



959 S. Waukegan Road, 2nd Floor
Lake Forest, IL 60045

847-234-3250
fax 847-234-7765

beyondgynehealth.com

Patient Information

Name: _____

Social Security #: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City/State/Zip: _____

Employer/School: _____ Work Phone: _____

Occupation: _____ Email Address: _____

Marital Status (*please circle*): Married Single Widowed Divorced Other

Spouse/Parent Name: _____ Spouse/Parent Phone: _____

Referred by: _____ Primary Dr name and #: _____

Emergency Contact name and phone #: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Ins Effective Date: _____ Ins Effective Date: _____

Copay Amount: _____ Copay Amount: _____

Group Name or #: _____ Group Name or #: _____

Policy or I.D.#: _____ Policy or I.D.#: _____

Ins/Responsible Party: _____ Ins/Responsible Party: _____

Sex: M or F Birthdate: _____ Sex: M or F Birthdate: _____

I authorize the release of any medical information necessary to process claims on my behalf, and I authorize payment of insurance benefits to the Provider or Practice for claims submitted on my behalf.

Signature: _____ Date: _____



Beyond Gyne Health

Patient Medical History Form

Today's Date: _____

Name: _____ Preferred Pronoun: _____					Date of Birth: _____		
NAME OF CHILD	DATE OF DELIVERY MM/DD/YYYY	HOW MANY WEEKS AT DELIVERY	C-SEC OR VAG	M/F & WEIGHT	TYPE OF ANESTHESIA	HOSPITAL	COMPLICATIONS
1							
2							
3							
4							
5							
6							

History of miscarriages? ☐ Yes ☐ No # of miscarriages _____ Was a D&C required? (If yes) Date: _____
History of abortions? ☐ Yes ☐ No # of abortions _____

GYNECOLOGICAL HISTORY	
Age of first period? _____	Date of last menstrual period? _____
How often do you get your period? (ie. every 2 weeks, every month?) _____	
How many days does your period last? _____	
How many pads and/or tampons do you use on an average day? _____	
Cramps/pain? _____	What medications do you use? _____
Contraceptive method currently being used? ☐ Patch ☐ Vasectomy ☐ Ring ☐ Depo ☐ Condom ☐ Natural Family Planning ☐ Rhythm ☐ Withdrawal ☐ IUD (type) _____ ☐ Pill (type) _____	
Sexually Transmitted Infections? ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ HPV Was this treated? ☐ Yes ☐ No	
Sexually Dysfunction problems? _____	
SOCIAL HISTORY	
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Same Sex Partner	
Age of first intercourse? _____ # of partners _____	
Currently sexually active? ☐ Yes ☐ No If yes, ☐ with Male ☐ with Female ☐ with Both	
Domestic abuse? ☐ Yes ☐ No Sexual abuse? ☐ Yes ☐ No	
Smoking? ☐ Yes ☐ No # of packs per day _____ # of years used _____	
Alcohol? ☐ Yes ☐ No # of drinks per day _____ # of drinks per week _____	
Have you received the COVID-19 vaccine? ☐ Yes ☐ No Please list dates: 1st dose _____ 2nd dose _____ Booster #1 _____ Booster #2 _____ Booster #3 _____	
Have you received the Gardasil (HPV) vaccine? ☐ Yes ☐ No If yes, please list year received: _____	
Have you received a flu shot in the last 12 months? ☐ Yes ☐ No If yes, please list date: _____	
Date of last pap? _____	Date of last mammogram? _____

[illegible]

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY TO YOU)		
Cardiovascular:	☐ Heart Attack	☐ Artery disease ☐ Angina ☐ CHF ☐ High BP ☐ High Cholesterol
Endocrine:	☐ Diabetes	☐ Low Thyroid ☐ High Thyroid
Respiratory:	☐ Asthma	☐ Allergies
Immune:	☐ HIV+	
Gastrointestinal:	☐ Reflux	☐ Hepatitis ☐ Irritable Bowel ☐ Colitis
Genitourinary:	☐ 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	
PLEASE LIST ANY MEDICATION AND HERBAL SUPPLEMENTS THAT YOU TAKE	DOSE	HOW FREQUENTLY (PLEASE LIST HERBAL SUPPLEMENTS ALSO)

