Westmoreland Obstetric and Gynecologic Associates, S.C.

Kelley London, MD Adam Cohan, MD Scott Logan, MD
Teri Hejazinia, FNP-BC/APNP

917 Sherwood Drive, Suite 200
Lake Bluff, IL 60044

1475 E. Belvidere Road, Suite 316
Grayslake, IL 60030

Phone 847-234-9110
Fax 847-234-0900

Dear Patient,

Thank you for choosing Westmoreland OB/GYN as your Women's Principal Healthcare Provider.

In preparation for your first appointment, please download and complete the attached forms prior to your visit. If the forms are not completed by the time of your appointment, your appointment may need to be rescheduled.

You may mail, fax or email the completed forms to the Lake Bluff Office at the address/fax number listed above, or you may bring them with you to your appointment. Completing these forms prior to your appointment will expedite your registration and allow us to address your medical needs more efficiently. **Our email address is: Receptionist@Westmorelandobgyn.com**

If you have any previous provider records (prenatal records, pap results, ultrasounds, CT scans, etc.) that are relevant to your visit, please mail, fax or email them in advance or bring them with you to your appointment.

Additionally, please bring your current **INSURANCE CARD** and a **PICTURE ID**

Lake Bluff Office Hours:

8:30am - 4:30pm	M
8:00am - 4:30pm	T - Th - F
8:00am - Noon	W
7:30am - 10:30am	Saturday

Grayslake Office Hours:

9:20am - 3:30pm	M
8:20am - 3:30pm	T
8:20am – 1:00pm	W
11:30am - 5:00pm	Th
8:20am - Noon	F
No Saturday hours	

Our office closes for lunch between Noon and 1pm

Sincerely,

Westmoreland Obstetric & Gynecologic Associates, S.C.

Name: _____ **Today's Date:** _____
First Middle Last

DOB: _____ SSN: _____ _____Married _____Single _____Divorced _____Widowed

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Email address: _____ Occupation: _____

Employer: _____ Work Phone: _____

Employer's address: _____
Street City State Zip

Primary physician: _____ Primary physician phone: _____

Primary physician address: _____

Preferred Pharmacy: _____ Pharmacy phone: _____

How did you hear about us? _____

Ethnicity (please circle one): Caucasian Hispanic African American Asian Other: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to You: _____

Home Phone: _____ Cell Phone: _____

PRIMARY INSURANCE INFORMATION:

Primary Insurance Company Name: _____ Primary Cardholder Name: _____

Primary Cardholder DOB: _____ Member ID #: _____

Company Name: _____ Group #: _____

Secondary Insurance Company Name: _____

Member ID #: _____ Group #: _____

Medicare ID number: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize payment of medical benefits to the provider above for professional services rendered. I authorize the release of any medical information necessary to process this claim.

Signature: _____

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FINANCIAL PAYMENT POLICY

The purpose of this form allows Westmoreland Obstetric & Gynecologic Associates, SC to treat you, bill any insurances you may have, share information with other health care offices/facilities, and to collect on your account.

REGARDING INSURANCE: Due to the numerous healthcare plans available, it is the patient's responsibility to verify that we are in network with your specific insurance plan. Should your insurance coverage be with more than one of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurances, deductibles, and non-covered services that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered. If you have an insurance with which we do not participate, we **require** that payment be made at the time services are rendered. As a courtesy to our patients, we will submit a claim to your insurance company.

SPECIAL NEEDS: There are times when paying balances can be a financial hardship. It may be necessary to set up a payment plan for patients who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our Billing Department to arrange a payment plan.

I authorize treatment by the providers of Westmoreland Obstetric & Gynecologic Associates, SC. I also authorize the release of any information requested by insurance companies or liable third parties and I assign any insurance benefits to Westmoreland Obstetric & Gynecologic Associates, SC. If the correct insurance information is not given or the proper referral is not obtained, then the patient will be responsible for the balance in full.

I acknowledge that I have received a copy of Westmoreland Obstetric & Gynecologic Associates, SC Notice of Privacy Practices. I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the patient below. I further agree to pay any incurred collection fees, attorney fees and court costs related to collection on my account balance.

