LosAngeles Center for Women's Health

California Hospital Medical Center
A Dignity Health Member

Directions & Parking Information

DRIVING DIRECTIONS:

Harbor Freeway (110) Southbound: take **EXIT 22B** toward **9th St. / Convention Center;** turn **slight left** onto **W. 8th Pl**. Stay **straight** to go onto **James M Wood Blvd.**, which becomes **W 9th St**. Stay on **W 9th St.** for 3 blocks, then turn **right** onto **S Grand Ave**. Travel 5 blocks, turn **right** into the parking lot at **1513 S. Grand Ave.**, just past the pedestrian crosswalk at the California Hospital Medical Center circle drive. If you miss the entrance, proceed half a block to Venice Blvd. and turn right, then right on Hope St. and right again into the driveway on Hope St.

Our location **Parking options**

Harbor Freeway (110) Northbound: take the **Adams Blvd. (EXIT 20C)** exit, turn **left** onto **W. Adams Blvd**. Just past the 110, take a **soft right** (near Flower), then another **soft right** onto **S. Figueroa St**. Turn **right** onto **W. Pico Blvd**. Turn **right** onto **S. Grand Ave**. Travel 1 block, turn **right** into the parking lot at **1513 S. Grand Ave.**, just past the pedestrian crosswalk at the California Hospital Medical Center circle drive. If you miss the entrance, proceed half a block to Venice Blvd. and turn right, then right on Hope St. and right again into the driveway on Hope St.

Santa Monica Freeway (10) Eastbound: **exit at Grand Ave., cross Grand** (as it is one-way street in the other direction), travel 1 block then **turn left** on Olive St. Travel 2 blocks, then turn **left** on Venice Blvd. Travel 2 blocks (pass Grand Ave.), **turn right on Hope St.**, then **right into 15th St. driveway/parking lot entrance.**

Santa Monica Freeway (10) Westbound, **exit at Los Angeles St. (EXIT 14A)** and continue parallel to the freeway for 3 blocks (Los Angeles St. becomes 17th St.). **Turn right** on **Olive St.**, travel 3 blocks then **turn left on 14th St.** Travel 1 block turn **Left** onto **Grand Ave.** and **Right** into the parking lot at **1513 S. Grand Ave.**, just past the pedestrian crosswalk at the California Hospital Medical Center circle drive. If you miss the entrance, proceed half a block to Venice Blvd. and turn right, then right on Hope St. and right again into the driveway on Hope Street.

Please Note:

- **Grand Avenue is a southbound, one-way street.**
- **The parking lot entrances are accessible via Hope Street or Grand Avenue. Collect the parking ticket at the gate.**
- **Closest parking is in the lot under or adjacent to the Center at Venice & Grand.**

