Patient Information

Patient ID: ____________________

Patient's Name _______________________________________ Date of Birth ______/______/______

Social Security Number ____________________ Email Address ________________________________

Ethnicity (please circle): Hispanic / Non Hispanic Race __________________________________

Primary Language ________________________ Primary Phone Number _________________________

Mailing Address ____

City ______________________________ State __________ Zip code _______________

Primary Health Insurance

Insurance Company Name ____

Identification #_________________________________ Group # _____________________________

Policy Holder's Name _______________________ D.O.B ____/____/___ S.S. # ________________

Relationship to Patient __________________________ Employer ______________________________

HIPAA

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Fox Valley Women & Children's Health Partners Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Signature of Patient/Parent or Legal Guardian: _________________________ Date: ________________

Release and Consent

I hereby authorize the physician's of Fox Valley Women & Children's Health Partners and staff under their direction to release all medical information including test results, regarding my collection and medical treatment to my primary care physician and/or insurance company. I understand that I am financially responsible for all medical charges, whether paid or not paid by insurance, and I hereby authorize the use of this signature on all insurance submission.

Signature of Patient/Parent or Legal Guardian: _________________________ Date: ________________

Advance Directive

I hereby acknowledge that I have received a copy of "Statement of Illinois Law on Advance Directives and DNR Orders".

Please check the statement that applies:

_____I have an Advance Directive and will be providing a copy to Fox Valley Women & Children's Health Partners

_____I do not have an Advance Directive

Signature of Patient/Parent or Legal Guardian: _________________________ Date: ________________

Patient ID _______________

Patient Name ______________________________________

Preferred Communication

Please initial next to your preferred form of communication:

_____Email: ______________________________ Add me to your mailing list: Yes No

_____Phone: Home _______________________

Cell _______________________

Work _______________________

Please list your preferred pharmacy:

Pharmacy Name: ____

Pharmacy Location and/or Phone Number: _________________________________

Check the box next to your preferred communication for the following:

Detailed Messages

Home Cell Work Email Never Leave a Message

Lab Results

Home Cell Work Email Never Leave a Message

Prescription Information

Home Cell Work Email Never Leave a Message

Clinical Summaries

Mail to Home Email Do Not Send

Please list any person or persons with whom we MAY discuss care with or leave detailed messages including lab results:

Name	Relation
____________________________________	____________________________
____________________________________	____________________________
____________________________________	____________________________

Answering machines and voicemail must have an identifying message to confirm these are your numbers. Example: "You have reached Mary Smith".

Signature of Patient/Parent/Legal Guardian: ___________________________ Date: __________________

Fox Valley WOMEN & CHILDREN'S HEALTH PARTNERS

Thank you for choosing Fox Valley Women & Children's Health Partners as your health care provider.
We are committed to your treatment being successful and to a long-term relationship with you.
Please understand that payment of your bill is considered a part of your treatment.

The following is a statement of our Financial Policy, please review and initial each section.

______**Things to bring with you to EACH appointment:**

- Health Insurance Card
- Drivers License
- Method of Payment

______**Appointments:**

- Please inform the receptionist of any demographical changes (e.g. phone number, address, email, etc) or financial changes (e.g. insurance information, etc). Failure to notify us immediately of changes in demographical or financial information may result in denial of your medical claim(s) by your insurance provider, thus increasing your financial responsibility for any services provided by our practice.
- It is your responsibility to verify that the physician you are seeing is currently participating with your insurance plan and that you have obtained all necessary referrals BEFORE your scheduled appointment. Failure to confirm this may result in your responsibility for any and all charges.
- **24 hours notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a cancellation fee charged to the patient.**

______**Minor Patients:**

- The parent(s) or guardian(s) accompanying a minor are both responsible for providing current insurance information for the minor; as well as, payment of any copay or balance due.
- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment.

