Affinity
WOMEN'S HEALTH CARE

Dr. Susan Catt, OB/GYN
Heather Porto, CNM
Amy Pheiffer, APN
Shannon Graves, APN

Thank you for choosing Affinity Women's Health Care! Enclosed in this envelope is the paperwork needed to be completed and brought to your appointment. **We ask that you arrive for your new patient appointment 30 minutes early with your paperwork completed.** If your paperwork is not complete, and this delays us from being able to start your appointment on time, you may be asked to reschedule your appointment. Our goal is to stay on time for all the appointments we have scheduled each day and respect the time of both our patients and providers.

Along with your completed paperwork, please make sure to bring the following items to your appointment. Failure to have any of the listed items below may cause your appointment to be rescheduled:

- Insurance card – failure to produce card will result in a self-pay or rescheduled appt
- Photo ID
- Medication list
- Medical records (if you have not already had them sent) – **Fax 309-966-3863**
- Co-payment (all co-pays that are applicable will be collected at time of service) Inability to pay your co-pay at time of service may require your appointment to be cancelled.

Thank you for your cooperation and we look forward to meeting you!

Appointment date & time: _____

Dr. Susan Catt **Heather Porto, CNM**

Amy Pheiffer, APN **Shannon Graves, APN**

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DATE: _____

Name: _____
First MI Last Maiden

Reason for Visit: _____ Date of Birth: _____ Age: _____

Primary Care Provider: _____

Gender assigned at birth: ☐ Female ☐ Male

I identify with the following pronoun: ☐ She/Her ☐ He/Him ☐ They/Them

PATIENT MEDICAL HISTORY (Please mark Y if applicable to you)

History	Y	History	Y	History	Y	History	Y
Abnormal Pap Smears	☐	Depression	☐	Hypertension	☐	Seizure (last one)	☐
Allergic Rhinitis	☐	Diabetes, Type 1	☐	Infertility	☐	Sickle Cell Disease/Trait	☐
Anemia/Hematologic	☐	Diabetes, Type 2	☐	Intestinal Disease (specify)	☐	Skin Disease (specify)	☐
Anxiety	☐	Frequent UTI's	☐	Kidney Disease (specify)	☐	Stomach Problems (specify)	☐
Arthritis	☐	Gestational Diabetes	☐	Liver Disease	☐	Stroke (when)	☐
Asthma/Pulmonary	☐	Heart Disease	☐	Migraines/Headaches	☐	Thyroid Disorder (specify)	☐
Autoimmune Disorder (specify)	☐	Hepatitis	☐	Mitral Valve Prolapse	☐	Trauma-mental/physical	☐
Blood Transfusion	☐	Herpes	☐	Neuro Disorder (specify)	☐	Urinary Incontinence	☐
Bowel Disorder (specify)	☐	High Blood Pressure	☐	PCOS	☐	Uterine Abnormalities (specify)	☐
Breast Disorder (specify)	☐	High Cholesterol	☐	Pulmonary Embolism	☐	Varicosities/DVT/Blood Clot (when)	☐
Chlamydia/Gonorrhea/Trich	☐	HIV/AIDS	☐	Psychiatric Disorder (specify)	☐	Yeast	☐
Complication w/Anesthesia	☐	HPV	☐	(Rh) Sensitized	☐		☐

EXPOSURE AND INFECTION HISTORY

Exposure/Infection History	Y	Exposure/Infection History	Y
Partner has history of HIV	☐	Rash or viral illness since last menstrual period (LMP)	☐
Patient or Partner has history of Genital Herpes	☐	History of Sexually Transmitted Disease (STD)	☐
Exposure to TB	☐	Other exposure or history of infection	☐

Surgical History (Please provide month/year for all that apply)

_____/_____ Appendectomy _____/_____ Wisdom Teeth _____/_____ Lithotripsy

_____/_____ Tonsillectomy _____/_____ Orthopedic Surgery _____/_____ Lung

_____/_____ Gallbladder _____/_____ Brain Surgery

_____/_____ Bladder _____/_____ Bowel

Additional Surgeries: _____

Previous Gyne Surgical History (Please provide month/year for all that apply)