1513 South Grand Ave.
Suite 400
Los Angeles, CA 90015
www.lacwh.org

213-742-6400

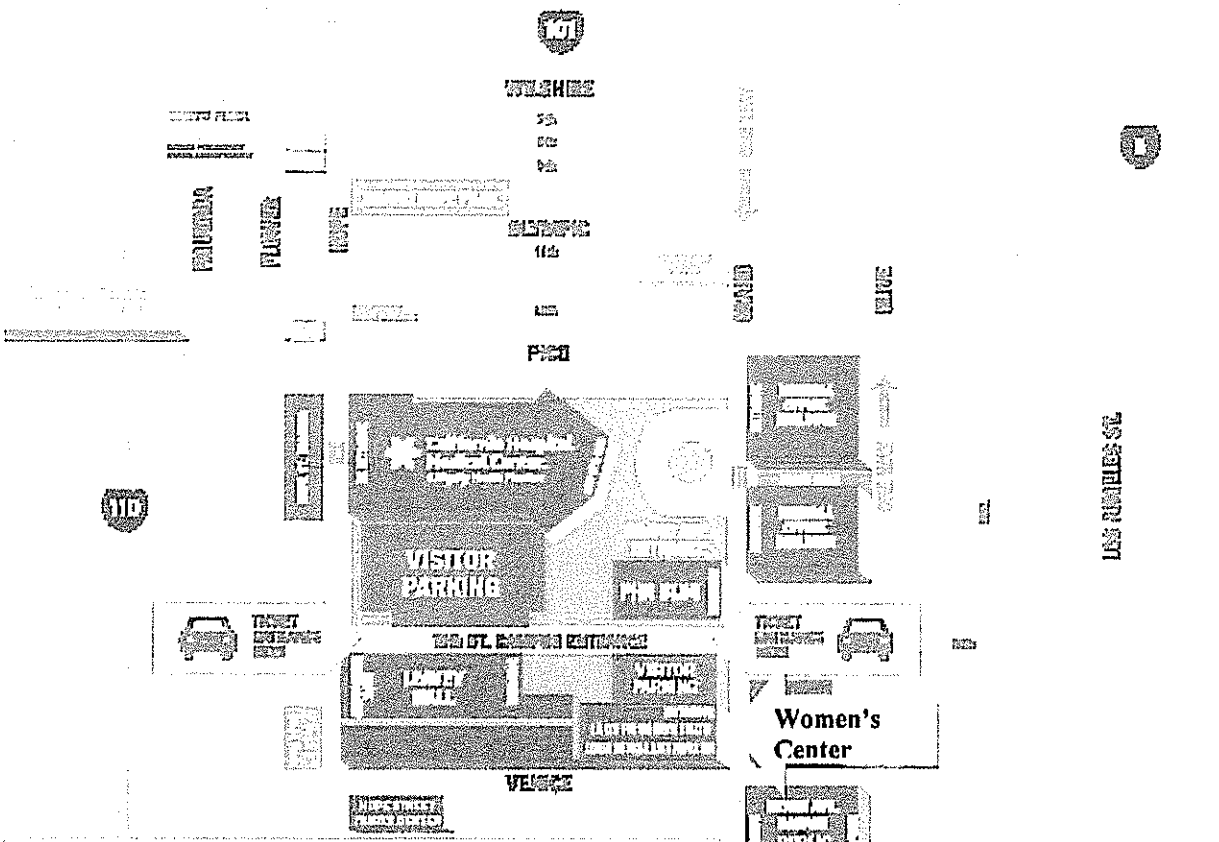
LosAngeles Center for Women's Health

California Hospital Medical Center
A Dignity Health Member

Dignity Health.
California Hospital Medical Center

1401 South Grand Ave.
Los Angeles, CA 90015
www.chmcla.org
(213) 748-2411

Location Map



DRIVING DIRECTIONS

10 Freeway (East):
Exit Grand Ave. Turn slight right onto 12th St. Turn left onto Olive St. Turn left onto 14th St. Turn left onto Grand Ave.

10 Freeway (West):
Exit Los Angeles St. Stay straight to go onto E 17th St. Turn right onto Olive St. Turn left onto 14th St. Turn left onto Grand Ave.

110 Freeway (North):
Take the Santa Monica Freeway/I-10 exit. Take the exit on the left toward Pico Blvd. Stay straight to go to LA Live Way. Turn right onto Pico Blvd. Turn right onto Grand Ave.

110 Freeway (South):
Exit 9th Street. Turn right onto Grand Ave.

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LosAngeles Center for Women's Health

California Hospital Medical Center
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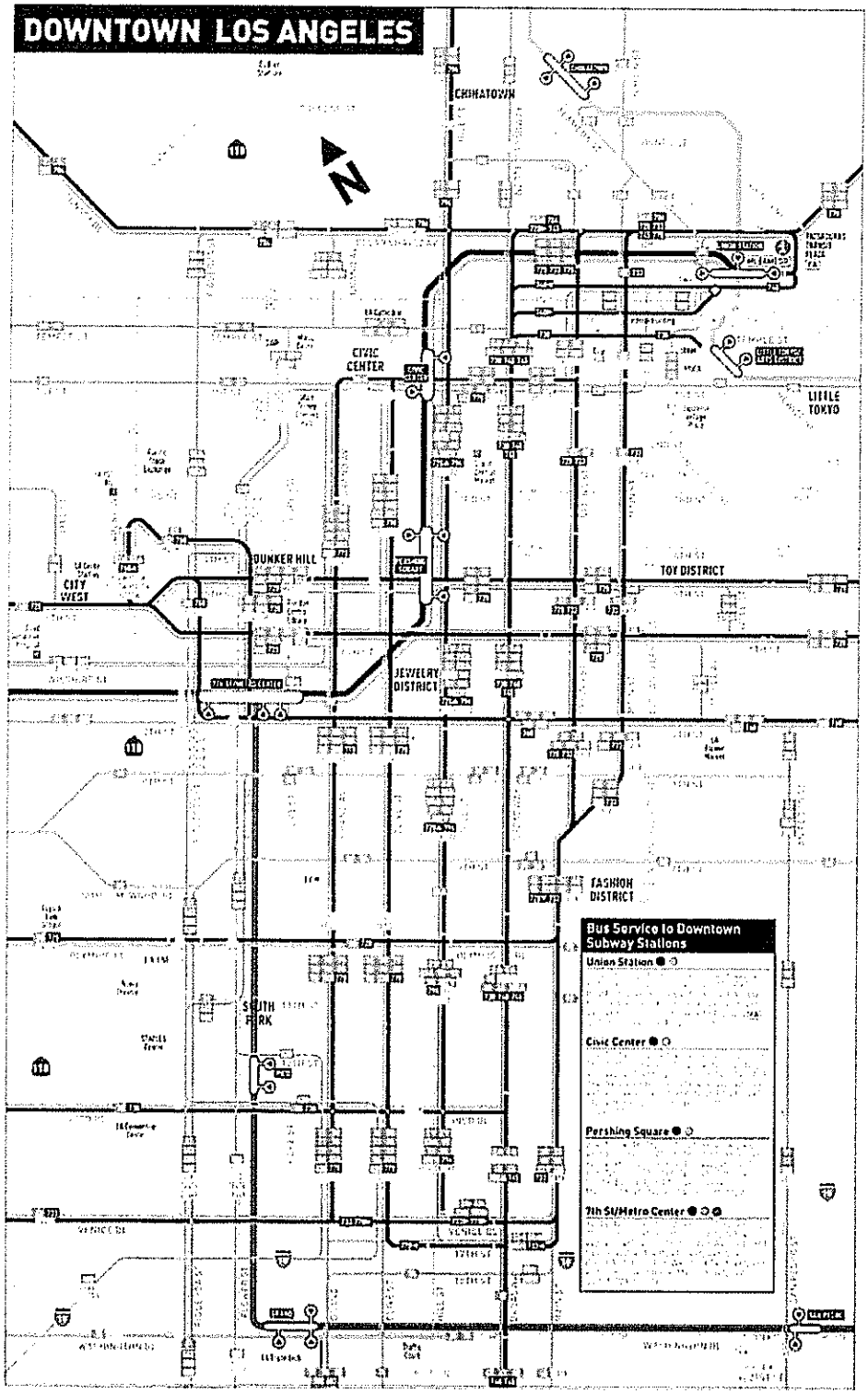
Downtown Los Angeles Metro & Bus Routes

