



Last Name: _____ **First Name:** _____ **Middle:** _____

Nickname/Preferred Name: _____ **Date of Birth:** _____

Social Security # _____ **Preferred Service location:** Downtown or Northbrook

Race: (circle one below)

- American Indian/Alaska Native
- Asian
- Black/African American
- Declined
- Native Hawaiian/Pacific Islander
- Other Race
- White/Caucasian

Ethnicity: (circle one below)

- Declined
- Hispanic or Latino
- Not Hispanic or Latino

Marital Status: (circle one below)

- Single
- Married
- Widowed
- Divorced
- Other

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
(please circle which number you prefer as your primary number)

Email Address: _____

Preferred Pharmacy Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

How were you referred to our office? i.e., Patient (name) _____,
facility (full name) _____, **physician (first last name)** _____,
social media (which one) _____

Employer Information:

Name: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Position: _____ **Status:** Full-Time Part-Time **Employer Phone:** _____

Emergency Contact: **Relationship:** _____

Name: _____ **Phone #:** _____ **D.O.B#:** _____

Insurance Information:

Primary Insurance Plan: _____ **Policy #:** _____

Group # (if applicable): _____

Policy Holder's Information (if different from the Patient): Relationship: _____

Last Name: _____ **First Name:** _____ **Middle:** _____

D.O.B.# _____

If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 26% of your outstanding balance, a \$35 account placement fee, court costs and attorney fees.

I hereby authorize The Women's Group of Northwestern to furnish information to my insurance carriers concerning my treatment and illness, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance(s).

SIGNATURE (Patient and/or guardian, if minor): _____ **DATE:** _____

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OBSTETRICS AND GYNECOLOGY

WWW.WOMENOBGYN.NET

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CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

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

I, _____, hereby give my consent to The Women's Group of Northwestern
(Name of Patient or Authorized Agent)

to use and disclose, for carrying out **treatment, payment, or health care operations (TPO)**, all information contained in the patient record of _____.
(Patient's Name)

With this consent, the Women's Group of Northwestern may mail to my home or alternative location, email and/or text my items that assist the practice in carrying out TPO, such as appointment reminder, lab result notifications and patient statements, as long as they are marked Personal and Confidential. The Women's Group of Northwestern may also retrieve any personal health information that relates to my prescription history. I understand that if information is emailed or sent via text message, there may be some level of risk that this information could be read by an unauthorized party. By providing my mobile telephone number and email address, I am accepting the risks and authorizing the Women's Group of Northwestern, its physicians and staff to communicate with me electronically about my care including normal lab results and appointment reminders, account, service, surveys, new services offered and/or education. I will be provided the option to "Opt Out" on each text and automated email I receive.

By signing this form, I am consenting to the Women's Group of Northwestern use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Women's Group of Northwestern may decline to provide treatment to me. **My current email to be used is:** _____.

I am giving authorization to leave a detailed message on the following numbers, if email or text message fails:
YES NO

Cell Phone#: _____ Home Phone #: _____ Work Phone#: _____

Signature: _____ Date: _____

AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

I authorize the Women's Group of Northwestern to release protected health information to my family member(s) listed below:

<u>Name</u>	<u>Relationship</u>	<u>Contact Number</u>
_____	_____	(____) _____ - _____

_____	_____	(____) _____ - _____
Signature: _____		Date: _____

PHARMACY UPDATE:

Preferred Pharmacy Name: _____ Phone Number (____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

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INSURED PATIENTS

As of January 1st, 2015, The Women's Group of Northwestern will no longer bill for pap smears and pathology specimens. Pap smears will be billed through Health Lab and pathology will be billed through Northwestern Memorial Hospital unless your insurance dictates otherwise. Your insurance will be billed directly from the lab Health Lab or Northwestern Memorial Hospital. Any outstanding payments concerning pap smears or pathology will be between you and the lab. The Women's Group of Northwestern will charge a lab specimen handling fee in the amount of **\$30.00** for all specimen handling.

Our office uses a liquid based system for pap smears called Thin Prep. Studies have shown it to be more effective than the conventional Pap smear test.