- **THE FEE FOR A RETURNED CHECK IS $25.00.**
- **AS WE REQUIRE AT LEAST 24 HOURS NOTICE TO CANCEL OR RESCHEDULE AN APPOINTMENT, YOUR CREDIT CARD ON FILE WILL BE CHARGED $50.00 FOR ANY CANCELLED OR RESCHEDULED APPOINTMENT WITH LESS THAN 24 HOURS NOTICE, OR FOR ANY NO SHOW APPOINTMENTS.**
- **CO-PAYS ARE DUE IN FULL AT THE TIME OF SERVICE.**
- **IT IS YOUR RESPONSIBILITY TO PROVIDE WESTMORELAND OBSTETRIC & GYNECOLOGIC ASSOCIATES, SC WITH YOUR CURRENT INSURANCE INFORMATION. ANY BALANCES INCURRED DUE TO INCORRECT INSURANCE INFORMATION OR INSURANCE INFORMATION SUBMITTED TO US PAST THE TIMELY FILING DATE, WILL BE YOUR FULL FINANCIAL RESPONSIBILITY.**
- **ANY SERVICE THAT IS NOT COVERED BY YOUR INSURANCE COMPANY, FOR WHATEVER REASONS, IS YOUR FINANCIAL RESPONSIBILITY. ANY UNPAID BALANCES OVER 60 DAYS FOLLOWING INSURANCE RESPONSE WILL BE CHARGED TO THE CREDIT CARD ON FILE, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.**
- **INSURANCE WILL BE VERIFIED FOR ALL PROCEDURES PERFORMED IN THE OFFICE AND YOU WILL BE NOTIFIED OF ANY AMOUNT WHICH INSURANCE WILL PUT TO YOUR RESPONSIBILITY. THIS AMOUNT WOULD NEED TO BE PAID PRIOR TO THE SERVICES BEING PERFORMED.**
- **CALLS REGARDING PRESCRIPTION REFILLS WILL ONLY BE ADDRESSED DURING OFFICE HOURS. THE CHARGE FOR PRESCRIPTIONS THAT ARE NOT HANDLED DURING OFFICE HOURS IS $50.00.**
- **THE CHARGE FOR ISSUES THAT ARE HANDLED VIA PHONE CONSULTATION INSTEAD OF AN OFFICE VISIT IS $50.00. SOME INSURANCE PLANS DO NOT COVER PHONE CONSULTATIONS, AND SO YOU MAY BE RESPONSIBLE FOR THE COST.**

_____ _____

Patient or Guardian Signature
(Must be 18 or older to sign)

Date

_____ _____

Please print patient name

Please print Guardian's name

Westmoreland Obstetric & Gynecologic Associates, SC

Information Authorization

I, _____ authorize the methods of communication of my protected health information by Westmoreland OB/Gyn Associates, S.C. as indicated below. I understand that under the HIPAA guidelines, my patient information is held confidential unless authorized by my signature, with the exception of payment operations.

The following person(s) can inquire Protected Health Information, pick up records, prescriptions, take messages regarding my lab results, physician messages and appointment reminders with my Doctor and/or their staff at Westmoreland OB/Gyn Associates, S.C.:

1. PLEASE PRINT _____ Relationship _____

2. PLEASE PRINT _____ Relationship _____

3. PLEASE PRINT _____ Relationship _____

Please initial each option you authorize:

Telephone Answering Machine: _____ Home (Initial) _____ Work (Initial) _____ Cell Phone (Initial)

Patient's Cell Phone #: _____

Via E-Mail: _____ (Initial)

Patient's E-Mail: _____

Mail to Home: _____ (Initial)

Signature of Patient: _____ Date: _____

Printed Patient's Name: _____

Legal Guardian (If Applicable)

Signature: _____ Date: _____

Printed Guardian Name: _____

This consent will remain in your permanent record for three years or until revoked in writing by signee.

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Consent to the use and disclosure of medical information for treatment, payment and healthcare operations

I consent to the use or disclosure of my medial information by ***Westmoreland Obstetric and Gynecologic Associates, S.C***. for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment or to conduce healthcare operations of the practice. I understand that treatment by the practice may be denied if I do not sign this consent.

I understand that I have the right to request restrictions as to how this information is used or disclosed for treatment, payment or healthcare operations and that ***Westmoreland Obstetric and Gynecologic Associates, S.C.*** is not required to agree to the restrictions that I may request, but if the Practice agrees to a restriction the practice is bound by the agreement.