Closest stations are at Pico and Flower or Washington and Grand (blue line).



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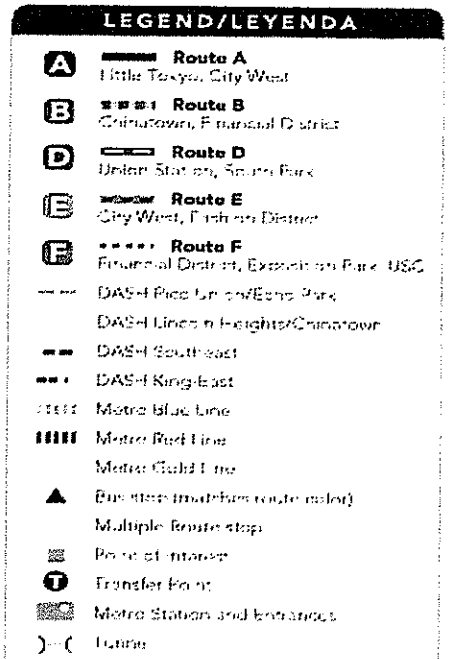
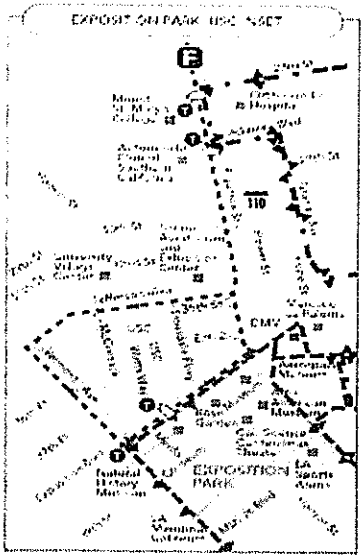
LosAngeles Center for Women's Health

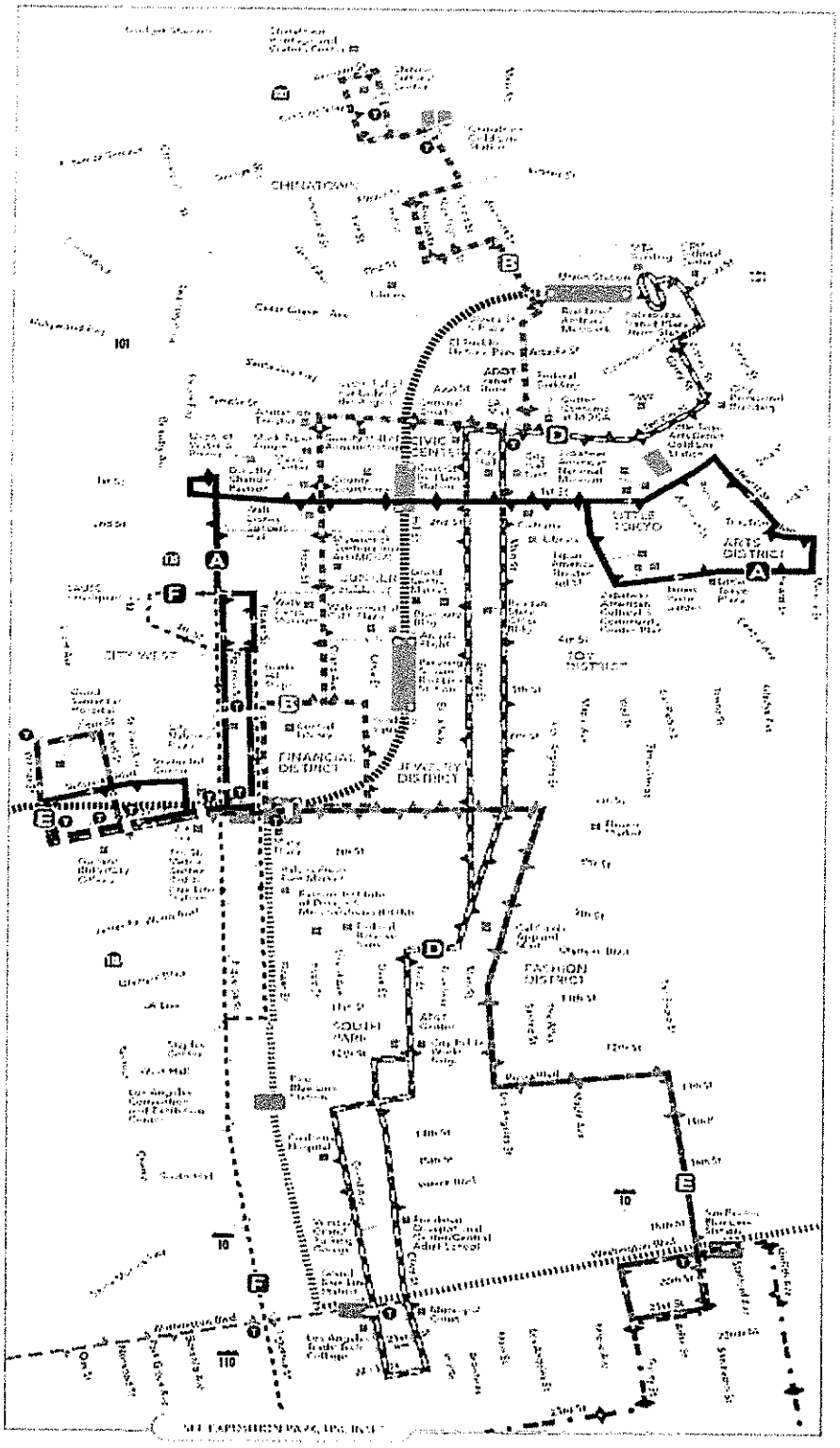
California Hospital Medical Center
A Dignity Health Member