_____/_____ Colposcopy _____/_____ Bilateral Tubal Ligation _____/_____ Ablation

_____/_____ Cryotherapy _____/_____ Breast Augmentation _____/_____ LEEP

_____/_____ Cone Biopsy _____/_____ Cesarean Section _____/_____ D&C

_____/_____ Breast Biopsy (Left/Right) _____/_____ Essure

_____/_____ Hysterectomy (Abdominal or Laparoscopic)

_____/_____ Removal of one or both ovaries

Additional Surgeries: _____

Gynecology History (Please complete all questions that apply)

How old were you when you had your first menstrual period? _____

Are you currently in menopause? ☐ Yes ☐ No

First day of your last period _____ ☐ N/A

Do your periods occur regularly? ☐ Yes ☐ No

How long do your periods typically last? _____

How do you consider your menstrual flow? ☐ Heavy ☐ Moderate ☐ Light

How do you consider your menstrual pain? ☐ Severe ☐ Moderate ☐ Mild

Do you perform self-breast exams? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No

If yes, who are you currently sexually with? ☐ Men ☐ Women ☐ Both

How many partners have you had in the past 12 months? _____

Do you experience any pain or bleeding with intercourse? ☐ Yes ☐ No

What is your current method(s) of contraception? _____

Past method(s) of contraception? _____ Any problems? ☐ Yes ☐ No

Obstetrical History (Please complete all questions that apply)

Total Pregnancies _____ Full Term Deliveries _____ Preterm Deliveries _____

Living Children _____ Miscarriages _____ Elective Abortions _____

Multiple Births _____ Ectopic Pregnancies _____

Please include date(s) of miscarriage(s): _____

Delivery Date	Weeks Pregnant	Length of Labor	Birth Weight	Sex M or F	Hospital	Type of Delivery
1.			____lbs ____oz			☐ Vaginal ☐ C-Section
2.			____lbs ____oz			☐ Vaginal ☐ C-Section
3.			____lbs ____oz			☐ Vaginal ☐ C-Section
4.			____lbs ____oz			☐ Vaginal ☐ C-Section
5.			____lbs ____oz			☐ Vaginal ☐ C-Section
6.			____lbs ____oz			☐ Vaginal ☐ C-Section

Please list any complications with any pregnancies:

_____

_____

Family Medical History (Please choose Mother/Father/Sister/Brother/Maternal or Paternal Grandparents)

_____ Ovarian Cancer _____ Heart Disease _____ Diabetes

_____ Uterine Cancer _____ Stroke _____ Osteoporosis/Fractures

_____ Breast Cancer _____ Hypertension _____ Blood Clotting Disorders

Additional Diseases or Cancer Types: _____

Social History

Do you smoke? ☐ Yes ☐ No # of cigarettes per day _____

Do you drink alcohol? ☐ Yes ☐ No # of drinks _____ Frequency _____

Do you use recreational drugs? ☐ Yes ☐ No Type _____ Frequency _____

Are you employed? ☐ Yes ☐ No If yes, where? _____

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Who do you live with? _____

Do you exercise regularly? ☐ Yes ☐ No Type of exercise _____ Frequency _____

Do you consume caffeine regularly? ☐ Yes ☐ No # of drinks per day _____ Coffee/Tea/Soda/Other

Do you wear seatbelts regularly? ☐ Yes ☐ No

Routine Health Screening History (Please provide month/year for all that apply)

_____/_____ Lipids Testing ☐ Normal ☐ Abnormal
_____/_____ Thyroid Testing ☐ Normal ☐ Abnormal
_____/_____ Other Blood Work ☐ Normal ☐ Abnormal
_____/_____ Most Recent Pap Smear ☐ Normal ☐ Abnormal
_____/_____ Previous Abnormal Pap Smear
_____/_____ Gonorrhea/Chlamydia ☐ Negative ☐ Positive
_____/_____ RPR (Syphilis) Testing ☐ Negative ☐ Positive
_____/_____ HSV (Herpes) Culture ☐ Negative ☐ Positive
_____/_____ HSV (Herpes) Blood Testing ☐ Negative ☐ Positive
_____/_____ HIV Testing ☐ Negative ☐ Positive
_____/_____ Mammogram ☐ Normal ☐ Abnormal
_____/_____ Bone Densitometry ☐ Normal ☐ Abnormal
_____/_____ Colonoscopy ☐ Normal ☐ Abnormal

Additional Health Screening _____

Immunization History (Please provide month/year for all that apply)

_____/_____ Flu Vaccine _____/_____ HPV Vaccine _____/_____ Gardasil
_____/_____ Pneumonia Vaccine _____/_____ Zoster Vaccine

Additional Immunizations _____

Preferred Pharmacy _____ _____
Name Location

Please list <u>all</u> medications and dosages you are currently taking (prescription, supplements, over the counter)

_____

_____

Please list <u>all</u> medical allergies and symptoms (medicine, latex, etc.)