Name and location of pharmacy that you use: _____

Phone number of pharmacy: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.) Little interest or pleasure in doing things	0	1	2	3
2.) Feeling down, depressed or hopeless	0	1	2	3

Score: ____

M.A.Initials: ____

Review of Systems

(Please check yes or no for all symptoms occurring in the past TWO weeks)

Systemic Symptoms:

Weight change	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No
Difficulty sleeping	☐ Yes	☐ No

Head and Neck Symptoms:

Headache	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No

Pulmonary Symptoms:

Shortness of breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Snoring or stopping breathing in sleep (apnea)	☐ Yes	☐ No

Cardiovascular Symptoms:

Chest pain or discomfort	☐ Yes	☐ No
Fast heart rate	☐ Yes	☐ No
Palpitations or irregular heart rate	☐ Yes	☐ No
Fainting	☐ Yes	☐ No

Gastrointestinal Symptoms:

Change in appetite	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Increase in abdominal girth	☐ Yes	☐ No
Early satiety (feeling full)	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Black/Bloody stools	☐ Yes	☐ No

Genitourinary Symptoms:

Dysuria (pain with urination)	☐ Yes	☐ No
Increased urinary frequency	☐ Yes	☐ No
Hematuria (blood in urine)	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Incomplete emptying	☐ Yes	☐ No
Genital pain	☐ Yes	☐ No

Gynecologic Symptoms:

Irregular cycle intervals	☐ Yes	☐ No
Bleeding between periods	☐ Yes	☐ No
Pelvic pain	☐ Yes	☐ No
Bloating	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No
Vaginal itch	☐ Yes	☐ No

Breast Symptoms:

Breast pain	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No
Breast lump/mass	☐ Yes	☐ No

Endocrine Symptoms:

Excessive sweating	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Libido/Sex drive change	☐ Yes	☐ No

Psychological Symptoms:

Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Anger	☐ Yes	☐ No
Alcohol/Substance abuse	☐ Yes	☐ No
Irritability prior to menses	☐ Yes	☐ No
Moodiness	☐ Yes	☐ No

Skin and Hair Symptoms:

Pruritus (itching)	☐ Yes	☐ No
Skin lesions	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No
Rash	☐ Yes	☐ No

Financial Policy

Thank you for choosing our office for your OB/Gyne care. The following is a summary of our financial policy. Your understanding of this policy is a key element in your care. If you have any questions, please feel free to contact our billing department at 847-234-3250.

The patient or patient's guardian is responsible for payment of services rendered by our providers. As a courtesy, our billing office will submit claims to your insurance carrier. In order to file your claim, please be sure that we have your most current insurance information on file. If a co-pay is required by your insurance plan, you will be expected to pay your co-pay at each visit. If you are seen for a scheduled preventative visit and another condition is treated at the same time, the provider will bill for each service rendered. Our office can only code and file a claim for your visit with a diagnosis that was encountered and documented in the medical record. To ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

After insurance benefits have been received, patients will be asked to forward payment of any remaining balance due within 30 days. Balances after 60 days will be subject to finance charges. Fee for service, co-pays, co-insurance and deductibles are due at time of service. Cash, check, Visa, Mastercard, Discover, and American Express are acceptable forms of payment. If your account is referred to our collection agency, your account will be assessed a 30% collection fee and you will be dismissed from our practice. Should you file bankruptcy, you will also be dismissed.

After hours phone consults with the physician will incur a charge. All prescription refills, and mail order insurance prescriptions will be handled during your office visit. Requests for prescription and mail order insurance prescriptions that are not handled at an office visit will result in a charge. In addition, disability forms will be completed for a fee per occurrence.