Downtown Los Angeles DASH Route Map

Closest station is at Grand and Venice.







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LosAngeles Center for Women's Health

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213.742.6400

Billing Information For Los Angeles Center For Women's Health (LACWH)

-The Los Angeles Center For Women's Health is an outpatient department of California Hospital and Dignity Health. **You will receive a "facility" bill from CHMC and/or Dignity Health.** California Hospital also has relationships with outside facilities. Depending on your visit type and/or any additional studies and/or labs that are performed you may also receive bills from the following facilities;

- *CMCLA Pathology Medical Group*
- *Hawthorne Rad Assoc Med Group*
- *Pathology Inc*
- *Quest Diagnostics*

-Doctors are independent Medical Care Providers. Doctors caring for patients at LACWH are independent providers of medical care and are not employees or agents of LACWH or California Hospital. **You will receive a separate "professional" bill from the doctors for their services.**

If you have questions regarding the above please contact:

LACWH, Eduardo Meza-213.742.6170
Dignity Health Billing Department-888.488.7667

Financial Assistance

We believe that no one should delay seeking needed medical care because they lack insurance or have high medical costs. That's why we assist patients with applying for public health coverage programs, offer discounts and payment plans for uninsured patients, and offer Payment Assistance to eligible patients for selected hospital services.

Government Program Eligibility

To get more information on government sponsored programs like Medi-Cal, Medicare, Healthy Families, or to request an application, please call the number listed on the back of this brochure. Applications are available at the hospital.

Uninsured Patient Discount

Eligible uninsured patients will pay a reduced rate for certain hospital services. This rate will be reflected on the patient's first billing statement. Uninsured patients who meet the criteria outlined below are eligible for this uninsured discount:

- Annual household income does not exceed $250,000
- Patient is uninsured
- Patient assigns benefits relating to claim to Dignity Health.

Dignity Health Payment Assistance

If you are not eligible for a government program, you may be eligible for Dignity Health's need-based Payment Assistance Program or for an interest-free payment plan. This Program is ONLY for your Hospital Bill and does not cover any other bills. For further information or to obtain an application for Payment Assistance, please contact us at the number listed on the back of this brochure or visit Admitting / Patient Registration.

Revised 07/14

Our Mission

Dignity Health and our Sponsoring Congregations are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

Delivering compassionate, high-quality, affordable health services;

Serving and advocating for our sisters and brothers who are poor and disenfranchised; and

Partnering with others in the community to improve the quality of life.

Our Vision

A growing and diversified health care ministry distinguished by excellent quality and committed to expanding access to those in need.

Our Commitment to You

Patient Financial Services is strongly committed to ensuring that you understand your billing statements and are aware of financial assistance options.

Please call us with any questions.

How to Reach Us

California Hospital Medical Center
[illegible] South Grand Avenue
Los Angeles, CA 90015

Financial Counselor
(213) [illegible] (213) [illegible]

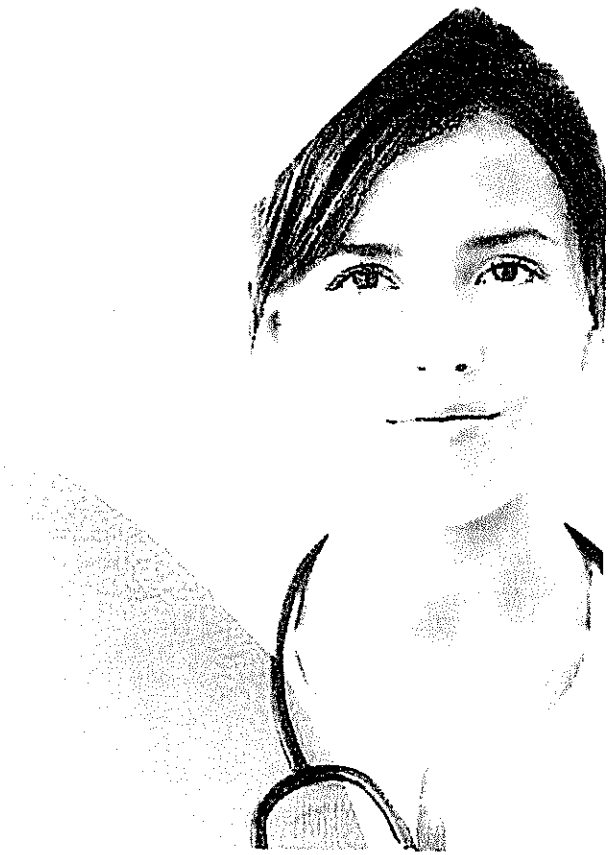
Department of Human Services
(General information about Government Programs)
(310) 852-2074