_____

_____

Please list <u>all</u> other allergies and symptoms (environmental, food, etc.)

_____

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Patient Name: _____ DOB: _____ Date: _____

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

		Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
c.	Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d.	Feeling tired or having lack of energy	☐	☐	☐	☐
e.	Poor Appetite or Overeating	☐	☐	☐	☐
f.	Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h.	Moving or speaking so slowly that other people could have noticed. Or the opposite -being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i.	Thoughts that you would be better off dead or of hurting yourself in any way	☐	☐	☐	☐

2. **If you checked off <u>any</u> problem on this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult
☐	☐	☐	☐

Total # symptoms: _____

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FINANCIAL POLICY AND AGREEMENT

Patient Name: _____

Date of Birth: _____

We here at Affinity Women's Health Care, S.C., know that choosing a physician is a very important decision and we thank you for choosing our office. Please take a minute to carefully read this overview of some of our financial policies.

INFORMATION REGARDING INSURANCE COVERAGE

You inform yourself and understand the details of your health insurance coverage and fulfill any associated requirements (pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing staff and if you fail to timely provide any information or assistance then we have the right to not submit the claim to your insurance company and you will be fully responsible to pay us for the balance. In the case of an IUD, a $100.00 non-refundable deposit is required prior to the device being ordered. This deposit will be applied to any charges remaining from this appointment or any unpaid balances on the account of any type.

NON-PARTICIPATING PROVIDER OR NON-COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes.

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services, we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (co-payments, deductibles, and fees for non-covered services), which are due at the time of service.

TYPES OF PAYMENT

OUR OFFICE ACCEPTS CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. All past due balances are due in their entirety, prior to or at the time of your visit. Balances that are 30+ days old will be assessed a finance charge of 18% per annum (1.5% per month) from the original due date that will accrue monthly until paid. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorney's office. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance. You will be charged $35.00 for any check returned from your bank for any reason. If we choose to resubmit the check additional times, you will be charged an additional $35.00 each time it is returned. Failure to pay any

charges described herein shall result in a refusal of non-emergency services until the full balance is paid off or any payment plan agreed to in a signed writing by both parties.

MISSED APPOINTMENTS

It is important that you appear for all scheduled appointments. As a courtesy, an appointment reminder will be initiated one to two days before the scheduled appointment. If speaking to you is not possible for any reason, we will attempt to leave a voicemail. Failure to cancel your appointment without giving more than 24 hours' notice deprives other patients of an opportunity to visit our office. A records fee of $25 will be charged if you fail to appear for any scheduled appointment. We recognize that there may be circumstances which may not permit you to give a 24-hour notice and such circumstances are exceptional and shall be considered on a case-by-case basis. Consecutive missed appointments may result in a discharge from the practice. On this occasion, a written notification will be mailed to the patient.

RETENTION OF FILE

Affinity Women's Health Care, S.C. agrees to assert a diligent effort, subject to casualties beyond the control of Affinity Women's Health Care, S.C. to retain the files relative to this relationship for a period of three (3) years after the conclusion of each service, and during such time to afford Patient reasonable access to such files.

COMPLETE INTEGRATION BINDING UPON ALL PARTIES

This Agreement contains the entire agreement between the Patient and Affinity Women's Health Care, S.C., regarding this matter and fees, charges, and expenses to be paid relative thereto. This agreement shall not be modified except by written agreement signed by Patient and Affinity Women's Health Care, S.C. This agreement shall be binding upon the Patient and Affinity Women's Health Care, S.C., and their heirs, executors, legal representatives, successors and assigns.