______**Medicare / Medicaid Patients:**

- Medicare requires that we provide patients with a written notification (Advance Beneficiary Notice) whenever it is likely that you will be responsible for a bill.
- **Medicaid/ IDPA Patients MUST bring a current insurance card each visit**. Failure to present a current insurance card at check-in may result in rescheduling of the appointment.

______**Lab / Hospital Charges:**

- Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with lab or hospital charges should be directed to and resolved by the lab or hospital; dispute resolution is not the responsibility of our practice.

______**Insurance:**

- It is the patient's responsibility to understand their insurance coverage.
- Your insurance coverage and benefits are a contract between you and your insurance company; therefore, all disputes must be handled between you and your insurance.

Effective as of January 1st, 2012

Fox Valley
WOMEN & CHILDREN'S
HEALTH PARTNERS

______**Payment in full is due at the time services are rendered:**

- Co-pays and all non-covered services are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment may result in your appointment being rescheduled.
- Past due balance's are required to be paid prior to any further services provided by our office unless other arrangements have been made with our Patient Financial Services Department. Failure to pay any past due balances will result in restricted services for you and your family.

______**Payment Plans:**

- In certain cases, our practice will consider establishing a structured payment plan. Each case is reviewed individually to determine eligibility and establishment of a structured payment plan and is at the sole discretion of the practice.
- Please contact our Patient Financial Services team to have your case considered for a structured payment plan.

______**Collections and Outstanding Balances:**

- Delinquent accounts may be placed with a collection agency and may be subject to legal action. In the event that your unpaid balance is turned over to a collection agency for recovery or legal action is warranted, collection and attorney fees; as well as, court costs will be added to your balance.
- Returned checks will incur a $25.00 service fee.

______**Disability, FMLA, School, Camp and Sports forms**

- Completion of Disability or FMLA forms will incur a fee of $25.00 for EACH completed form.
- Completing a School, Camp, or Sports form **separate from an office visit** will incur a fee of $25.00 per form.

_______**Medical Records (paper copy or electronic copy)**

- If a paper copy is requested, the following fees will be incurred: a $25.55 handling fee, plus a per page fee as follows: $0.96 for pages 1-25, $0.64 for pages 26-50 then $0.32 per page for each page over 50. These fees are the responsibility of the patient. Within 10 business days of payment receipt, a paper copy will be provided.
- If an electronic copy is requested, the following fees will be incurred: a $25.55 handling fee, plus a per page charge of 50% of the per page charge for paper copy. Within 3 business days of payment receipt, an USB will be provided.

Our Patient Financial Services office is open Monday–Thursday 8am to 5pm & Friday 8am to 4pm

As a courtesy to our patients, we accept Visa, MasterCard, Discover, and American Express

Please sign below to confirm that you have read and understand the Financial Policy that has been provided to you by Fox Valley Women & Children's Health Partners.

Signature ______________________________ **Date** ____________________

Effective as of January 1st, 2012

3310 W. Main St., Ste. 200, St. Charles, IL 60175 • 82 Miller Dr., Ste. 102, North Aurora, IL 60542 • Phone: 630.897.6044
fvwchp.com • facebook.com/fvwchp • twitter.com/fvwchp

HIPAA Notice of Privacy Practices

Effective as of April/14/2003

Fox Valley Women and Children's Health Partners

3310 W. Main St. Suite # 200
St. Charles, IL. 60175

Office Locations

82 Miller Rd. Suite #102
North Aurora, IL. 60542

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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

HIPAA

Patient Name:	**Date of Birth:**	**Today's Date:**
Mother: Living__ Deceased / Cause_______ Age___	**Father**: Living___ Deceased / Cause________ Age____	
Siblings: Number Living____ Number Deceased____ Cause(s) / AGE ____		