Billing Inquiries
(888) 638-2667

www.DignityHealth.org/chlpay

Dignity Health.
California Hospital Medical Center

Hospital Billing Process & Payment Assistance Options



Welcome

Thank you for choosing Dignity Health for your health care needs. This brochure will provide you with information on how your services will be billed and to inform you of payment assistance options available to you.

Hospital Billing

Patient Financial Services is made up of several departments: Admitting / Registration, Financial Counseling, and the Patient Accounts Business Office.

We have opened an account in your name where we will record all financial transactions related to your care. If you have provided insurance information, we will submit a claim on your behalf. When the amount you owe has been determined by the hospital or insurance company we will send you a "Balance Due" notice, like the one printed to the right.

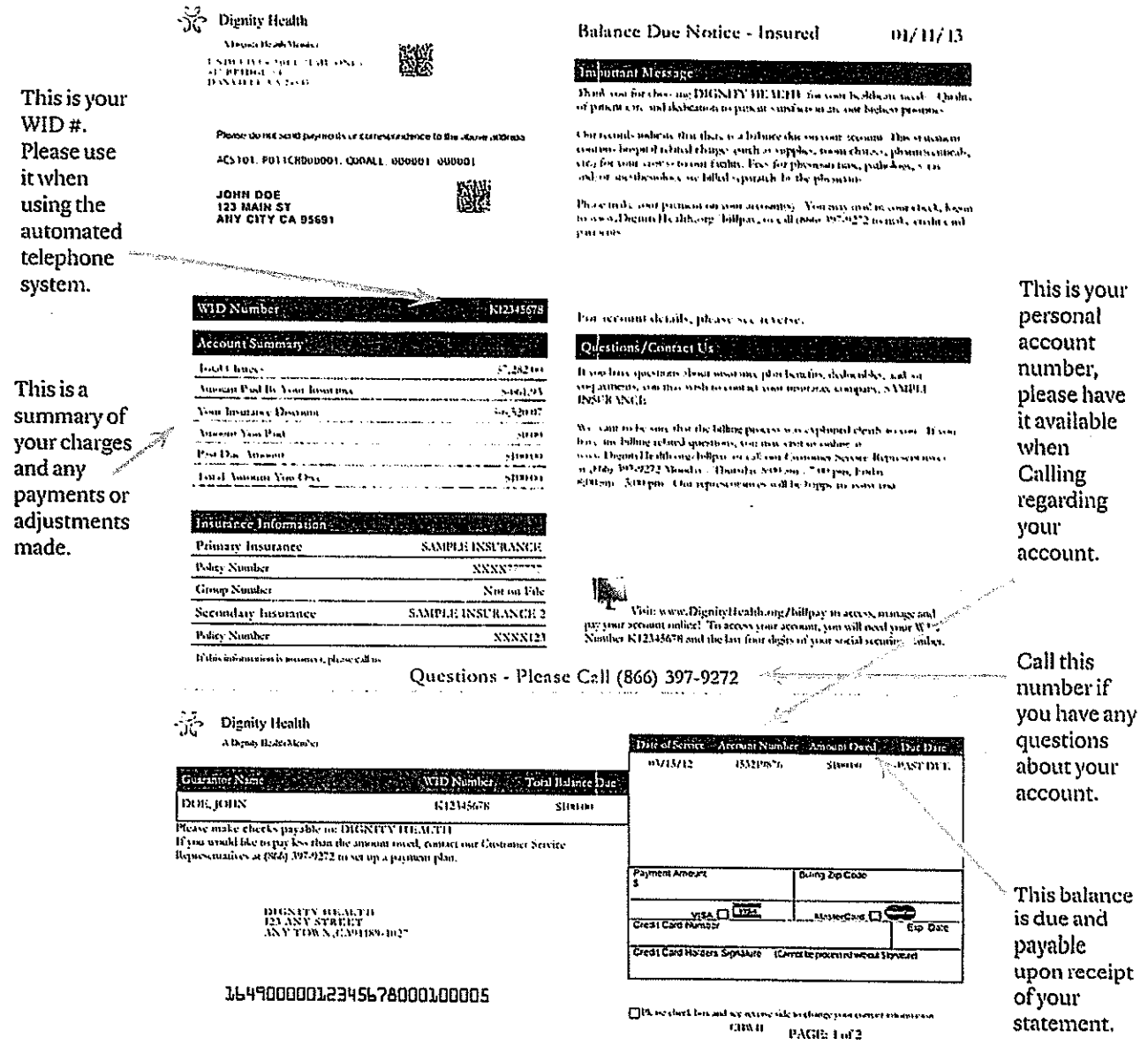
You may receive separate billing statements from other doctors or clinical staff that assisted in your care. This could include Emergency Physicians, Anesthesiologists, Radiologists, Home Health, Hospice and/or Pathologists. These doctors could have different arrangements with your insurance company that may lead to additional bills. If you do not have insurance or have high medical costs, you may also qualify for a discount on your physician's bill from your emergency room physician. For more information, please contact your physician.

