Women's Health Group
NEW PATIENT REGISTRATION FORM

Pharmacy Name and Number____

PATIENT INFORMATION: (Please use full legal name)
Last Name:_________________________________ First Name:____________________ Middle Initial______________

Address:____

City:____ State:__________ Zip:______________________

Home Phone #:__________________ Cell Phone #__________________

Social Security#:________________________________

Date of Birth:_____________ Age:_______ Sex______ Marital status:__________ Drivers Lic#:____________________

Ethnicity: _________________________Race:__________________Primary Language:____________________________

Employer Name and Address:____

Email Address:____
- ○ Yes, please sign me up to receive email/text messaging confirmations/appointment reminders
- ○ No, I do not wish to be contacted via e-mail and or text messages regarding confirmations/appointments

Emergency Contact Name/ Relationship:__________________________

Emergency Phone #: _____________________

We are glad that you chose Women's Health Group Chicago for your healthcare needs. Please kindly tell us how you heard about us
Friend/Family_________ Website ____ Insurance Plan Listing ____ Drive By _____ Physician Referral ________________

Hospital/Urgent Care ____ Chamber of Commerce ______ Other _____________

ASSIGNMENT OF COORDINATION OF BENEFITS & INSURANCE

Oftentimes our patients have more than one insurance policy. This creates confusion when submitting your claim for reimbursement. Please clearly define your primary and secondary insurance policy below (if applicable). Failure to do so may cause lack of payment by your insurance carrier leaving you responsible for the balance.

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name)

Relationship of Guarantor to Patient: Self______ Spouse______ Parent ______ Other______________________

Last Name:__________________________________ First Name:___________________ Middle Initial________________

Address:____

City:____ State:_________ Zip:________________________

Home Phone#:(____)________-________________ Social Security #:_________________________________

Date of Birth:______________________ Age:________ Sex:_____

Employer Name and Address:____

INSURANCE INFORMATION: ***(IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DOB FOR CLAIMS)***

PRIMARY INSURANCE:

Plan Name:____ Insured's Name:__________________________________

Insured's Social Security #:_____________________________ Insured's Date of Birth:___________________________

Policy / ID#:__________________________ Group #:_____________________ Effective Date:_____________________

SECONDARY INSURANCE:

Plan Name:____ Insured's Name:_________________________________

Insured's Social Security #:_____________________________ Insured's Date of Birth:___________________________

Policy / ID#:___________________________ Group #:_____________________ Effective Date:____________________

I hereby disclose this is my primary insurance and understand it is my primary responsibility to know my insurance benefits, coordination of benefits, as well as any additional information the insurance requests prior to my visit. I understand and agree that I will be liable for any balances that are applied to my account if my coordination of benefits are not updated. Additionally, I disclose my annual questionnaires have been updated and I am liable for balances for claim denials.

Patient Signature**_______________________________________** ***Date*****_________________________**

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name:____ **Date of Birth:**__________________
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Women's Health Group Chicago or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Women's Health Group Chicago is unable to collect form my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Women's Health Group Chicago or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Women's Health Group Chicago Patient Information Privacy Policy. I hereby authorize Women's Health Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risk of the mail, phone calls, and e-mail. I hereby authorize a Women's Health Group Chicago representative or my physician to mail, call, text with communications regarding my healthcare, including but not limited to such things as appointments reminders, referral arrangements, laboratory results, and bill payment. I understand that I have the right to rescind this authorization at any time by notifying Women's Health Group Chicago to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Women's Health Group Chicago physician or his or her designee.

PATIENT SIGNATURE:____ **DATE:**____________________

GUARANTOR SIGNATURE:______________________________________ **DATE:**____________________
(If different from patient)

GUARANTOR SIGNATURE (please print):____

WOMEN’S HEALTH GROUP CHICAGO - PAYMENT POLICY

Thank you for choosing Women’s Health Group Chicago as your women’s health care provider. We are committed to providing you with quality and affordable health care. Below are our payment policy guidelines.

