ ] Unknown
   - [ ] Declined
Please complete this form in order to ensure proper billing of your services. Please Print.

<table>
<thead>
<tr>
<th>Patient’s Last Name</th>
<th>Patient’s First Name</th>
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</table>

<table>
<thead>
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<th>Sex</th>
<th>Social Security Number</th>
<th>Language</th>
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<th>Ethnicity</th>
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<th>Address Line 2</th>
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<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>Home Phone</th>
<th>Daytime Phone</th>
<th>Cell Phone</th>
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</table>

<table>
<thead>
<tr>
<th>Home E-mail</th>
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<tr>
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<th>Employer</th>
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<table>
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<tr>
<th>Guarantor’s Last Name</th>
<th>Guarantor’s First Name</th>
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</table>

<table>
<thead>
<tr>
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<th>Sex</th>
<th>Social Security Number</th>
<th>Patient’s Relationship to the Guarantor</th>
<th>Home Phone</th>
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</thead>
</table>

Guarantor’s Address Line 1

<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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</table>

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<tr>
<th>Guarantor’s Employer</th>
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<table>
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</table>

<table>
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<th>Guarantor Employer’s Address Line 1</th>
<th>Guarantor Employer’s Address Line 2</th>
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<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>Emergency Contact’s Last Name</th>
<th>Emergency Contact’s First Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient’s Relationship to the Emergency Contact</th>
<th>Daytime Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Use select the source in which you heard of our practice</th>
</tr>
</thead>
</table>

| Primary Insurance Company Name | Subscriber’s Last Name | Subscriber’s First Name | Subscriber’s DOB | Patient’s Relationship to the Subscriber | Secondary Insurance Company Name | Subscriber’s Last Name | Subscriber’s First Name | Subscriber’s DOB | Patient’s Relationship to the Subscriber |
Part A
You have informed Jefferson University Physicians (JUP) that in certain circumstances, you would like us to share your medical information with specified individuals (e.g., your spouse, mother, etc.).

JUP agrees to communicate with persons whom you designate regarding your protected health information. This agreement will remain in effect unless you provide us with written notice to terminate this consent.

Part B
I hereby grant Jefferson University Physician’s department/division of

permission to communicate my protected health information to the following individuals:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Telephone #:</th>
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</thead>
<tbody>
<tr>
<td>Address:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Telephone #:</th>
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</thead>
<tbody>
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<td>Address:</td>
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<th>Telephone #:</th>
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<tbody>
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<td>Address:</td>
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<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Telephone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
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</tbody>
</table>

Patient Signature: ___________________________ Date:_________________________


Patient Name: ____________________________ Date of Birth: ____________________________

IDX Account #: ____________________________

Medicare
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jefferson University Physicians and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

- Are you or your spouse employed? ☐ Y ☐ N
- Do you or your spouse have other insurance? ☐ Y ☐ N
- Are you disabled or have end stage renal disease? ☐ Y ☐ N
- Is illness/injury the result of an auto accident? ☐ Y ☐ N
- Did illness/injury occur at work? ☐ Y ☐ N

- Has treatment been authorized by the V.A.? ☐ Y ☐ N
- Are you covered under the Black Lung Program? ☐ Y ☐ N
- Is there Medigap coverage secondary to Medicare? ☐ Y ☐ N
- Is there insurance coverage primary to Medicare? ☐ Y ☐ N
- Is there employer supplemental coverage secondary to Medicare? ☐ Y ☐ N

Medigap (Medicare Secondary Insurance)
I request that payment of authorized Medigap benefits be made either to me or on my behalf to Jefferson University Physicians for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage any information needed to determine these benefits payable for related services.

Pennsylvania Medical Assistance
I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

Commercial
Assignment of Insurance Benefits
hereby authorize payment directly to Jefferson University Physicians for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this agreement, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

General
Release of Information
hereby authorize Jefferson University Physicians to disclose to my insurance company(s) copies of my medical record(s) to obtain payment for services or part of a payment review of medical services, or in the case of Workers Compensation claims, to my present or past employer(s). Additionally, I authorize Jefferson University Physicians to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose of such formation. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.

Se of Photograph
I, the undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

Financial Agreement
Consideration of the services rendered to the below named patient, the undersigned agrees to pay Jefferson University Physicians in accordance with its regular charges and terms and, if this account is referred to an attorney or agency for collection, to pay attorney(s) fees, court costs, and collection expenses. I also agree to be responsible for charges not covered by insurance. I understand that my obligation to pay Jefferson University Physicians may not be deferred for any reason, including pending legal action against other parties, to recover medical costs.

The undersigned certifies that each has read and understands the above terms and conditions.