Our financial counseling and registration staff can assist you with providing an estimate of what your charges will be in advance of receiving care. These totals are only estimates because it is difficult to anticipate the exact services that a patient may actually receive.

To pay your bill online, go to www.DignityHealth.org/billpay

Understanding Your Bill

We accept cash, credit cards, money orders, cashiers checks or personal checks as payment. If you are unable to pay your bill, or would like to set up a payment plan, please do not hesitate to ask for assistance. If you would like an itemized billing statement, one can be requested after you leave the hospital by calling the business office listed on the back of this brochure. We're here to help.



This is your WID #. Please use it when using the automated telephone system.

This is a summary of your charges and any payments or adjustments made.

This is your personal account number, please have it available when Calling regarding your account.

Call this number if you have any questions about your account.

This balance is due and payable upon receipt of your statement.

LosAngeles Center for Women's Health

New Patient Health Questionnaire

Name: _____

Date of Birth: _____

Date completed: _____

Dear Patient,

In order to offer optimal care for you, we need to understand your complete health status and health history. With this goal in mind, we appreciate you spending ten to twenty minutes completing this comprehensive health questionnaire.

Review of Systems

For the **Review of Systems** section, please indicate "Yes" if you are currently experiencing the symptom or if you have experienced the symptom within the past three months.

Please fill in the appropriate bubble completely. For example..... ● Yes ○ No

General

Chills ..... ○ Yes ○ No		Change in appetite ..... ○ Yes ○ No	
Fever ..... ○ Yes ○ No		Weight gain ..... ○ Yes ○ No	
Night sweats ..... ○ Yes ○ No		Weight loss ..... ○ Yes ○ No	
Sleep disturbance ..... ○ Yes ○ No		Lightheadedness ..... ○ Yes ○ No	
Frequent or persistent headaches ..... ○ Yes ○ No		Fatigue ..... ○ Yes ○ No	

Skin

Acne ..... ○ Yes ○ No		Dry skin ..... ○ Yes ○ No	
Rash ..... ○ Yes ○ No		Discoloration ..... ○ Yes ○ No	
New skin moles ..... ○ Yes ○ No		Eczema ..... ○ Yes ○ No	

Behavioral

Anxiety ..... ○ Yes ○ No		Depression ..... ○ Yes ○ No	
Mental or Physical abuse ..... ○ Yes ○ No		Suicidal thoughts ..... ○ Yes ○ No	
Auditory/visual hallucinations ..... ○ Yes ○ No		Eating disorder ..... ○ Yes ○ No	

Neurologic

Numbness or tingling in hands or feet . ○ Yes ○ No		Memory loss ..... ○ Yes ○ No	
Difficulty balancing / frequent falls ..... ○ Yes ○ No		Fainting ..... ○ Yes ○ No	
Tremor ..... ○ Yes ○ No		Seizures ..... ○ Yes ○ No	
Pain ..... ○ Yes ○ No		Dizziness ..... ○ Yes ○ No	

Patient Name: _____

Endocrine

Heat intolerance	O Yes	O No	Excessive thirst	O Yes	O No
Cold intolerance	O Yes	O No	Frequent urination	O Yes	O No

Eyes

Flashes of light in visual field	O Yes	O No	Decreased vision	O Yes	O No
Floaters in visual field	O Yes	O No	Blurred vision	O Yes	O No
Elevated pressure	O Yes	O No	Dry eyes	O Yes	O No

Ear / Nose / Throat

Decreased hearing	O Yes	O No	Dry mouth	O Yes	O No
Ringing in the ears	O Yes	O No	Difficulty swallowing	O Yes	O No
Ear pain	O Yes	O No	Sore throat	O Yes	O No
Sinus pain or infection	O Yes	O No	Swollen glands	O Yes	O No

Allergy

Itching	O Yes	O No	Sneezing	O Yes	O No
Hives	O Yes	O No	Watery eyes	O Yes	O No

Respiratory

Wheezing	O Yes	O No	Dry cough	O Yes	O No
Shortness of breath at rest	O Yes	O No	Productive cough	O Yes	O No
Shortness of breath with exertion	O Yes	O No	Bloody cough	O Yes	O No

Cardiovascular

Shortness of breath when lying flat	O Yes	O No	Chest pain at rest	O Yes	O No
Irregular heartbeat	O Yes	O No	Chest pain with exertion	O Yes	O No
Palpitations	O Yes	O No	Ankle swelling	O Yes	O No