Medical History	**Patient**	**Family Member**	**NOTES**
Asthma			
Alcohol / Drug Problems			
Alzheimer's Disease			
Anemia			
Arthritis / Joint Pain / Back Problems			
Autoimmune Disease			
Blood Clots in Lungs or Legs			
Blood Transfusions			
Bowel Problems			
Broken Bones			
Cancer: Breast			
Cancer: Colon			
Cancer: Ovarian			
Cancer: Uterine			
Cancer, Type:			
Chickenpox			
Depression / Anxiety / Mental Illness			
Diabetes			
Eating Disorders			
Fibroids			
Headaches			
Heart Attack / Heart Disease			
Hepatitis / Yellow Jaundice			
High Blood Pressure			
High Cholesterol			
HIV /Aids			
Infertility			
Kidney Infections /stones			
Liver Disease			
Osteoporosis			
Prolactinoma			
Reflux / Hiatal Hernia / Ulcer			
Seizures / Convulsions / Epilepsy			
Sexually Transmitted Infections			
Stroke			
Thyroid Disease			
Tuberculosis			
Genetic Syndromes	**Family Member**	**Genetic Syndrome**	**Family Member**
DownSyndrome		Thalasemia	
Tay Sachs		Trisomy	
Sickle Cell Anemia		Cystic Fibrosis	
OTHER			

Patient Name:	Date of Birth

*****Operations /Procedures / Hospitalizations*****

Date	Reason	Provider / Facility

*****Current Medications*****

Include Hormone, Vitamin ,Herb and non-prescription medication

Medication Name	Dose	Prescriber	Medication Name	Dose	Prescriber

*****Allergies*****

Medication:	Betadine Y N	Penicillin Y N
Food:	Shell Fish Y N	EGGS Y N
Environment:		LATEX Y N

Reproductive History: *** All Patients please answer the following 2 questions:**

Number of Vaginal Deliveries: ______ Number of Cesarean Sections______

****If you are still within childbearing years please complete information below** :

Gestational Diabetes YES NO	High Blood Pressure Yes No	Postpartum Depression Yes No	Complications…

Pregnancies	Full Term	Preterm	Abortions	Miscarriage	Multiple	Live Births	Living Children

If you are still within childbearing years please complete information below :

No.	Birth Date	Wight at Birth	Male / Female	Weeks of Pregnancy	Type of Delivery	NOTES

Patient Name:	Date of Birth:
Gynecologic History:	

Are you still getting Menstrual Periods? YES NO

IF you Answered **YES** please answer the questions in this column	IF you answered **NO** please answer the questions in this column
What was the first day of your last menstrual period? __/__/__	When was your last menstrual period… # of years, year or month…
Age Periods began ____	Age of Menopause onset__________
Length of Periods. #_______________ days	Do you take Hormone Replacement? YES NO
Flow: Circle one Light Medium Heavy	Any vaginal bleeding since menopause? YES NO
Pain with Menstruation? YES NO	Do you experience vulvar itching? YES NO
Any irregular bleeding patterns YES NO	

*******CONTRACEPTION*******

1. Current form of birth control (circle)

PILL	IUD	Nuvaring	Depo Provera	NONE	Tubal Ligation	Essure or Adiana	Vasectomy

2. How long have you been using your current birth control? (circle)

Two or less years	3 to 5 years	6 to 10 years	Over 10 years

3. Are you planning another pregnancy? (circle)

Within the next year.	Within the next 5 years.	Within the next 10 years.	My family is complete.

Urinary Health

1.	Do you ever leak urine when you cough, laugh or sneeze?	YES	NO
2.	Do you ever feel as though you have to urinate urgently?	YES	NO
3.	Do you feel like you have to urinate too frequently ?	YES	NO
4.	Do you ever experience painful urination?	YES	NO

HEALTH CARE MAINTENANCE		**Immunizations**	
Pap Smear		Flu Shot	
Dexascan (>age 60)		Tetanus-Diptheria-Pertusis Booster	
Colonoscopy (>age50)		Hepatitis A Vaccine	
Mammogram(>age 40)		Hepatits B Vaccine	
Cholesterol (>age 45)		Varicella Vaccine (chickenpox)	