Fees:

After hours phone consult	\$100.00
Forms completion/letters-per occurrence	\$50.00
Lost prescription/Rx called into pharmacy	\$20.00
NSF/Returned check	\$50.00
No show for appointment	\$50.00

As a courtesy to our patients, Lab Corp of America provides in office laboratory services. It is the patient's responsibility to confirm with your insurance if they are in your plan.

If you are uncertain whether or not our providers or any of our services are covered by your insurance plan, please call your insurance company before seeing the provider. In the event you need to change, reschedule, or cancel your appointment, you must do so within 24 hours of your appointment to avoid being charged. All no show appointments will be charged a fee.

I have read and understand the financial policies described above. By choosing to proceed with care, I am also agreeing to comply with these policies.

Printed Name

Signature

Date



Beyond Gyne Health

Dual-Service Billing Policy

At Beyond Gyne Health, we are committed to providing thorough and convenient care during your visits. An annual gynecological exam is focused on preventive care, such as screenings and routine assessments. If you have additional concerns beyond your annual exam, we are happy to address them during the same appointment to save you time and ensure your needs are met.

By signing below, I acknowledge that I understand an additional office visit may be billed alongside my annual exam if other medical concerns are addressed during the same appointment. I also understand this may result in a balance due depending on my insurance coverage.

Patient's Name

Date of Birth

Patient's Signature

Date



Communication Request

Date: _____ Date of Birth: _____

Patient Name: _____

Patient's Phone: _____

Patients Email: _____

When contacting you by phone, may we leave a message on voicemail to return our call?

☐ Yes

☐ No

When contacting you by phone, may we leave a message with normal results on voicemail?

☐ Yes

☐ No

How would you like to receive appointment reminders and confirmations?

☐ Call

☐ Text

Please list your **Next of Kin** OR anyone with whom we may share your PHI (private health information) through all forms of communication including electronic (phone, email, patient portal, etc.)

Name/Relationship/Contact Phone Number:

1. _____

2. _____

3. _____

Emergency Contact: Name, Phone Number, and Relationship:

Signature of Patient or Legal Representative

Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgement that you received this Notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called “protected health information” or “PHI.”

We are also required by law to notify you if you are affected by a breach of your unsecured PHI.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send you PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury, or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and Federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity to our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting a medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the Safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correction institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclose PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: We do not engage in fundraising activities and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Illinois Law: Illinois law also has certain requirements that govern the use or disclosure of you PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make specific type of use and disclosure without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment, and health care operations. We are not required to accommodate your request, except as required by law. The practice is required to comply with your request for restrictions on the use or disclosure of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restrictions in writing, and the disclosure is not required by law.

Communications: You have a right to receive confidential communications about you PHI. For example, you may request that we only call you at home. If the request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billings and medical information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options. You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in you PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at (847)234-3250. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.



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Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations). You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

We are required to abide with terms of the Notice currently in effect, however, we may change this notice. If we materially change this Notice, you can get a revised Notice **on our website at** www.beyondgynehealth.com or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

EFFECTIVE DATE:_____

**Consent for Release and Use of Confidential Information and
Receipt of Notice of Privacy Practices Form**

I, _____, hereby give my consent to Beyond Gyne Health
(Name of Patient or Authorized Agent)

to use or disclose, for the purpose of carrying out treatment, payment, or healthcare
operations, all information contained in the patient record of

(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of
Privacy Practices provides detailed information about how the practice may use and
disclose my confidential information.

I understand that the provider has reserved the right to change their 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 by request through Beyond Gyne Health
Patient Portal.

I understand that this consent is valid until it is revoked by me. I understand that I may
revoke this consent at any time by giving written notice of my desire to do so to the
provider. I also understand that I will not be able to revoke this consent in cases where
the provider has already relied on it to disclose my health information. Written
revocation of this consent must be sent to the provider's office.

Signed: _____ Date: _____