Peripheral Vascular

Decreased sensation in hands or feet	O Yes	O No	Foot or leg ulcers	O Yes	O No
Cold hands or feet	O Yes	O No	Leg pain when walking	O Yes	O No

Breast

Breast pain	O Yes	O No	Skin redness	O Yes	O No
Nipple discharge	O Yes	O No	Enlarged lymph nodes	O Yes	O No
Nipple retraction / inversion	O Yes	O No	Breast lump	O Yes	O No

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Patient Name: _____

Gynecologic

Hot flashes	O Yes O No	Irregular periods	O Yes O No
Vaginal discharge / itching	O Yes O No	Missed periods	O Yes O No
Vaginal bleeding between periods	O Yes O No	Heavy periods	O Yes O No
Painful intercourse	O Yes O No	Painful periods	O Yes O No

Gastrointestinal

Heartburn / indigestion	O Yes O No	Constipation	O Yes O No
Nausea	O Yes O No	Diarrhea	O Yes O No
Abdominal pain	O Yes O No	Blood in stool	O Yes O No
Vomiting	O Yes O No	Rectal bleeding	O Yes O No

Urinary

Urinary incontinence	O Yes O No	Blood in urine	O Yes O No
Change in force of stream	O Yes O No	Painful urination	O Yes O No

Hematology (Blood)

Easy bruising	O Yes O No	Prolonged bleeding	O Yes O No

Musculoskeletal

Painful joints	O Yes O No	Leg cramps	O Yes O No
Swollen joints	O Yes O No	Muscle aches	O Yes O No

OB/Gyn History

Age at first menstrual period _____

Date of last menstrual period _____

Birth control pills used O Yes O No

If yes, number of years _____

Hormone replacement therapy used O Yes O No

If yes, number of years _____

Total pregnancies _____

Number of live births _____

Number of miscarriages _____

Number of abortions _____

Number of C-Sections _____

Number of ectopic pregnancies _____

Age when first child was born _____

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Patient Name: _____

Medical History

For **Medical History**, please indicate if you have ever been diagnosed with or treated for any of the following conditions.

	Yes		Yes
Asthma	O	Carpal tunnel	O
Bronchitis	O	Sleep apnea	O
Hyperthyroidism	O	Kidney stones	O
Hypothyroidism	O	Kidney disease	O
Tuberculosis	O	Autoimmune disorder	O
Thrombosis / Blood Clots	O	HIV/AIDS	O
Varicose veins	O	Lupus	O
Diabetes, type I (insulin dependent)	O	Hepatitis B	O
Diabetes, type II (non-insulin dependent)	O	Hepatitis C	O
Heart murmur	O	Mitral valve prolapse	O
Hypercholesterolemia / high cholesterol	O	Atrial fibrillation	O
Hypertension / high blood pressure	O	Congestive heart failure	O
Coronary artery disease / angina	O	Stroke	O
Abnormal pap smear	O	Ovarian mass	O
Abnormal uterine bleeding	O	Pelvic organ prolapse	O
Arthritis	O	Osteoporosis	O
Rheumatoid arthritis	O	Gout	O
Neurologic disorder	O	Multiple sclerosis	O
Anxiety disorder / panic attacks	O	Alcohol abuse	O
Schizophrenia	O	Drug abuse	O
Depression / mania / bipolar disorder	O		

Other diagnosed conditions:

Preventive Health (indicate date of last screening)

	Date (Mo/Yr)		Date (Mo/Yr)
Pap smear	_____	Bone Density	_____
Mammogram	_____	Cholesterol measurement	_____
Colonoscopy	_____		

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Patient Name: _____

Social History

Alcohol Consumption

Frequency ..... O Less than 1 drink per week O 2-3 drinks per week
O 1 drink per day O 2 or 3 per day O More than 3 per day

Tobacco Use

Do you smoke? .....O Yes O No Cigarettes per day? _____

Hospitalizations and Surgeries

Month / Year	Reason

Allergies (including lidocaine, other topical anesthetics, horse serum)

Substance	Reaction

Current Medications (including over-the-counter meds, vitamins, nutritional supplements)

Name	Strength	Qty	Frequency	Start Date	Stop Date

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Patient Name: _____

Family Medical History

Family Members		Status (A / D / U) Alive, Deceased, Unknown	Family History Age at which member was diagnosed: Breast cancer	Ovarian cancer	Uterine cancer	Colon cancer	Prostate Cancer	Stomach cancer	Pancreatic cancer	Melanoma	Heart disease	High blood pressure	Diabetes	Other
Example		*A*	*62*									*51*		*Lymphoma (68)*
Paternal Family	Father			n/a	n/a									
	Grandfather			n/a	n/a									
	Grandmother						n/a							
	Aunt						n/a							
	Uncle			n/a	n/a									
Maternal Family	Mother						n/a							
	Grandfather			n/a	n/a									
	Grandmother						n/a							
	Aunt						n/a							
	Uncle			n/a	n/a									
Personal	Self						n/a							
	Sister						n/a							
	Brother			n/a	n/a									

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☐ Mammogram ☐ Ultrasound ☐ Procedure ☐ Provider ☐ DEXA

Los Angeles Center for Women's Health
Mammography Questionnaire (Please complete highlighted areas)
Cuestionario de Mamografía (Por favor complete el área resaltada)