Social History

Primary Care Physician		Tobacco Use	Never	Former	Current
Occupation			Age Onset		
Highest Level of Education			Packs per Day		
Marital Status		Illicit Drug Use	Never	Former	Current
Sexually Active			Age Onset		
Sexual Preference			Type		
Lifetime Partners	>5 OR <5	History of sexual Abuse		YES	NO
		History of Domestic Violence		YES	NO
		History of Emotional Abuse		YES	NO

Fox Valley WOMEN & CHILDREN'S HEALTH PARTNERS
committed to providing full circle quality care

Name: ____ DOB___/___/____

What is the reason for this visit? Incontinence Pain Prolapse

Have you had previous treatments for this problem? Yes No

Previous treatments include: Medication Physical Therapy Surgery
Dates and treatment:
____

Please list the names of other physicians you have seen for this problem:

____

Urinary Function Questionnaire:

Do you have to empty your bladder frequently?	NO	YES
How Often Every Hour	Every 1-2 hours	Every 2-3 hours
Does the sound or sight of running water cause you to lose urine?	NO	YES
If your bladder is full, do you have to run to the nearest bathroom?	NO	YES
Do you ever leak urine when trying to reach the bathroom?	NO	YES
Amount: SMALL LARGE	AVERAGE	VARIES
Do you get up during the night to urinate?	NO	YES
Do you lose urine when resting (just lying or sitting)	NO	YES
Do you lose urine during sexual activity?	NO	YES
Do you have pain with sexual intercourse?	NO	YES
Do you lose urine without being aware it is passing?	NO	YES
Do you lose urine during coughing, sneezing, laughing or lifting?	NO	YES
Do you lose urine when you are walking?	NO	YES
Do you lose urine if you suddenly stand up from a sitting position?	NO	YES
When you are urinating, can you usually stop the flow?	NO	YES
Do you have the feeling your bladder is not empty after you urinate?	NO	YES
Do you have to strain or push to empty your bladder?	NO	YES
Is it usually painful or difficult to pass your urine?	NO	YES
Do you have pain when your bladder is full?	NO	YES
Do you have burning during or after urination?	NO	YES

Fox Valley WOMEN & CHILDREN'S HEALTH PARTNERS
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Have you had multiple urinary tract infections?	NO	YES
Is you urine ever bloody?	NO	YES
Do you have pain with bowel movements?	NO	YES
Do you have a problem controlling bowel movements?	NO	YES
Do you have a problem controlling gas from the rectum?	NO	YES
Do you have a problem with constipation?	NO	YES
Do you find it necessary to wear protection because you get wet?	NO	YES

Quality of Life Questionnaire

Has urine leakage or prolapse affected the following:	Not at all	Slightly	Moderately	Greatly
Ability to do chores such as cooking, cleaning, or laundry?	Not at all	Slightly	Moderately	Greatly
Activities such as walking, swimming or other exercise?	Not at all	Slightly	Moderately	Greatly
Entertainment (movies, concerts, etc)?	Not at all	Slightly	Moderately	Greatly
Ability to travel by car or bus?	Not at all	Slightly	Moderately	Greatly
Social activities outside your home?	Not at all	Slightly	Moderately	Greatly
Emotional health (nervousness, depression)?	Not at all	Slightly	Moderately	Greatly
How much are you bothered by the following?				
Feeling frustrated?	Not at all	Slightly	Moderately	Greatly
Frequent urination?	Not at all	Slightly	Moderately	Greatly
Urine leakage with physical activity, coughs, or sneezes?	Not at all	Slightly	Moderately	Greatly
Small amounts of urine leakage (drops)?	Not at all	Slightly	Moderately	Greatly
Difficulty emptying your bladder?	Not at all	Slightly	Moderately	Greatly
Pain in the lower abdominal or genital area?	Not at all	Slightly	Moderately	Greatly

ALLERGIES

NO KNOWN DRUG ALLERGIES

LATEX BETADINE Other________________________