I have the right to revoke this consent, in writing, except where the Practice has already made disclosures in reliance on prior consent.

I understand and, upon request, will be provided with ***Westmoreland Obstetric and Gynecologic Associates, S.C.*** *Notice of Privacy Practices* that provides information about how the practice may use and disclose medical information. I understand that I have the right to review the notice prior to signing this consent.

Westmoreland Obstetric and Gynecologic Associates, S.C. has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent via e-mail or asking for one when I am in the office.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Name of Patient or Authorized Representative

Westmoreland Obstetric and Gynecologic Associates, S.C.

Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with our practice. In providing us with your credit card information, you are giving Westmoreland Obstetric & Gynecologic Associates, S.C. permission to automatically charge your credit card on file for any copays or balance due 60 days from date of insurance payment. By signing this form, you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Copays: Copays are due at time of the office visit

Outstanding Balance: If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, you will receive a statement. If we do not receive a response from you or your payment in full at that time, any balance owed will be charged to your credit card unless other arrangements have been made in advance. A copy of the charge will be sent through our patient portal or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder or his/her minor children.

I authorize Westmoreland Obstetric & Gynecologic Associates, S.C. to charge copays and outstanding balances over 60 days on my account to the following credit card:

☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER** ☐ **AMERICAN EXPRESS**

Name as it Appears on Card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Credit Card Billing Address: _____

_____

Signature of Card Holder: _____ Date: _____

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Name:	DOB:	Date:

REASON FOR APPOINTMENT:

☐ **Annual/Routine** ☐ **Pregnancy** ☐ **Birth Control** ☐ **Other:** _____

GYNECOLOGICAL HISTORY

1st day of last period: **How often do you get a period?** **How many days does your period last?**

Do you have heavy bleeding? ☐ Yes ☐ No **Do you have break through bleeding?** ☐ Yes ☐ No

If Yes, how many pads/tampons do you use on an average day?

Do you experience severe cramping? ☐ Yes ☐ No

If Yes, what medications do you use for cramping pain?

Have you been sexually active? ☐ Yes ☐ No **If Yes, with:** ☐ **Men** ☐ **Women** ☐ **Both**

Age of first intercourse? **Total number of partners?** **Any bleeding after intercourse?** ☐ Yes ☐ No

Age of first period? **Has menopause occurred?** ☐ Yes ☐ No

If Yes, any problems with postmenopausal bleeding?

Current contraceptive method?

Contraceptive method used in the past?

☐ Patch ☐ Nexplanon ☐ Nuva Ring ☐ Depo Provera ☐ Condoms

☐ Natural Family Planning ☐ Vasectomy ☐ Tubal Ligation

☐ IUD (type) ☐ Pill (type) ☐ Other:

Sexually Transmitted Infections? ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ HPV Was this treated? ☐ Yes ☐ No

Have you had a pap smear? ☐ Yes ☐ No **If Yes, date of last pap smear?**

Have you ever had an abnormal pap? ☐ Yes ☐ No **If YES, when?**

Any history of the following:	
Cervical Cryotherapy (freeze)	☐ Yes ☐ No Date:
Cervical LEEP	☐ Yes ☐ No Date:
Cervical Cone Biopsy	☐ Yes ☐ No Date:
Colposcopy	☐ Yes ☐ No Date:

Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Unsure

Date of your last mammogram? ☐ Normal ☐ Abnormal

Breast Surgery ☐ Yes ☐ No	**If Yes, please check the following:**		
Biopsy:	☐ Right Breast	☐ Cancerous	Date:
	☐ Left Breast	☐ Cancerous	Date:
Mastectomy:	☐ Right Breast	☐ Cancerous	Date:
	☐ Left Breast	☐ Cancerous	Date:
Lumpectomy:	☐ Right Breast	☐ Cancerous	Date:
	☐ Left Breast	☐ Cancerous	Date:

Date of your last dexascan (bone scan)?

Date of your last colonoscopy?

Name: _____ **DOB:** _____

OBSTETRICAL HISTORY

How many times have you been pregnant?

Date of Delivery	Full Term or Preterm	Vaginal or C/S	Female or Male	Birth Weight	Type of Anesthesia	Hospital	Complications

History of Miscarriages? ☐ Yes ☐ No **Number of Miscarriages:** **Was a D&C Required? If Yes, date:**

History of Abortions? ☐ Yes ☐ No **Number of Abortions:**

History of postpartum depression? ☐ Yes ☐ No

History of blood transfusion? ☐ Yes ☐ No

Have you had any of the following vaccines?