1. **Insurance** - We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at time of visit. If you are insured by an insurance plan but do not have an insurance card. Please provide the clinic with an updated copy of your insurance card to successfully bill your insurance claims. Failure to provide proof of coverage may result in being responsible for the balance of a claim.

2. **Copayments and deductibles** - All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect from patients can be considered fraud, so please help us in upholding the law by paying your scheduled copays at time of service.

3. **Non-Covered Services (MEDSPA)**- Please be aware that some services including MEDSPA are not covered by insurance. You must pay for these services in full at the time of visit.

4. **Claims Submission** - We will submit your claims to your insurance, however your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and the insurance company.

5. **Coverage Changes** - If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive maximum benefits.

6. **Nonpayment** - If your account is over 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. *Please be aware that if a balance is not paid, you will not be able to schedule an appointment until the account is satisfied.*

I understand if I have an unpaid balance with the Women's Health Group and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. In order for Women’s Health Group, their designated external collection agent to service my account, and where not prohibited by applicable law, I agree that Women’s Health Group and the designated external collection agency are authorized to contact me by phone, text, and/or email of which I have provided to Women’s Health Group.

Our practice is committed to providing the best treatment to our patients and I have read and understand the payment policy and agree to abide by the guidelines.

____ Date: ______________________________

Signature of Patient or responsible party

WOMEN’S HEALTH GROUP CHICAGO

CONSENT TO RELEASE MEDICAL AND FINANCIAL INFORMATION

As part of the Women's Health Group HIPPA privacy practice notice, please inform this office with whom we share your medical information and billing/account information with.

CONSENT TO RELEASE MEDICAL INFORMATION:

I, ______________________________________, hereby consent to have my medical information released to the individual(s) listed below;

1. ______________________________ ______________________________
(Name) (Phone)

____
(Relationship to Patient)

2. ______________________________ ______________________________
(Name) (Phone)

____
(Relationship to Patient)

Women's Health Group Chicago

5311 S. Harlem Avenue, Chicago, IL 60638
Phone: (773) 586-0076, Fax: (773) 586-0052

CONFIDENTIAL HEALTH INFORMATION RELEASE

I, ____ hereby authorize my records to be released from:
(Patient Name)

__________________________________ Address: ______________________________________

Phone: ________________________________ Fax: ____________________________________

and to be sent to :

WOMEN'S HEALTH GROUP / DR. AWAD
5311 S. HARLEM AVENUE, CHICAGO, IL 60638

We are requisition the following information to be sent to us:

Entire Medical Record:_____
Laboratory Reports: _____
X-ray Reports:_____
Operative Reports:_____
Other:_____, Specifically; ____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
I understand that I may revoke this authorization at any time giving written notice to the physician of my desire to do so.

___________________________ ______________________ ___________________________
(Patient and/or Guarantor's Signature) (Date of Birth) (Date)

WOMEN'S HEALTH GROUP

Credit Card on File Agreement

Dear valued patient,

Women's Health Group (WHG) has implemented a credit card policy. Recent changes in healthcare markets and payment processes have altered insurance coverages. **The credit card on file policy is a convenient method to pay for the portion of services that are deemed a patient's responsibility, such as copay, deductible and coinsurance which result in balances.**

At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies WHG of the balance due, if any. At that time, the billing department will issue out one statement via mail and through our patient portal. Patients will have 30 days to pay the balance or make other payment arrangements. After 30 days, the debit/credit card on file will be automatically charged for any outstanding balance. In the case when a credit card has reached its limit maximum, the billing department will notify the patient via a mailed letter. The patient will have an additional 30 days to arrange payment before the bill is subject to additional collection activity.

This policy will ensure safe, timely and convenient payments for the quality care you are provided. This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment. If you are due a refund, you can be assured we will do our part to immediately refund any credit directly to the card on file.

I also understand my information will be saved to file for future NO SHOW cancellations. I may inquire on my account if I am unable to provide the office 24 hour notice. I authorize Women's Health Group to charge my credit card $50 for agreed cancellation/no show policy. If you have any questions about the policy, please email your inquiries to info@whgchicago.com.

