The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

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:_____

The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

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:

Name	**Relationship**	**Contact Number**
_____	_____	(____) _____-_____
_____	_____	(____) _____-_____

Signature: _____ Date: _____

PHARMACY UPDATE:

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

Address: _____ City: _____State: _____ Zip: _____

The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

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	**(855) 694-2866**
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: _____

737 N. Michigan Avenue Suite 600, Chicago, IL 60611 - 312.440.3810 Main/312.440.1572 Fax
40 Skokie Blvd, Suite 550, Northbrook, IL 60062 - 847.291.3999 Main/847.400.4081 Fax

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
(Y)	N	U	**EXAMPLE:** Do you have a close relative diagnosed with breast cancer before age 50?	**Grandmother**	**41**	**Aunt**	**37**
Y	N	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_____				
Y	N	U	Do you have a close relative diagnosed with breast cancer **before age 50**?				
Y	N	U	Do you have a close relative diagnosed with ovarian (peritoneal/fallopian tube) cancer **at any age**?				
Y	N	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.	
Y	N	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.	
Y	N	U	Do you have Pancreatic cancer or aggressive prostate cancer and one relative with breast cancer at age 50 or younger?				
Y	N	U	Do you have a close relative diagnosed with **multiple breast cancers** in the same or both breasts?				
Y	N	U	Do you have a close **MALE RELATIVE** diagnosed with breast cancer?				
Y	N	U	Are you of Ashkenazi Jewish ancestry **AND** have any family member with breast, pancreatic, or ovarian cancer?				
Y	N	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
Y	N	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.	
Y	N	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.	
Y	N	U	Do you have a relative diagnosed with **colon/rectal or uterine cancer** before age 50?				
Y	N	U	Do you have a relative/self with 20 or more colon/rectal polyps found throughout their lifetime. Specify number_____				
Y	N	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

_____

_____

_____

The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

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

The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

THE WOMEN'S GROUP OF NORTHWESTERN, S.C.

VISITOR WAIVER

This waiver is required for patients and any visitors to The Women's Group of Northwestern, S.C.

The Practice has implemented policies and procedures which are intended to reduce the possible transmission of the COVID-19 virus to our staff, patients and visitors. These policies and procedures are based upon, and are intended to comply with, guidance provided by the Federal and State governments, as well as by the American Medical Association. We expect and appreciate your full and complete cooperation and compliance with these measures as they are intended to safeguard everyone's health and well-being. If you refuse to comply with our policies, we may not be able to complete or continue treatment of the patient you have accompanied and may ask you to leave the Practice office.

There is no guarantee that, despite our best efforts, the policies and procedures we have implemented will be effective to prevent a patient, staff member or visitor to our office, from being exposed to or contracting the virus. Accordingly, by signing where indicated below, you acknowledge and confirm your understanding and agreement that by coming to our office you have knowingly and voluntarily assumed this risk and you hereby release the Practice, its employees, owners, officers, directors and managers from any liability in the event that you contract the virus as a result of your visit to our office today. You agree that you understand the information herein and have been given the opportunity to ask related questions.

Date: _____, 2022.

_____
Signature

_____
Chart #

_____
Printed Name of Patient

_____
Printed Name of Visitor