Insurance Authorization (PPO, POS, HMO and all commercial insurances)

I hereby authorize The Association for Women's Health Care, LTD to release any medical information necessary to process insurance claims. I hereby assign The Association for Women's Health Care, LTD the benefits to which I am entitled to under my health insurance(s). I understand that I am financially responsible for all charges.

Your insurance carrier does not assume financial responsibility for any unpaid claims

_____ _____

Patient Signature Date

Medicare Authorization

I hereby authorize release of any personal health information (PHI) to or from CMS (Centers for Medicare and Medicaid Services) when necessary, in order to process my claims. I also authorize payments from my insurance programs to be made directly to The Association for Women's Health Care, LTD for any services furnished by this office. I further permit copies of this authorization to be used in place of the original.

_____ _____

Patient Signature Date

Summary of Our Notice of Privacy Practices

We understand that patient information is personal. We are committed to protecting the confidentiality of patient information. Our complete Notice of Privacy Practices describes how we may use and disclose your patient information without your written authorization to provide treatment, obtain payment for services, conduct our health care operations, or for other purposes that are permitted or required by law. When required by law, we will obtain your authorization before using or disclosing any of your patient information. It also describes your rights to access and control your patient information. "Patient information" is information that may identify the patient and that relates to the patient's past, present or future physical or mental health or condition and related health care services or payments for such services.

You have the following rights regarding patient information we maintain about you:

- Right to receive a copy of our complete Notice of Privacy Practices
- Right to inspect and copy patient information in your medical or billing records
- Right to request an amendment of patient information in your medical or billing records
- Right to an accounting of certain disclosures made by us
- Right to communicate with us via alternative means or have communications sent to alternative locations
- Right to request restrictions on how we use or disclose patient information
- Right to revoke an authorization given to us

Although you have these rights, we may deny your requests if they do not meet certain requirements. If you have any questions about this Notice, your privacy rights described above or believe your rights have been violated; please contact The Association for Women's Health Care, LTD or you may file a complaint with the Director of the Office for Civil Rights of The U.S. Department of Health and Human Services.

I understand by signing this form, I give my consent for The Association for Women's Health Care, LTD to use or disclose any and all information contained in my medical record for the purpose of carrying out treatment, payment, and/or all other health care operations. I also acknowledge receipt of my physicians Notice of Privacy Practices.

_____ _____

Patient Signature Date

Authorization To Discuss My Case

I authorize the physicians and staff at The Association for Women's Health Care, LTD to discuss my case with the following family members or third party persons, when necessary, to expedite my care, and/or the processing of claims. I understand that I may revoke this consent by sending written notice or my desire to do so to The Association for Women's Health Care, LTD. I understand that I will not be able to do so when the physician has already relied on it to use or disclose my health information. I understand any person NOT listed will NOT receive any personal health information (PHI) about me.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

Financial Policy

The Association for Women's Health Care, LTD is committed to providing the highest quality of care to you. As part of your relationship with us a clear understanding of our financial policy is important so you will know what actions we will be undertaking on your behalf as well as what your financial responsibilities are.

Health Insurance

Your health insurance policy is a contract between you and the insurance company. You have certain responsibilities to ensure that proper, accurate and timely submission of charges occurs. You are required to:

- Present your insurance card at the time of each visit
- Present a picture ID (driver's license preferred) for verification of identity
- Inform us of any insurance carrier changes and provide us with a copy of the new card. We will need a copy of the front and back of the card.

Patient Responsibility

- Co-Pay – Your health insurance policy may state that you must pay a copayment for physician visits. This payment is due at the time of check-in. The Association for Women's Health Care, LTD has a contractual agreement with your health care plan to collect your copay on the date the services are rendered. We accept cash, check, Visa, MasterCard, American Express and Discover
- Balance after Insurance – The Association for Women's Health Care, LTD will file your claim to your insurance carrier for all services rendered. Once the insurance company has process your claim we will post any payment and contractual adjustments to your account. If there is a remaining balance, the balance is now your responsibility. This balance may include your deductible, co-insurance and all non-covered services. We will send you a statement showing what is due. All payments are due within 30 days of the statement date.
- Non-Covered Services – There are some services offered by the Association for Women's Health Care that may not be covered by insurance, not considered medically necessary by your insurance company. Your physician, however, considers these necessary for your treatment. You are still responsible for payment of treatment regardless of The Association for Women's Health Care's contract status when it comes to non-covered services. Some common examples may include physical therapy, ultrasound, contraception, infertility and some vaccines.