Patient's Name *(Nombre de Paciente)*	Date of Birth *(Fecha de nacimiento)*
Home Phone *(Teléfono de casa)*	Cell Phone *(celular)*
Address *(Dirección)*	Primary Language *(Idioma primario)* English / Español / Other
City, State, Zip *(Ciudad, Estado, Código postal)*	Referring Physician *(Medico Remitente)*

Prior Imaging Information *(Información de Imágenes anterior)*

First Mammogram? *(Primera Mamografía?)* Yes *(Si)* No *(No)*	If No, when and where did you have your last Mammogram? *(Si no, cuando y adonde fue su última mamografía?)* Date *(fecha)*_____ Location *(Lugar)*_____
Did you bring films with you today? *(Trajo su placas hoy?)*	Yes *(Si)* No *(No)*
If no, please sign a release of records so we can request these films *(Si no, favor de firmar un autorización de uso o divulgación de información privada de salud para solicitar sus imágenes.)*	*Films requested* _____

Patient History Information *(Informacion de historia de el paciente)*

Personal History of Breast Cancer? Yes *(Si)* No *(No)* *(Ud. Ha tenido cáncer en el seno?)*	Right *(Derecho)* _____ Left *(Izquierdo)* _____	Age at diagnosis? *(Edad de diagnóstico?)* _____
Personal History of Breast Biopsy? Yes *(Si)* No *(No)* *(A Ud. le han hecho una biopsia en el seno?)*	Right *(Derecho)* _____ Left *(Izquierdo)* _____	Diagnosis? *(Diagnostico?)*
Family History of Breast Cancer? Yes *(Si)* No *(No)* *(Alguien en su familia con cáncer en el seno?)*	If yes, who? *(Si si, quien?)* _____	Age at diagnosis? *(Edad de diagnóstico?)* _____
When was your last menstrual period? *(Fecha de última menstruación?)* _____	Late Child Bearing (after 30)? Yes *(Si)* No *(No)* *(Maternidad tardía después de los 30 años?)*	
History of Endometrial Cancer? Yes *(Si)* No *(No)* *(Ud. ha tenido cáncer endometrial?)*	History of Ovarian Cancer? Yes *(Si)* No *(No)* *(Ud. ha tenido cáncer en los ovarios?)*	
Estrogen Usage? Yes *(Si)* No *(No)* *(Ud. usa estrógeno?)*	Hormonal Contraceptives Usage? Yes *(Si)* *(No)* *(Ud. use anti conceptúas hormonales?)*	
Progesterone Usage? Yes *(Si)* No *(No)* *(Ud. usa progesterona?)*	*Tamoxifen Usage* Yes *(Si)* No *(No)* *(Ud. usa Tamoxifen?)*	

Reason for Today's Exam

☐Annual Screening (No new problems) ☐ Diagnostic

I attest that the information I have provided on this form is true to the best of my knowledge.
(Testifico de que la Information que he proporcionado en este formulario es verdadera de lo major de mi conocimiento.)

Patient's Signature _____ **Date** _____
(Firma del paciente) ***(Fecha)***

Technologist Performing Exam _____ Date _____ CAD: Yes / No

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Patient Label (CHMC use only)

Demographics/Registration

Today's Date: _____

Full Legal Name: _____
First Middle Last

Mailing Address - Street: _____

City: _____ State: _____ Zip: _____

Home Address (if different from mailing address) – Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Contact #: _____

Date of Birth: _____ Social Security: _____

E-mail Address: _____

Primary Language: _____ Interpreter Needed? ☐ Yes ☐ No

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Native American ☐ _____

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed ☐ Domestic Partner

Place of Birth: _____ Religious preference: _____

Primacy Care Physician's First & Last Name: _____

Primacy Care Physician's Phone: _____ City: _____

Preferred Pharmacy Name: _____ Phone: _____

Pharmacy Street Address: _____ City: _____

Advance Directive

An advance directive is a document or documentation allowing you to give directions about future health care or to designate another person(s) to make health care decisions if you lose decision-making capacity.

☐ I have an advance directive. – Please bring a copy to your appointment so we have it on file.

☐ I do not have an advance directive, but I would like further information about completing one.

☐ I do not have an advance directive, and I decline to complete one at this time.

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Patient Label (CHMC use only)

Referral

How did you find out about our center? ☐ Insurance company ☐ Family/friend ☐ Radio

☐ Website/Facebook ☐ Newspaper ☐ Health event: _____

☐ Physician referral – First & Last Name: _____

Physician address: _____

Employment

☐ Employed ☐ Retired ☐ Unemployed ☐ Active Military

Patient's Employer: _____

Patient's Occupation/Title: _____

Insurance

Subscriber: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Parent

Subscriber Name (if not Self): _____

Subscriber's Employer (if not Self): _____

Name of Insurance Company: _____

Identification Number: _____ Group Number: _____

Insurance Type: ☐ Medicare ☐ PPO ☐ POS ☐ HMO ☐ Medi-Cal ☐ Other: _____

Emergency Contact

Contact Name: _____ Relationship: _____

Mailing Address – Street: _____

City: _____ State: _____ Zip: _____

Contact's Home Phone: _____ Contact's Cell Phone: _____