Questions about your bill or fees may be directed to the following:

Health Lab	630-777-0851
Northwestern Memorial Hospital	(312) 926.6900

We appreciate your understanding and we are sorry for any inconvenience.

HPV Typing

I have read the information above. I hereby give consent to receive the Thin Prep test with HPV typing if deemed necessary by my physician. I understand that I am responsible for payment if my insurance neglects to pay or if the claim reaches 30 days or over. I also understand that if the Women's Group of Northwestern does not participate with my insurance plan, then payment is due at the time of service.

Signature: _____ Date: _____

CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name: _____

Account Number: _____ Today's Date _____

Date of Birth: _____ Age: _____

Provider You are Seeing Today: _____

INSTRUCTIONS: Screening Questionnaire for the Common Features of Hereditary Cancers

Please circle Yes, No or Unknown (Y, N, U) if there is a **PERSONAL OR FAMILY** history of any of the following cancers. For this section include close relatives including yourself, mother, father, siblings, children, aunt, uncle, grandparents, niece, or nephew. **DO NOT** include cousins or great relatives.

Breast and Ovarian Cancer Family History				Mother's Side of Family	Age at Diagnosis	Father's Side of Family	Age at Diagnosis
<input checked="" type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	EXAMPLE: Do you have a close relative diagnosed with breast cancer before age 50?	Grandmother	41	Aunt	37
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Have you or a close relative ever been tested for BRCA or other genetic mutations for a hereditary cancer syndrome? Who: (self/maternal/paternal) _____ Results _____ Year _____				
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a close relative diagnosed with breast cancer before age 50 ?				
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a close relative diagnosed with ovarian (peritoneal/fallopian tube) cancer at any age ?				
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have TWO close relatives on the same side of the family diagnosed with breast cancer, one before age 50 ?	1. 2.		1. 2.	
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have THREE relatives on the same side of the family diagnosed with breast cancer, pancreatic, or aggressive prostate cancer* at any age? (*Gleason score greater than or equal to 7)	1. 2. 3.		1. 2. 3.	
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have Pancreatic cancer or aggressive prostate cancer and one relative with breast cancer at age 50 or younger?				
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a close relative diagnosed with multiple breast cancers in the same or both breasts?				
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a close MALE RELATIVE diagnosed with breast cancer?				
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Are you of Ashkenazi Jewish ancestry AND have any family member with breast, pancreatic, or ovarian cancer?				
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a relative with Triple Negative Breast cancer at age 60 or younger?				

Colon and Endometrial (Uterine) Cancer Family History				Mother's Side of Family	Father's Side of Family	Age at Diagnosis
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have two close relatives on the same side of the family (can include yourself): at least one diagnosed with colon or endometrial (uterine) cancer at any age AND ALSO one diagnosed before age 50 with a Lynch-associated cancer *?	1. 2.	1. 2.	
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have three relatives on the same side of the family diagnosed with a Lynch-associated cancer at any age, with at least 1 being colon/rectal or uterine cancer?	1. 2. 3.	1. 2. 3.	
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a relative diagnosed with colon/rectal or uterine cancer before age 50?			
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a relative/self with 20 or more colon/rectal polyps found throughout their lifetime. Specify number _____			
<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> U	Do you have a personal history of endometrial (uterine) cancer at any age?			

* Lynch-associated cancers include: colon, endometrial (uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).

List **ANY OTHER** cancer in your family that is not listed above? Include any **3rd DEGREE RELATIVES HERE**: COUSINS, GREAT GRANDPARENTS, GREAT AUNTS/UNCLES

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Confidential Agreement Regarding a Minor

Parent

I, _____ (parent or guardian), will allow my daughter, _____ (patient), to enter a confidential patient –physician relationship. I understand that my daughter can make independent health care decisions, but that my input and involvement will be encouraged.

My daughter has permission to schedule appointment and receive confidential reports from this office. I further understand that various laboratory test may be necessary in medical protocols and accept responsibility for physician charges and laboratory fees.

Parent or Guardian Signature

Date

Patient

I, _____ (patient) am entering a confidential physician-patient relationship with _____ (physician). I will make an effort to communicate with my parent(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the healthcare recommendations my physician and I establish.

Patient Signature

Date

Physician Signature