Cancellation Policy

All cancelled appointments (doctor, physical therapy, ultrasound, nurse, etc.) require at least one business day advance notice of the scheduled appointment day. This allows us to accommodate other patients seeking appointments. Appointments cancelled without sufficient notice or no shows will be subject to a fee of $50.00

Credit Card Payment System

We are pleased to announce that we offer a credit card payment system. We ask that you complete the appropriate form so that we may charge your credit card for your patient responsibility portion as listed above. See the form for details.

Online Bill Pay

We offer the convenience of online bill pay. Please go to www.chicagoobgyn.com to pay your bill online.

Non-Payment on Account

The Association for Women's Health Care, LTD will make every effort to communicate with you about your account and will present reasonable options for payment. In the event the bill goes unpaid, after 90 days, your account will be turned over to collections. If your account is sent to collection a charge of 35% of the amount due will be added to the balance of your account.

Certificate of Insurance

I certify that I am covered by the insurance provided and I assign directly to The Association for Women's Health Care, LTD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance on file. I hereby authorize The Association for Women's Health Care, LTD to release all information necessary to secure the payment of benefits.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date

I have read the above financial policy and I agree to the terms listed.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date

The Association For Women's Health Care, Ltd

REGISTRATION CARD

Patient Information

Date | MRN | Referred By:

Last Name | First Name | Middle Name | DOB | Birth Place

Address | Unit # | City | State | Zip Code

Marital Status | Race | Ethnicity | Religion

Maiden Name | Social Security # | Email Address

Phone Number | Cell Number | PH # - Cell # - Email - Text — Preferred Method of Contact

Employer's Name | Work Phone # | Occupation

Pharmacy Information

Preferred Pharmacy Name | Pharmacy Address | City | Pharmacy Phone Number

Mail In Pharmacy | Pharmacy Addres | City, State Zip Code | Phone Number

Spouse/Partner Information

Husbands/Partners Name | Husband's/Partners DOB | Spouse's SS#

Employer Name | Occupation | Work Address

Work Phone Number | City, State, Zip Code

Nearest Relative Not Living With You | Phone # | Yes - No — Permission to Contact

INSURANCE COVERAGE

PRIMARY INSURANCE

Insured's Name (Name on Policy) | Insureds DOB | Insurance Company Name

Policy Holder Name | ID # | Group #

Address | City/State/Zip Code | Phone #

SECONDARY INSURANCE

Insured's Name (Name on Policy) | Insureds DOB | Insurance Company Name

Policy Holder Name | ID # | Group #

Address | City/State/Zip Code | Phone #

Pharmacy Benefits Managers Consent Form

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for The Association for Women's Health Care, Ltd to access my pharmacy benefits data electronically through RxHub. This consent will enable The Association for Women's Health Care, Ltd to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/Guardian Signature Date Signed

Ronald M. Meltzer, M.D.
Norman A. Ginsberg, M.D.
Sue A. Hungerford, M.D.
David A. Baum, M.D.
Mark A. Sibul, M.D.
Marc J. Kleinberg, M.D.
Gil A. Weiss, M.D.
Mia M. Song, M.D.
Julian B. Ullman, M.D.
Dawn M. McGee, M.D.
Leilah E. Backhus, M.D.
Gwyneth A. Bryant, M.D.

CREDIT CARD PAYMENT SYSTEM

In order to facilitate our billing process, The Association for Women's Health Care, LTD has implemented a Credit Card payment system. Our goal is to assist our patients in eliminating past due patient accounts.

Insured Patients:
Your credit card information will be held securely on file until your Insurance Company has paid your claim. Once your "Explanation of Benefits" has been filed, any remaining balance owed by you "patient responsibility", will be charged to the credit /debit card we have on file. A copy or receipt of those charges will then be mailed to you.

The advantage to you is that you will no longer need to write out checks and send payments in mail. You will also not have to worry about any past due accounts.

This in no way will compromise your ability to dispute charges or question your insurance company's determination of payment. All credit card contracts give card holders the right to challenge any charges against an account.