__________________________  ____________________________
Patient Signature                                                    Date

__________________________  ____________________________
Patient's Agent Representative and Guarantor Signature                 Date
Jefferson University Physicians

Medical History Questionnaire

Provider you are seeing today: ____________________________  Today's Date: ____________________________

Patient's Name: ______________________________________  Date of Birth: ____________________________

Why are you here today? ____________________________________________

Did a physician request that you see one of our providers today? □ Yes □ No

If yes, name of physician: ____________________________

Past Medical History (check all that apply): □ No Past Medical History

- Acute Myocardial Infarction (Heart Attack)
- Anemia (Low Blood Count)
- Arthritis
- Asthma
- Autoimmune Disorder (Lupus/Scleroderma/RA)
- Bleeding Disorder
- Blood Transfusion Complications
- Cancer – list type(s):
- Chest Pain (Angina)
- Chronic Liver Disease
- COPD (Chronic Obstructive Pulmonary Disease)
- Diabetes Mellitus
- Emotional Disturbance
- Gastric/Duodenal Ulcer
- Heart Disease
- Heartburn
- Hepatic (Liver) Disease
- Hepatitis
- HIV Infection
- Hypercholesterolemia
- Hypertension
- Intractable Bowel Syndrome
- Kidney Problems
- Lower Back Pain
- Mitral Valve Disorder
- Murmurs
- Obesity
- Obstructive Sleep Apnea
- Osteoporosis
- Peripheral Vascular Disease (Poor Circulation)
- Pneumonia
- Pulmonary Disease (Lung Disease)
- Recent Methicillin-resistant Staph aureus (MRSA)
- Rheumatic Fever
- Seizure Disorder
- Sinusitis
- Stroke Syndrome
- Thromboembolic Disease (Blood Clot Disorder)
- Thromboembolitis
- Thyroid Disorder
- Transient Ischemic Attack (Mini Stroke)
- Tuberculosis
- Other (specify):

Surgery: □ No Surgical History  Date: ____________________________

Family History (check all that apply): □ No Family Medical History

<table>
<thead>
<tr>
<th>Anemia (Low Blood Count)</th>
<th>Family Member*</th>
<th>Hypercholesterolemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer – list type(s):</td>
<td></td>
<td>Hypertension</td>
</tr>
<tr>
<td>COPD</td>
<td></td>
<td>Osteoporosis</td>
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<tr>
<td>Diabetes Mellitus</td>
<td></td>
<td>Pulmonary Disease</td>
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<tr>
<td>Emphysema</td>
<td></td>
<td>Renal Disease</td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td>Stroke Syndrome</td>
</tr>
<tr>
<td>Hepatic (Liver) Disease</td>
<td></td>
<td>Thromboembolic Disease</td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td>Unattainable-Patient Adopted</td>
</tr>
</tbody>
</table>

Family Health Status of Father - Deceased  Age: ______  Cause: ______
Family Health Status of Mother - Deceased  Age: ______  Cause: ______

*Please indicate the family member affected: mother, father, brother, sister, maternal or paternal grandmother/grandfather, etc.
# Medical History Questionnaire

**Social History:**

- **Marital Status:**
  - [ ] Married
  - [ ] Single
  - [ ] Widowed
  - [ ] Separated
  - [ ] Divorced
  - [ ] Life Partner

(check all that apply):

- [ ] Alcohol Use
- [ ] Drug Use (Recreational)
- [ ] Using Intravenous Drugs

**Previous History of Smoking**

- Date Quit:
- Packs Per Day:
- Years of Smoking:
- Attempts to Quit:
- Methods Used to Quit:
- [ ] No History of Smoking
- [ ] Wishing to Stop Smoking

**Smoking/Nicotine Substances**

- Cigarettes
- Cigars
- Chewing Tobacco
- Pipe

- Packs/Times Per Day:
- Years:

**Current Diet**

- Explain:

**Exercise Habits**

- Times per week:

**Being Sedentary (Do not exercise)**

- [ ] Sexually Active

**Occupation**

- List All:

**Travel**

- If recently out of the country, where?

---

Do you have an advanced directive? [ ] Yes [ ] No

## Allergies

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
</tr>
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<tbody>
<tr>
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</table>

## Medications

Include vitamins, herbal supplements and over the counter medications:

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason for Taking</th>
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</table>

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Have you participated in any clinical trials or used experimental drugs? [ ] Yes [ ] No

Explain:

Are you pregnant? [ ] Yes [ ] No

Last Menstrual Period Date: __________

Is there anything else about your medical history that we should know? __________

---

Patient Signature: ______________________ Date: __________

Certify that I have reviewed the above information with the patient. ______________________ Date: __________

Provider Signature: ______________________ Date: __________
Jefferson Center for Women's Medical Specialties
Supplemental Medical History Questionnaire

For all items in this questionnaire, please feel free to leave any item blank and discuss directly with your care provider. This form may be scanned into your confidential electronic medical record.