Influenza		☐ Yes ☐ No
Chicken Pox vaccine <u>OR</u> exposure to this virus		☐ Yes ☐ No
Hepatitis B		☐ Yes ☐ No
HPV (Gardasil)		☐ Yes ☐ No
Pneumococcus		☐ Yes ☐ No
Tetanus (within the last 10 years)		☐ Yes ☐ No
German measles (Rubella) <u>OR</u> exposure to this virus		☐ Yes ☐ No
COVID-19	☐ Moderna ☐ Pfizer ☐ Johnson/Johnson	☐ Yes ☐ No

PERSONAL HISTORY	**If you check YES to any of the following, please provide the date**
Appendectomy	☐ Yes ☐ No Date:
Gall Bladder Removed	☐ Yes ☐ No Date:
Total Abdominal Hysterectomy	☐ Yes ☐ No Date:
Vaginal Hysterectomy	☐ Yes ☐ No Date:
Laparoscopy	☐ Yes ☐ No Date: Ovarian Cysts: ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both Endometriosis: ☐ Yes ☐ No
Removal of Ovaries	☐ Yes ☐ No ☐ Right ☐ Left ☐ Both Date:
Any Other Surgeries	☐ Yes ☐ No **If Yes, please list below:**
#1	Date:
#2	Date:
#3	Date:
#4	Date:

Name: _____ **DOB:** _____

SOCIAL HISTORY	
Check one:	☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**
Do you smoke? ☐ Yes ☐ No	**Previous Smoker?** ☐ Yes ☐ No **Do you vape?** ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No	**If Yes, how many drinks a week?**
Use Other Substances?	☐ Yes ☐ No
Has anyone ever abused you:	**Physically** ☐ Yes ☐ No **Sexually** ☐ Yes ☐ No **Verbally** ☐ Yes ☐ No
Please list any religious affiliation you would like us to know about (optional):	
Are you a Jehovah's Witness?	☐ Yes ☐ No
Do you wear a seat belt?	☐ Yes ☐ No
Do you exercise?	☐ Yes ☐ No **If Yes, how many times a week?**

FAMILY HISTORY	
Breast cancer	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Uterine cancer	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Ovarian cancer	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Colon cancer	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Heart disease	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Hypertension	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Diabetes	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
High cholesterol	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Thyroid disease	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Bleeding problems	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Blood clots	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Sickle cell anemia	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Stroke	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:
Osteoporosis	☐ Yes ☐ No ☐ Maternal ☐ Paternal Who?
Age of diagnosis:	Still Alive? ☐ Yes ☐ No Age of Death:

Name: _____ **DOB:** _____

MEDICAL HISTORY:	(Please check what applies to you)
Cardiovascular:	☐ Heart Attack ☐ Artery Disease ☐ Angina ☐ CHF ☐ High BP ☐ High Cholesterol
Endocrine:	☐ Diabetes ☐ Low Thyroid ☐ High Thyroid ☐ PCOS
Respiratory:	☐ Asthma ☐ Allergies
Immune:	☐ HIV +
Gastro-intestinal:	☐ Reflux ☐ Hepatitis ☐ Irritable Bowel ☐ Colitis/Chrohn's
Genito-urinary:	☐ Stones ☐ Kidney Infection ☐ Chronic UTI
Musculoskeletal:	☐ Arthritis ☐ Osteoporosis ☐ Osteopenia
Psychiatric:	☐ Depression ☐ Anxiety ☐ PMS ☐ Bipolar ☐ Post-Partum Depression
Neurological:	☐ Stroke ☐ Mini Stroke ☐ M.S. ☐ Seizures ☐ Migraines
Rheumatology:	☐ Fibromyalgia ☐ Lupus
Hematology/Oncology:	☐ Factor 5 ☐ MTHFR ☐ Blood Clots/Thrombophilia

MEDICATIONS YOU ARE CURRENTLY TAKING (Include Any Supplements)	DOSAGE	FREQUENCY/HOW OFTEN

PLEASE LIST ANY ALLERGIES: (i.e. drug, egg, latex, etc.) ALLERGY	REACTION