Self Pay Patients:
Self pay patients (ie: patients without health insurance or who choose to not use their health insurance) are required to pay in full for services and/or labs at the time of their visit. No further discounts will be applied to the self-pay fee schedule; we have already discounted these fees to facilitate your ability to obtain appropriate care. At the time you check-in we will collect your credit card information. At the time you check-out we will provide a receipt for the charges billed to your credit card. If a payment plan has been prearranged, please notify the receptionist at the time of check-in. Otherwise, no exception to the policy will be made.

Name on Card_____

Patient name_____

Visa _____ MasterCard_____American Express _____ Discover _____

Account #_____Expiration_____ CVV #_____

Signature_____

Our goal is to provide you with the highest quality of medical care while keeping the cost of medical care low.
Thank you for your assistance

Name _____ **Today's Date** _____

Age _____ **DOB** _____

Reason for Today's Visit

☐ **Annual Exam**

☐ **Pregnancy**

☐ **Problem** _____

_____

Menstrual History

Age when periods started _____ **First day of last period** (LMP) _____

Cycle regularity	☐ Regular	☐ Irregular	☐ Variable	☐ None
Cycle length	☐ Average	☐ Long	☐ Short	☐ Variable
Duration of flow	☐ Average	☐ Long	☐ Short	☐ Variable
Heaviness of flow	☐ Average	☐ Heavy	☐ Light	☐ Variable
Cramps/pain	☐ None	☐ Mild	☐ Moderate	☐ Severe

Other menstrual symptoms (PMS, Migraines, Bloating, etc) _____

_____

Menopause History

Age when periods stopped _____ ☐ Natural ☐ Surgical (eg: Hysterectomy)

Menopause symptoms (eg: Hot flashes, Vaginal dryness, Post-menopausal bleeding) _____

_____

Hormone replacement therapy (HRT) ☐ Never ☐ Former ☐ Current

Gynecologic History

Gynecologic problems (eg: Abnormal Pap, Fibroids, Endometriosis, Infertility, etc) _____

_____

Gynecologic surgeries (eg: D&C, LEEP, Hysterectomy, Laparoscopy, etc) _____

_____

Obstetric History

Total Pregnancies	Full Term	Premature	Abortions	Miscarriages	Ectopic Pregnancies	Twins	Living Children

Date of Delivery	Length of Pregnancy	Length of Labor	Birth Weight	Sex	Type of Delivery	Anesthesia	Premature Labor	Complications

Sexual History

Sexually active (currently)	☐ No	☐ Yes	Number of partners _____
Using contraception/birth control	☐ No	☐ Yes	Method _____
Dissatisfied with contraception	☐ No	☐ Yes	Reason _____
Sexually transmitted infections (STD)	☐ No	☐ Yes	Type of STD _____
Need/want STD testing	☐ No	☐ Yes	☐ n/a
Practicing "safe sex"	☐ No	☐ Yes	☐ n/a

Breast History

Breast problems (eg: Lumps, Cysts, Cancer) _____

_____

Breast surgeries (eg: Biopsy, Lumpectomy, Implants, Reduction) _____

_____

Urologic History

Urologic problems (eg: Recurrent UTI, Blood in urine, Incontinence) _____

_____

Urologic surgery (eg: Cystoscopy, Bladder lift, Prolapse surgery) _____

_____

Medical History

Medical problems (eg: High blood pressure, Diabetes, etc) _____

_____

Surgeries (eg: Tonsillectomy, Appendectomy, etc) _____

_____

Medications (Prescriptions, Vitamins, Supplements, etc) _____

_____

Allergies (Medications, Environmental, Food, etc) _____

_____

Social History

Cigarettes	☐ Never		☐ Former		☐ Current
Alcohol	☐ Never		☐ <5-10 drinks/week		☐ >5-10 drinks/week
Drugs	☐ Never		☐ Former		☐ Current
Exercise	☐ Never		☐ Occasionally		☐ Regularly
Employment	☐ Employed	☐ Unemployed	☐ Retired	☐ Homemaker	☐ Student
Marital status	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Other

Religious or cultural beliefs (eg: Jehovah's Witness) that may limit the care we might provide ☐ No ☐ Yes

Family Medical History

Breast cancer	☐ No	☐ Yes	_____
Ovarian cancer	☐ No	☐ Yes	_____
Uterine cancer	☐ No	☐ Yes	_____
Colon cancer	☐ No	☐ Yes	_____
Other cancer	☐ No	☐ Yes	_____
Other medical problems	☐ No	☐ Yes	_____