Pregnancy History

<table>
<thead>
<tr>
<th>Year of</th>
<th>Miscarriage</th>
<th>Abortion</th>
<th>Ectopic Pregnancy</th>
<th>Vaginal Delivery</th>
<th>Cesarean Delivery</th>
<th>Weight of Baby</th>
<th>Weeks Pregnant at Delivery</th>
<th>Problems/Complications</th>
</tr>
</thead>
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<tr>
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</table>

Personal History (check all that apply)

Have you ever had:

- Hormonal problems, abnormal hair growth
- Problems with leaking urine
- Stomach or bowel pain or problems
- A mammogram; Date of most recent:
- Sexually transmitted diseases
- Fibroids
- Any kind of abusive relationship
- Psychiatric illness
- Any type of excessive bleeding, vaginal or other
- Pain or bleeding with urination
- Breast problems (lumps, tumors, cysts, discharge)
- Vaginal problems/discharge
- Ovarian cysts
- Abnormal Pap smear
- Pain or bleeding with sex
- Severe pain or emotional problem with periods

Sexual and Contraceptive History

Age at first intercourse: ______  No. of partners since first intercourse ______  No. of partners last year: ______

Partners:  ☐ Male  ☐ Female  ☐ Both

You using birth control now:  ☐ Yes  ☐ No

You satisfied with your current contraceptive method:  ☐ Yes  ☐ No

You want birth control, what method do you want? ______

You plan children in the future?  ☐ Yes  ☐ No  ☐ Undecided

You have any questions about sex you'd like to discuss?  ☐ Yes  ☐ No

You interested in HIV testing/information?  ☐ Yes  ☐ No

Would you like to be tested for STD's (gonorrhea, chlamydia, syphilis, hepatitis)?  ☐ Yes  ☐ No
Please tell us about any methods of birth control you or your partner are now using or have used in the past, and any problems you have had with them:


Pap Smear and Menstrual History

When did you have your last Pap smear? ____________________ Was it normal? □ Yes □ No
If not, what further testing or treatment did you have?


Age at first menstrual period: _____ First day of last menstrual period: ________________
Periods come every ______ days. Number of days of flow: _____ Periods are: □ Light □ Moderate □ Heavy
Was your last menstrual period normal? □ Yes □ No
Do you ever miss periods? □ Yes □ No
Do you ever bleed between periods? □ Yes □ No
Do you think you may be pregnant now? □ Yes □ No □ Not sure
Do you take medicine for painful periods? □ Yes □ No Name of medicine: ____________________________
If you are menopausal, have you had any bleeding since menopause? □ Yes □ No
Are you having severe symptoms of menopause? □ Yes □ No
Please provide any additional information that you want us to have:
PHARMACY INFORMATION

Patient Name: ____________________________________________

Please complete your pharmacy information below.

Retail Pharmacy

Name: ___________________________________________________

Address: _________________________________________________

City, State: ______________________________________________

Phone: ___________________________ Fax: ______________________

Mail Order Pharmacy

Name: ___________________________________________________

Address: _________________________________________________

City, State: ______________________________________________

Phone: ___________________________ Fax: ______________________
January 22, 2013

Dear Patient,

Please be advised that effective January 1, 2012, Jefferson University Physicians began charging a fee to patients that request a copy of their medical records. The fees below are the 2013 allowable amounts approved by the State of Pennsylvania. Please note that the fees are updated annually and are subject to change.

- $1.42 per page for the first 20 pages.
- $1.05 per page for pages 21-60
- $0.35 per page for pages over 61

Actual postage amounts will also be charged for the mailing of the records.

Just as a reminder, a completed JUP medical records release form must be on file.

If you have any questions please contact Jefferson University Physicians Central Medical Records at 215-503-8768.

Thank you.
Dear Patient:

The state of Jefferson Center for Women’s Medical Specialties will be glad to help you with the completion of various forms, which may be necessary to assist you with your healthcare. Examples of these forms are:

- Disability Forms
- FMLA Forms
- Insurance Forms

*Please be advised:* You will be charged a $10.00 fee for each form that is submitted to our office for completion. This fee is not covered by insurance and is completely separate from any co-pay or coinsurance. Payment will be expected prior to your receipt of the completed form(s).

You will have the option to pay with cash or a check.

We appreciate your understanding and thank you in advance for your cooperation.

Sincerely,

Jefferson Center for Women’s Medical Specialties