__________________________________ ___________________________________

Patient Signature and Date Printed Name

Credit Card Authorization

❒ MasterCard ❒ Visa ❒ Discover ❒AMEX ❒Other

Cardholder Name (As shown on card): ____________________________________

Card Number: ____

Expiration Date: _______________ CSV: _____________

WOMEN'S HEALTH GROUP
Initial Health History Form

***Today's Date:____________**

Legal Name:____ Age:________ Date of Birth___________

Primary Care Physician:_______________________________________ Phone #:__________________

Reason for your visit:____

GENERAL MEDICAL HISTORY

Condition	**None**	**Self**	**Mother**	**Father**	**Brother or Sister**	**Your Child**	**Grandparents Paternal/Maternal (P/M)**	**Aunt or Uncle**
Alcoholism								
Arthritis/Lupus								
Asthma								
Blood disorder								
Cancer								
Diabetes								
Heart disease								
High blood pressure								
Stroke								
Kidney disease								
Liver disease								
Depression								
Seizure disorder								
Osteoporosis								
Thyroid disease								

Please list any medical problems not listed above:____

Do you smoke/use tobacco? No Yes How many per day?___________ How long have you smoked?__________
Do you drink alcohol? No Yes How many drinks per week?____________________________
Do you use recreational/illegal drugs? No Yes What and how long?___________________________________

Have you had any surgeries? List what surgeries you have had and the year you had it:
____
____
____
____

What was the month and year of your last physical exam?_____________________________
What was the month and year of your last:

Pap test______________ never/normal/abnormal   If abnormal Pap, did you have a colposcopy? Y/N
Bone density___________________ never/normal/abnormal   Cholesterol____________ never/normal/abnormal
Colonoscopy__________________ never/normal/abnormal   Mammogram___________ never/normal/abnormal

Allergies:
________ No known drug allergies   ___________ Allergic to latex   _______ Allergic to tapes/adhesives

Drug allergies?____   Reaction:____________________________
Food allergies?____   Reaction:____________________________
Environment allergies:_____________________________________   Reaction:____________________________

What Medications do you take? (Include birth control /hormones)

Prescription Medication	**Dose, #times/day**	**What is it for?**

Do you take multivitamins? Yes/No   Do you take calcium supplements? Yes/No
Other____________________

OB/GYNE MEDICAL HISTORY

How old were you when you had your first period? ___________

How many days from the first day of one period to the first day of the next one? ___________

How many days do your periods last? ___________

Are your periods regular? Yes/No Do you have cramps with your period? Yes/No (mild, moderate, severe)

How would you describe the flow of your periods? _____Lite _____Medium _____Heavy

Do you bleed or spot between periods? Yes/No Do you bleed after intercourse? Yes/No

What was the **first** day of your last period, or if you are menopausal, when was your last period?___________________

Do you have menopausal symptoms? Yes/No What are they?____

How old were you when you first had sexual intercourse?______________ # of sexual partners________________

Are you sexually active now? Yes/No

Have you had the Gardasil Injection Series? Yes / No #1_______ #2______ #3______

Do you use anything to keep from getting pregnant? Yes/No If yes, (circle which method)

Condoms Depo-Povera Pill Patch Ring Tubal Ligation Vasectomy Diaphragm Spermicides

Rhythm Withdrawal IUD inserted (date & type of IUD________________________)

Do you have: (circle) FIBROIDS ENDOMETRIOSIS POLYCYSTIC OVARIES HIGH RISK HPV

SUMMARY OF PREGNANCIES

# of pregnancies___________ # of deliveries>37 weeks ________________ # of deliveries <37 weeks ____________

# of miscarriages or abortions ________________ # of living children ____________________

Delivery Date	#weeks of Pregnancy	Vaginal ?	C-Section	Baby's Weight	Diabetes?	High BP?	Other Complications	Miscarried at ?weeks	Aborted