ACKNOWLEDGMENT

Patient further acknowledges that Patient has signed this agreement after having fully read and reviewed it. Patient acknowledges that Patient understands the agreement and has been presented by Affinity Women's Health Care, S.C., and support staff with an opportunity to read and review it at the time of signature and to ask such questions as would enable Patient to fully understand this agreement. Patient further acknowledges that upon the signing and execution of the original of this agreement Patient was given a copy thereof and that Patient acknowledges receipt of such copy.

By signing below, the patient or responsible party acknowledges that he/she has read and understands the Financial Policy of Affinity Women's Health Care, S.C. and agrees to be bound by the terms and conditions set forth therein.

_____

Signature of Patient or Responsible Party

Address of Responsible Party

_____

Print Name of Patient or Responsible Party

Phone Number of Responsible Party

_____

Date

_____

Signature of Parent/Guardian of Minor Patient

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HIPAA

I, _____ hereby acknowledge receipt of the Physician's Notice of Privacy Practices. This notice provides detailed information about how the practice may use my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available in the office at my request. I also understand that my protected health information may be requested by my insurance company in order to process my medical claims on my behalf.

In order to ensure patient privacy and confidentiality, our office will not release information to friends or family members without your written consent. Please list any family member or other persons who may contact our office on your behalf. This consent will allow us to inform them about your general medical conditions.

Name	Relationship	Contact Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. Can appointment reminders or messages asking you to call our office be left on the phone number you have provided to our office? ☐ Yes ☐ No
2. Can lab results or details of appointments be left on the phone number you have provided to our office? ☐ Yes ☐ No
3. Can we contact your place of employment to inform you of your test results or other health care information? ☐ Yes ☐ No

_____
Printed Name

_____ _____
Signature Date

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PATIENT INFORMATION

Patient Name _____
Last First MI Maiden Name

Date of Birth _____/_____/_____ Age _____ SS# _____/_____/_____

Address _____
Street City State Zip

Cell Phone (_____)_____ Home Phone (_____)_____

E-Mail _____ Appointment notification ☐ Text ☐ Phone ☐ Call ☐ Email

Place of Employment _____ Work # (_____)_____

Preferred Hospital ☐ OSF ☐ Carle Health Gender Assigned at Birth ☐ Female ☐ Male

Preferred Pharmacy (name, street, and city) _____

Race/Ethnic background: Please circle all that apply
Caucasian African American Hispanic/ Latino Middle Eastern Asian Native American Hawaiian/ Pacific Islander Decline

INSURANCE SUBSCRIBER INFORMATION (If Different from Patient)

Name _____ DOB _____/_____/_____ SS# _____/_____/_____

Relationship _____ Phone (_____)_____ Employer _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone (_____)_____ DOB _____/_____/_____

INSURANCE INFORMATION

Primary Ins. _____ Policy # _____ Group # _____
Insured: ☐ Self ☐ Spouse ☐ Other _____ (List Relationship)

Secondary Ins. _____ Policy # _____ Group # _____
Insured: ☐ Self ☐ Spouse ☐ Other _____ (List Relationship)

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested regarding processing my claim. I certify that information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ **Date:** _____

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GOVERNMENT ASSISTANCE & MEDICARE POLICY

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES & MEDICARE

Affinity Women's Health Care has a policy of providing care to patients who are covered by government assistance programs such as The Illinois Medical Assistance Program (MEDICAID), including All Kids and Healthy kids and any form of Medicare. However, our office must limit the number of Medicaid and Medicare patients to whom we provide services. Our office is **NO LONGER ACCEPTING** any Illinois Department of Public Aid coverage as **Primary or Secondary**. We are also **NO LONGER ACCEPTING** any **new** patients with Medicare policies of any type. Current patients who age into a Medicare policy will be accepted. This policy will be effective January 2, 2018. If you choose to transfer to another physician based on insurance coverage, Affinity Women's Health Care will transfer all medical records without charge.

AUTHORIZATION: I HAVE READ THE ABOVE POLICY FOR AFFINITY WOMEN'S HEALTH CARE AND AGREE TO COMPLY WITH THE TERMS OF THE GOVERNMENT ASSISTANCE POLICY.

PLEASE SIGN EVEN IF THIS DOES NOT APPLY TO YOUR CURRENT INSURANCE SITUATION.

NAME PRINT: _____

NAME SIGNATURE: _____

DOB: _____

DATE: _____